Summer 1997

Congress Crafts Child Health Insurance Program

George Washington University Medical Center, Center for Health Policy Research

Congress Crafts Child Health Insurance Program

As this issue of Health Policy & Child Health goes to press, a Congressional conference committee is meeting to iron out differences between budget reconciliation bills passed in June by the House and Senate. Among key health policy issues to be resolved are the House and Senate's differing approaches to providing health insurance coverage to uninsured children who do not now qualify for Medicaid and whose parents cannot afford health insurance. While the conference will decide on the specifics of a final bill, the basic tenet upon which both the House and Senate bills are based—shifting responsibility for social policy from the federal government to the states—is likely to remain.

Some key points on which the House and Senate differ include:

- Coverage Rules. While both bills require states to cover children with lower income first before covering other children, the House bill would cover children up to 300% federal poverty level (FPL) whereas the Senate bill would go up to 200%.
- Cost Sharing. In the Senate bill, children with family incomes above 150% FPL may have to pay for part of their care, but not those below that income level. The House bill, on the other hand, exempts preventive services, but not other services, from any cost sharing for all children regardless of income.
- Benefit Structure. The House version requires states to cover four categories of benefits (inpatient and outpatient services; physician surgical and medical services; laboratory and x-ray services; well-baby and well-child care, including age-appropriate immunizations). The Senate version is more prescriptive—benefits provided by a state program must be at least equivalent to the Blue Cross/Blue Shield standard PPO option under the Federal Employee Health Benefit Plan, including dental, vision and hearing. In addition, the Senate included a provision requiring mental health parity.
- Medicaid Maintenance of Effort. Unlike the House bill, the Senate bill requires states to maintain Medicaid eligibility rules in place as of June 6, 1997 to qualify for additional funding under the new children's health insurance plan; also, states must spend the same dollar amount as before on children's programs, including Medicaid, Title V, and school based services.
- Financing. While both bills budget $16 billion over five years for child health coverage, the Senate also added an $8 billion tobacco tax increase which appears to be directed toward additional child health coverage.

The tables on pages 2-9 compare selected aspects of the child health insurance provisions in the House and Senate budget reconciliation bills, as well as related provisions modifying the Medicaid program. The table on page 10 looks at additional Medicaid provisions in the two bills that would affect children.

Summer 1997
Volume 4 Number 3

SPECIAL ISSUE:
CHILD HEALTH INSURANCE

Tables prepared by the Center for Health Policy Research compare child health insurance and selected Medicaid provisions in Senate and House versions of the budget reconciliation package currently being finalized by Congress.

