Tough Choices:
A Policy Maker’s Guide
to Cost Containment Actions Affecting
Children in Medicaid and SCHIP

Cindy Shirk

February 2004

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David and Lucile Packard Foundation
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by

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INTRODUCTION

Across the country, states are grappling with how to balance their budgets. Forty-seven states experienced budget deficits in 2003. Program cuts were made in areas that had not experienced significant reductions in years, including such previously protected areas as health and education. 2004 looks no better; 41 states are expected to face a total deficit of over $78 billion, representing budget deficits of more than five percent of the general fund in most of these states.¹

State revenues have fallen significantly as the economy has softened since 2001. At the same time, the costs of Medicaid have risen 25 percent in two years and more than 50 percent since 1997, and enrollment is rising at the fastest pace in a decade.² While most of the enrollment growth has been among families and children, it is important to note that most of the cost increases have been to provide care to the elderly and disabled.

The effect of the decline in state revenues, however, is much larger than the effect of rising Medicaid costs. One analysis estimates the drop in state revenue collections cost states $62 billion in unexpected shortfalls in fiscal year 2002, while the unexpected growth in Medicaid spending accounted for only $7 billion in shortfalls.³ Medicaid spending now totals $257 billion (federal and state funds) nationwide and represents almost as much of state budgets as K-12 education. As Table 1 illustrates, states, on average, spent 20 percent of their budget on Medicaid in 2001.

Table 1  Medicaid spending is second only to public education funding

<table>
<thead>
<tr>
<th>Total state spending in FY 2001</th>
<th>$1 Trillion</th>
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<tr>
<td>Elementary and secondary education</td>
<td>22%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>20%</td>
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<tr>
<td>Higher education</td>
<td>11%</td>
</tr>
<tr>
<td>Transportation</td>
<td>9%</td>
</tr>
<tr>
<td>Corrections</td>
<td>4%</td>
</tr>
<tr>
<td>Public Assistance</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>28%</td>
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Source: National Conference of State Legislatures, November 2002 State Budget Update.

With declining revenues and increasing costs on a collision course in almost all states, a discussion of cost containment and revenue enhancement options for SCHIP and children’s Medicaid coverage is warranted. Lawmakers and policymakers have tough choices ahead of them. These programs provide demonstrable benefits for the children receiving services and bring federal matching funds into the state; yet trimming costs in most states seems inevitable. At this point, it appears that 2004 will put even greater budgetary pressures on both of these public health coverage programs for children.

This briefing paper is designed to help legislators, state health policy officials, and other stakeholders think through the tough decisions they may need to make regarding cost containment activities in health care coverage programs, with a focus on actions that affect children under Medicaid and SCHIP. It identifies a menu of cost containment options that states have considered along with the pros and cons of those options. How states deal with fiscal pressures in Medicaid and SCHIP will differ because of the different rules for each program. This paper identifies those differences where they exist, as well as options for each program. In Medicaid, some measures will affect all populations; this paper focuses on those actions that have a greater impact for children. It is organized into three sections:

- Section I addresses states’ fiscal environment and children’s health programs. It discusses the current fiscal situation relative to children’s coverage through Medicaid and SCHIP.

- Section II identifies the menu of potential areas for cost containment. It briefly describes methods used to control costs for each area and discusses the pros and cons associated with those methods.

- Section III attempts to assist states in evaluating cost containment strategies by rating each strategy on three criteria: impact on children’s health, the magnitude of savings that can be obtained, and the administrative ease or difficulty of implementing the strategy.

Background

Medicaid and SCHIP are federal/state programs that provide health care coverage to low-income Americans. Together, they cover one out of every six children. Medicaid, established in 1965, is the single largest health insurer for children and provided approximately 24 million children health insurance at some point in 2002.\textsuperscript{4} It operates under a complex set of federal rules, including requirements for mandatory and optional categories of populations that can be covered, mandatory and optional benefits, and permissible cost sharing. Medicaid also requires that comparable services are offered to all eligible individuals on a statewide basis and that services are sufficient in amount, duration, and scope to address the needs of the populations. These rules, among others, will drive the cost containment strategies used by states. For example, the rules requiring that services are offered statewide to all eligible individuals prevent states from imposing enrollment caps on Medicaid populations.

The enactment in 1997 of Title XXI, the State Children’s Health Insurance Program (SCHIP), was the largest public health insurance expansion since Medicaid’s inception. Enrollment in SCHIP has steadily increased as each state’s program has matured. The Centers for Medicare & Medicaid Services (CMS) reports that the number of children enrolled in SCHIP during the year increased from 4.6 million in FY01 to 5.3 million in FY02. States choosing to participate in SCHIP may: 1) expand Medicaid to include children in families with incomes higher than those served by their existing Title XIX (Medicaid) program, 2) create a separate SCHIP program, or 3) create a program that combines the two: Medicaid SCHIP expansion and separate SCHIP program.

Title XXI offers states significant flexibility in the design and management of their SCHIP programs. States choosing to expand coverage through Medicaid must follow Medicaid rules for those children. States choosing to implement a separate program follow rules outlined in the Title XXI statute. In separate programs, there are no requirements for statewideness, comparability and amount, duration and scope of services. Benefit packages may be designed based on ones offered in the commercial market, and cost sharing rules for children in a separate SCHIP program are more flexible. The greater flexibility under separate SCHIP program rules means that there are more cost containment options available to states.

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5 Centers for Medicare & Medicaid Services, “Fiscal Year 2002 Number of Children Ever Enrolled in SCHIP: Preliminary Data Summary,” January 30, 2003, at http://www.cms.hhs.gov/schip/enrollment/schip02.pdf. The SCHIP enrollment number is an unduplicated count of the total number of children receiving services throughout the year.
SECTION I: STATES’ FISCAL ENVIRONMENT AND CHILDREN’S HEALTH PROGRAMS

The current fiscal situation is the most difficult that states have faced in the history of the Medicaid program. Every state and the District of Columbia have implemented Medicaid cost containment measures in 2003 and plan to take additional steps in 2004. A recent investigation by Gannett News Service found that 22 states have implemented eligibility and other restrictions in their SCHIP programs during the last year and a half, with more cuts possible for 2004.

All states have a Medicaid program and a SCHIP program, including 37 states that operate at least a portion of SCHIP through the separate program option. SCHIP is a smaller program than Medicaid, yet its reach and influence have been broad. In 1999, the number of uninsured children declined by one million, which can be partially attributed to Medicaid and SCHIP expansions. In 2000 through 2002, the percentage of uninsured children held steady at 11.6 percent, or about 8.5 million children, despite the fact that the number of all people without health insurance rose and the number of people with employer-based coverage fell. This fact supports the view that public health programs for children have helped to stem the decline in coverage that is occurring in the general population. And the benefits of providing health insurance to children are great.

Research has shown that uninsured children are more likely to lack access to health care, utilize fewer needed services, have poorer quality of care and have worse reported health status. Preventative care provided through Medicaid and SCHIP coverage can help avoid more costly health care services in the future.

SCHIP and Cost Containment: The view from the states

“Research shows that with SCHIP, sick children’s health improves dramatically and school attendance and participation improves. Investment in children’s health saves money in the long run.”

