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policy brief

FAMILIES AT RISK:

THE IMPACT OF CO-PAYMENTS AND REDUCED BENEFITS ON CHILDREN ENROLLED IN HUSKY A

SUMMARY

- Connecticut will become the first and only state to abolish federal minimum standards for children's health care services and the first state to charge co-payments for all children in its Medicaid program.
- If co-payments are charged, children's visits to health care providers can be expected to decline by as much as 30 percent.
- The health of 30,000 to 40,000 children with special health care needs will be at risk if Connecticut eliminates Medicaid's guarantee of necessary health care services for children and charges co-payments for their care.
- Eliminating Connecticut's accountability to see that children in HUSKY A receive regular check-ups will decrease the number of children receiving preventive care and increase costs for preventable conditions.

When Connecticut's Medicaid managed care program began, health plans sometimes applied to Medicaid some restrictions applicable to commercial business. The following cases, handled by the Children's Health Infoline, show the importance of EPSDT to low-income families. While these services were eventually covered under EPSDT, such services will no longer be covered if EPSDT is eliminated.

- A child with asthma had prescriptions for a humidifier and pulmonaid nebulizer, but coverage for "non-covered durable medical equipment" was denied by the health plan.
- A child with a broken tooth was denied a crown on the grounds that the type of crown she needed was not covered by the health plan.
- A child who needed eyeglasses to replace a broken pair was denied because the health plan allowed only one pair every 12 months.

CONNECTICUT PLANS UNPRECEDENTED CHANGES IN MEDICAID FOR CHILDREN

In August 2003, the Connecticut General Assembly passed a law requiring that the Department of Social Services (DSS) ask the federal government for a waiver that would make unprecedented changes in Connecticut's Medicaid program, known as HUSKY A.[1]

In addition to charging monthly premiums for children and pregnant women in families with income over 50 percent of the federal poverty level, the new law calls both for a reduction in HUSKY A benefits and for co-payments on services for children:[2]

- Benefits will be reduced to the typical commercial package currently offered in the state employee health benefit program, effectively eliminating the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is a federal requirement that sets a minimum benefit level for low-income children covered by Medicaid and holds states accountable for providing these services.
- For the first time, families will be charged co-payments for children's medical services and medication; in some circumstances, prescriptions will not be filled without payment of the fee.

Pending federal approval, these changes would apply to all 210,000 children enrolled in HUSKY A, including 30,000 to 40,000 children with special health care needs.[3]

If federal approval is granted, Connecticut will become the first and only state to eliminate EPSDT standards for children in families with income below the federal poverty level and the first to charge co-payments for services delivered to these children. The impact of these changes will be greatest for the lowest income families and for families whose children need health care services for chronic and disabling conditions.[4]

Connecticut Health Foundation

THE ANTHEM FOUNDATION OF CONNECTICUT, INC.

EPSDT MEANS CARE FOR CHILDREN, ACCOUNTABILITY FOR CONNECTICUT

Nearly one out of four Connecticut children under 19 are enrolled in the state's Medicaid program, known as HUSKY A. Since 1967, the EPSDT program has ensured timely and comprehensive preventive care and medically necessary treatments for children covered by Medicaid — including services that the state has chosen not to cover for adults.[5]

Children in HUSKY A receive well-child exams, dental care, vision and hearing screening, immunizations, laboratory tests, lead screening, prescriptions, and health education. EPSDT was designed to meet the health care needs of low-income children and those with chronic or disabling conditions.[6]

Regular well-child care is the foundation of the EPSDT program. Periodic screening and preventive care can reduce vaccine-preventable diseases, sexually transmitted disease, impaired vision, dental caries, unplanned pregnancies, and other conditions, with better health for individuals and families and long-range cost-savings for the state. [7]

Besides guaranteeing a high standard of care, EPSDT holds states accountable for providing that care. States must inform families about the importance of preventive care and provide assistance with scheduling appointments and transportation. States must submit annual reports on their progress in meeting the 1989 federal goal that at least 80 percent of children receive at least one well-child visit each year. While Connecticut has yet to meet the federal goal, it has made some progress. In federal fiscal year 2002, Connecticut's participant ratio was 56 percent, up from 41 percent in 1994.[8]

To ensure that children receive necessary services, federal law prohibits states from charging co-payments for services to children. Therefore, Connecticut would need a waiver of federal law to impose co-payments on children's health care services.[9]

MEDICAID IMPROVES ACCESS TO CARE

By guaranteeing health care services to children and holding states accountable for providing services, the federal Medicaid program has improved access to care for children who would otherwise probably be uninsured. Children in Medicaid are more likely than uninsured children to receive preventive services.[10]

In fact, children with Medicaid coverage use preventive services at rates that are comparable to privately insured children. Results of the 1997 and 1999 National Surveys of America's Families showed that children in low-income families who are covered by Medicaid are actually more likely than uninsured and privately insured low-income children to have had recommended periodic well-child care.[11]

Eliminating the state's responsibility for ensuring that children get regular well-child care is likely to increase the number and severity of preventable childhood health problems.