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
I. Status		Recommendations transmitted 06/12/97 from Commerce Committee to Budget Committee. H.R. 2015 passed House 06/25/97.	Recommendations transmitted 06/19/97 from Finance Cte. to Budget Cte. H.R. 2015 (spending bill) and H.R. 2014 (tax bill) as passed by the Senate 06/25/97 and 06/27/97.
II. General Approach	No systematic approach to financing health coverage for children. Coverage is through employer-sponsored private insurance, publicly-subsidized private plans, and Medicaid. In 1994 among children under age 18: • 14% (10 million) were uninsured; • 61% had private coverage; and • 18% had only Medicaid coverage. The percentage of uninsured children varied by income, with no coverage among: • 22% of poor children (with family income below 100% FPL); • 45% of near-poor children (with family income between 100-200% FPL); • 9% of those with higher income. Most uninsured children live in working families with incomes <250% FPL. One third of uninsured children are eligible for Medicaid but not enrolled.	**Children's Health Insurance** Child Health Assistance Program (CHAP) creates an entitlement in states, but not in individuals.Entitles states to payments ($14 billion over five years) to cover uninsured, low income children using any or all of the following methods: (1) provision of benefits under Medicaid; (2) purchase of private (self-insured/insured group or individual) coverage; (3) direct purchase of services; or (4) other methods as specified by the state. Requires states to submit to HHS a plan describing use of funds, with approval of the plan triggering state eligibility for payments. Requires state plans to follow federal framework on eligibility, benefits, cost-sharing, and other matters. Effective October 1, 1997. *Number of children covered under CHAP = 500,000 previously uninsured children (CBO estimate).* **Medicaid** Permits states to speed up the current mandatory phase-in of Medicaid coverage for children born after September 30, 1983 who are under age 19 and whose family income is below 100% FPL. *Children covered = 125,000 (CBO estimate).* Allows states the option to provide 1 year of continuous coverage under Medicaid for children under 19 ($0.7 billion over five years). *Children covered = 130,000 (CBO estimate).* Permits states to provide Medicaid during a presumptive eligibility period for children under 19 years old ($0.5 billion over five years). *Children covered = 110,000 (CBO estimate).* *Total number of children covered = 865,000 previously uninsured children (CBO estimate).*	**Children's Health Insurance** Children's Health Insurance Initiatives creates an entitlement in states, but not in individuals. Entitles states to payments ($16-$24 billion over five years) to cover uninsured, low income children using one of two methods: (1) expansion of Medicaid; or (2) purchase or provision of children's health insurance through a grant program. Requires states to carry out outreach activities to enroll children who are eligible for Medicaid and to encourage employers to provide health insurance coverage for children. Requires states to submit to HHS a program outline identifying which one of the two options the state intends to use. Effective October 1, 1997. **Medicaid** To qualify for new funds, states must speed up (by 2000) the current mandatory phasing-in of Medicaid coverage for children born after September 30, 1983 who have not reached the age of 19 and whose family income is below 100% FPL. Allows states the option to provide 1 year of continuous coverage under Medicaid for children under age 19. *Total number of children covered = 1,670,000 previously uninsured children (CBO estimate).*

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
III. Coverage Rules	Eligibility and coverage rules vary with type of plan (e.g., employer-based plan, Medicaid, state insurance program). States have an option to extend Medicaid to all uninsured children. Five states cover children under age 18 or 19 in near-poor families with incomes up to 185% FPL or higher.	Defines low income children as children who are under 19 years old and whose family income is below 300% FPL. Further defines targeted low-income children as those who: (1) are determined eligible for assistance under the program; (2) have family income above the applicable Medicaid level in the state but not exceeding an income level that is 75% greater than the Medicaid applicable level, or, if higher, 133% FPL; and (3) are not eligible for Medicaid or covered under a group plan or other private insurance. Prohibits discrimination on the basis of diagnosis or denial of eligibility on the basis of a preexisting medical condition, although group health plans may continue to exclude coverage of preexisting conditions as under current law. Permits states to establish coverage standards based on age, income, resources, disability status, duration of eligibility and geographic area. Within each category, states must give priority to children with lower family incomes. Requires state plans to include a description of: (1) the methods (including a methodology consistent with Section 1902(1)(3)(E)) to establish and continue eligibility and enrollment; and (2) the procedures to screen for eligibility, coordinate coverage with Medicaid and other insurance programs, and avoid substitution of private coverage by the new assistance provided by the state.	Defines low income children as children who are under 19 years old and whose family income is below 200% FPL. Permits states to establish coverage standards with priority to children with lower family incomes. Requires program outlines to include a description of (1) the standards and methodologies used to determine eligibility; and (2) the procedures used to screen for eligibility, coordinate coverage with other programs, and avoid substitution of private coverage by the new assistance provided by the state.
IV. Premium Assistance		Requires that, to the extent possible, states set individual premiums on a income-based, sliding scale, giving priority to children in lower income families. Any state payments (in the form of cash or vouchers) would not be counted as income for purposes of determining eligibility for any means-tested federal or federally-assisted program (e.g., food stamps).	Permits states to impose premiums on families with incomes above 150% FPL. Imposes same limits on beneficiary costs as Medicaid for those below 150% FPL (i.e., no cost-sharing for mandated populations, but nominal cost-sharing for optional populations).