--State SCHIP Director


Children comprise about 51 percent of the population in Medicaid; however, only about 18 percent of state Medicaid dollars go toward children’s services; therefore, making changes to child health programs will not yield high savings in overall program costs.8

Children’s services are relatively inexpensive, at about $1,500 per year per enrollee, when compared to costs for the elderly and people with disabilities, which exceed $11,000 per year per enrollee.9 The federal government pays an average of 57 percent of eligible medical expenses in Medicaid and an average of 70 percent for SCHIP. Covering children, especially with Medicaid and SCHIP federal matching participation, does not represent a large portion of state program costs relative to other health care spending. Nonetheless, states spent almost $39 billion on Medicaid services for children in FY 2002, and SCHIP expenditures totaled about $4.4 billion in FY 2002.10

Increased enrollment is the prime driver of costs for children; therefore, states may want to consider scaling back eligibility for this group. However, this strategy is something of a double-edged sword. Both the SCHIP statute and the fiscal relief measure passed by Congress which provides an increased Federal medical assistance percentage (FMAP) for states from April 2003 through September 2004 contain maintenance of effort requirements (discussed further in Section II) that can result in the loss of federal financial participation (FFP) for states that cut Medicaid eligibility. States will need to find other cost containment measures for their Medicaid programs in order to preserve access to these federal funds.

Unfortunately, the outlook for FY04 and FY05 remains bleak. States are projecting additional Medicaid budget deficits in the neighborhood of over $70 billion in 2004 for all populations. While health programs for children were relatively unscathed during initial cost cutting efforts by states in 2002 and 2003, it is likely that even these politically popular programs will be unable to escape the budget axe in the next couple of years. The remainder of this paper discusses a menu of cost containment options that states may want to consider as they make the tough choices that will be necessary to stay within available budget limitations.

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9 Kaiser Commission on Medicaid and the Uninsured, Medicaid Fiscal Challenges to Coverage, August 2003.
10 Ibid.
SECTION II: POTENTIAL AREAS FOR COST CONTAINMENT

This section covers the variety of cost containment mechanisms that are available to states and looks at the pros and cons associated with each one. Cost containment approaches may vary for Medicaid (which includes Medicaid SCHIP expansions) and separate SCHIP programs because of differing state philosophies and rules for each program type. The discussion in this section identifies cost containment mechanisms that can be used in the Medicaid and/or SCHIP programs.

Provider and MCO Payment Rate Freezes and Reductions

One of the most common ways that states have acted to reduce program costs is by altering payments to providers and managed care organizations (MCOs). The Kaiser Commission on Medicaid and the Uninsured reported in September 2003 that 50 states had taken action to either freeze or decrease rates for at least one provider group in 2003. However, 39 states also increased rates for one or more provider groups.11 These actions come on the heels of similar measures by many states in 2002 and are expected to continue into 2004.

States may purchase covered services on a fee-for-service basis from providers, a capitation basis from managed care organizations (MCOs), or through a combination of both. Many separate SCHIP programs contract separately from Medicaid. States have broad authority in both Medicaid and SCHIP to set rates, although Medicaid is subject to somewhat greater federal regulation in regard to payment ceilings, known as the upper payment limit, for institutional hospital and nursing home services and for managed care organizations. Rate setting, particularly for managed care arrangements, can be complex and often involves risk adjustment to assure that MCOs receive adequate rates to cover the services that are delivered taking into consideration the health risks of the population being served. Payment rates are usually adjusted annually to account for inflation in the cost of goods and services. Changes to provider payment rates affect the entire enrolled population. Because children’s services comprise only about 18 percent of Medicaid costs, the savings from provider payment reductions will be small compared to adult and disabled populations.

Methods to control provider payment amounts:

- *Eliminate inflation increases.* States can eliminate scheduled payment increases for providers and MCOs. Providers must operate within their current reimbursement levels if they continue to participate in the program.

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• **Reduce payment rates.** States can decrease the rates they are currently paying providers. This approach may be particularly effective if there are providers that the state believes are being overpaid for the services that are provided.

• **Change the payment arrangement.** States can move to a capitated payment arrangement for services that are currently paid on a fee-for-service basis. For example, some states are beginning to explore managed long-term care, an area that has traditionally remained fee-for-service in most states. States could also move to a prospective payment system (PPS), similar to those used in Medicare, in areas such as hospital, home health, and nursing home services. While complex to establish, the PPS approach has saved significant amounts in Medicare, and many states already use PPS for hospital services.

**Pros**

• **Enrollment is not impacted.** Families often are unaware of changes in provider payment and, therefore, enrollment rates are not directly affected. Children can continue to receive coverage.

• **Programs get immediate savings.** When scheduled rate increases are cancelled, the resulting savings accrue to the state budget immediately. Savings continue to accrue as providers bill for services at reduced rates throughout the year.

• **Some provider rates may be brought more in line with actual costs.** Although Medicaid has a reputation for paying very low rates to providers, particular types of providers or MCOs may in fact be receiving higher rates than are needed to deliver services. For example, states have sometimes paid higher rates to specialty providers when starting a new program for more chronically ill populations to ensure payments are adequate and attract new providers. However, program experience may show that costs were initially overestimated.

**Cons**

• **Providers and MCOs may leave the market.** Providers and MCOs that believe payments will not be adequate to provide services or make their businesses viable may refuse to serve the Medicaid or SCHIP populations.

• **Children may have difficulty accessing services, or quality of care and continuity of care may be affected.** While loss of providers from the program is the most obvious way that access can be affected, it may also take longer for families to obtain appointments. Providers may spend less time with patients resulting in poorer quality of care. Families may need to find new providers for their children if their usual provider leaves the program. This can have a particularly negative impact for children with special health care needs, such as severe emotional disturbances, for whom continuity of care is important.
• **Contracts must be renegotiated.** Contract negotiations can be long and difficult. Renegotiation may open other aspects of the contract to changes that the state does not want to alter. For example, if a contract contains quality standards that an MCO has been struggling to meet, the MCO may also want to renegotiate those aspects of the contract.

• **The impact on providers and MCOs increases in future years.** While eliminating an inflation increase or reducing payment amounts may have a minimal impact initially, the impact becomes greater as providers’ costs continue to rise and payments remain stagnant. For example, if provider costs grow 3 percent annually, payments will be 6 percent lower than the actual growth rate after two consecutive years without inflation increases. This impact will probably be greatest on primary care physicians because children use more primary care services than do other populations.

### Eligibility Restrictions

Expanded eligibility for children in Medicaid and SCHIP is one of the key reasons for cost growth in children’s services. Children’s eligibility for public health programs has grown dramatically since SCHIP was enacted in 1997. At that time, only four states covered children in families with income at 200 percent of the federal poverty level (FPL) or higher, while today 39 states cover children at these income levels. Enrollment in Medicaid has climbed from 21.3 million children in 1996 to 24 million children in 2002. SCHIP enrollment has also climbed steadily since its implementation, serving 5.3 million children in 2002. Many of these newly covered children are from working families who cannot afford the coverage available through their employers or in the individual market. While eligibility expansions appear to be a prime target for budget cuts because of their contribution toward increased costs, public health programs for children are politically and publicly popular and attempts to reduce eligibility are sure to be met with strong opposition.

The Medicaid statute requires coverage of certain populations of children; therefore, states are unable to reduce eligibility for those groups. Other groups are covered at state option.12

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Medicaid Mandatory Coverage for Children

- Children (and their parents) who would have been eligible under historical AFDC coverage standards.
- Children under age 6 to 133% of the FPL.
- Children ages 6 through 18 to 100% of the FPL ($15,020 for a family of three in 2003).

Medicaid Optional Coverage for Children

- Medically needy – individuals who “spend down” to Medicaid income levels because of high medical expenses.
- Infants to age 1 up to 185% FPL. Children aged 19 through 21.
- Targeted low-income children (SCHIP Medicaid expansions).
- Institutionalized individuals with low income and resources.

SCHIP permits states to expand coverage up to 200 percent of the FPL, or 50 percentage points above the Medicaid eligibility levels that were in effect on April 15, 1997 (whichever is higher).

Methods to reduce eligibility:

- Reduce income levels or eliminate eligibility groups. States can eliminate optional populations in the Medicaid program and reduce income levels for their SCHIP programs. However, reducing eligibility for optional Medicaid populations may jeopardize a state’s ability to access its SCHIP allotments and the additional FMAP provided by Congress for fiscal relief. (See further discussion under cons.)

