Presentation to:

Health & Human Services Appropriations Subcommittee

By Charles Bruner
Child & Family Policy Center

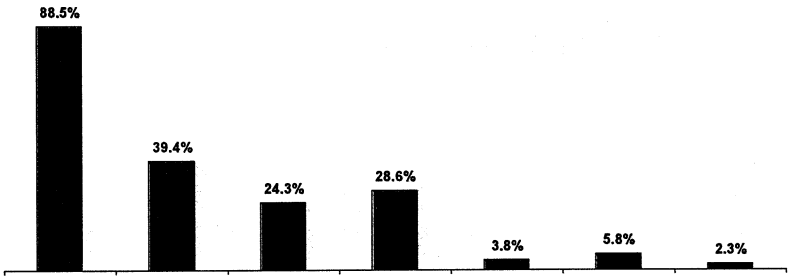
January 31, 2007

CHILD & FAMILY POLICY CENTER

Every Child Counts/Off to a Good Start Recommendations

- SCHIP Reauthorization at Federal Level
  - Address the 2007 shortfall ($18 million in Iowa)
  - Provide Funding for maintenance and continued state expansion of SCHIP coverage and content ($14.6 billion + $35 billion over five years
- Family Opportunity Act
  - Offer Medicaid buy-in for children 0-6, going to children 0-17
- Children's Healthy Development
  - Adopt "Off to a Good Start" recommendations

Children's Healthy Development – Who Sees Young Children?



	Preventive Health Care Visit (0-5)	EPSDT Visit (0-2)	WIC Participation (0-5)	Formal Child Care Arrangement (0-4)	Head Start/Early Head Start (0-5)	Part B of IDEA (3-5)	Part C of IDEA (0-2)
Iowa:	*90.7%*	*41.2 %*	*31.0%*	*N/A*	*4. 4%*	*5.7%*	*2.35%*

Sources:
Preventive Health Visit: National Survey of Children's Health
EPSDT 416 Forms, Centers for Medicare and Medicaid Services (CMS)
WIC - FDA, Food and Nutrition Services, Office of Analysis, Nutrition, and Evaluation
Formal Child Care: Census Bureau Special Report: Who's Minding the Kids?
Head Start: National Head Start Association, Program Fact Sheets
Part B: U.S. Department of Education, Office of Special Education Programs, Data Analysis System
Part C: IDEAdata.org Data Tables for Office of Special Education Programs State Reported Data

From Health Insurance to Child Health

Health Insurance = Medical Care = Child Health

Establishing Coverage (XIX/SCHIP) Getting Children Enrolled (Covering Kids)	use of primary/preventive services coverage for comprehensive and behavioral health services (SCHIP)	screening for developmental health needs referral and follow-up to address broad health needs

Healthy Development Initiative Model

Pediatric Practitioner Training/Developmental Surveillance

"Do you have questions about how your child is learning, behaving, or developing?"

ABCDII

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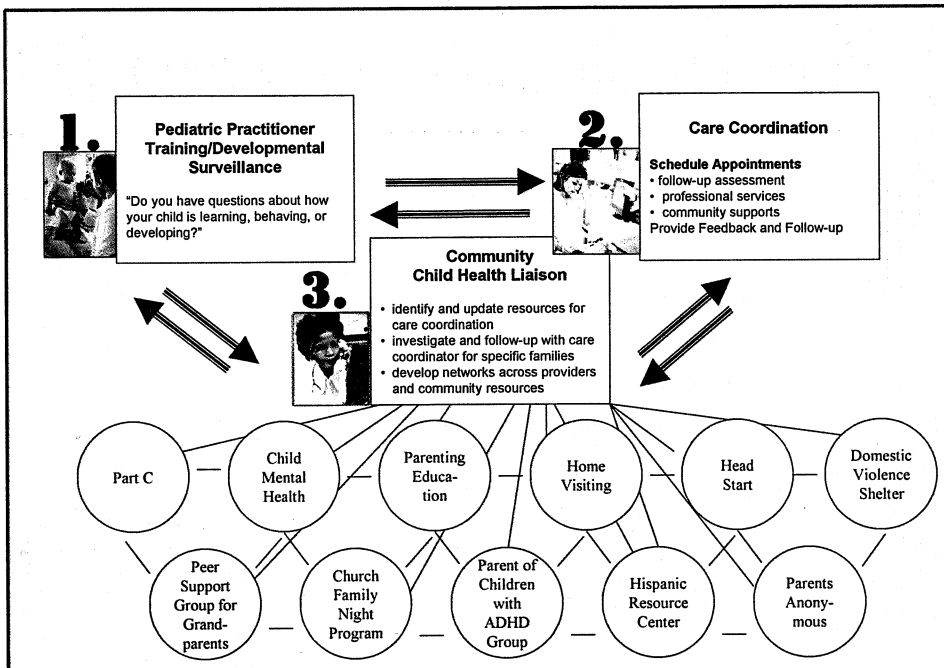
Care Coordination

