



FAMILY COVERAGE MATTERS

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Differences that Make a Difference: Comparing Medicaid and the State Children's Health Insurance Program Federal Benefit Standards

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The principle that children ought to have access to the health care they need enjoys broad support. Consistent with this principle, Congress has long required states, as a condition of receiving federal Medicaid funding, to provide children with comprehensive coverage under their state Medicaid programs. This broad coverage standard is particularly important for Medicaid-eligible children whose health care needs are often greater than the norm and whose families' limited incomes make it difficult for them to afford care that Medicaid does not cover.

In the context of the federal budget debate, Congress is considering a proposal advanced by the National Governors Association to replace these rules for some children with a benefits standard modeled after the State Children's Health Insurance Program (SCHIP). This Issue Brief analyzes the profound differences between these two standards and the health care guarantees that children would lose if the Medicaid standard was replaced by SCHIP-like rules.

Key Findings

- **Medicaid's benefit guarantee for children (known as "EPSDT") is designed to assure access to care at a level that is consistent with each child's medical needs.** The Medicaid benefits standard, which is much stronger for children than for adults, requires state Medicaid programs to cover preventive care as well as all medically necessary services that a child has been determined to need.
- **Federal SCHIP standards are much weaker, permitting coverage that can be ill-suited for children with special health care needs and limited incomes.** Some SCHIP plans, for example, limit services like speech or physical therapy to situations where substantial improvement is expected within a short period of time, a standard that does not address the needs of children with ongoing developmental problems. One state reduced its mental health coverage for SCHIP children by half due to budget constraints, and some limit coverage for certain mental health conditions to 20 outpatient visits a year regardless of need. Well-child care must be provided under SCHIP, but routine dental, vision, and hearing care need not be covered.
- **Without strong federal Medicaid standards, fiscal pressures will result in wide variation, ending the national commitment that all children enrolled in Medicaid have access to comprehensive care.** The variation across states could be even greater than in SCHIP in part because SCHIP's higher federal matching rate is an incentive for states to provide broader coverage. Medicaid matching rates are not as favorable to states. Without strong federal standards, the progress that has been made to assure children access to the health care they need is likely to be reversed.

Introduction

Over the past four decades, the nation has made steady progress toward the goal of assuring that all children have access to the health care services they need. The Medicaid program is the backbone of this effort. Over time, federal Medicaid rules have been strengthened both to expand children's eligibility to coverage and to require that the coverage provided is comprehensive.¹ Children enrolled in Medicaid often have health care needs that exceed the norm,² and their families' limited incomes make it difficult for them to pay for care that is not covered by Medicaid. Although children enrolled in Medicaid still may have problems accessing care as a result of under funding or unnecessary red tape, the evidence is strong that children enrolled in Medicaid generally have access to the care they need.³

This longstanding commitment to children's coverage is at the center of the current debate over proposals to cut Medicaid spending and adopt major structural changes in program rules – a debate occurring in many states as well as in Congress. Prompted largely by state fiscal pressures, the National Governors Association (NGA) has proposed replacing the federal Medicaid benefit standard for some children with one that is modeled after the State Children's Health Insurance Program (SCHIP).⁴ The SCHIP standard would permit much more limited coverage than is now allowed under Medicaid. Some Congressional leaders are considering this proposal to meet federal spending reduction targets.

The outcome of this debate will have a huge impact on children. Some 28 million children – one out of four children in the nation-- are covered by Medicaid. More than one-fifth of these children would be subject to the weaker federal standard under the NGA proposal.⁵ Jointly funded by the federal government and the states, Medicaid covers very poor children as well as children in families with somewhat higher, but still quite limited, incomes. Its benefit standard for children is known as the "Early Periodic Screening Diagnostic and Treatment" ("EPSDT") benefit.

SCHIP is also jointly funded by the states and the federal government, although, unlike Medicaid, federal funding under SCHIP is capped. States can use SCHIP funds to cover additional children either by expanding Medicaid, creating a separate program, or combining the two approaches. If a state uses SCHIP funds to expand Medicaid, EPSDT rules apply. A different and more limited federal standard applies to separate SCHIP programs. In 2004, about four million children were covered through these separate SCHIP programs.⁶

Benefit Standards Compared

The federal Medicaid and SCHIP benefits standards set out the minimum level of health services that must be covered in order for a state to qualify for federal Medicaid or SCHIP matching payments. These standards determine, for example, whether a child enrolled in Medicaid or in SCHIP must be provided coverage for specialists, prescription drugs, laboratory tests, eye glasses and hearing aids. They also determine the scope of the services that will be covered – for example, whether coverage for hospital stays can be limited to a certain number of days per year or subject to a benefit cap as often occurs in private insurance policies. Federal benefits standards also set the framework for how state programs will determine whether a particular child will be provided a covered service, known as the “medical necessity” determination.