- Institute asset tests. As of April 2003, six states considered family assets, such as a house, car, or savings, when determining eligibility for Medicaid or SCHIP. In fact, the trend in recent years has been to eliminate asset tests as a criterion for eligibility in order to simplify the eligibility process. Savings are unclear due to the administrative costs associated with obtaining asset information.

- Eliminate income disregards. Many states disregard a portion of family income when determining eligibility. Medicaid rules require states to disregard certain expenses, such as payments for child care, when determining eligibility. However, most income disregards are used at state option.

- Change how medical bills are counted for determining spend down eligibility. The Medicaid program gives states the option to adopt programs for the medically needy, in which families who have children with high medical costs can deduct those costs from their income. The child becomes Medicaid eligible when the family income minus medical bills falls below the Medicaid income limit. The state could limit the types or amount of medical bills that can be considered when determining spend down eligibility.
Pros

- **Addresses a key driver of recent cost increases for children.** Eligibility expansions in recent years, coupled with decreased family income resulting from the economic downturn, have greatly increased enrollment in Medicaid and SCHIP.

- **Savings to program are almost immediate.** When an entire eligibility group is dropped as of a certain date, the state will see an immediate decrease in costs and the number of new children coming into the program will slow rapidly.

- **Focuses program on lowest income groups who are most in need of services.** Some states believe that the Medicaid and SCHIP programs should concentrate their efforts and resources on those who are least able to afford coverage on their own. Lower income populations also tend to be in poorer health than higher income populations and, therefore, more in need of health care.

Cons

- **Children do not receive needed services.** Health outcomes for children are likely to be significantly worse without a regular source of health coverage. In a survey of parents of uninsured children likely to be eligible for Medicaid and SCHIP, one in five parents reported that they had delayed or skipped needed medical treatment for their children in the past year.\(^{13}\)

- **Reducing Medicaid eligibility levels jeopardizes the state’s ability to access its SCHIP allotment and to receive fiscal relief.** The SCHIP statute requires that states maintain the Medicaid eligibility levels that were in effect on April 15, 1997, in order to draw down funds from their SCHIP allotments. The Jobs and Growth Tax Relief Reconciliation Act of 2003 (TRRA) provides states with increased FMAP for Medicaid services for the last two quarters of FFY03 and the first three quarters of FFY04. TRRA contains a provision that eligibility under the Medicaid state plan (including any waivers under title XIX or section 1115) can be no more restrictive than it was on September 2, 2003, in order to obtain this increased FMAP. This maintenance of effort requirement includes any Medicaid SCHIP expansions. Instituting asset tests and eliminating income disregards have been interpreted by CMS as “more restrictive” and also would prevent states from receiving the increased FMAP.\(^{14}\)

- **More strain on safety net providers.** Children who are without a regular source of health care coverage will seek out services through safety net providers such as Federally Qualified Health Centers (FQHC), Title V programs, and hospital emergency rooms. For example, one

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study found that children who do not have a regular provider were 60 percent more likely to visit an emergency room and were 54 percent more likely to be hospitalized.\textsuperscript{15} Receiving care in these settings can be more expensive than receiving care through a regular provider. The state may have to pay for these costs with state-only funds or providers may have to absorb the costs.

- **Requires legislation and may be difficult to reinstate at a later date.** Many states have fought hard to increase eligibility for children in recent years and may be reluctant to reverse the gains that have been made in coverage. Most changes in this area would require the state legislature to act in order to alter eligibility levels for the program. These legislative debates can, at times, be contentious and protracted. As state fiscal situations improve, it may be difficult to reinstate eligibility for children who lost coverage as a result of eligibility cuts.

- **Strong opposition and legal challenges.** Health programs for children are popular and often enjoy strong advocacy on their behalf. States that attempt to reduce eligibility for children are likely to face political pressure. In addition, some states have been sued when attempting to reduce eligibility.

- **Reprogram eligibility systems and retrain eligibility workers.** In order to implement reduced eligibility, states (or their contractors) will need to reprogram their eligibility systems to calculate income differently. In addition, eligibility workers will need to be retrained to use the new eligibility rules when working with families during the application process. This can result in increased administrative costs for the state.

### Limiting Enrollment

Rather than reducing the income levels at which children are covered, some states have chosen to contain costs by limiting enrollment. As mentioned earlier, enrollment is one of the key reasons costs for children’s programs have grown in recent years. Enrollment limits can only be used in separate SCHIP programs; the Medicaid statute requires states to serve all eligible children within an eligibility group, except within the home and community-based services waiver program.

Methods to limit enrollment:

- **Cap or freeze enrollment.** States can chose to cap or freeze enrollment in order to be able to provide services within a budgeted amount of dollars. Under an enrollment cap, states set the overall number of children to be served, and, as children leave the program, new children are enrolled to take their place. This approach requires states to continue to accept applications and establish a waiting list from which to draw as slots become available. Medicaid home and community-based waiver programs also use this method to fill the set number of slots identified in the waiver and approved by CMS. An enrollment freeze differs in that

enrollment is frozen at a certain point in time, after which no new applications are accepted. Enrollment declines as children leave the program and continues to decline until enrollment is reopened and new applications are accepted.

- **Open enrollment periods.** States may designate open enrollment periods similar to open enrollment periods in the private health insurance market. Application and enrollment take place only during this time limited period which usually occurs once or twice per year. The time limit assures that enrollment cannot continue to grow throughout the year and also makes it unlikely that all potential eligibles can or will apply within the given time frame.

**Pros**

- **Avoids reducing eligibility levels.** Some children within the affected income category (perhaps the majority of them, depending on where the enrollment limit is set) can continue to receive health coverage.

- **Easily reversible.** Because the systems and processes are already in place to enroll eligible children in the income group, the cap limit can be raised or eliminated without much additional work.

**Cons**

- **Equity.** Some children within the same or lower income level as those receiving coverage will go without needed care. This aspect raises equity concerns. Some children without coverage may have more significant health needs or more compelling family circumstances than those who are enrolled.

- **Confusion for the public.** It is difficult to communicate with the public about a program that is *sometimes* available. Marketing funds are needed to make the public aware of when the program is open and to inform them of how the program operates.

- **Administrative hassles of capping/uncapping/maintaining waiting list.** The operational aspects of maintaining a waiting list can be complex. States pursuing this approach must set up processes to accept applications, establish a list and determine how to prioritize children on the list for entry into the program (e.g., first come- first serve, lowest income, health needs, etc.). Enrollment, as well as the list, must be continuously monitored to determine when enrollment can be reopened.

- **Plans and providers don’t like on/off programs.** MCOs prefer to have steady enrollment which helps to assure that risk is spread among a larger number of enrollees and a steadier source of income. This could affect the number of HMOs participating in the program or the financial viability of an HMO.
• **Some children are lost to the system entirely.** Families may become frustrated in their attempts to enroll their children in the program and decide not to pursue coverage.

• **Can jeopardize fiscal relief:** In the case of the home and community-based services waiver programs, CMS has issued guidance that decreasing the limit on the numbers of individuals served is considered “more restrictive” eligibility and affects a state’s ability to received increased FMAP under TRRA.  

### Application/Enrollment Process Changes

A significant reason for enrollment increases, in addition to eligibility expansion, is that most states have taken action to simplify the application and enrollment processes for both Medicaid and SCHIP over the last several years. The “hassle factor” is an important aspect for families when applying for services for their children. The more complex and confusing the process, the fewer children will be enrolled.

Over the past few years, states have invested significant amounts of time and funds to simplify applications and renewal forms; eliminate asset tests, face to face interviews, and verification requirements; and institute presumptive eligibility and continuous eligibility. However, in 2003, a few states rescinded some of these process improvements.