Schedule Appointments
- follow-up assessment
- professional services
- community supports

Provide Feedback and Follow-up

Title V EPSDT Outreach



Enhanced 2-1-1/Community Empowerment

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Off to a Good Start Coalition

Iowa has been a leader in developing innovative and evidence-based strategies to improve children's healthy development in the critical early years. Many of these strategies start in the health practitioner's office but extend beyond a narrow definition of medical care to ensure children get what they need for healthy development.

The Off to a Good Start Coalition is composed of a broad based coalition of organizations with expertise in children's healthy development working together to develop and support policies that can make Iowa a model for the country on ensuring all children's healthy development.

PURPOSE

The pupose of the Off to a Good Start Coalition is to:

- Promote evidence-based public policies and funding
- That improve children's healthy development
- At the federal, state and community levels
- For the early childhood years (prenatal through five)
- Through Medicaid, ***hawk-i*** and private health insurance
- Starting with primary health care and linking with other services and supports

GOAL AREAS

The Off to a Good Start Coalition has adopted the Early Childhood Iowa goals for children's healthy development and will work on policies in each of the following areas:

- Increase access to and utilization of social, emotional and mental health services
- Increase access to and utilization of preventive health services
- Increase the number of children with a medical home
- Increase the number of children with a dental home
- Increase the number of children with health care coverage
- Increase access to and utilization of prenatal care

CURRENT MEMBERSHIP

Child and Family Policy Center; Child Health Specialty Clinics; Children's Hospital of Iowa; Delta Dental of Iowa; Early Childhood Iowa; Every Child Counts; Iowa Association of Nurse Practitioners; Iowa Chapter of the American Academy of Pediatrics; Iowa Department of Public Health; Iowa Empowerment Board; Iowa/Nebraska Primary Care Association; Iowa Prevention of Disabilities Policy Council; State Public Policy Group; The University of Iowa College of Public Health, Institute for Public Health Practice; and Visiting Nurse Services

Our vision:
Every child beginning at birth, will be healthy and successful.

CONTACT INFORMATION

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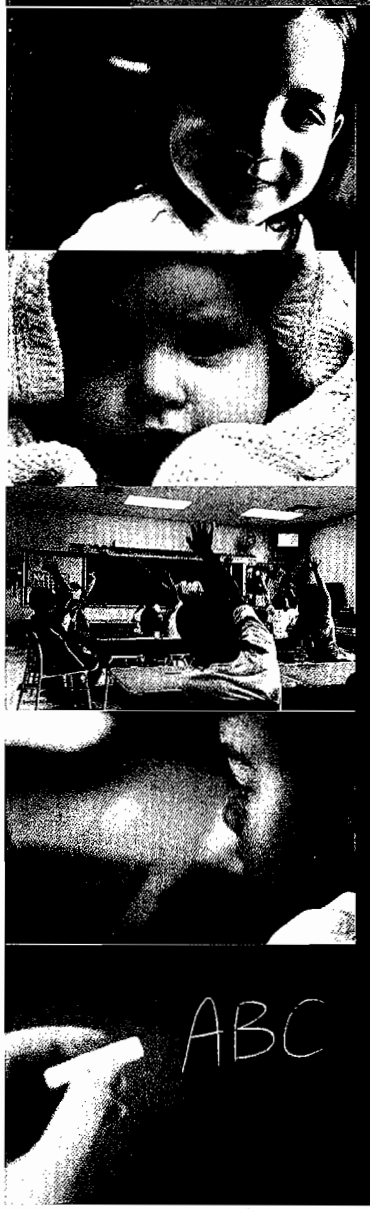
Off to a Good Start



