REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - A-07

Subject: No Child Left Uninsured
(Resolution 113, A-06)

Presented by: William A. Dolan, MD, Chair

Referred to: Reference Committee A
(Virginia E. Hall, MD, Chair)

At the 2006 Annual Meeting, the House of Delegates referred Resolution 113. Introduced by the California Delegation, the resolution calls for the American Medical Association (AMA) to "support federal legislation and funding to ensure the availability of health care coverage for all American children by: (1) requiring all parents to provide proof of insurance of each child (through employer-based, individual or government-sponsored coverage) with their federal tax returns, upon penalty of losing the tax exemption for that child; (2) allowing all parents the option to purchase coverage for their children through the State Children's Health Insurance Program (SCHIP) program (Healthy Families, in California) at actuarially-adjusted, revenue-neutral cost, without regard to pre-existing conditions; (3) incentivizing states to expand SCHIP coverage to families up to 300% of federal poverty line; (4) ensuring adequate physician reimbursement levels for the SCHIP program, and eliminating barriers to enrollment." Resolution 113 (A-06) also asks that the AMA "use all of its best efforts to bring about the passage of such legislation." The Board of Trustees referred Resolution 113 (A-06) to the Council for study and a report back to the House of Delegates at the 2007 Annual Meeting.

This report summarizes federal and state activity to reduce the number of uninsured children; reviews AMA advocacy efforts on increasing children's access to health insurance; provides a crosswalk of AMA policy with the actions proposed in Resolution 113 (A-06); and highlights state examples of extending coverage to children. As a result of this analysis, the Council believes that the elements of Resolution 113 (A-06) are substantially addressed, and in some cases improved upon, by AMA policy. Continued efforts on the part of the AMA to cover children are recommended.

FEDERAL ACTIVITY

Much of the language included in Resolution 113 (A-06) is identical to language contained in Senate bill S. 114, the "Kids Come First Act of 2005." S. 114, introduced by Senator John Kerry in January 2005, was a proposal to ensure that every uninsured child in America could obtain health insurance coverage. A corresponding House bill, H.R.1668, was introduced in May 2005, by Representative Henry Waxman. Both were referred to committee with no further action. Since then, several bills with similar intent have been introduced on the federal level, including the 2007 reintroduction of both the Kerry (S. 95) and Waxman (H.R. 1111) bills. These bills have been referred to committee with no action to date.

Testimony at the House of Delegates regarding Resolution 113 (A-06) raised significant concerns that the resolution's support for federal legislation had the potential to interfere with successful

state programs. This concern is consistent with the AMA's preference for providing states with the freedom to test different models for expanding health insurance coverage to the uninsured. For example, in January 2007, the AMA supported the reintroduction of Senate bill S. 325, the "Health Partnership Act" and House bill H.R. 506, the "Health Partnership Through Creative Federalism Act." These bills seek to reduce the number of uninsured Americans by providing state-based grants that would provide an opportunity for states to experiment with innovative approaches to expand coverage, increase quality, and decrease health care costs. In addition, SCHIP is due for reauthorization in 2007. The key issues of contention as Congress debates reauthorization will be eligibility, the formula for allocating federal funds to the states, and funding levels.

STATE ACTIVITY

Since June 2006, when Resolution 113 (A-06) was introduced to the House of Delegates, state legislatures and governors have responded to the lack of federal legislation with a number of proposals to cover the uninsured. Massachusetts and Vermont have enacted laws that aim to provide universal coverage. The activities in these two states have prompted numerous others to seek comprehensive reform, many of which include Medicaid and SCHIP expansions.

At least 10 states are either currently attempting to increase coverage for children, or have already done so. *All Kids* in Illinois was the first program to offer government health insurance to all children and many states are planning to follow suit. Even so, increased state efforts to expand health insurance coverage comes at a time when funding is uncertain. Fourteen states are projected to experience federal funding shortfalls this year for SCHIP. Although President Bush's Fiscal Year (FY) 2008 budget proposal includes a $4.8 billion increase in funds for SCHIP over five years, the Congressional Research Service estimates that $15 billion in new funds are needed to maintain coverage for current program enrollees.