States can make changes to both Medicaid and SCHIP programs but, when changes are made to one program without making changes to the other, the two programs will not be seamless and may be confusing to families. Most states now have joint applications but may need to revert to using separate applications if rules in the two programs vary significantly.

Methods to change application and enrollment processes:

• **Require face-to-face interviews.** Face-to-face interviews often deter families from enrolling their children into coverage for several reasons. The parent(s) may work and may be unable to take time off to go to the appointment. Transportation may be an issue for some families. Others may not want to apply for a program that is associated with “welfare” since the same workers who determine eligibility for TANF often conduct Medicaid and SCHIP eligibility interviews. This approach requires additional time for both the state and for families to complete the eligibility process.

• **Require documentation of income.** Twelve states have eliminated income documentation for children’s Medicaid and 11 states do not have this requirement for their separate SCHIP. In states that require income documentation, one of the most common reasons for denial of

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18 Ibid.
eligibility is the failure to provide such documentation. Some parents may work in non-traditional jobs that do not provide pay stubs, or they simply do not keep records.

- **Eliminate presumptive eligibility.** Presumptive eligibility allows a child to immediately receive covered Medicaid or SCHIP services prior to a formal determination of eligibility on the basis of preliminary information about the child’s family income. The vast majority of children who are determined to be presumptively eligible are, in fact, eligible when a full determination is made. However, since presumptive eligibility is usually done at the point when families seek out medical attention for their children, some states believe that it increases costs by enrolling sicker children and those who might not otherwise pursue application. Presumptive eligibility raises the possibility that states will provide services to children who are not eligible or who do not go on to complete the application process because they have already received the services they needed.

- **Renew coverage more frequently.** Many states have adopted one year of continuous eligibility, during which families are not required to report changes in status, such as income, that could affect eligibility. Renewing coverage more frequently means that some children who become ineligible can be removed from the rolls earlier. Some children also will be dropped from the rolls because their parents fail to complete the renewal process.

- **Reduce outreach.** One of the first measures that many states took when the budget crisis began was to reduce or eliminate many of their outreach initiatives. If families don’t know about the program, they won’t enroll.

- **Impose waiting periods.** Some states have begun imposing a waiting period on enrollment after eligibility is determined. This method is believed to help prevent adverse selection and churning that occurs when a parent enrolls a child during a period of illness and then disenrolls when the child is healthy. It also saves money for the state because no payments are made for services provided during the waiting period because the child is found eligible but is not enrolled into the program for a period of time (e.g., 3 months).

**Pros**

- **Highly effective:** Many states saw dramatic increases in enrollment when they began simplifying their application processes in the late 1990s; therefore, it is reasonable to assume that increased complexity in the application and enrollment process will decrease the number of children receiving Medicaid or SCHIP coverage.

- **No maintenance of effort problem:** As discussed earlier, both SCHIP and the new fiscal relief enacted by Congress have maintenance of effort requirements that put federal funding at risk if eligibility cuts are made. However, process changes are not considered eligibility reductions by CMS.
• **Legislation often not required:** Many process changes can be done without the need for state legislation. Even when legislation is required, these types of changes may be more palatable than eliminating an eligibility category.

**Cons**

• **Children will not receive needed services:** Children who do not apply or do not become enrolled as a result of procedural barriers may not receive primary health care services, immunizations, or treatment for illnesses or disease. As discussed earlier, this can result in either delayed or complete lack of health services for children who need them.

• **Confusion and frustration:** Increased procedures create barriers to enrollment and are confusing and frustrating for both families and for the workers who take applications and determine eligibility.

• **Reverses recent improvements:** Over the last several years states have made great strides in simplifying their eligibility and enrollment processes. States have spent a significant amount of time and money to make systems changes, retrain eligibility workers, and rewrite procedure manuals. All of these gains would need to be reversed in order to adopt these procedural changes. Administrative costs of eligibility determination would increase as the time required to complete eligibility determinations increased. Changes of this nature can be difficult to reverse at a later date because of the complexity of the changes that must be made.

• **Reprogram eligibility systems and retrain eligibility workers.** In order to implement application and enrollment process changes, states (or their contractors) will need to reprogram their eligibility systems to process the applications differently based on new documentation requirements and on new start and end dates for coverage. Application forms will need to be revised. In addition, eligibility workers will need to be retrained to use the new process requirements when working with families during the application process. These activities will require administrative funds.

• **Savings not immediately realized.** Process changes can take a significant amount of time to implement so savings will not accrue to the program immediately.

**Restructuring Benefits**

Many states have looked at restructuring their Medicaid benefit packages in order to contain costs. The Kaiser Commission reports that 18 states restricted or reduced availability of benefits in 2003. While most of these reductions involved adults, seven of the states made changes that would also impact children.

SCHIP and Medicaid differ in their benefit requirements; therefore, the changes that can be made to benefit packages will also differ. Medicaid rules require states to offer certain mandatory
services. In addition, states may offer a variety of optional services. Medicaid also requires that services be offered in sufficient amount, duration, and scope in order to achieve its purposes. States have some flexibility within this requirement to limit the amount of coverage for a particular service. For example, states can cover a specific number of days for hospital inpatient stays as long as the coverage reasonably meets the needs of individuals in the program.

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<tr>
<th>Medicaid Mandatory Services for Children</th>
<th>Medicaid Optional Services for Children</th>
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<tr>
<td><strong>Acute Care:</strong></td>
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<td>• Inpatient and outpatient hospital</td>
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<td>• Physician and nurse practitioner/midwife services</td>
<td>• Diagnostic, screening, preventative and rehabilitative service</td>
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<td>• Family planning</td>
<td>• Physical therapy and related services</td>
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<td>• RHC and FQHC services</td>
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<td>• Inpatient psychiatric services for individuals under age 21</td>
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<td>• Home and Community-Based Services</td>
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An important consideration when eliminating or reducing services is that it can cause use of other, possibly more expensive, services. For example, limiting the number of physician visits may increase usage of emergency room services. Another important factor in altering the Medicaid benefit package is the mandatory requirement to provide Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for children. EPSDT requires that children receive all medically necessary treatment for conditions identified during periodic screenings regardless of whether that service is covered under the Medicaid state plan. The EPSDT requirement effectively limits the state’s ability to find major cost savings through alterations to the benefit package for children.

States with separate SCHIP programs are required to provide benchmark coverage that is the same as either a state employee health plan, the Blue Cross/Blue Shield Preferred Provider Plan offered to federal employees, or the benefit plan with the largest enrollment that is offered by an

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19 For more information about Medicaid benefit requirements see Schneider, et al, *The Medicaid Resource Book.*
HMO in the state. States may also provide coverage that is actuarially equivalent to one of those plans, or “Secretary-approved coverage” which is approved by CMS on a case-by-case basis.

Methods to restructure benefits:

- **Eliminate Medicaid optional services.** States have flexibility under Medicaid rules to eliminate optional services. To date, states have resisted completely eliminating services and have looked instead to limit the amount, duration, or scope of covered services.

- **Change the amount, duration, or scope of Medicaid covered services.** Some of the actions states have taken in this area include limiting the number of visits to physicians or for specialty services such as speech therapy, occupational therapy, chiropractic care, and psychology services.

- **Change to a different benchmark plan or actuarial equivalent in the separate SCHIP program.** The benchmark plans that are available in each state may vary considerably; therefore, some packages may cost less. Any package chosen or designed is required to include well child visits and immunizations, physician services, inpatient and outpatient hospital services, and laboratory and X-ray services.

Some states may also want to consider changing their Medicaid expansion SCHIP to a separate program in order to use a benchmark package rather than the Medicaid benefit package. In this way, a potentially less costly benefit package can be used for these children. Reducing Medicaid eligibility levels and shifting children into the separate SCHIP also shifts their costs to SCHIP which is a capped allotment program. For some states, the SCHIP allotment may be insufficient to cover these added children. In addition, moving children into the separate program requires a corresponding reduction in the Medicaid eligibility level which affects the availability of the additional FMAP which was provided by TRRA.