- **The services that must be covered**

Current Medicaid benefit rules for children are fairly straight forward. Under EPSDT, regular health, dental, hearing and vision screenings must be covered as well as any medical service that a child is found to need as long as it is the kind of service that Medicaid covers.⁷ These include hospital and clinic services, physician care, laboratory services, durable medical equipment (e.g., hearing aids, wheelchairs), and prescription drugs.⁸ EPSDT requires that all of these services be available if a child is found to need the service, even if the service is not covered for adults. A state, for example, need not cover speech therapy for adults enrolled in Medicaid but it must cover speech therapy for a child who needs that care.

Just as important, EPSDT requires that the scope of coverage for a particular service must be consistent with a child’s needs. If a state does cover speech therapy for adults it may limit the number of sessions it will cover, for example, to 10 or 15 sessions per year. However, if a youngster with a speech delay needs weekly sessions on an ongoing basis, that 10- or 15-session limit cannot be applied to that child. States may adopt procedures to review and determine

Medicaid is Particularly Important for Children with Special Health Care Needs

“Children with special health care needs” includes children with disabilities as well as chronic conditions with diagnoses as diverse as asthma, diabetes, developmental delays, and cancer. Estimates of the percentage of all children with special health care needs vary from 13 to 18.5 percent. One study found that one out of every five households with children had at least one child with special health care needs.

Medicaid is a particularly important source of coverage for these children. An estimated 29 to 38 percent rely on public insurance, with much higher rates of public coverage among low-income children with special health care needs. Comprehensive coverage is vital because of the range of their health care needs and the important role that timely, appropriate health care services can play in allowing children to reach and function at their greatest potential. One study, for example, found that children with special health care needs are almost three times as likely as other children to miss school because of illness.

Sources: Amy Davidoff, Urban Institute, *Insurance for Children with Special Health Care Needs: Patterns of Coverage and Burden on Families to Provide Adequate Insurance*, *Pediatrics*, August 2004; 394-402; Ha T. Tu, Peter Cunningham, Center for Studying Health System Change, *Public Coverage Provides Vital Safety Net for Children with Special Health Care Needs*, Issue Brief, No. 98, September 2005; Christie Provost Peters, *Children with Special Health Care Needs: Minding the Gaps*, National Health Policy Forum Background Paper, June 2005.

whether such care is necessary for a particular child (for example, through prior authorization procedures), but they may not apply across-the-board limits on children’s coverage.

Federal SCHIP rules do not require either the breadth or the scope of services that are guaranteed to children under Medicaid. The same types of services that must be made available to children under Medicaid may, but need not be covered through SCHIP. Well-child care, immunizations and emergency services are required to some degree, but coverage of other services is largely left to states’ discretion (Table 1). Texas offers a striking example of this flexibility. In 2003, Texas severely limited coverage of mental health services for all SCHIP children. (The cut that was recently restored by the Texas legislature.)

Federal SCHIP rules offer a rather complicated set of guidelines, but a close examination of the guidelines show that they provide little in the way of a solid, objectively defined benefit guarantee. Ultimately, a state or the Secretary of HHS can set the SCHIP benefit package for a state without reference to any independent, objective standard.⁹ (See Box, “Standards without a Standard,” page 5.)

Table 1

Medicaid and SCHIP: Services Covered and Service Limitations

	Medicaid	SCHIP	Examples Of SCHIP Exclusions and Limitations
What services must be covered?	All services a child is determined to need must be covered as long as the service is the type of medical assistance that can be covered under Medicaid.	Well-child services, immunizations and emergency services must be covered; states can generally determine which other services they will cover as long as the plan meets or is actuarially equivalent to a benchmark plan or has been approved by the Secretary of HHS.	Hearing aids not covered (MT). Eyeglasses not covered (UT). Speech therapy to address delayed language development or articulation disorders not covered (MS). Dental care not covered (TX) – very limited coverage will be provided beginning in 2006.
What kinds of limits on covered services are permitted?	Coverage must be consistent with the health needs of the particular child. States can limit coverage based on a child’s needs but cannot impose pre-set, across-the-board limits on children’s services.	Federal standards generally leave the scope of services to states’ discretion as long as the plan meets or is actuarially equivalent to a benchmark plan or has been approved by the Secretary of HHS.	Inpatient mental health services limited to 15 days/year (NH). Outpatient mental health services for certain conditions limited to 20 visits/year (CO). Lead screening not required as part of regular well-child visits (NH, MT, TX, IA, MI, MS). Dental coverage capped at \$500 or less per year (CO, MT). Speech therapy only covered if substantial improvement will result within 60 days (NY).