To aid states in 2007, Congress approved, as part of the "National Institutes of Health Reform Act of 2006," an amendment to redistribute unspent SCHIP allotments from FY 2004 and 2005. The funds are being redistributed monthly among states facing FY 2007 program shortfalls. Each eligible state is receiving funds during the month in which it is expected to face a shortfall. However, this reallocation only succeeded in delaying the date that states started experiencing shortfalls through early May 2007. Although these provisions redistribute an additional $125 million for projected FY 2007 shortfalls, the remaining shortfalls for the fiscal year are projected at $716 million.

AMA POLICY AND ADVOCACY ON THE UNINSURED

The AMA proposal for covering the uninsured is based on long-standing policy that advocates for individually selected and owned health insurance, and supports refundable and advanceable tax credits that are inversely related to income that would enable patients to purchase coverage of their own choice (Policies H-165.920 and H-165.865, AMA Policy Database). In addition, AMA policy supports implementation of individual tax credits for the purchase of health insurance for specific target populations, including children (Policy H-165.851[1]). In the absence of private sector reform, the AMA supports eligibility expansions of public sector programs, such as SCHIP, with the goal of improving access to health care coverage to otherwise uninsured groups (Policy H-290.974[1]).

Whereas Resolution 113 (A-06) seeks to define eligibility and coverage through federal legislation, AMA policy with respect to Medicaid and SCHIP supports federal legislation as a means to authorize and fund state-based demonstration projects to expand health insurance coverage to the uninsured (Policies D-165.959, D-165.968[1]). Furthermore, the AMA is committed to working with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income individuals (Policy D-165.966[3]).

With SCHIP due for reauthorization this year, the AMA is working with members of Congress to reauthorize the program with provisions to intensify outreach efforts to ensure that all eligible individuals become enrolled. The AMA strongly supports the simplification of enrollment and renewal and has been promoting important elements to ensure the inclusion of comprehensive services and children's access to health insurance.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. It ensures that children receive periodic assessment, screening of potential medical, mental health, dental, vision, and hearing conditions as well as diagnosis and necessary treatment services. While these services are covered under Medicaid, not all SCHIP programs provide comprehensive EPSDT coverage. For states that opt for a Medicaid expansion, the services provided under SCHIP mirror the Medicaid services provided by the state. However, states that have implemented a separate SCHIP program may not necessarily include full EPSDT services. In 2005, 32 states and Washington, DC had programs that were classified as Medicaid expansions or combinations, while the following 18 states were classified as separate programs: Alabama, Arizona, Colorado, Connecticut, Georgia, Kansas, Mississippi, Montana, Nevada, North Carolina, Oregon, Pennsylvania, Texas, Utah, Vermont, Washington, West Virginia, and Wyoming.

The AMA advocates that children's access to physicians at an early age is essential and supports adequate preventive care services. Specifically, the AMA promotes the importance of the EPSDT program, advocating for it to remain intact as critical to the health and well-being of children (Policy D-290.987). In addition, the AMA encourages state and county medical societies to work to ensure that services to children, adolescents, and young adults meet EPSDT requirements (Policy D-290.985[3]).

Health Coverage Coalition for the Uninsured (HCCU)

Expanding health insurance coverage for the uninsured is a top AMA priority. Through participation in the Health Coverage Coalition for the Uninsured (HCCU), the AMA has prioritized the coverage of all children as soon as possible. The HCCU agreement, announced in January 2007, proposes to expand coverage to the uninsured in two phases, the first being the "Kids First" initiative and support for state experimentation. The second phase focuses on uninsured adults.

The HCCU Kids First initiative proposes to improve enrollment of children who are uninsured but currently eligible for SCHIP and Medicaid. This would be accomplished by giving states the flexibility to deem low-income uninsured children eligible and enroll them in SCHIP or Medicaid when they qualify for other means-tested programs. It would also provide states with the additional federal SCHIP funds needed to pay for the resulting increased enrollment of children

from lower-income families. In addition, the proposal supports increasing children's health insurance coverage in the private sector by creating a new family tax credit for the purchase of children's health coverage through employer-sponsored health insurance plans. The tax credit would be available to families with incomes up to 300% of the federal poverty level (FPL). In addition, under the HCCU proposal, the federal government would authorize and fund demonstration projects giving states flexibility to experiment with new approaches to expand health insurance coverage. Competitive grants would be provided to the states which, unlike Medicaid waivers, would provide additional funding above current federal funds provided to states for Medicaid and SCHIP. This state demonstration program would reward performance toward the achievement of expanded coverage benchmarks.