KEY POINTS

1. **SCHIP has been well implemented in Iowa and, with Medicaid, has helped to ensure coverage and a medical home for more children; this despite rising costs and subsequent declines in employer-sponsored family coverage. [Attachment One]**

Recommended federal actions:

- Additional federal supplemental funding to cover the $ 18 million Iowa shortfall in the short-term (06-07)

- Overall federal funding well above $5.04 billion annually over the next five years to maintain Iowa's current program

2. **Some gaps remain in SCHIP health coverage in Iowa both in terms of coverage and content of that coverage; these need additional support to improve child health. [Attachment Two]**

Recommended federal actions:

- Federal funding for continued outreach efforts and supports, maintaining the covering kids strategy ably developed under MCH

- Federal financial support to expand SCHIP according to established Iowa needs

3. **Federal leadership is needed to support cost-effective preventive and primary health services for children that employs a child health (not adult health) model, including preferred guidelines and quality incentives. [Attachment Three]**

Recommended federal actions:

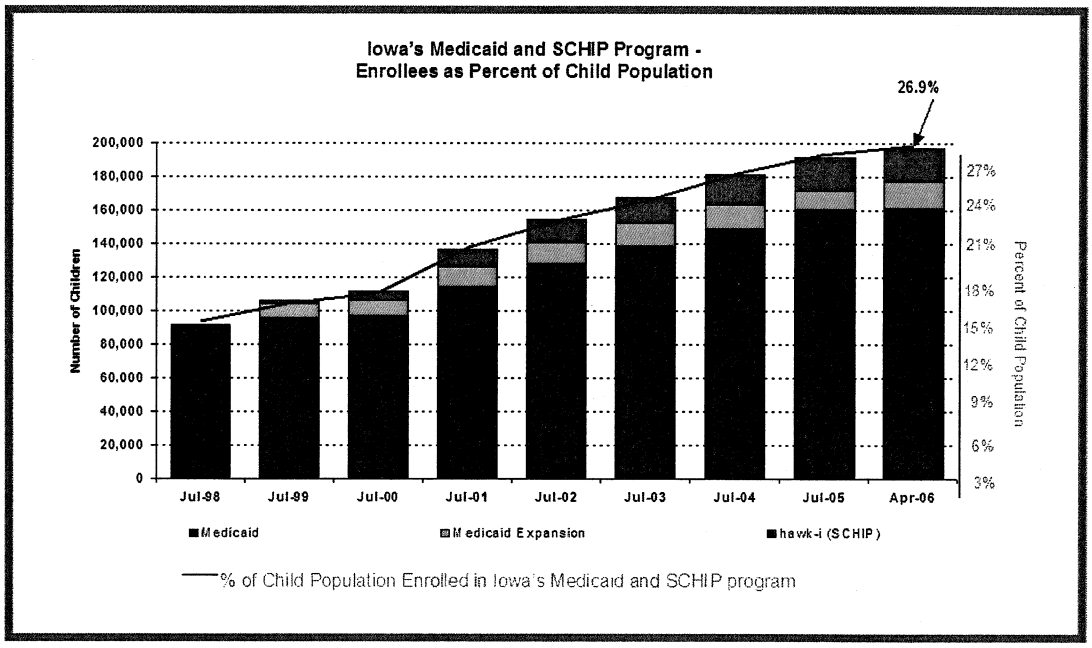
- Federal presence and leadership in promoting practices that improve children's healthy development that are built upon recognized medical practice guidelines

    - Additional set-aside/designation for states to enhance program quality and accountability and expand effective practices that improve child health (building upon such successes as Iowa's Medicaid healthy mental development/ABCDII initiative)

ATTACHMENTS TO IOWA CHILDREN AND SCHIP REAUTHORIZATION KEY POINTS

Attachment One: Maintaining Iowa's Progress in Covering Children

Since Congress established the federal state child health insurance program (SCHIP) in 1997, the overall landscape regarding health insurance coverage has changed dramatically. The federal SCHIP program and Iowa's use of that program have enabled Iowa to retain high coverage levels for children and avert what otherwise would have been a major rise in the number of uninsured children in the state. Together, Medicaid and ***hawk-i*** now cover 200,000 children, approximately 30% of all children in the state. ***hawk-i*** accounts for a little over 10% of this coverage and the expansion of Medicaid under SCHIP a significant additional share. Even with Medicaid and ***hawk-i,*** however, between 35,000 and 50,000 (depending upon different surveys and estimates) Iowa children do not have health insurance coverage. About two-thirds of these would be eligible for ***hawk-i*** or Medicaid, were they to apply. The chart below shows the growth in coverage since the beginning of SCHIP.