Source: Sara Rosenbaum, Anne Markus, Colleen Sonosky, George Washington University, *Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP*,” Journal of Health & Biomedical Law, 1 (2004), updated by Anne Markus and Richard Mauery of George Washington University and CCF researchers.

“Standards Without a Standard”

Most states have two choices for meeting the federal SCHIP benefit standard.^{*}

1. States can design a plan that is “equivalent” to or that has an “aggregate actuarial value equivalent” to one of the following benchmark plans:
 - The standard Blue Cross/Blue Shield preferred provider option under the Federally Employee Health Benefit Plan;
 - Any state employee plan offered by that state, or
 - The health insurance plan offered by the health maintenance organization that has the largest commercial non-Medicaid enrollment in the state;

or

2. A SCHIP plan can meet federal standards as long as the Secretary of HHS determines that it provides “appropriate coverage.”

Under the first option, two of the benchmarks would assure a relatively comprehensive scope of coverage (although subject to the more standard, commercial medical necessity definition discussed below), but the state employee health plan benchmark essentially undoes any “bottom line.” Any plan a state decides to make available to state employees can qualify as the SCHIP benchmark in that state, without regard to whether most (or even any) state employees choose that plan. This benchmark is, therefore, ultimately a matter left entirely to states’ discretion and could result in a significantly scaled back SCHIP benchmark. Some states, for example, are now offering limited catastrophic coverage plans to state employees; these would qualify as a benchmark for children enrolled in SCHIP.

“Secretary-approved coverage” (#2 above) also lacks any objective assurance of a particular level of coverage since any plan deemed adequate by the Secretary can suffice under federal standards. Under the Secretary’s Health Insurance Flexibility and Accountability (“HIFA”) waiver initiative guidelines issued in 2001, significantly scaled back benefit plans may be approved for all so-called “optional” children.**

^{*} Social Security Act, Title XXI, sec. 2103; three states (Florida, New York, and Pennsylvania) were authorized to maintain the coverage they had implemented in their pre-SCHIP, state-funded coverage programs.

** The HIFA guidelines are at <http://www.cms.hhs.gov/hifa/hifagde.asp>

● Medical Necessity

In addition to the differences between Medicaid and SCHIP standards on which services and the scope of the services that must be covered for children, the programs have fundamentally different rules for determining whether a service will be covered for a particular child. Every health plan, whether private or public, employs some definition of “medical necessity” to determine whether a service covered under that plan will be allowed for a particular individual enrolled in the plan. No plan would –or should– cover services that are not medically necessary, but plans differ widely on how the term is defined and applied.

A basic difference between Medicaid and SCHIP is that the Medicaid EPSDT standard requires coverage of medical services necessary “to correct or ameliorate defects and physical and mental health conditions.” This standard has been described as a “preventive” rather than a

“treatment” standard.¹⁰ It is designed not just to cure or treat an illness or injury but to cover medical care and health services that will prevent and ameliorate the long-term effects of chronic illness and disability and help a child attain or maintain an optimal level of health.

This “preventive” standard is not required by SCHIP. State SCHIP programs may narrow coverage to treatment services that will cure or correct a diagnosed illness or injury. An analysis of 15 separate SCHIP programs conducted by researchers at George Washington University shows that only six of these states have adopted a medical necessity standard (either under their state plans or through their managed care contracts) that has the preventive component applicable in Medicaid.¹¹

Without Strong Federal Standards, Fiscal Pressures Will Weaken Coverage and Lead to Variation in Children’s Access to Care.

Under Medicaid’s federalism structure, each state can decide how it will deliver health care services—for example, through private managed care organizations, individual practitioners or clinics, or “primary case managers” — and states have broad discretion to set their provider payments. The coverage standard for children, however, is the same regardless of where a child may reside. This commitment to a national floor for the health coverage available to low-income children financed with federal Medicaid funds would dissolve without strong federal standards.