**Pros:**

- **More in line with commercial market.** Restructuring the Medicaid or separate SCHIP benefit packages can make them look more like the benefit packages that families get when they participate in their employer’s health plans. Some states believe that this approach helps to prevent families from joining the public program, rather than their employers’ health plans.

- **Easily reversible at later date.** States often make adjustments to benefit plans, and plans in the commercial market also change their benefits on a regular basis. A few states actually restored benefits in 2003 that were previously restricted.
Cons:

• **Savings may not meet expectations.** Some states have found that limiting covered services did not produce the savings that were expected. While the reasons for this are unclear, one possibility is that providers and enrollees found ways to substitute covered services for those services that had been limited. In Medicaid, the EPSDT requirements may serve to limit the amount of savings that can be obtained.

• **Special needs children disproportionately affected.** Although special needs children are a small portion of the child population in Medicaid and SCHIP, they use more services and more expensive services than other children. Limitations usually tend to be placed on benefits that are utilized by these children, such as physical therapy, speech therapy and psychological services. Poorer health outcomes may be seen for special needs children as a result.

• **Strong opposition.** Benefit changes that reduce services to children, especially children with special needs, are usually met with strong opposition from the public and advocacy groups. In addition, states that consider switching to a separate SCHIP in order to use a benchmark package may find resistance to this approach because there is no individual entitlement to services in a separate SCHIP, a feature of Medicaid that is strongly supported by many stakeholders.

### Increased Cost Sharing

Increased cost sharing for enrollees is a common method that states have used to contain their program costs, with 32 states reporting new or higher co-payments for one or more services during the 2002-2004 period, according to the Kaiser Commission study. Cost sharing can take the form of enrollment fees that are paid upon joining the program and premiums that are paid on a monthly basis, as well as co-payments, deductibles, and coinsurance that are paid at the point of service. Medicaid does not permit cost sharing for children. For this reason, states that want to implement cost sharing for Medicaid-covered children would need to either apply for a waiver from the federal government or convert those children to a separate SCHIP program. In addition, providers in the Medicaid program are prohibited from denying service based on the inability to pay cost sharing. A few states have been permitted to charge cost sharing to low-income children in Medicaid through Section 1115 demonstration projects; however, approvals from CMS for these demonstration projects have usually retained the Medicaid requirement to provide services regardless of the inability to pay which can affect state and provider costs.

Separate SCHIP programs can charge “nominal” cost sharing for children in families with incomes at or below 150 percent of the FPL. Nominal cost sharing is defined as $5 or less for co-payments and $19 or less per month (depending on family size and income) for premiums. Above 150 percent of the FPL, there are no specific dollar limits on co-payments and premiums but total out-of-pocket costs cannot exceed 5 percent of the family’s income. (The 5 percent limit applies to families in all income ranges.) No cost sharing can be charged for preventative services (well-child visits) and immunizations.
A number of studies have looked at the impact of cost sharing on utilization and health status. While utilization is consistently shown to be reduced, the impact on health status is unclear. The most comprehensive study, the Rand Health Insurance Experiment, was conducted over 30 years ago but is still cited today. That study found little difference in health status based on cost sharing. Other studies have used the Rand data and found the probability of receiving “highly effective care” was decreased for low-income children in cost sharing plans as compared to higher income children. The general pros and cons of cost sharing are discussed first in the narrative that follows. Premiums/enrollment fees and co-payments/coinsurance/deductibles are also discussed separately below as each type of cost sharing has differing effects.

**Pros:**

- **Equity.** Some policymakers believe that it is unfair that many low-income workers contribute to their employer-sponsored health insurance while others in the same economic bracket receive free coverage through public programs. Because SCHIP includes families with incomes above poverty, it is more likely that families of SCHIP participants will have the same income as working families who are struggling to afford employer coverage. Some also believe that higher income families should pay more for their coverage than lower income families.

- **Reduced state costs.** When enrollees pay for a portion of their care, the costs to the state are less than they would have been when free coverage is provided because the enrollees’ contributions offset some state costs. Note that enrollee cost sharing can not be counted as part of the state share for federal matching payments.

- **Cost sharing makes SCHIP different from a “welfare program.”** Cost sharing is common in the private market, but limited in Medicaid. Some policymakers consider cost sharing to be something of a bridge from SCHIP to private insurance, one that builds personal responsibility by helping families to learn the value of health insurance coverage and become more accustomed to contributing to the cost of care.

**Cons:**

- **Fewer people will sign up and those who do may not use services.** Low-income families often lack disposable income and will forfeit health insurance in order to pay for other necessities. Even minimal cost sharing can reduce the number of families who enroll in public programs. Families who do sign up may delay getting care for their children because of co-payments or other point-of-service cost sharing. (See discussions below.)

- **Cost to providers.** Doctors and administrators often find that collecting fees is difficult and billing can be expensive. As discussed in the introduction to this section, Medicaid providers can not deny services based on the inability to pay; therefore, they may lose money if patients do not pay their cost sharing. Separate SCHIP programs do not have this requirement but the providers’ administrative costs of collecting can still be high.
• **Administration.** States will have to set up systems and processes to collect payments which add to the cost of administering the program.

• **Savings unclear.** Some states have found that there is little revenue gain when the costs of administration, such as billing and collection efforts, are taken into account. States must devote additional staff to collecting and tracking premium payments and following up with families who fail to submit payments. New systems and processes must be put in place for billing and collection.

### Increasing premiums and enrollment fees

*Premiums* are charged on a monthly basis. They can be set either as a percentage of income or as a flat rate that may vary by income or family size. Premiums are always charged in the private insurance market and either the insured or the employer pays them to the insurer. In public health insurance programs (such as Medicaid and SCHIP) usually the state, a third party administrator, or the insurer collects premiums from the insured or his or her family.

*Enrollment fees* are similar to premiums but, rather than being charged monthly, are charged to cover a longer period of time (such as every 6 months or once a year). An enrollment fee is not usually imposed in the private insurance market, but five states use them in SCHIP. They are most often collected by the state.

### Specific pros:

• **Targeting the program.** If premiums are assessed on a sliding scale, higher income families can contribute more to their coverage while poorer families receive more highly subsidized care. In this case, the program is targeted so that the families who need the most help get the highest subsidies.

• **Shared responsibility.** Some policymakers believe that families should be required to contribute to the cost of their care both because it is required in the private market and because it should be a shared responsibility between families and the state.

• **No need to track cost sharing paid at point of service.** When premiums, enrollment fees, or deductibles are used without other cost sharing, the amount of the families’ payments for the year is known. Therefore, there is no need to set up a system to track payments against the 5 percent cap.

• **May offset some administrative costs.** Some states have found that the collection of premiums helps offset costs associated with eligibility determination, member services support, call centers, etc.
Specific cons:

- **Barrier to participation.** Studies show that premiums may prevent people from joining the program. A research study by the Urban Institute has estimated that participation declined from 57 percent to 18 percent as premiums rose from 1 percent to 5 percent of family income.\(^{20}\) For a family of four earning $3,000 per month (about 200 percent of the FPL), 1 percent of income is $30 per month and 5 percent of income is $150 per month. Most states are not considering such large premium increases.

- **Continuity of care.** Many low-income families experience fluctuations in income because they are seasonally employed or because they lose hours on their jobs. If they are unable to pay premiums, children will come on and off the program, making consistent care difficult and undermining clinical goals.

- **Administration.** States must establish systems and processes for the billing, receipt and collection of premiums and enrollment fees and devote staff to or contract out for this function. Rules will need to be established around enforcement for failure to pay, including any sanctions and re-enrollment, making administration more complex. Some states also believe that administering sliding scale premiums is too complex because the premium amounts vary based on income.