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
V. Benefit Structure	Medicaid's EPSDT program covers comprehensive benefits for children, including: medical, dental, preventive, primary, hospital, specialty, developmental, and long term care services. Employer plans vary in scope of benefits, with most including preventive, primary, and inpatient services and few covering developmental or long term care services. Special state programs and private insurance plans for children vary in scope of benefits; most have preventive and primary care, but many do not include inpatient or long term care services.	Requires states to cover at least four categories of services: (1) inpatient and outpatient hospital services; (2) physician surgical and medical services; (3) laboratory and x-ray services; and (4) well-baby and well-child care, including age-appropriate immunizations. Requires states to specify • amount, duration and scope of benefits; • level of cost-sharing, including premiums, deductibles, coinsurance and other cost-sharing; • delivery method (e.g., fee-for-service, managed care, direct service provision, vouchers); and • utilization control systems. Group plans are exempt from covering the minimum categories of benefits if they provide the same coverage to children eligible for assistance as provided to other individuals covered by the group plan. Prohibits states from using funds to pay for abortions or to assist in the purchase of benefits that include coverage of abortion except in cases of rape, incest, or danger to the mother.	Requires states using the grant program to provide benefits at least equivalent to the Blue Cross/Blue Shield standard PPO option under Federal Employee Health Benefit Plan (FEHBP), including dental, vision and hearing. The Secretary of HHS will certify that plans are equivalent or better than this standard FEHBP benefit package. Requires parity in mental health coverage if insurers offer such coverage. Prohibits states from using funds to pay for abortions or to assist in the purchase of benefits that include coverage of abortion except in cases of rape, incest, or danger to the mother.
VI. Cost-Sharing		Prohibits states from imposing cost-sharing on preventive services.	Permits states to impose cost-sharing requirements on families with incomes above 150% FPL. Imposes same limits on beneficiary costs as Medicaid for those below 150% FPL.
VII. Insurance Reforms		Prohibits states from permitting the use of any preexisting condition exclusion for covered benefits. Group plans are exempt from preexisting conditions requirements so long as they are in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.	Not specified.

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
VIII. Treatment of Medicaid	Medicaid coverage mandated for: • persons who meet AFDC income rules as of 07/16/96; • children born after 09/31/83 with family income <100% FPL; • children below age 6 with income <133% FPL; • infants of mothers covered by Medicaid; • others (e.g., SSI, foster care). Optional groups: • infants with family income <185% FPL; • children ages 13-21 with income <100% FPL; • other children under liberalized income eligibility criteria (1902 (r)(2)). No cost-sharing for children's services. States have an option to extend Medicaid to all uninsured children. Five states cover children under age 18 or 19 in near-poor families with incomes up to 185% FPL or higher.	**Phase-In Of Poor Children** Permits states to speed up the current mandatory phase-in of Medicaid coverage for children born after September 30, 1983 who have reached age 6 and whose family income is below 100% FPL. (Under the current mandatory phase-in schedule, all poor children under 19 will be eligible for Medicaid by the year 2002). **Eligibility** Permits states to use new funds available under the child health assistance program with an enhanced federal match to expand Medicaid eligibility under the following conditions: • income and resource standards are not more restrictive than those applied as of 06/01/97; • reporting of information to HHS about expenditures and payments for the expansion is provided for; and • amount of increased payments does not exceed total amount of allotment not otherwise expended. **Outreach and Enrollment** Requires state plans to describeoutreach efforts to inform eligible families about assistance under the new program or other public or private coverage and to assist them in the enrollment process; andcoordination strategies for the administration of the child health assistance program and other public and private insurance programs. **Continuous Coverage** Permits states to provide 12-month continuous coverage under Medicaid for children under 19. **Presumptive Eligibility** Permits states to provide Medicaid during a presumptive eligibility period for children under 19 years old; coverage financed through the state allotment for the child health assistance program. **Reductions in Federal Grant** Reduces federal grants to states based on costs related to presumptive eligibility.	**Phase-In of Poor Children** To qualify for new funds, states must complete the phase-in of Medicaid to provide coverage for all children under age 19 whose family income is below 100% FPL by 2000. The phase-in can be staggered: under 17 by 1998 and under 19 by 2000. **Eligibility** Permits states to use new funds available under the child health assistance program to expand Medicaid with an enhanced federal match for children in eligibility expansion group. **Outreach and Enrollment** Funds set aside for states to carry out outreach activities, including: • identification and enrollment of Medicaid eligible children; and • conduct of public awareness campaigns to encourage employers to provide health insurance coverage. Requires states to coordinate coverage with other programs (e.g., Medicaid). **Continuous Coverage** Permits states to provide 12-month continuous Medicaid coverage for children under age 19 for 1 year after eligibility is determined (option would trigger coverage of other Medicaid-eligible populations). **Maintenance of Medicaid Effort** Requires state maintenance-of-effort according to which states must maintain • children's Medicaid eligibility rules in place as of 06/01/97; and • same amount of children's health expenditures (i.e., Medicaid, Title V, school based services, etc.) as FY 96. **Reductions in Federal Grant** Reduces federal grants to states based on costs related to three aspects of Medicaid expansion: • providing 12-month continuous eligibility; • increased enrollment as a result of outreach; and • accelerating phase-in of all poor children.