COMPARISON OF RESOLUTION 113 (A-06) WITH AMA POLICY

Health Insurance Mandate

Resolution 113 (A-06) calls for a requirement that all parents provide health insurance for their children. This requirement exceeds the income threshold for individual responsibility established by Policy H-165.849, which supports all individuals and families earning greater than 500% of FPL to obtain at least coverage for catastrophic health care and evidence-based preventive health care. This policy also supports an individual responsibility requirement for those families earning less than 500% of FPL only upon implementation of a system of refundable tax credits or other subsidies to help obtain the required health insurance coverage.

The following four states have enacted comprehensive health system reform proposals: Massachusetts, Vermont, Maine, and Hawaii. Of these, only Massachusetts' plan includes an individual mandate for residents to purchase "creditable" health insurance coverage where an affordable product is available. If no affordable policy exists, a waiver is processed through the new state Connector. Those living below 300% of FPL who are not eligible for publicly-funded programs will be provided subsidized insurance based on a sliding scale, with those living below 100% of FPL eligible for total subsidization.

Buy-In Options

As called for in Resolution 113 (A-06), the AMA supports providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level (Policy H-290.982[8]).

As of July 2006, the following eight states were operating some form of SCHIP buy-in program: Connecticut, Florida, Illinois, Maine, North Carolina, New Hampshire, New York, and Pennsylvania. All eight states offer the same benefit package to buy-in recipients that SCHIP recipients receive. Four of the eight states (Connecticut, Florida, Illinois, and Maine) offer the buy-in program to all children regardless of income and are part of comprehensive efforts to cover all children in the state.

The Deficit Reduction Act (DRA) of 2005, which included the Family Opportunity Act (FOA), created a new option that allows states to offer Medicaid buy-in coverage to children with disabilities in families with income below 300% of FPL. This provision began in January 2007. The Congressional Budget Office estimates that 115,000 children with disabilities will gain

Medicaid coverage by 2015 as a result of these provisions, and about two-thirds of the states will eventually participate in this program.

Expanding Eligibility

As called for in Resolution 113 (A-06), the AMA supports providing additional funding for SCHIP earmarked to enroll children to higher percentages of the poverty level (Policy H-290.982[8]). Most importantly, AMA policy advocates that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes including combining advance and refundable tax credits to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; and also advocates changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds (Policy D-165.966[1,2]).

SCHIP is designed to provide coverage to "targeted low-income children." A "targeted low-income child" is one who resides in a family with an income below 200% of the FPL or whose family has an income 50% higher than the state's Medicaid eligibility threshold. While some states have expanded SCHIP eligibility for families with incomes beyond the 200% of FPL limit, others are covering entire families and not just children.

Physician Reimbursement

As called for in Resolution 113 (A-06), the AMA supports setting Medicaid and SCHIP payment rates at a level that encourages wide health care physician participation in both programs and affirms a commitment to advocating for reasonable SCHIP and Medicaid reimbursement for medical providers, defined as at minimum 100% of RBRVS Medicare allowable (Policies D-290.996[2d] and H-290.976[2]). Adequate physician payment under Medicaid and SCHIP is essential to enable state programs to have enough physicians to treat beneficiaries. Access to care becomes more limited when physicians cannot afford to accept Medicaid or SCHIP patients. Limited access to care significantly impacts the level, frequency and location (e.g. emergency room) of care Medicaid recipients receive, often resulting in increased costs and poorer health outcomes.

According to a 2005 survey conducted by the Center for Studying Health System Change, 21% of physicians reported not accepting new Medicaid patients, whereas 4.3% reported not accepting new private insured patients and 3.4% reported not accepting new Medicare patients. According to the American Academy of Pediatrics (AAP), on average, Medicaid reimburses a pediatrician for a standard office visit at only 69% of Medicare rates and only 56% of commercial rates. Recent advocacy efforts on Medicaid reimbursement have succeeded in convincing at least the following six states to increase Medicaid rates for physicians: Maryland, Michigan, New Mexico, Oklahoma, Virginia, and Wyoming.

With wide variance in Medicaid programs between states, North Carolina is one of the few that comes close to the AMA's recommended payment rate. Through the Community Care for North Carolina program, primary care providers in North Carolina receive an enhanced case management fee of $2.50 per member per month and are paid 95% of the Medicare fee schedule for Medicaid covered services. This program manages about 74% of all eligible Medicaid beneficiaries in the

state and is viewed as an example of a successful strategy for delivering cost-effective primary care to Medicaid beneficiaries.