During this period, Iowa's efforts under SCHIP have improved child health insurance coverage, even while uninsurance rates among adults have climbed significantly. In large measure, SCHIP has enabled Iowa to counter two significant changes in the health insurance coverage landscape that otherwise would have jeopardized many Iowa children in receiving needed health coverage.

First, welfare reform has greatly reduced the number of children and parents who are categorically eligible and covered under Medicaid. In part, this is due to increases in workforce participation of parents and in part this is due to decisions by families not to seek or continue with the Temporary Assistance to Needy Families (TANF) program. While some families are financially better off through their employment than they were under the older Aid to Families with Dependent Children (AFDC) program, many families are working at lower wage jobs

without health benefits who previously had participated in AFDC and were receiving medical assistance. From 1996 to 2005, the Iowa Family Investment Program (FIP, the name for of Iowa's TANF program) caseload declined by 36%, from 33,537 down to 21,595. This included both children and their parents. The overall number of FIP recipients automatically eligible for Medicaid, dropped from 91,448 to 57,840, many of these working adults. Today, parent eligibility for Medicaid coverage for a family of three is below $6,000 in annual income, at 29% of the federal poverty level, if a parent is not enrolled on FIP.

Second, the costs of health insurance have risen dramatically, placing new barriers both for employers and employees in providing family coverage, in particular. Employers have responded to rising costs by increasing co-payments and deductibles and employee payment expectations and, in extreme instances, by dropping coverage altogether. The areas of job growth in the private employer market also are in sectors less likely to provide health benefits. Between 2000 and 2005 alone, the average annual premiums for employer-sponsored health insurance coverage nationally rose from $2,400 to $4,024 for employee coverage, and from $6,228 to $10,880 for family coverage.

Iowa policy makers and the public have supported both SCHIP and Medicaid during this period, even during state budgetary crises from 2001-2004. Iowa has established a strong outreach program under its Title V agency for SCHIP and has avoided establishing waiting lists for eligible children or otherwise negatively impacting child health coverage.

As a result, Iowa has fully used its federal SCHIP allocations and now faces a deficit in 2006-7 of $18 million simply to maintain its programs. In addition, Iowa would face major cutbacks in federal funding were SCHIP to be only funded for the future at the current level of $5.04 billion per year. The Off to a Good Start Coalition recommends:

- **Additional federal supplemental funding to cover the $18 million Iowa shortfall in the short-term (FFY06-07)**

- **Overall federal funding well above the $5.04 billion annually over the next five years to maintain Iowa's current program**

Attachment Two: Building Upon Success and Strengthening SCHIP

While Iowa has used federal funding under SCHIP very effectively, there remain opportunities to cover more Iowa children, reduce Iowa's uninsurance rate, and further improve the content and effectiveness of what is being provided.

Iowa has the potential to enroll and cover more children under current eligibility guidelines, but this is dependent upon a strong outreach effort and available funding to cover those children. Iowa's Covering Kids efforts, through Iowa's Title V agency, have been very effective, but there is no longer private sector support to continue that effort. A modest amount of federal funding directed to continued outreach, coupled with sufficient funding to provide coverage for the additional children enrolled, could reduce the number of uninsured Iowa children further, perhaps by as much as one-half. That is a top priority for strengthening SCHIP.

In addition, there are reasons to further expand Iowa SCHIP coverage through expanded eligibility for children on a sliding schedule for those above 200% of poverty and to cover at least some parents of children. Research is clear that children are most likely to be enrolled and use health services when parents also secure coverage. In addition, child health is also dependent to a significant measure on parent's health, and mental health, needs being addressed. With changes in Iowa FIP program, many more working parents, particularly in low wage jobs, no longer have access to affordable health coverage. Additional funding could provide the option for Iowa to expand its own resources in providing this coverage.

Finally, while the ***hawk-i*** program provides basic health coverage, it does not offer coverage for some services that some children need for their healthy development and is not as preventive or comprehensive in orientation as either Iowa's Medicaid or Iowa's state health insurance plan. This issue is covered in more detail in attachment three.

