Advocates Call SCHIP Enrollment Data Misleading

An AAP committee chairman says the HHS's recent statements indicating enthusiasm are disingenuous.

BY ALICIA AULT
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The federal government's portrayal of enrollment growth in the State Children's Health Insurance Program in 2007 is disingenuous and somewhat misleading, advocates for children's programs said.

According to the Centers for Medicare and Medicaid Services, 7.1 million children were enrolled in the program (SCHIP) in 2007, up from 6.7 million in 2006.

"While we are pleased that SCHIP continues to grow, we must do more to reach those at the lowest income levels who still need this coverage," Mike Leavitt, Health and Human Services secretary, said in a statement. "Toward that end, we will continue to work with Congress on the reauthorization of this vital program."

That comment is "disingenuous," Dr. Steve Wegner, chairman of the child health funding committee at the American Academy of Pediatrics, said in an interview. He noted that President Bush vetoed a compromise agreement to reauthorize SCHIP not once, but twice, in 2007.

"The administration did everything possible to stand in the way of the reauthorization," Jenny Sullivan, a health policy analyst with Families USA, said in an interview. SCHIP was finally given a reprieve, with Congress passing, and the president signing, a funding extension through March 2009. But the program still has not been formally reauthorized.

And, said Ms. Sullivan and Dr. Wegner, many millions more children would have been covered in 2007 if the reauthorization had been approved when it was first taken up early in the year.

CMS spokeswoman Mary Kahn said that it was not accurate to imply that the Bush administration did not want to continue the SCHIP program. The administration did, however, want to fund it at a lower level, she said in an interview.

Also in the HHS statement, Kerry Weems, CMS acting administrator, said, "We continue to work with states to [ensure] that as many eligible, uninsured children as possible are enrolled in SCHIP and Medicaid."

Dr. Wegner took exception to that statement as well, noting that a CMS directive issued in August 2007 has effectively prevented states from expanding eligibility. The CMS said it would limit states' ability to expand coverage to children in families who had incomes at 250% of the poverty level or above.

Ms. Sullivan said that the directive had, in many cases, reversed expansion plans that previously were approved by the CMS.

Twenty-three states are expected to be affected by the directive, according to the Kaiser Family Foundation. Nine already cover children in families with incomes above 250%, and 13 states had received approval to expand eligibility at or above that level. In addition, Washington was covering children at the 250% level and had gotten approval to raise that cap.

The directive is consistent with the administration's belief that every effort should be made to enroll 95% of children eligible at the lowest income levels before expanding it to those who are in higher-income families, said Ms. Kahn.

President Bush has proposed increasing SCHIP funding by $19.7 billion, a far cry from the $35 billion hike in the two legislative packages he vetoed.

The increase in SCHIP enrollment was not unusually high for the program, said Ms. Sullivan. And, she said, U.S. Census Bureau figures indicate that the overall number of uninsured children actually increased in the last 2 years. There are approximately 9 million uninsured children in the United States, according to a Families USA analysis.

Both Ms. Sullivan and Dr. Wegner said they expect that number to grow in the current year, as states face harsh budget realities.

A much larger number of children are covered under traditional Medicaid programs—about 28 million in 2005, according to Kaiser—but their coverage is also being threatened because of a series of CMS regulations taking effect this year. Rep. John Dingell (D-Mich.) and Rep. Tim Murphy (R-Penn.) introduced a bill in March (H.R. 5613) that would place a 1-year moratorium on seven of those regulations.

According to Congressional Budget Office estimates the two legislators cite, the regulations could translate to $20 billion in cuts to Medicaid over the next 5 years.

The National Governors Association, the National Association of State Medicaid Directors, and the American Public Human Services Association, have expressed their opposition to the regulations in letters to HHS.

Looking ahead into next year, the picture grows even dimmer.

For fiscal 2009, President Bush proposed increasing SCHIP funding by $19.7 billion (added to the current baseline of $25 billion) through 2013.

That is a far cry from the $35 billion that was authorized in the two legislative packages vetoed by the President last year.

And the budget also seeks to formalize the CMS directive that limited states' expansion plans by proposing to cap SCHIP eligibility at 250% of the poverty level.

Specialist Shortage Leaves Care of Obese Children to PCPs

BY BRUCE K. DIXON
Chicago Bureau

The distribution of children with diabetes and obesity does not parallel that of pediatric endocrinologists in the United States, largely because of geographic disparities in the supply of these specialists, according to Dr. Joyce M. Lee and colleagues at the University of Michigan, Ann Arbor.