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
IX. Treatment of Employer-Based Coverage		Permits states to deny benefits under the child health assistance program if other private coverage is available. Exempts group plans from covering the minimum categories of benefits if they provide the same coverage to children eligible for assistance as provided to other individuals covered by the group plan. Permits group plans to impose preexisting condition exclusions so long as they are in compliance with HIPAA. Requires HHS to establish rules for payment of family coverage under group plans. Permits payment if state demonstrates that purchase of that coverage is cost effective relative to the purchase of comparable coverage limited to targeted low income children.	Provides FEHBP-equivalent coverage. Requires states to avoid substitution of private coverage by the new assistance provided by the state.
X. Children w/ Special Health Care Needs		Requires states to ensure access to specialty care, including the use of a specialist as a primary care provider, for eligible children who have a chronic condition, a life-threatening condition, or a combination of conditions warranting such care.	Provides for financial parity of mental health coverage if insurers offer such coverage.
XI. State Role in Program Administration	Multiple approaches to financing children's health insurance. States administer Medicaid. In general states determine the eligibility process, payment levels, providers, etc. State Medicaid programs use options and waivers to further modify program eligibility categories, benefits, payments, and provider types. Over 30 states operate child health insurance initiatives including premium subsidy programs, insurance pools, and Medicaid optional expansions.	States may choose to cover uninsured, low income children using any or all of the following methods: (1) provision of benefits under Medicaid; (2) purchase of private (self-insured/insured group or individual) coverage; (3) direct purchase of services; (4) other methods as specified by the state. Requires states to prepare a plan in compliance with federal requirements and to submit it to HHS for approval. Gives states the flexibility to design a child health assistance program within broad federal guidelines. Requires states to set up a process to involve the public in the design and implementation of the plan as well as to ensure ongoing public involvement. Mandates state spending to match federal allocation. Requires states to collect data, maintain records and furnish reports to HHS for monitoring of administration and compliance as well as evaluation and comparison of state plan effectiveness.	States may choose to cover uninsured, low income children using one of two methods (1) expansion of Medicaid; or (2) purchase or provision of children's health insurance through a grant program. Requires states to prepare a program outline in compliance with federal requirements and to submit it to HHS for approval. Gives states the flexibility to design a grant program within broad federal guidelines. Mandates state spending to match federal allocation. Requires states to submit annual progress reports to HHS. Denies payments to states in the following cases: • if state modified income or assets standards or methodology in place as of 06/01/97; and • if states decreased amount of all types of children's health expenditures below FY 96 levels.