How Will Children Fare Under “Targeted” or “Tiered” Benefit Plans?

The NGA proposal would replace the current federal Medicaid benefits standards with a “tailored” approach where different groups of beneficiaries would be eligible for different benefit plans. “Tailoring” or “targeting” benefits has surface appeal — why provide coverage for services that someone does not need?

Existing Medicaid rules, however, already do not permit states to cover care that a child does not need. States employ various utilization control procedures (as well as managed care delivery systems) designed to ensure that only appropriate care is covered. Targeting benefits by “group” designations rather than by determinations based on a child’s medical needs will, by definition, cause some children to be denied care they need. Indeed, it is only by denying care that otherwise would be authorized based on need that savings can be achieved.

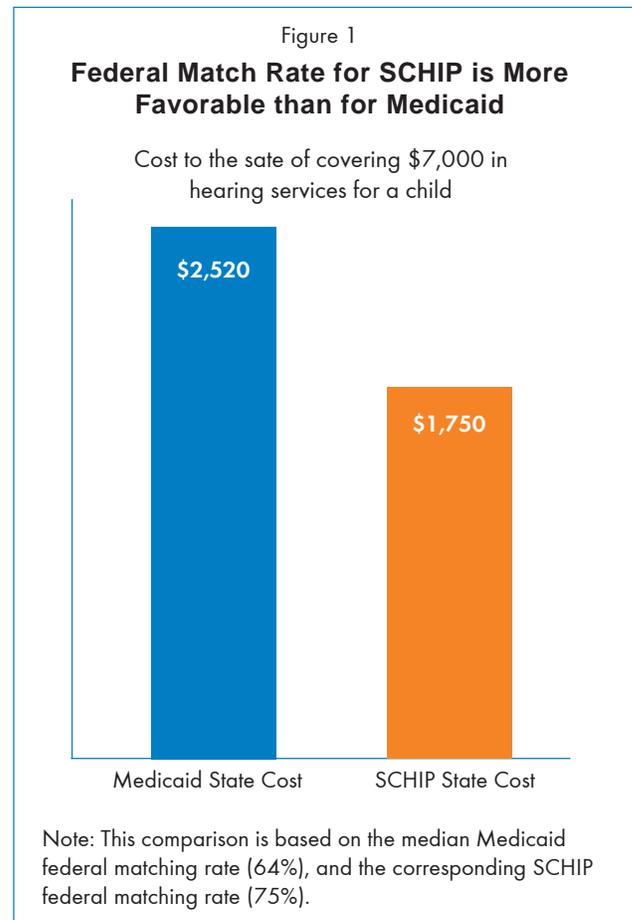
The NGA targeting approach under consideration in the Congress would assign children different benefit packages based largely on their eligibility category.* Children can qualify for Medicaid under a number of different eligibility categories, but their health care needs cannot be compartmentalized along these lines. A study that looked at the “eligibility pathways” for children enrolled in Medicaid in four states found that children with chronic conditions often are not enrolled under the eligibility categories that would retain EPSDT protections under the NGA proposal. It showed, for example, that about four out of ten children with diabetes and children with pulmonary conditions, such as asthma, would likely lose their EPSDT benefits under the NGA proposal.**

* *Short-Run Medicaid Reform*, National Governors Association, August 29, 2005, available online at <http://www.nga.org/Files/pdf/0508MEDICAIDREFORM.PDF>.

** Center for Health Care Strategies Inc., *The Faces of Medicaid*, October 2000. The analysis was based on 1994 and 1995 data and therefore likely understates the extent to which children with chronic conditions are currently in “unprotected” eligibility categories in light of the Medicaid expansions in children’s coverage that have occurred since 1995.

The variation across states could result in considerable disparities in coverage for children, perhaps even greater than in SCHIP. SCHIP was designed without many federal requirements but with a fiscal incentive to encourage states to provide children with needed coverage. This incentive takes the form of an “enhanced” matching rate, the rate by which the federal government shares the costs of the program. In both Medicaid and SCHIP, the federal matching rate varies by state, but in every state the SCHIP federal matching rate is more favorable than the Medicaid rate.¹²

Consider the state of Iowa, a state with a federal Medicaid matching rate that is close to the median. Iowa’s matching rate is 64 percent in Medicaid compared to 75 percent in SCHIP. These different rates can translate into considerably different state costs. For example, if a toddler showing early signs of speech delay needs hearing services that cost \$7,000, Iowa’s share would be \$1,750 under SCHIP and \$2,520 under Medicaid (Figure 1). That extra \$770 (the difference between the \$1750 in state costs under SCHIP and the \$2,520 in state costs under Medicaid) multiplied by the numbers of children served by Medicaid who might need such services – far more than those served under SCHIP – will inevitably push even some of the states that have adopted relatively broad coverage under SCHIP to consider restricting children’s coverage under a weakened Medicaid standard.