This patient-specialist disparity is made especially acute by the growing epidemic of obesity, the authors report.

Data from the American Board of Pediatrics were used to estimate the number of board-certified pediatric endocrinologists by state, and national estimates of children with diabetes and obesity were derived from the National Survey of Children's Health, a representative cross-sectional random-digit-dial telephone survey of households with children younger than 18 years of age.

The investigators compared the observed ratios of obese children to pediatric endocrinologists under "index" conditions of greater supply and equitable distribution. They assumed that the ratio of the child population to specialists for each state was similar to that in the state with the largest supply, Massachusetts, where the ratio of obese children to endocrinologists was 5,132:1.

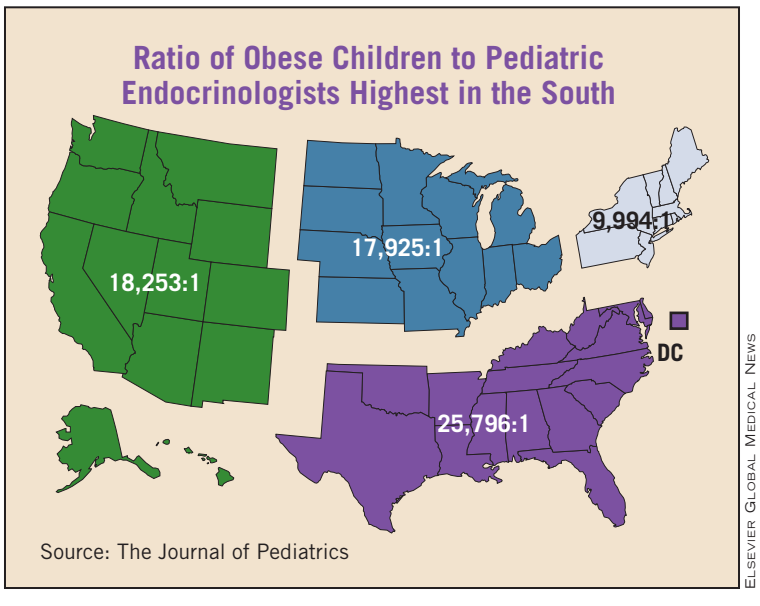
The highest ratio—99,984:1—was in Mississippi. Two states, Montana and Wyoming, had no endocrinologists.

Nationwide, there were 17,741 obese children for each board-certified pediatric endocrinologist. By region, the northeast had the lowest ratio (9,994:1) and the south had the highest (25,796:1).

When the scientists examined the ratio of endocrinologists to children with diabetes, they found the best conditions in New England (113:1) and the worst in the east south-central region (594:1).

The nation as a whole had a ratio of 290:1 (Journal of Pediatrics 2008;152:331-6).

With an almost sixfold difference in ratios of children with diabetes to certified pediatric endocrinologists across census divisions, and no ideal benchmark ratio for children with chronic disease to pediatric subspecialists, the authors believe it is unclear what effect this distribution has on access to the pediatric endocrinologists and health outcomes across geographic areas.



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When observed ratios were compared with "index" ratios calculated under assumptions of equitable supply, the "index" ratios showed considerably less variation, the investigators explained.

The data suggest that geographic differences in endocrinologist supply, not geographic differences in diabetes and obesity prevalence, might be driving the variation.

The authors point out that childhood obesity clinics are receiving increasing attention as a possible solution to the treatment of pediatric obesity.

However, given the scope of the problem in the United States, "it is unclear whether childhood obesity clinics run by subspecialty providers represent a model of care that is either sustainable or effective in addressing the increasing burden," the investigators said.

Given this state of affairs, the role of the primary care pediatrician and the medical home in caring for the obese child becomes even more critical, Dr. Lee said in an interview.

"Our study may actually underestimate the ratios because most pediatric endocrinologists are affiliated with academic medical centers and spend a lot of time teaching and conducting research rather than seeing patients," said Dr. Lee of the division of pediatric endocrinology at the university.

The huge demand for obesity and diabetes treatment is expected to continue to outpace the slow growth in new specialists, so emphasis should be placed on helping primary care pediatricians prevent and treat childhood obesity, she said.

"The American Diabetes Association states that, ideally, these children should be treated by pediatric endocrinologists, but they also can be treated by adult endocrinologists and even internists and family practitioners," Dr. Lee said in an interview.

"The bottom line is these children need a medical home, and that home really resides with the primary care pediatrician," she concluded.