The EPSDT program is especially important for children with special health care needs who are more likely than other children to be covered by public insurance.[12] Nearly one in four Connecticut children with special health care needs has HUSKY coverage, either alone or with private coverage.[13]

Medicaid's EPSDT benefit package was designed to meet the needs of these low-income children, who suffer disproportionately from ill health and chronic, disabling conditions.[14]

For example, through EPSDT thousands of Connecticut children with asthma have access to the supplies, equipment, and prescriptions they need to avoid unnecessary and costly trips to the emergency room. Disabled children can get hearing aids, wheel chairs, or other equipment they need to attend school.

Comparison of HUSKY A and State Employee Health Benefits Plan

Benefit	Husky A (Medicaid)	State Employee Plan
Durable medical equipment such as wheelchairs, walkers, and nebulizers	covered	not covered
Special shoes and braces	covered	not covered
Medically necessary over–the-counter drugs	covered	not covered
Eyeglasses	covered	not covered
Hearing aids	covered	not covered
Medical and surgical supplies (including mattress and pillow covers and vacuum filters for children with asthma)	covered	not covered
Physical, occupational, and speech therapy	covered to attain or maintain optimal level of health	covered if therapy is expected to result in reasonable improvement
Non-emergency medical transportation	covered	not covered

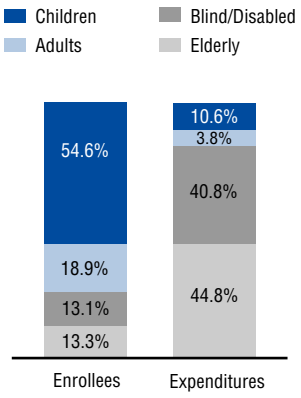
The Anthem Point of Enrollment plan, one of three such plans available to state employees, was used as the comparison for this analysis.

CHILDREN'S HEALTH COVERAGE IS ECONOMICAL

While EPSDT coverage is comprehensive, it is not expensive. Although children make up 54.6 percent of Medicaid beneficiaries in Connecticut, the cost of children's health care is just 10.6 percent of the state's Medicaid expenditures.[15]

In FY 2001, the annual cost of insurance for children and parents in HUSKY A was just two-thirds of the cost of insurance for Connecticut state employees and retirees ($1,730 per covered individual vs. with $2,598).[16]

Children Are More Than Half of Medicaid Enrollees but Account for Only 10.4 Percent of Program Costs



Source: Centers for Medicare and Medicaid Services MSIS data, 2001. Does not include 5.6 percent of total expenditures which are not attributed to an enrollee group.

CHILDREN WITH SPECIAL NEEDS HIT HARDEST BY REDUCTIONS

The proposed changes — elimination of coverage for transportation, over-the-counter medication, and eyeglasses, as well as reductions in dental and mental health services — will affect all families with children in HUSKY A. However, the impact will be most significant for children with special health care needs.

Under federal law, Medicaid covers all medically necessary services for children according to individual need. In contrast, private health insurance coverage typically limits services through service exclusions or through definitions of medical necessity that are more restrictive than the EPSDT definition.[17]

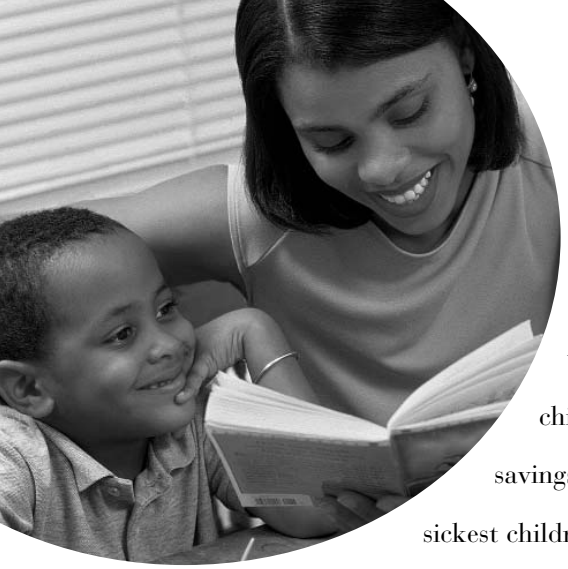
Even when specialty care and services are covered, private insurance plans often provide these services only to children with conditions that are likely to improve. However, even children with chronic conditions and disabilities that may not improve can benefit from services targeted to maintaining their ability to function at an optimal level. Commercial plans typically list specific exclusions for therapy (physical, occupational, speech) and mental health services, regardless of whether the services are medically indicated.[18]

In fact in 1998, when Connecticut modeled the benefit package for Connecticut's State Children's Health Insurance program (HUSKY B) on the state employee health plan, two supplemental benefit programs for children with special health care needs were created. These supplemental programs addressed the shortcomings in the state employee health plan benefit package for children with special health care needs — those whose health will be most severely compromised by the proposed changes.