Additional federal funding to SCHIP would enable and encourage Iowa policy makers to strengthen the current SCHIP program in ways that make sense for Iowa, including addressing any further changes in private health insurance coverage that could adversely affect children.

While the overall issue of health care reform is very complex and many proposals are very controversial, there is widespread support for state efforts, supported by federal funding, to strengthen child health coverage. This also is the area where there is the greatest potential for long-term benefits and gain. The Off to A Good Start Coalition recommends:

- **Federal funding for continued outreach efforts and support for children enrolled, maintaining the covering kids strategies developed in Iowa**

- **Federal financial support to expand SCHIP program coverage according to established Iowa needs**

Attachment Three: Ensuring Health Care Coverage for Children's Health and Development

Child health care coverage needs to be viewed differently from adult health care coverage. Health care for children is both an individual service to improve the child's health and a social investment to assure that children become healthy adults able to participate fully in work and community affairs. Consequently, the scope of benefits for children's health insurance coverage should aim to promote good current health but also the development of optimal future physical and mental health and social functioning.

Particularly when children are very young (birth to five), the health practitioner plays a key role in the early identification and response to children's health and developmental needs. Virtually all young children are seen by a primary health care practitioner, and, until they reach school age, this is the only system where virtually all young children are certain to be seen by a professional. This also is a period where families play their most critical role in ensuring their children's health and development. Yet studies show that parents, and particularly first-time

Desired Outcomes of Well-Child Care at School Entry

Physical Health & Development

- No undetected hearing or vision problem
- No chronic health problems without a treatment plan
- Immunizations complete for age
- No untreated dental caries
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- No exposure to tobacco smoke

Emotional, Social, and Cognitive Development

- No unrecognized or untreated developmental delays (emotional, social, cognitive, communication)
- No unrecognized maternal depression, family violence, or family substance abuse
- Parents knowledgeable and skilled to anticipate and meet child's developmental needs
- Parents linked to all appropriate community services.

parents, often have limited knowledge of how best to nurture their child's health and growth and have the fewest resources to pay for identified service needs.

The Need for Action: Building Upon and Extending Iowa Coverage

Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program provides the authorization for coverage within the Medicaid program for many preventive and developmental health services. It recognizes the need for a different approach to children's health insurance coverage than for adults and has been used effectively in many states to strengthen children's health and development.

Iowa has been a leader in this area through its recently completed Assuring Better Child Development (ABCD II) Systems Change Initiative supported by the Commonwealth Fund. Iowa ABCD II has strengthened the early identification of and response to child health and development issues and the use of very cost-effective services. Specifically, ABCD II:

- Successfully tested a three-level process to identify young children with developmental, social or behavioral problems within health care practices.
- Developed guidelines for health provider identification of young at-risk children that have been endorsed by Iowa's major health provider associations and adopted by Iowa Medicaid.
- Examined referral processes and tested a model public-private system to coordinate care and link families with needed community services.

Iowa has now launched two state-supported initiatives to spread the ABCD II innovations. The first initiative uses a partnership between Iowa Medicaid, Iowa Empowerment, the Prevention of Disabilities Policy Council and the University of Iowa's University Center on Excellence for Developmental Disabilities to promote the adoption of Medicaid policies and health care provider practices to identify young children who are at risk and deliver the developmental services they need. The second initiative is spearheaded by Iowa's Title V program and supports the development of community-based public and private systems to coordinate care and link at-risk children and families to appropriate community services

These comprehensive identification and care coordination approaches could be effectively incorporated into Iowa's SCHIP program, ***hawk-i***, and its benefit package made more consistent both with Iowa's public employee dependent health coverage program and Iowa's Medicaid program. Currently, due to funding limitations, some identified medically necessary services for children that are covered under Medicaid and the state plan (such as speech therapy) are not covered under ***hawk-i***.

The Effectiveness of Primary and Developmental Services for Children

SCHIP reauthorization offers the opportunity for states, including Iowa, to develop such strategies, building accountability for improving child health into the structure. It also offers the opportunity to meet the individual needs of children that is consistent with the philosophy behind the Family Opportunity Act, but extended to an earlier point of intervention and more preventive services.

The following are illustrations of services that, while they may not be relevant to an adult health insurance benefit package, have shown very promising results in improving children's (and particularly young children's) healthy development and can make claims for long-term cost-effectiveness. They deserve consideration by states as part of developing quality SCHIP programs and services.