- **Political challenges.** States must impose sanctions for non-payment of premiums for enforcement purposes. This typically means termination of coverage for at least some period of time. Regardless of the circumstances, there may be significant political costs involved with kicking children out of a health program.

Increasing co-payments/deductibles/coinsurance

Co-payments are a form of cost sharing in which enrollees pay a small fee (typically $5 to $10) each time a service is rendered (such as when a physical examination is conducted or a prescription is filled). Co-payments are utilized in both the private and public insurance markets and are most often collected by the provider of services (hospital, clinic, doctor, pharmacist, psychologist, etc.) at the time the service is rendered. No co-payments are permitted for preventive services in separate SCHIP programs.

A deductible is a specified amount of expense that an enrollee must incur before an insurer will assume any liability for all or part of the remaining cost of covered services. A deductible may be a fixed-dollar amount or the value of specified services (such as two days of inpatient care or one physician visit) and is usually tied to some reference period, e.g., $1,000 per calendar year, benefit period, or spell of illness. Deductibles are common in the private insurance market but are less so in public insurance programs.

Coinsurance is the portion or percentage of the cost of service enrollees pay when a service is rendered (such as 2% of the cost of a $50 service, or $2.50). Coinsurance is often charged in Medicare, but not as often in the private insurance market and rarely in Medicaid and SCHIP.

**Specific pros:**

- **Utilization changes.** Many policymakers believe that co-payments can affect utilization in a positive way. When people must pay each time they visit a doctor, they may be more careful and judicious about when they choose to go, avoiding overuse or abuse of services. For example, states have found that the non-emergency use of emergency rooms decreases significantly when co-payments are charged for that service. While most studies show that co-payments reduce utilization, the impact on health status is unclear. Hospital expenditures in the Rand study varied little for children with different levels of cost sharing. Office visits for children, both in terms of annual costs and number of episodes of care, were about 30 percent below those with no cost sharing. However, little difference in the health status was seen for children with different cost sharing levels.

- **Cost savings.** If services are used more appropriately, costs are kept down. Also, family contributions may offset some of the costs of the program.

- **Fewer administrative costs for states.** Because providers are responsible to collect co-payments and coinsurance, states do not need to set up administrative systems to handle collection. However, states will still need to have a mechanism to track enrollee payments toward the 5 percent cap on out-of-pocket costs that is a requirement for separate SCHIP programs. Most states use the “shoebox” method, in which families keep their receipts and notify the state when their limit is reached, to accomplish this task.

**Specific Cons:**

- **Affects provider revenue.** Providers will lose money if they are unable to collect required point-of-service cost sharing from enrollees. This may have particularly negative financial consequences for providers who are already struggling due to low reimbursement rates.

- **Barrier to care.** Families may delay going to the doctor until their children are very sick because they have other expenses, such as rent or utilities, which are also a priority.

- **Administration.** Tracking deductibles and co-payments can be a costly and time-consuming undertaking.
Premium Assistance

Some states are looking to premium assistance programs as a way to reduce the costs of providing health care coverage to their Medicaid and SCHIP populations. In these programs, states help families purchase health insurance through their employers. State costs are reduced as employers pay a portion of health insurance premiums for employees and their dependents.

Premium assistance programs are authorized for the Medicaid program under Section 1906 and approved by CMS through an amendment to the Medicaid state plan. The Medicaid benefit package is provided by “wrapping around” the health insurance offered through the employer, and Medicaid cost sharing requirements must be met. Premium assistance programs can also be provided under separate SCHIP programs through an amendment to the Title XXI state plan. The SCHIP benefit and cost sharing requirements must be met, and special rules exist to prevent public coverage from substituting for private coverage, known as crowd-out. In both Medicaid and SCHIP, premium assistance programs are administratively complex and have met with mixed success. Section 1115 demonstration projects (including the HIFA initiative)\(^{21}\) can also be used as a mechanism to provide premium assistance and have provided states with more flexibility to operate these programs. Nonetheless, premium assistance programs remain highly complex.

Several factors are critical to assuring that premium assistance programs can operate in a cost-effective manner. First, administrative costs must be minimized. For this reason, many states are exploring the HIFA option which appears to offer the opportunity to avoid some of the complex administration that is required under Medicaid and SCHIP rules. Second, sufficient numbers of people must be enrolled to offset high front-end administrative costs.

**Pros:**

- **Cost effective.** Because the employer pays a portion of the costs for the employee’s health insurance, state costs for health services can be reduced. States will need to have a mechanism in place to determine the amount of premiums and the portion that will be paid by the state. Note that the employer and employee shares of the premium can not be counted as part of the state share for purposes of federal matching payments.

- **Encourages use of private coverage.** Subsidizing employee’s health premiums may help to shore up the private market and prevent crowd-out. In addition, this approach may help families to transition into the private market on their own when their income rises because they will have gained experience with health insurance and learned its value.

- **Family members in the same health plan.** Coverage is easier for families to understand and manage because all family members are in the same plan and subject to the same rules. Some studies have indicated that when entire families are insured, they are more likely to access services because they have consistent providers.

\(^{21}\) Health Insurance Flexibility and Accountability Demonstration Initiative
Cons:

- **Affordability.** Private health insurance costs have been rising more rapidly than public sector costs. If the state subsidizes only the cost of coverage for the children, the parent may not be able to afford his or her portion of the premium that must be paid in order to enroll dependents. In addition, depending on the amount employers contribute and the overall premium cost, it may not be cost-effective for the state to subsidize coverage.

- **Administration.** The administration of premium assistance programs is extremely complex. New processes must be established to gather information about available employer-sponsored coverage (including benefits, cost sharing, and employer contribution), to enroll and make premium payments and, in many cases, to supplement employer benefits and cost sharing. In addition, new data systems are needed to track a variety of information about employer plans and to monitor application and enrollment. Significant staff resources will need to be devoted to these activities and some or all of them may need to be contracted out. Some states have found that the costs associated with administration are too high to make the programs cost effective.

**Prescription Drug Cost Containment**

Prescription drug costs grew at an average rate of about 18.1 percent a year between 1997 and 2000 and accounted for nearly 20 percent of the increase in Medicaid spending during that time. In 2003, 46 states implemented cost containment actions related to prescription drugs, and 44 states plan to take new or additional action for FY04. Actions to contain prescription drug costs in the Medicaid program affect the entire population, not just children. While the importance of state efforts to address these costs cannot be overlooked, children’s drug costs make up a small portion of the overall costs. In 1998, children accounted for only about 12 percent of drug payments in the Medicaid program. Spending per child is only about one-tenth of that for people who are elderly and disabled. However, some children with chronic conditions utilize prescription drugs more than others, especially those with conditions such as asthma, allergies, and neurological and psychological disorders. The impact of cost containment on these children will depend in large part on how the measures are operationalized in a particular state. However, overall savings from cost containment measures for children’s prescription drug costs are likely to be very small.

The Medicaid program has rules that address limits on the amounts that the federal government will match for brand name and generic drugs, prior authorization, and preferred drug lists, as well rebate amounts required from manufacturers. Separate SCHIP programs are not subject to these rules, although similar cost containment methods can be used in separate programs.

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Some common methods to contain prescription drug costs include:

- **Prior Authorization.** Prescribers must obtain approval from the state Medicaid or SCHIP program before a prescription can be dispensed by the pharmacy.

- **Preferred Drug Lists (PDL).** A PDL is a list of drugs that can be dispensed without prior authorization. The lists are established by a committee that includes physicians and pharmacists and include all drugs from manufacturers that have a rebate agreement with the federal government. Drugs are selected for the list based on their clinical effectiveness and cost, and the state then negotiates the lowest possible price for each drug on the list. Drugs excluded from the list must be available through a prior authorization process.