Conclusion

Infants and children in low-income families have medical needs that exceed the norm. They have higher rates of allergies, asthma, and other chronic illnesses, and they are at higher risk of developmental disabilities and delays. Standards operating in the commercial insurance market increasingly leave children without coverage for the care they may need.¹³ The potential harm to low-income children of less-than-adequate coverage is particularly great given their heightened health care needs and diminished resources. Without coverage standards that appropriately address their medical needs, many low-income children will simply not be able to obtain necessary care.

Endnotes

¹The evolution of children's coverage under Medicaid is reviewed in, Cindy Mann, Georgetown Health Policy Institute, Diane Rowland, Rachel Garfield, Kaiser Commission on Medicaid and the Uninsured, "Historical Overview of Children's Health Care Coverage," *Packard Journal on the Future of Children*, Spring 2003. See key points in this history at <http://www.ccfgeorgetown.org/timeline.html>.

² For example, poor and near-poor families are significantly more likely to report that their children are in fair or poor health and that they had an asthma attack in the past 12 months. Vital and Health Statistics, Series 10: Data From the National Health Interview Survey (2004), No. 227, Tables VIII and IV, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention.

³ Lisa Dubay, Genevieve Kenny, "Health Care Access and Use Among Low-Income Children: Who Fares Best?," *Health Affairs*, Volume 20, No. 1, January/February 2001; Leighton Ku, *Improving Health, Saving Lives*, Center on Budget and Policy Priorities, revised August 17, 2005. An Urban Institute analysis of 2002 data shows that low-income children covered by Medicaid are even more likely than low-income children with private insurance to have a well child visit and one or more doctor or dental visits. *Health Care Coverage for Children*, September, 2004, Kaiser Commission on Medicaid and the Uninsured.

⁴ *Short-Run Medicaid Reform*, National Governors Association, August 29, 2005.

⁵ Anna Sommers, Arunabh Ghosh, The Urban Institute, David Rousseau, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories*, (Appendix A, Table 1), Kaiser Commission on Medicaid and the Uninsured, June 2005.

⁶ SCHIP point in time enrollment data is from the Kaiser Commission on Medicaid and the Uninsured, *SCHIP Enrollment in 50 States*, September 2005. Thirty-nine states have separate SCHIP programs (including 20 that also use SCHIP funds to expand Medicaid). Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/schip/chip-map.pdf>, August 9, 2005.

⁷ Social Security Act, Title XIX, sec. 1905(r) (5); see also, Centers for Medicare and Medicaid Services, at <http://www.cms.hhs.gov/medicaid/epsdt/default.asp>.

⁸ *The Medicaid Resource Book*, Kaiser Commission on Medicaid and the Uninsured, July 2002, lists the categories and identifies which are optional or mandatory for adults at Table 2-1, p. 53.

⁹ Social Security Act, Title XXI, sec. 2103.

¹⁰ Sara Rosenbaum, Anne Markus, Colleen Sonosky, George Washington University, "Public Health Insurance Design for Children: The Evolution from Medicaid to SCHIP," *Journal of Health & Biomedical Law*, 1 (2004), page 14.

¹¹ The researchers conducting this study examined the SCHIP benefit rules in the 15 states that designed their own managed care contracts in 2002, looking at state SCHIP plans, provider manuals and managed care contracts. The analysis in this CCF Issue Brief relies on an unpublished update of that study conducted by Anne Markus and Richard Mauery at George Washington University and CCF researchers. The data are current as of September 2005.

¹² Federal Medicaid matching rates for fiscal year 2006 range from 50 percent to 76 percent; SCHIP matching rates range from 65 percent to 83 percent. <http://aspe.hhs.gov/health/fmap06.htm>.

¹³ Michelle M. Doty, Jennifer N. Edwards, Alyssa L. Holmgren, *Seeing Red: Americans Driven into Debt by Medical Bills*, The Commonwealth Fund Issue Brief, August 2005.



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