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
XI. State Role in Program Adminis-tration *(continued)*		Requires states to submit an evaluation to HHS by March 31, 2000 that would include • assessment of the effectiveness of the state plan in increasing coverage; • description and analysis of the characteristics of children and families covered, the quality of coverage, the amount and level of assistance provided by the state, the plan service area, coverage time limits, choice of insurers, and sources of non-federal funding; • assessment of the effectiveness of other public and private programs in increasing coverage; • review of activities to coordinate the state plan with other programs, including Medicaid and maternal and child health services; • analysis of changes and trends that affect health insurance and health care for children in the state; • description of any activities to improve the availability of health insurance and care for children; and • recommendations for improving the child health assistance program. Denies payments to states in the following cases: • if state modified income or assets standards or methodology in place as of 06/01/97; • if services were furnished by providers excluded from participation under Title V, XVIII, XX, or new Title XXI, except for emergency services other than hospital emergency room svcs.; • if insurer that would have been obligated to provide assistance limited or excluded obligation in a provision of the insurance contract because of the child's eligibility for assistance under the state plan; • if state plan is a secondary payer to other federally operated or financed health care insurance programs (with the exception of the Indian Health Svc.), which could have been expected to pay; • if state paid for abortions or assisted in the purchase of benefits that include coverage of abortion except in cases of rape, incest, or danger to the mother.	Requires maintenance-of-effort according to which states must maintain • children's Medicaid eligibility rules in place as of 06/01/97; and • same amount of children's health expenditures (i.e., Medicaid, Title V, school based services, etc.) as FY 96.

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
XII. Allocation and Distribution of Funds to States	Federal-state entitlement funding for Medicaid, in which a set federal contribution is made to states for each dollar spent—known as federal matching (FMAP). Employers have tax deduction for contributing to employee health benefits. Typically, employees make a contribution to health benefit costs. Some employers "self-insure" under ERISA, (i.e. they assume the risk associated with health insurance rather than buying coverage from an insurance company).	**Federal Matching** For expanded coverage of children through Medicaid the Enhanced FMAP = FMAP + [30% x (100-FMAP)]. For expanded coverage of children through grant program, provides for quarterly payments by HHS not to exceed 80% of state expenditures. **Allocation of Funds** Entitles each state to receive a yearly minimum allotment of $2 million (each territory: $100,000). Ratio for allotments **=** (Number of uncovered low income children for a fiscal year in the state[1] **x** State cost factor[2]) **/** (Sum of the products in numerator) Reduces the allotment of states opting for the increased Medicaid matching option by the amount of additional payment made under Medicaid that is attributable to the increase in the federal medical assistance percentage. **Authorized Expenditures** Permits payments for: • child health assistance; • health services initiatives to improve the health of children; • outreach activities; and • other reasonable costs incurred to administer the program. Caps payments for health services initiatives to improve the health of children, outreach activities, and other reasonable costs incurred to administer the program at 15% of total program expenditures. Gives states three years to expend the money under the child health assistance program. **Reductions in Federal Grant** Reduces federal grants to states based on costs related to presumptive eligibility.	**Federal Matching** Defines bonus amount as (1) 5% of the cost of providing health insurance to the base year child population who are being covered at state option (paid out of the basic allotment pool); and (2) 10% of the cost of providing health insurance to additional children who are being covered at state option (paid out of the coverage incentive pool). Provides for quarterly payments by HHS in an amount equal to the federal medical assistance percentage of the cost of providing coverage to low income children in the state through either option augmented by a bonus amount. Total amount paid to an eligible state should not exceed 85% of the total cost of the state program. **Allocation of funds** Entitles states to receive a base allotment. Allotment percentage **=** (Number of low-income children in the base period in the state[3]) **/** (Total number of low income children in the base period in all states) Creates two financing pools • basic allotment pool (85% of funds after deduction for Medicaid outreach, continuous coverage and phase-in); and • coverage incentive pool (15% of funds after deduction for Medicaid outreach, continuous coverage and phase-in). Permits HHS to adjust the 85/15 split annually.