- **Mandated use of generics.** Because generics are less expensive than brand name drugs, several states have mandated that generic drugs are substituted for brand name drugs when available.

- **Reduce payments for drugs.** Medicaid payments for drugs include acquisition costs and dispensing fees, both of which are paid to the pharmacy. For acquisition costs, most states pay a percentage of the average wholesale price (AWP) of the drug. To reduce costs states can lower the percentage of AWP that is paid. States have also reduced dispensing fees to pharmacies.

- **Supplemental rebates from manufacturers.** States may negotiate with manufacturers to include their drugs on a preferred drug list in exchange for an additional rebate over and above that which is required by the federal government.

- **Limit the number of prescriptions.** As discussed in the section on benefits, states have the ability in the Medicaid program to limit the amount, duration, and scope of benefits. Some states have opted to control the number of prescriptions or the number of prescriptions for brand name drugs that can be dispensed within one month. States may also limit the number of days for which a supply of drugs can be dispensed.

**Pros:**

- **Addresses key driver of rapidly escalating costs for adults.** However, for children’s programs the impact of cost containment measures in this area will be less because children do not utilize prescription drugs as much as other populations.

- **Minimal enrollee impact if designed well.** Assuming that formularies are comprehensive and developed with participation from individuals with adequate expertise, enrollees should not experience adverse effects. Provisions for prior authorization for drugs not on the PDL permit other drugs to be prescribed when clinically indicated.
• **Clinical efficacy drives prescribing habits.** An ongoing concern in medical care has been that physicians do not always prescribe the most clinically effective and cost effective drugs. The use of a PDL can encourage physicians to become familiar with newer or less well known alternatives.

• **Drug companies are better able to absorb cuts than many others.** Some policymakers believe that drug company profits indicate that they are in a position to share in the cost containment that must occur.

**Cons:**

• **Administration.** Implementing measures such as a PDL require considerable planning, resources, and systems changes to implement. States adopting this approach must be prepared to devote the necessary resources and staff.

• **Enrollees may not receive needed medications.** Limiting number of prescriptions means that some enrollees with chronic health conditions that require a lot of medications will not have access to them. Similarly, a poorly conceived PDL can result in enrollees not receiving needed medications.

• **Legal challenges.** Some states have been sued by beneficiaries who did not have access to needed drugs. Both Maine and Michigan were sued by PhRMA when those states attempted to implement preferred drug lists, but the courts ruled that the programs could go forward.

• **Limited immediate savings.** Changes to prescription drug programs usually involve a great deal of planning and time to fully implement. While savings can be significant, it may take a longer period of time to realize these savings.

**Delivery System Changes**

Medicaid and SCHIP deliver services either through fee-for service or capitated managed care delivery systems. Over half of the populations in both Medicaid and SCHIP are enrolled in MCOs. While arrangements vary from state to state, MCOs usually cover acute care services, and long-term care types of services are carved out; that is, they are still provided on a fee-for-service basis, and enrollees have freedom of choice of providers. States also use primary care case management (PCCM) systems. In a PCCM, primary care for enrollees is “managed” by a physician who then refers the enrollee for other needed services in return for a case management fee. Rarely, states have capitated the PCCM services. States moved to these arrangements beginning in the 1980s and on a large scale basis in the 1990s as a way to control spiraling health care costs.

States seeking to contain costs have used delivery system changes to a lesser degree than other approaches. In large part, this is because most states moved to managed care to the extent possible in the past and managed care penetration is probably not adequate in many areas of the
country to support new initiatives. In addition, these types of initiatives take longer to plan and implement, and states are looking for more immediate program savings.

Disease management and case management activities are planned by 18 states for 2004, and disease management is being looked on as a promising approach to controlling costs, much as managed care was in the 1990s. However disease management usually addresses the needs of older populations with chronic conditions such as diabetes and congestive heart failure, rather than children. Children with chronic conditions may also be able to benefit from similar initiatives. They constitute a small but expensive portion of the child population.

Types of delivery system changes:

- **Expand use of managed care/PCCM.** While most states have used managed care arrangements to the maximum extent possible for acute care services, some states are beginning to explore managed care approaches for long-term care services. Because these services comprise a large portion of Medicaid expenditures, a more “managed” and capitated system offers potential cost savings.

- **Use transportation brokers, dental brokers, and pharmacy benefit managers.** Some states are using brokers to manage specific benefits in order to control utilization and negotiate better rates from suppliers.

- **Move enrollees from PPOs to HMOs.** In recent years, the backlash against managed care has resulted in more open managed care arrangements in which enrollees have the option to use providers outside the managed care network. Because those providers receive fee-for-service payments, the associated costs are higher. Some states have decided to use HMOs rather than PPOs for this reason.

- **Disease management and case management.** Some states have reported significant savings from disease management initiatives for chronic conditions in older populations. States have also used case management for high cost cases, including in children’s populations. CMS has recently expressed concern about multiple case management services being used for people with disabilities in the Medicaid program. Better management of care for children with chronic medical conditions, developmental disabilities, and serious emotional disturbances is an area that could be explored for potential cost savings.

**Pros:**

- **More efficient management of care.** When care is coordinated, there is less duplication of effort and better outcomes can result for enrollees.

- **Decrease inappropriate utilization.** Good care management prevents enrollees from seeing multiple providers for the same problem. It also encourages the use of less costly services. For example, when enrollees have a medical home, emergency room visits and hospitalizations are decreased.
• **Capitation can save money.** When MCOs or providers are paid capitation rates, the cost of services is decreased because the MCO/provider assumes some risk for the cost of services. Capitation saves money when costs are close to the capitation amount. If the capitation rate is set too high, which can sometimes happen when they are based on historical costs that include inefficiencies, no savings will be gained. Capitation rates also are often adjusted for risk, which is based on an actuarial projection of health care utilization and can be overestimated.

**Cons:**

• **Managed care availability may be limited.** MCOs are not available in all parts of the country, particularly rural areas. PCCMs may be a more viable option in those areas.

• **Providers and advocates/enrollees may oppose.** Some providers oppose capitated payments because they do not receive as much reimbursement under these systems, but they may be more likely to accept capitation in a fiscal crisis. Enrollees often do not like being restricted to certain providers and there have also been concerns about adequate access, particularly to specialty providers who are used more frequently by children with chronic conditions.

• **Administration.** These types of changes take more planning, systems changes and staff resources to implement than many other strategies. For this reason, changes will take longer to implement, and cost savings will not be as immediate.

**Program Management**

Changes in program management offer states the potential for cost savings. For Medicaid, the activities described in this section would affect the entire population, not just children.

Methods to contain program management costs:

• **Increase fraud and abuse activities.** Federal Medicaid and SCHIP rules require all states to have methods to identify and investigate suspected fraud and to refer suspected cases to law enforcement officials. Provider fraud can be a significant drain on state budgets.

• **Increase third party liability recoveries.** Children who participate in Medicaid may also have health care coverage from another source, for example, as a dependent under a parent’s health insurance policy. The private insurance is the primary payer, with Medicaid paying only for services that the private policy does not cover. Savings accrue to Medicaid when states are able to identify and pursue payment from other sources of coverage that are available to enrollees. (Children are not eligible for separate SCHIP programs when they have private coverage; therefore, savings from this source are not available for separate SCHIP programs.)
• **Billing errors.** Some states have found program savings by examining their billing systems and processes to correct erroneous payments. For example, providers may use incorrect billing codes that cause excess payments.

• **Data collection and evaluation.** Some states may spend significant amounts of money on data collection and evaluation of its Medicaid and SCHIP programs. For example, some states have established contracts with universities and other research organizations to assess quality and other aspects of the program. States may want to prioritize which data and evaluation activities are the most essential to fund. Lower priority activities can be curtailed or other sources of funding such as grants could be pursued for some types of initiatives.

