Differences that Make a Difference: A Comparison of Federal Medicaid and SCHIP Benefit Standards

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Kevin Hall, a 12-year-old, has severe allergic asthma that until recently was out of control. He required 13 medications a day, was in and out of the doctor’s office (and sometimes the ER) 2 – 3 times/month and for a period required a visiting nurse.

Kevin’s mother had coverage from her job, but it left her with unaffordable cost sharing and uncovered treatments. Medicaid’s coverage of a new drug has “given Kevin back his life.”

Brandie Haughey, age 10, has multiple medical and developmental problems. She weighs only 55 pounds, requires 3 different medications for epilepsy, intensive speech and physical therapy, and ongoing monitoring for lesions.

Her problems will never be “cured” but now her seizures are under control. She can use scissors, ride a bike (not yet around curves), color within lines, and her gait, speech, and physical strength are improving.
“When you consider the extensive mental health needs of so many of our low-income children, Pennsylvania’s CHIP program (Pennsylvania’s State Children’s Health Insurance Program) is what I would consider “very basic.” I say that not because there are very harsh limits on the number of outpatient clinic visits or inpatient days that are covered, but because the range of services covered under CHIP is quite narrow and considerably less child- and family-centered.”

What Must be Covered

**Medicaid**
- For children, preventive care, including hearing, vision, and dental screenings and all medically necessary treatment (EPSDT)
- For adults, mandatory services must be covered and, for all services that are covered, services must be comparable across groups, available statewide, and sufficient in “amount, scope, and duration.” No discrimination based on diagnosis/disease.

**SCHIP**
- Well-child services, immunizations and emergency services
- Other services largely at state discretion as long as the plan meets or is actuarially equivalent to a benchmark plan or has been approved by the Secretary of HHS.
A Benefits Standard Without Standards

New federal benefit standard permits states to use any state employees health plan as its Medicaid benchmark

States establish their state employees health plans

States can use any employee plan - regardless if most/any state employees use the plan - as its new Medicaid benchmark
Medical Necessity

Medicaid
For children, a service must be covered if necessary “to correct or ameliorate defects and physical and mental health conditions.”

SCHIP
No federal standard; more commercial-like definition can control
- Of the 15 states with separate SCHIP programs studied, 6 use a Medicaid-like definition.
Examples Of SCHIP Exclusions

- 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 beginning in 2006.

Examples of SCHIP Limitations

- 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: Based on study by S Rosenbaum, A. Markus, C. Sonosky, George Washington University, updated by A. Markus, R. Mauery and CCF researchers; see CCF, Differences that Make a Difference, October 2005.
How Would SCHIP Standards Work for Kevin or Brandie?

- Would Kevin’s expensive asthma treatments be covered?
- Would his 13 prescriptions be covered?

• Would Brandie’s intensive speech, occupational, and physical therapy be covered?
• Would the combination of seizure medications be covered?
## Eligibility Pathways for Child Medicaid Beneficiaries with Chronic or Disabling Conditions, by Major Diagnostic Group

<table>
<thead>
<tr>
<th>Major Diagnostic Group</th>
<th>Entered Medicaid through SSI Eligibility</th>
<th>AFDC Eligibility</th>
<th>Other Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>15%</td>
<td>45%</td>
<td>40%</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>9%</td>
<td>48%</td>
<td>43%</td>
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<tr>
<td>Cancer</td>
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<td>30%</td>
<td>35%</td>
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<tr>
<td>Cardiovascular</td>
<td>16%</td>
<td>44%</td>
<td>40%</td>
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<tr>
<td>Cerebrovascular</td>
<td>27%</td>
<td>24%</td>
<td>31%</td>
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<tr>
<td>Nervous System</td>
<td>14%</td>
<td>49%</td>
<td>37%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14%</td>
<td>65%</td>
<td>26%</td>
</tr>
<tr>
<td>Developmental Disability</td>
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<td>38%</td>
<td>43%</td>
</tr>
<tr>
<td>Eye</td>
<td>7%</td>
<td>47%</td>
<td>46%</td>
</tr>
<tr>
<td>Genital</td>
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<td>47%</td>
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<td>Gastrointestinal</td>
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<tr>
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<tr>
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<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Renal</td>
<td>14%</td>
<td>44%</td>
<td>42%</td>
</tr>
<tr>
<td>Skeletal and Connective</td>
<td>7%</td>
<td>54%</td>
<td>39%</td>
</tr>
</tbody>
</table>

The Reduction in Benefits is the Largest Source of Medicaid Savings Under the House Proposal

Total gross cuts = $52.3 billion

Notes: Total gross cuts and reductions in benefits and cost sharing are offset by the $11 million increase in spending for exemption for women with certain cancers. “Other” includes changes relating to third-party recovery, targeted case management, citizenship verification requirements, payment for emergency services, and non-emergency medical transportation. The House bill re-invests $4.6 billion (8.8%) of total cuts into Medicaid, making net cuts $47.7 billion.