



## STATE SCHIP PROGRAM DESIGN CHOICES MAY OFFER CRITICAL LESSONS FOR UPCOMING DEBATE ON MEDICAID REFORM IN THE 109<sup>TH</sup> CONGRESS

**Washington, D.C., February 10, 2005** – The majority of states that have implemented SCHIP as a separately-administered program have opted for benefit and coverage design in the case of early childhood preventive and developmental services that are considerably less comprehensive than the standard of coverage furnished to infants and young children under Medicaid. This is the central finding of a major new analysis of state pediatric coverage under Medicaid and the State Children’s Health Insurance Program (SCHIP), which appears in the latest issue of the *Journal of Health & Biomedical Law* of Suffolk University Law School. The Health Resources and Services Administration, Commonwealth Fund, and David and Lucile Packard Foundation provided financial support for the research.

The study’s findings come at a particularly important time in federal child health policy, as Congress and the Administration consider whether to grant states added flexibility in designing the coverage components of their Medicaid programs. Medicaid coverage standards for near-poor children, whose entitlement to Medicaid is considered “optional,” could be affected by proposals that would provide states with additional flexibility to curb benefits in the case of “optional” Medicaid eligibility categories. These findings are also important for informing future generations of SCHIP contracts as administration officials expressed hope to “build on the success” of SCHIP. As a program that offers states more discretion over coverage, SCHIP’s experience to date offers important insights into how states might use this added authority to control access to child health benefits.

The GW study represents the culmination of a multi-year project, whose aim was to gain an in-depth understanding of state SCHIP implementation, especially in the case of children with special health care needs, and assess the implications of state choices. The study’s principal finding is that when states are given the flexibility to do so, they tend to reduce the level of coverage to that found in standard health insurance products, rather than the level of coverage that has been the hallmark of Medicaid since the 1967 enactment of the Medicaid Early and Periodic Screening Diagnosis and Treatment program (EPSDT). Added to Medicaid in response to widespread evidence of long-term health and developmental disabilities among low-income children, EPSDT provides both comprehensive coverage for preventive medical, dental, vision, and health care services, as well as extended coverage for children for whom sustained health care is necessary to ameliorate the effects of suspected physical and mental conditions. As a result, EPSDT covers services that commercial insurance typically excludes, such as comprehensive

developmental assessments, extended physical and mental health therapies, and other services not found in standard commercial insurance plans. EPSDT also utilizes a unique standard of medical necessity. This special medical necessity standard requires that states pay for health care interventions at the earliest possible juncture in order to promote growth and development, not merely “cure” illnesses.

The study’s principal findings are as follows:

- Despite the fact that, as a group, both poor and near-poor children experience heightened levels of functional impairments, SCHIP and Medicaid benefits differ significantly, in ways that cannot be explained by a markedly superior health status among near-poor children.
- Among the 35 separately-administered SCHIP programs studied that operate outside of Medicaid’s more comprehensive coverage rules and that contract with health plans to deliver services, all states cover basic well-baby and well-child care in their service agreements. Wide variation was found among states in their use of coverage standards that explicitly require participating health plans to cover child development services required under Medicaid, such as anticipatory guidance (18%), lead screening (43%), and comprehensive developmental assessments (68%). While at least a threshold level of anticipatory guidance would be part of any well-child encounter between a pediatric health professional and a parent or caretaker, this cannot be assumed for comprehensive developmental assessments and assessments of elevated levels of lead in children’s blood. This is because both interventions are relatively resource intensive and, in the case of developmental assessments, also time consuming from a pediatric practice standpoint.
- Only half of the states with separately-administered SCHIP managed care programs require participating health plans to employ a medical necessity standard that meets Medicaid’s comprehensive requirement that coverage be available to ameliorate the effects of physical and mental conditions. The other half uses definitions of medical necessity that are consistent with traditional commercial insurance principles and that permit insurers to limit coverage to treatments that focus on coverage on defined medical conditions and that can be expected to “restore” a child’s health to a level of “normal” functioning. Such a narrow standard would exclude many interventions necessary to help children with disabilities and delays attain more normal growth and development or avoid the loss of, or deterioration in, functioning.
- The standards used by SCHIP agencies contain significantly fewer contractual expectations related to continuity of care, coordination with early intervention services offered by other public agencies such as state maternal and child health agencies, and other outreach and child development activities.

Professor Sara Rosenbaum, who directed the overall study, noted, “These findings raise exceedingly important issues for low-income child health policy. Medicaid has played a historic and unique role in financing comprehensive health services to low-income children, whose growth and development – and school readiness and performance – ultimately hinge in great measure on early investment in highly enriched health services. Medicaid’s pediatric coverage design under EPSDT is one of the program’s hallmarks and for nearly 40 years, has clearly set the program apart from standard commercial product offerings. To the extent that Medicaid standards are revised – through §1115 waivers or legislation – to permit further movement toward commercial insurance limits for children, such a change in turn would raise major questions regarding how early intervention services will continue to be financed for children at risk.”

The *Journal of Health & Biomedical Law* article is titled “Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP.” Sara Rosenbaum, Anne R. Markus, and Colleen Sonosky are the study authors. The article is available from Lexis-Nexis and Westlaw (1 J. Health & Biomed. L. 1 (2004)) and from the authors upon request (202-530-2339; [armarkus@gwu.edu](mailto:armarkus@gwu.edu)). Policy briefs reporting on various aspects of the research discussed in the article are publicly available at <http://www.gwumc.edu/sphhs/healthpolicy/chsrp/chiri.html>.

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