Children's Health Insurance Provisions in the 1997 Budget Reconciliation Bills

	Current Law and Status	House Bill	Senate Bill
XII. Allocation and Distribution of Funds to States *(continued)*			**Authorized Expenditures** Permits payments for: • health insurance assistance for eligible children through Medicaid or grant program; • outreach activities; and • administrative costs (10% of total expenditures in FY 98-99; 7.5% in FY 2000; 5% in FY 2001). Prohibits use of funds for • families of state public employees; or • children who are committed to a penal institution. Gives states three years to expend the money. **Reductions in Federal Grant** Reduces federal grants to states based on costs related to three aspects of Medicaid expansion: (1) providing 12-month continuous eligibility; (2) increased enrollment as a result of outreach; and (3) accelerating phase-in of all poor children.
XIII. Estimated Cost		$16 billion over 5 years: • $14 billion over 5 years for child health assistance program; and • $2 billion over 5 years for Medicaid provisions.	$16-$24 billion over 5 years for children's health insurance initiatives, with $8 billion through 20 cents/pack increase in the cigarette tax.

1. Defined as the arithmetic average of the number of low income children (i.e., children whose family income is below 300% FPL) with no health insurance coverage as reported in the three most recent March supplements to the Current Population Survey before the beginning of the fiscal year.
2. Defined as (.15) **+** [(.85 **x** (annual average wages per employee for the state for a fiscal year **/** annual average wages per employee for the 50 states and D.C.].
3. Defined as the average number of low income children in the state between 10/01/92 and 09/30/95 as reported in the March 1994, 1995, and 1996 supplements to the current population survey.

Selected Medicaid Provisions: 1997 Budget Reconciliation[1]

Issue	Current Law and Status	House Bill (H.R. 2015)	Senate Bill (S. 947)
OVERVIEW	A program which entitles individuals who meet eligibility conditions to coverage for a range of required and optional medical assistance services.	Retains Medicaid as individual entitlement with a continued state entitlement to open-ended federal financing.	Contains similar provisions.
ELIGIBILITY **General Approach** *[See Table p.2 and p. 5 for more details]*	Individuals who meet eligibility requirements are entitled to coverage for medical assistance items and services covered under a State's Medicaid plan when furnished by participating providers.	Retains the entitlement to coverage among eligible individuals but permits states to condition coverage for all beneficiaries who are not special needs children on mandatory enrollment in a managed care entity.	Contains similar provisions. Exempts from the mandatory enrollment requirements special needs children and certain Medicare beneficiaries.
Coverage of Disabled Children	Children who are disabled and receive SSI automatically receive Medicaid in nearly all states. Disability criteria for children restricted under 1996 welfare reform legislation to remove functionally disabled children and to tighten criteria for mental illness-related disability. Approximately 150,000 children are expected to be removed from SSI; CBO estimates that most will requalify for Medicaid as poverty-level children.	Authorizes states to provide Medicaid to all children who previously qualified on the basis of SSI eligibility, who lose SSI as a result of welfare reform.	
BENEFITS **General Approach**	Medicaid beneficiaries are entitled to coverage for a defined set of benefits. States are required to cover certain benefits as a condition of program participation and may elect to provide other benefits. Coverage must be sufficient in amount, duration and scope to reasonably achieve the purpose of the benefit and states are prohibited from arbitrarily discriminating in coverage on the basis of a condition or diagnosis.	Retains the existing defined benefit structure while adding new benefit options.	Contains similar provisions.
Early and Periodic Screening Diagnosis and Treatment (EPSDT)	Provides for mandatory coverage of EPSDT benefits for eligible children <21, which consist of periodic and interperiodic health exams, vision, dental and hearing care, and all medically necessary treatment recognized under the Medicaid statute regardless of whether services are covered for adults. Coverage must be in accordance with standards of preventive health care and must be furnished in order to ameliorate both acute and chronic conditions. Coverage levels exceed normal coverage limitations under commercial insurance principles.	Directs the Secretary to undertake a study of the actuarial value of the EPSDT program, including the medically necessary treatment requirement.	Contains similar provision but study would be directed at EPSDT generally.
PROVIDER REIMBURSEMENT **Obstetric/Pediatric Providers**	States must submit data on obstetrical and pediatric payment levels to ensure that payments are sufficient to enlist adequate providers.	No change.	Repeals obstetrical and pediatric payment rate requirements.