Eliminating Barriers to Enrollment

As called for in Resolution 113 (A-06), AMA policy supports all states maximizing their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds. Specifically, AMA policy encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and SCHIP programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible (Policies H-290.976[1] and H-290.982[2]). Furthermore, AMA policy calls for states to streamline the enrollment process within their Medicaid and SCHIP programs by allowing mail-in applications, developing shorter application forms, coordinating application processes, placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care and urging states to administer their Medicaid and SCHIP programs through a single state agency (Policy H-290.982[5,6]).

In 2006, 28 million children were enrolled in Medicaid and 4.4 million in SCHIP. It is estimated that approximately 70% of the more than 8 million uninsured children are eligible, but unenrolled in public health coverage. Eliminating barriers to enrollment and facilitating the ease of renewal is key to ensuring these children obtain health insurance.

Summarizing recent state efforts, a 50-state survey (including Washington, DC) released in January 2007 by the Kaiser Commission on Medicaid and the Uninsured indicates that 17 states (one-third) increased access to health coverage in 2006, and for the first time in four years no states cut income eligibility in Medicaid and SCHIP. States reported using various strategies to increase enrollment and facilitate renewal.

Thirty-three states reported streamlining their programs by using a single application for Medicaid and SCHIP enrollment. Forty-six states have eliminated an interview at enrollment, while the following still require one: Kentucky (Medicaid and SCHIP), Mississippi (Medicaid and SCHIP), New York (Medicaid), Tennessee (Medicaid), and Utah (Medicaid and SCHIP). In addition, asset tests are not required in 46 states; however, the following states have instituted some form of asset limit for its Medicaid program: Montana, South Carolina, Texas, and Utah. Two states have set an asset test limit for its SCHIP program: Oregon and Texas.

The majority of state programs have not instituted presumptive eligibility, whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be eligible. Only nine Medicaid and six SCHIP programs had these practices in place as of July 2006. The Medicaid programs with presumptive eligibility are located in California, Connecticut, Illinois, Massachusetts, Michigan, Missouri, New Hampshire, New Jersey and New Mexico. The SCHIP programs with presumptive eligibility are in California, Illinois, Massachusetts, Michigan, New Jersey, and New York.

Eighteen states use a joint renewal form for Medicaid and SCHIP. Forty-eight states do not require an interview at renewal, while the following still require one: Arizona (Medicaid), Mississippi (Medicaid and SCHIP) and Tennessee (Medicaid). In addition, 44 states reported a 12-month renewal period, while the following are still on a six-month renewal basis: Alaska (Medicaid),

Georgia (Medicaid), Minnesota (Medicaid), Nebraska (Medicaid), Oregon (Medicaid and SCHIP), Pennsylvania (Medicaid), and Texas (Medicaid and SCHIP). Sixteen Medicaid and 25 SCHIP programs reported 12-month continuous eligibility in 2006, indicating the majority could improve renewal by instituting this practice.

DISCUSSION

The Council's comparison of AMA policy with elements of Resolution 113 (A-06) indicates substantial consistency. Where there is inconsistency is on the policy regarding individual responsibility. Whereas the AMA supports individual responsibility below 500% of FPL only if appropriate subsidies are available, Resolution 113 (A-06) proposes a mandate for all children, with no subsidy for children in families with incomes above 300% FPL. The Council believes that the threshold for individual responsibility established in Policy H-165.848 continues to be appropriate.

In light of comprehensive AMA policy and advocacy, including collaboration with HCCU, support of SCHIP reauthorization and support of state innovation, the Council is optimistic about the momentum to cover all uninsured children. Accordingly, the Council supports continued efforts on the part of the AMA to cover children.

Finally, given the absence of federal legislation to cover the uninsured, there has been a great deal of interest at the state level. The Council is monitoring state activity and will develop a report for the 2007 Interim Meeting outlining state initiatives to cover the uninsured, including children.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 113 (A-06), and the remainder of the report be filed:

1. That our American Medical Association continue to support health insurance coverage of all children as a strategic priority. (Directive to Take Action)

2. That our AMA continue to support efforts to expand coverage to uninsured children who are eligible for the State Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms. (Directive to Take Action)

3. That our AMA continue to support the reauthorization of SCHIP in 2007. (Directive to Take Action)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: Continue to support improved and streamlined enrollment for Medicaid and SCHIP, and continue support of SCHIP reauthorization at an estimated total staff cost of $2,525.