CO-PAYMENTS REDUCE ACCESS TO CARE

Imposing co-payments on low-income families results in reduced use of health care services. Nearly 20 years ago, the Rand Health Insurance Experiment showed that children's use of outpatient care decreased up to 30 percent, depending on the degree of cost-sharing.[19] Both well-child visits and acute care visits declined as cost-sharing increased.

In 1998, the Institute of Medicine reported that while "insurance coverage is the major determinant of whether children have access to health care…the presence of insurance alone will not eliminate all barriers to...appropriate health care services."[20] In particular, this panel cited the shortcomings of private coverage for low-income families by showing that out-of-pocket expenses represent a relatively high proportion of family income, especially for families with chronically ill children. Coupled with the reduced benefit package resulting from the elimination of EPSDT guarantees, charging co-payments will undermine the ability of already struggling families to get their children the care they need.



CONCLUSION: HIGH COST IN HEALTH FOR MINIMAL SAVINGS

A reduced benefit package, a more restrictive definition of medical necessity, the imposition of co-payments, and the elimination of government accountability for the delivery of services will have the greatest impact on low-income families with children who need the most care. While the proposed changes will result in only small savings to the state, the negative impact on the health of Connecticut's poorest and sickest children will be significant.

- Connecticut will become the first and only state to abolish federal minimum standards for children's health care services and the first state to charge co-payments for all children in its Medicaid program.
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- Eliminating Connecticut's accountability to see that children in HUSKY A receive regular check-ups will decrease the number of children receiving preventive care and increase costs for preventable conditions.

REFERENCES

1 Section 72, Public Act 03-3.

2 For further information about the potential impact of premiums on enrollment of parents and children in HUSKY A, see Alker J, Solomon J. *Families at Risk: The Impact of Premiums on Children and Parents in HUSKY A* (Farmington, Conn.: Connecticut Health Foundation and The Anthem Foundation of Connecticut, Inc., November 2003).

3 Estimate that 15 percent to 20 percent of children in HUSKY A have special health care needs is based on analysis of HUSKY enrollment and utilization data and is consistent with national data. For more information, see *Survey to Assess Access to Care and Satisfaction* (Hartford, Conn.: Children's Health Council, 2000) and Newacheck P.W., et al. "An Epidemiologic Profile of Children with Special Health Care Needs," *Pediatrics* (1998), 102(1): 117-121.

4 Federal guidelines on waivers would not allow co-payments and waiver of EPSDT requirements to affect the poorest children as is required by the Connecticut law. *Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative* (Washington, D.C.: Centers for Medicaid and Medicare Services) http://www.cms.hhs.gov/hifa/default.asp.

5 The Connecticut Department of Social Services defines medical necessity as "health care provided to correct or diminish the adverse effect of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnosis a condition or prevent a medical condition from occurring." Section 17b-262-673 of the regulations of Connecticut State Agencies.

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8 Form CMS-416 prepared by the Connecticut Department of Social Services.

9 The Committee report that accompanied the 1982 bill on cost-sharing in Medicaid stated that in the Committee's view there is "no justification for denying a poor child services because of that child's family's inability to pay." Report of the Energy and Commerce Committee, Rept. 97-757, Part 1, 97th Congress, 2d Session (Washington, D.C.: August 17, 1982).

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14 Blumberg SJ, Osborn L, Luke J.V., et al. *Estimating the prevalence of uninsured children: an evaluation of data from the National Survey of Children with Special Health Care Needs*, 2001 (National Center for Health Statistics). Vital and Health Statistics (forthcoming).

15 Ibid.

16 *Children With Disabilities: Medicaid can Offer Important Benefits and Services* [GAO/T-HEHS-00-15] (Washington, D.C.: U.S. General Accounting Office, 2000).

17 Centers for Medicare and Medicaid Services MSIS data, 2001

18 State of Connecticut Office of Health Care Access. Purchaser profile: HUSKY A and B. Hartford, Conn.: January 2001.

19 Leibowitz A, Manning WG, Keeler EB, Duan N, Lohr KN, Newhouse J.P. "Effect of Cost-Sharing on the use of Medical Services by Children: Interim Results from a Randomized Controlled Trial," *Pediatrics*, (1985), 75 (5): 942-951.

20 Edmunds M, Coye M.J. *American's Children: Health Insurance and Access to Care.* (Washington, D.C.: National Academy Press, 1998), 3.

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