**Pros:**

• **Enrollees are not impacted.** Unlike many other cost containment strategies that have been discussed, enrollees will probably not notice any change in their health care coverage.

• **Program is more efficient.** The overall program benefits because (previously misdirected) resources can be directed to the areas that are the most critical to accomplishing program goals.

• **GAO/Congressional concerns.** In June 2003, Congress launched an investigation of state Medicaid programs as a result of a January GAO report that placed Medicaid on its list of programs at high risk for fraud, waste, abuse, and mismanagement.25 Actions in this area can help to address some of these concerns.

**Cons:**

• **Requires increased administrative and personnel costs.** Personnel are needed in order to recover funds from fraud and abuse activities, third party liabilities, and billing errors. Many states have lost personnel as a result of budget cuts and may not have staff to devote to these activities. Some states have contracted with organizations that specialize in fraud and abuse activities. Systems changes may also be needed in order to be able to identify patterns that indicate fraud or to adequately track third party payers. States will need to carefully weigh whether the investments that are necessary to implement more aggressive action in these areas will result in sufficient program savings to make the activity worthwhile.

• **Compromises the state’s ability to monitor and evaluate the program.** As the state decreases its capacity to collect and evaluate data, it will be less able to determine what is working well and what needs to be changed.

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EVALUATING COST CONTAINMENT STRATEGIES

This section looks at the magnitude of savings in children’s health care programs that can be obtained from the cost containment strategies discussed in this paper, as well as their potential impact on children’s health. Some approaches will affect services received by the entire Medicaid population, but the ratings are based only on children’s programs. This section also assesses the complexity of implementing each strategy from a state perspective. Advocates and other stakeholders may hold differing views on the difficulty or ease of implementation.
Which Cost Containment Options Are Right for My State?

Each State’s Medicaid and SCHIP program is unique in its design. Determining which cost containment strategy to adopt will depend on factors such as current enrollment patterns, benefit structures, cost sharing features, delivery systems, and administrative structure. This section, in combination with the pros and cons described for each cost containment area, attempts to provide a framework for making tough choices. It presents one way of thinking through the overall impact that cost containment strategies may have on health programs for children. Cost containment areas are ranked on three criteria: impact on children’s health, magnitude of savings, and ease of change.

- **Impact on Children’s Health.** Each cost containment area is ranked using the following scale:
  - +++ Does not result in loss of coverage or access for children.
  - ++ May result in loss of coverage or access for a few children.
  - + May result in loss of coverage or access for a significant number of children.

- **Magnitude of savings for children’s’ programs.** Each cost containment area is ranked using the following scale:
  - +++ A high level of savings is possible.
  - ++ A moderate level of savings is possible.
  - + A low level of savings is possible.

Because state programs vary significantly in size and expenditures, it is essential that each state evaluate its individual expenditures to determine the magnitude of savings that may be available.

- **Ease of Change.** Each cost containment area is ranked using the following scale:
  - +++ Change for the state is administratively straightforward.
  - ++ Change is administratively challenging for the state or may meet with some resistance to reverse when budget situation improves.
  - + Change requires significant administrative resources for the state or is difficult to reverse in the future.

In the following chart, strategies that receive three pluses (+++) across all areas would be the most advantageous, i.e., have the least negative impact on children’s health, result in the greatest savings, and be administratively straightforward to implement. The desirability of the strategy decreases as the number of pluses decreases.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Impact on Children’s Health</th>
<th>Magnitude of Savings</th>
<th>Ease of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider payment freezes and reductions</td>
<td>++</td>
<td>+++</td>
<td>+++</td>
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<tr>
<td>Eligibility restrictions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• reduce income levels</td>
<td>+</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>• institute asset test</td>
<td>++</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>• eliminate disregards</td>
<td>+</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>• change spend down eligibility</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Limiting enrollment</td>
<td>+</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>Application and enrollment process changes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• face-to-face interviews</td>
<td>+</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>• document income</td>
<td>+</td>
<td>+++</td>
<td>++</td>
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<tr>
<td>• eliminate presumptive eligibility</td>
<td>++</td>
<td>+</td>
<td>++</td>
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<tr>
<td>• renew more frequently</td>
<td>+</td>
<td>++</td>
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<tr>
<td>• reduce outreach</td>
<td>++</td>
<td>+</td>
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<tr>
<td>• waiting periods</td>
<td>+</td>
<td>+</td>
<td>++</td>
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<tr>
<td>Restructuring benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• eliminate optional services</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>• change benchmark</td>
<td>++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>Increase cost sharing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• premiums, enrollment fees</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>• co-payments, etc.</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>Prescription drug cost containment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• prior authorization</td>
<td>++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>• preferred drug list</td>
<td>++</td>
<td>+++</td>
<td>+</td>
</tr>
<tr>
<td>• mandate use of generics</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
</tr>
<tr>
<td>• reduce payments</td>
<td>++</td>
<td>++</td>
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</tr>
<tr>
<td>• supplemental rebates</td>
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<td>++</td>
<td>+</td>
</tr>
<tr>
<td>• limit number of prescriptions</td>
<td>+</td>
<td>+</td>
<td>++</td>
</tr>
<tr>
<td>Premium assistance</td>
<td>+++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Delivery system changes</td>
<td>+++</td>
<td>++</td>
<td>+</td>
</tr>
<tr>
<td>Program Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• fraud/abuse</td>
<td>+++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>• third party liability recoveries</td>
<td>+++</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>• billing errors</td>
<td>+++</td>
<td>+</td>
<td>+++</td>
</tr>
<tr>
<td>• data collection</td>
<td>+++</td>
<td>+</td>
<td>++</td>
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</tbody>
</table>
CONCLUSION

Although facing severe budget shortages, programs for children in Medicaid and SCHIP have fared better than many other programs. Income eligibility for these programs in most states has been preserved to date. SCHIP in particular has avoided some of the more severe cuts. There are several reasons for this. SCHIP is relatively small in size compared to Medicaid; therefore, there are fewer cost savings to be obtained. SCHIP’s enhanced matching rate has helped to maintain its gains because the amount of federal funds that would be lost when enrollment is reduced is so great. The program is also politically popular, especially because of its success in insuring so many previously uninsured children from low-income working families. The greater flexibility of SCHIP is also viewed by some as contributing to its sustainability.26

Federal fiscal relief to states has also helped, at least temporarily, to stave off some cuts that might otherwise have been made in Medicaid. The infusion of an estimated $10 billion in increased FMAP alters incentives for states to scale back their Medicaid programs in fiscal years 2003 and 2004. The maintenance of effort requirements in TRRA will result in loss of the increased FMAP for states that restrict Medicaid eligibility. Cuts in services will save states less because the federal contribution to the program is greater.

Nonetheless, these are difficult times for state Medicaid and SCHIP programs. Several states are considering reducing, or already have reduced, enrollment for children using some of the methods discussed in this paper. While more children are enrolled now than ever before, the program simplifications that have contributed to increased enrollment are in danger of being reversed. However, program simplifications also contribute to program savings because they make Medicaid and SCHIP easier to administer. Adding new requirements that make the programs more complex adds to administrative costs.

More importantly, costs do not disappear when children are cut from or drop out of the program as a result of cost containment strategies. States may see higher expenditures in areas such as uncompensated care and emergency room usage. Other costs which are more difficult to quantify, such as lost school days due to illness and more parents missing days of work when their children are sick, are also likely.

Pressure on states to find additional cost savings is expected to continue into 2004 and 2005, and states are struggling to maintain the gains that have been made in children’s coverage in recent years. This struggle highlights the need for a more comprehensive state and federal response to address the health care needs of the nation’s low-income children that can assure adequate and stable funding for the future.

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