Developmental and Behavioral Surveillance. Particularly before children reach school age, health practitioners represent *the* nearly universal point of contact and opportunity to identify child developmental needs. A medical home provides the opportunity for continuity in providing parents information and anticipatory guidance about children's healthy development, identifying developmental issues and concerns, and linking children and their parents with needed and

available resources, including early intervention services under Part C of IDEA. While an estimated 15-18% of all young children have identifiable developmental and mental health issues, less than half are identified prior to school entry. Iowa's ABCD II and Connecticut's Help Me Grow program, being adapted and expanded upon in Polk County through Iowa's Healthy Mental Development Initiative, represents an exemplary, cost effective approach to identifying children's developmental and behavioral concerns in the primary care health practitioner's office, linking children and their families to existing community resources to address them, and providing feedback to the health practitioner for further follow-up.

Oral Health. Too many children also suffer from untreated dental problems, many starting at a very young age. Dental pain affects children's ability to concentrate and to learn, both in the early years and in school. Corrective dental care can be very costly. Early identification and response to dental issues results in savings in future dental costs, but also in school-related developmental costs.

Vision. It has been documented that up to half of low-income children have undetected vision problems at the time they come to school. These relate to more than corrective lenses, involving issues of focusing and tracking words on a printed page. They impact children's early literacy and, unaddressed, represent a major cost to children and society in school success. Early anticipatory guidance that educates parents on focusing exercises for their children can avert such problems and early vision screening can ensure that children start school with vision that enables them to learn to read.

Parental Depression. Research is clear that children suffer when their parents are battling depression. Addressing parental depression improves child mental health, as well as child development in school, and the child visit may be the only time such parents see a health provider. As part of their work, pediatric practitioners can screen for parental depression where it is warranted, and ensure timely treatment that benefits both the parent and the child. This screening is built into Iowa's endorsed ABCD II identification guidelines.

Language and literacy. Doctors and nurses know and can convey to parents that growing up healthy means growing up with books. Part of a well-child visit can stress the value of reading to and talking with children. Reach Out and Read is a research-based program model for using the pediatric visit as an effective way to improve young children's language and literacy development.

AD/HD and Autism. Child health conditions such as AD/HD and autism can most effectively be treated, with the fewest future consequences, when they are identified and addressed early. Currently, there are substantial time gaps between initial detection, actual diagnosis, and treatment for these conditions that increase eventual treatment costs and reduce their overall effectiveness. Increasing the early detection and treatment of such health conditions is possible, but involves child health insurance coverage that encourages such early detection and provides for the follow-up treatment. Iowa Medicaid is covering and promoting early detection of these conditions through its newly adopted ABCD II identification guidelines.

Nutrition and exercise. One of the greatest challenges to the child and adult health in America is obesity. Obesity is growing even among the youngest children in society, when lifelong patterns of eating and exercise are being set. This is the case for all children, but it is a more pronounced problem within low-income and minority populations. The future health costs – through diabetes and other health conditions – are immense. Research indicates that parents who receive strong anticipatory guidance that focuses upon child eating, nutrition, and exercise can change nutritional practices and their children's health trajectories related to obesity. It is in the earliest years that these activities can be most effective.

Opportunities for Federal Leadership

SCHIP reauthorization offers the opportunity for the federal government to take leadership in further developing appropriate primary, preventive, and developmental health services. This involves some set-aside funding and support for states to improve the quality of their programs and build state capacity to provide cost-effective child health services, including improving linkages across other federal programs, such as Part C of IDEA. The Off to a Good Start Coalition recommends:

- **Federal presence and leadership in promoting practices that improve children's healthy development, built upon medical practice and recognized guidelines**