[1] *Excerpted from: Sara Rosenbaum and Julie Darnell. (July 1997). A Comparison of the Medicaid Provisions in the House and Senate Budget Reconciliation Legislation. Prepared for the Kaiser Commission on the Future of Medicaid. Washington, DC: Center for Health Policy Research, The George Washington University Medical Center.*

Resources . . .

KIDS COUNT

The 1997 edition of the Annie E. Casey Foundation's *KIDS COUNT* Data Book provides updated national and state-by-state information on the status of the nation's children.

To order, call (410) 223-2890.

Managed Care and Prenatal Care

The National Academy of Social Insurance, with the support of the March of Dimes Birth Defects Foundation, presents a compendium of current publicly and privately-funded research projects that focus on how managed care affects the financing and the delivery of maternal and child health services.

To order *1997 Inventory of Selected Current Research on Perinatal Care in the Changing Health System* call (202) 452-8097.

Title V

The Association of Maternal and Child Health Programs' latest publication documents the range of roles that state Title V programs have pursued, often through partnerships, to assure quality services in managed care.

To order *Partnerships for Healthier Families: Roles for State Title V Programs in Assuring Quality Services for Women, Infants, Children, and Youth in Managed Care* call (703) 356-1964.

Clinical Policy

In a new report from the Milbank Memorial Fund and the March of Dimes, experts on clinical policy present consensus statements on four issues—scheduling of prenatal visits, HIV testing and treatment for pregnant women, use of cesarean birth, and hospital discharge of mothers and infants.

To order *Perinatal Practice in the Best Interest of Patients: Four Statements of Policy to Improve the Outcome of Pregnancy* call either (212) 355-8400 or (914) 428-7100.

Foster Care

In a publication by the Child Welfare League of America, foster parents and caseworkers will find an easy-to-read resource on using managed health care services.

To order *Managed Health Care Guide for Caseworkers and Foster Parents* call (800) 407-6273.

Minority Health

The Child Welfare League of America presents the proceedings of the First African American Child Welfare Summit that took place in June 1995, addressing the disproportionate rate of out-of-home placement of African American children and the implications for African American families and communities.

To order *Children in Social Peril: A Community Vision for Preserving Family Care of African American Children and Youth* call (800) 407-6273.

Fetal Alcohol Syndrome

This guide from the Child Welfare League of America Press offers practical advice and information on the fetal alcohol syndrome's lifelong behavioral and learning effects.

Order *Recognizing and Managing Children with Fetal Alcohol Syndrome/Fetal Alcohol Effects: A Guidebook* by e-mail at books@cwla.org or call (202) 638-2952.

The Future of Children

The last two issues of *The Future of Children* focus on the juvenile courts and welfare reform, respectively, and offer recommendations in both areas.

Order *The Juvenile Court* and *Welfare to Work* by e-mail at circulation@futureofchildren.org or FAX (415) 948-6498. The journal is also on-line at http://www.futureofchildren.org.

Health Insurance

Using data from the 1994 National Health Interview Survey, Families USA analyzes the impact of long and short spells without health insurance on children's access to health care.

To order *Unmet Needs: The Large Differences in Health Care Between Uninsured and Insured Children* call (202) 628-3030.

Key Indicators

The Federal Interagency Forum on Child & Family Statistics presents statistical information on 25 indicators of children's well-being in this new report.

The full text (in a PDF format) of *America's Children: Key National Indicators of Well-Being (July 1997)* is on-line at http://www.cdc.gov/nchswww/about/otheract/children/child.htm.

Access to Care

The Southern Regional Project on Infant Mortality provides an overview of the utilization of allied professionals in the South, reviews research on quality of care and cost-effectiveness of using these practitioners, provides general and state-specific results from a survey of key stakeholders regarding state practice environments, and concludes with policy recommendations.

