SCHIP Administrative Change May Trim Coverage

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The true impact isn't known yet, but an administrative change by the Centers for Medicare and Medicaid Services to rules governing the State Children's Health Insurance Program—made on a Friday night during Congress' August recess—may have the effect of dropping children who currently have coverage.

Sen. Jay Rockefeller (D-W.Va.), one of the original coauthors of SCHIP, sent a letter to President George W. Bush chiding the administration for making the change without congressional input.

"Not only do I question the wisdom and legality of this new policy, I also question the process," wrote Sen. Rockefeller, noting that "a policy change of this magnitude should, at a minimum, be handled through the formal rule-making process, with proper public notice and comment, and not through unilateral subregulatory guidance."

About 4 million children are eligible for Medicaid or SCHIP currently; some 6 million received benefits in 2006. An estimated 9 million children do not have health insurance.

SCHIP, now entering its 10th year, has been the subject of fierce battles this year, as lawmakers have struggled to come up with financing for the next 5 years that is palatable to both parties. Authorization for SCHIP expires Sept. 30. Before leaving for summer recess, the House and the Senate passed vastly different funding packages. (See box.)

President Bush said he would veto either bill, saying that he viewed both as a backdoor way of expanding government-financed health care at the expense of the private insurance market.

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So, the Aug. 17 letter from CMS Director for Medicaid and State Operations Dennis G. Smith to state health officials should not have come as a surprise. In the letter, states were told that if they were raising eligibility for children whose family incomes were equal to or above 250% of the federal poverty level, they would have to meet stringent new requirements. The goal: to ensure that these families aren't opting for SCHIP instead of private insurance.

"Existing regulations … provide that states must have 'reasonable procedures' to prevent substitution of public SCHIP coverage for private coverage," wrote Mr. Smith.

Many states have had such procedures in place, but the CMS is now requiring that specific processes be implemented. For instance, children will have to be uninsured for at least 1 year before receiving SCHIP benefits. Currently, only Alaska requires a year-long exclusion, said Judy Solomon, a senior fellow with the Center on Budget and Policy Priorities, a Washington-based policy research organization. Most states impose a 1- to 6-month waiting period, but most also have generous exceptions to those rules.

Under the administrative change, states also will have to prove that they've enrolled at least 95% of children who are below 200% of the federal poverty level, and document that the number of low-income children who are eligible for and covered by private insurance has not dropped by more than 2% in the past 5 years.

States that have already increased their eligibility to 250% or more—18 states—will have to comply with the new requirements within a year or lose some of their federal matching funds.

The CMS said that the requirements should not harm children who currently receive benefits. "We would not expect any effect on current enrollees," wrote Mr. Smith.

While it's not clear how many children might be dropped, "At the very least, you're going to have thousands of children unable to get coverage," said Ms. Solomon, noting that the hurdles might be too high for new enrollees.

SCHIP was designed to give states flexibility to meet the needs of their own citizenry, noted Ms. Solomon. For instance, states with a higher cost of living and the ability to shoulder a higher fiscal burden—like New York, New Jersey, and Massachusetts—have increased income eligibility levels.

But the new CMS policy is severely diminishing that flexibility. "This turns back the clock," said Ms. Solomon.

At presstime, the House and Senate were scheduled to meet in conference this month to determine the course of SCHIP over the next 5 years. ■

Senate and House SCHIP Bills Differ

In August, the Senate overwhelmingly passed S. 1893, which includes a $35-billion increase for SCHIP. The funds would come from an increase in the federal tobacco tax.

The approved House legislation (H.R. 3162), on the other hand, contains a number of provisions unrelated to SCHIP. For example, the bill would halt next year's planned 10% cut in the Medicare physician fee schedule, instead putting in a place a 0.5% increase for 2008 and another for 2009.

In terms of SCHIP funding, the House bill calls for a $50-billion increase in funding and would pay for it with both increases in the federal tobacco tax and cuts to subsidies given to Medicare Advantage plans.

The House bill also outlines a new physician payment structure under Medicare that would set a separate conversion factor for six service categories:

- Evaluation and management for primary care.
- Evaluation and management for other services.
- Imaging.
- Major procedures.
- Anesthesia services, and
- Minor procedures.

The proposed formula would also take prescription drugs out of the spending targets and would take into account Medicare coverage decisions when setting targets, according to Rich Trachtman, American College of Physicians legislative affairs director.

But the formula would still lead to deep payment cuts starting in 2010, so there is an understanding among legislators and leaders in medicine that the updates for 2010 and beyond would require additional action, Mr. Trachtman said.

But the American College of Cardiology expressed problems with the new structure for Medicare payments outlined in the House bill. The proposed payment structure would be based on a system of separate expenditure targets that ACC asserts would not take into account the appropriate growth in services, including many common cardiovascular services.

"While the ACC appreciates congressional efforts to stop Medicare physician payment cuts, it is critical that any new payment structure is fair to all physicians," the ACC said in a statement.

The House bill also would codify protection for six drug classes under Medicare Part D. Starting in 2009, Medicare drug plans would be required to include all or substantially all Part D drugs in each of the following classes: anticonvulsants, antineoplastics, antiretrovirals, antidepressants, antipsychotics, and immunosuppressants.

The bill would also waive cost sharing for Medicare beneficiaries for certain preventive services including diabetes outpatient self-management training services, cardiovascular screening blood tests, diabetes screening tests, screening mammography, screening Pap smear and pelvic exam, and bone mass measurement.

—Mary Ellen Schneider