To order *Increasing the Utilization of Certified Nurse-Midwives, Nurse Practitioners, and Physician Assistants in the South* call (202) 624-5460.

Child Health Coverage

The General Accounting Office presents updated data on health insurance coverage for children in three recent publications.

To order *Employment-Based Health Insurance—Costs Increase and Family Coverage Decreases* (HEHS-97-35), *Health Insurance For Children—Declines in Employment-Based Coverage Leave Millions Uninsured, State and Private Programs Offer New Approaches* (T-HEHS-97-105), and *Uninsured Children—Estimates of Citizenship and Immigration Status in 1995* (HEHS-97-126R) call (202) 512-6000.

FOR THE RECORD

Revisiting EPDST

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, the Medicaid benefit package for poor children through age 21, has been part of Medicaid since 1967. Children living in poverty are more likely than non-poor children to suffer from acute and chronic ill health; the program was designed to ensure poor children's access to early and comprehensive preventive care and treatment. EPSDT acknowledges that developing children have unique health needs that, if unaddressed, can have long-term consequences.

EPSDT is defined in Medicaid statute as four basic services: (1) screening, (2) vision, (3) dental, and (4) hearing services which are provided periodically according to standards of professional practice. Interperiodic screens are to be provided if there is reason to suspect a health problem between regularly scheduled screenings. Screening services include the following:

- comprehensive health and developmental history, including assessment of physical and mental health;
- a comprehensive unclothed physical exam;
- appropriate immunizations according to age and health history;
- laboratory tests including blood lead levels as appropriate; and
- health education, including anticipatory guidance.

Required services include periodic hearing and vision exams, according to medically appropriate timetables, and necessary follow-up care for vision and hearing problems, including hearing aids and eyeglasses. Also, dental screens at medically appropriate intervals, and restorative and emergency dental care, as needed. In addition, federal regulations require states to furnish any "medically necessary" diagnostic and treatment services for illnesses or conditions identified during screening. Covered services include all mandatory and optional services that a state is permitted to cover under Medicaid, even if the state has opted not to offer that service to adults. For instance, if a provider shows that physical therapy is medically necessary for a child with a disability, physical therapy must be covered, even if the child lives in one of the 10 states that does not pay for adults' physical therapy.

State Medicaid programs may not include copayments or coinsurance for the majority of Medicaid beneficiaries eligible for EPSDT. Unlike most private plans, very few limitations exist on the amount and duration of Medicaid EPSDT benefits. State Medicaid programs may not limit EPSDT benefits in any way that would have the effect of denying necessary health care. For example, if a state limits covered hospital days for adults (state limits are as low as 16 days per year) it must make an exception for children, such as sick newborns, who need longer hospital care.

In addition, states are required to conduct aggressive outreach and informing activities, provide case management services and non-emergency transportation necessary to obtain primary and preventive care and treatment, and to coordinate EPSDT services with other children's programs.

Sources: National Health Law Program; MCH Coalition; Congressional Research Service; National Institute for Health Care Management

HEALTH POLICY & CHILD HEALTH is published quarterly by the Center for Health Policy Research at The George Washington University Medical Center. The Center conducts sponsored research and policy analysis on a wide range of health and related scientific issues. *Health Policy & Child Health* seeks to promote awareness of the implications of state and federal policies and programs for the health of mothers, infants, children and adolescents and to disseminate information on federal and state activities, laws, programs and other public initiatives likely to affect maternal and child health.
The newsletter is supported by a grant from The David and Lucile Packard Foundation Center for the Future of Children.

Staff
Christopher DeGraw
M.D., M.P.H.
Project Director

Anne Rossier Markus
J.D., M.H.S.
Research Associate

Sara Rosenbaum, J.D.
Director
Center for Health Policy Research

For information on the newsletter or other activities of the Center for Health Policy Research, please write or call:

Health Policy & Child Health
Center for Health Policy Research
2021 K Street, N.W. Suite 800
Washington. D.C. 20006

Phone: 202-296-6922
Fax: 202-296-0025
E-mail: ihoarm@gwumc.edu