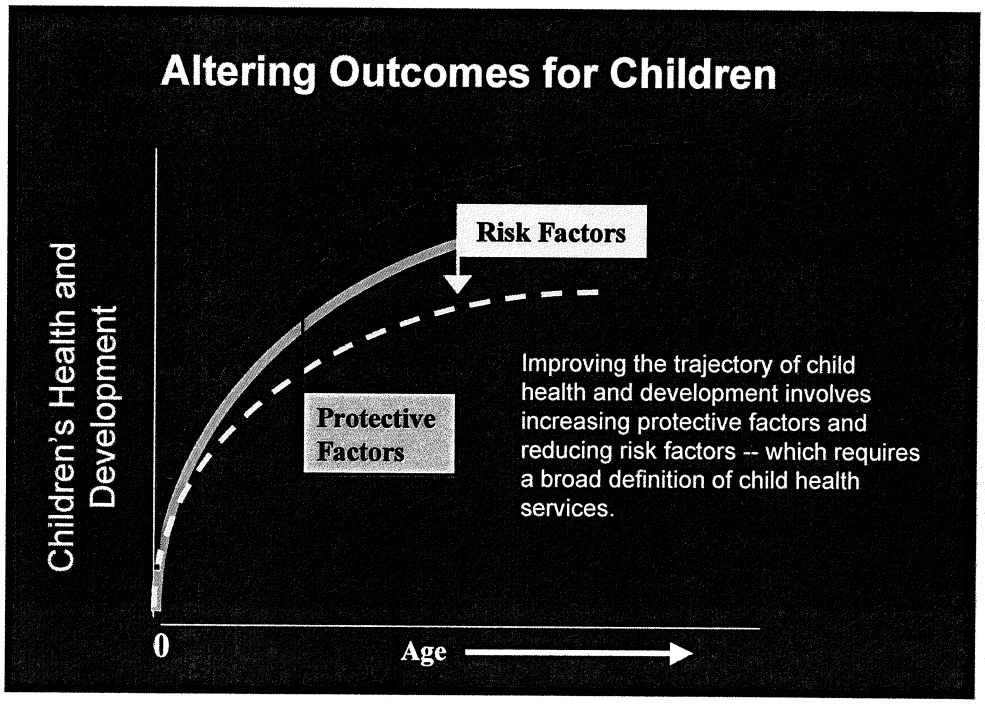
- **Additional set-aside/designation for states to enhance program quality and accountability and expand effective practices to improve child health (building upon such successes as the Iowa Medicaid Healthy Mental Development/ABCD Initiative)**

Rethinking Child Health Insurance Coverage

Rationale for a Comprehensive Approach to Child Health

Introduction

Children are growing and developing, and their life trajectories can be altered by a number of factors in their lives. Their own and their family's health play a major role in their social and educational development as well as their physical development and well-being. Research is clear that comprehensive primary and well-child care and early detection and treatment of child health and developmental needs can increase the protective factors and reduce the risk factors in children's lives – thereby improving the child's health and trajectory through life.



In short, it is much more important for child health services to be preventive and developmental than it is for adult health services. At the same time, health insurance coverage in the United States has developed largely based upon adult models for health care. **In moving to ensure that all children have access to health insurance, it is critically important that the insurance model is based upon child health, and not adult health, needs.**

The Necessary Content of Health Care for Children

Particularly when children are very young (birth to five), the health practitioner plays a key role in the early identification and response to children's health and developmental needs. Virtually all young children are seen by a primary health care practitioner, and, until they reach school age, this is the only system where virtually all young children are certain to be seen by a professional. This also is a period where families play their most critical role in ensuring their children's health and development. Yet studies show that parents, and particularly first-time parents, often have limited knowledge of how best to nurture their child's health and growth and have the fewest resources to pay for identified service needs.

The following represent the overall goals for the provision of pediatric well-child care for young children (an equivalent list is available for older children) that should be the basis for a child health insurance system.

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- No unrecognized or untreated developmental delays (emotional, social, cognitive, communication)
- No unrecognized maternal depression, family violence, or family substance abuse
- Parents knowledgeable and skilled to anticipate and meet child's developmental needs
- Parents linked to all appropriate community services.

Clearly, these goals apply to all children. While a majority of parents can and do take action to ensure that their children achieve these health goals and are able to pay for most needed services to do so, **a child health insurance system must ensure that needed services are provided to children and made affordable and accessible**.

The Need for and Cost-Effectiveness of Comprehensive, Preventive Child Health Services

Fortunately, providing such pediatric care does not involve major costs or expenditures. In fact, there is a growing research base that shows that there are significant savings –

in the health system, in the education system, and in the human service system – from such service provision. This involves the provision of much more than a bare-bones insurance package and includes comprehensive preventive services that ensure early identification of health and development concerns. The following are illustrations of cost-effective health practices that apply particularly to children – ones that very often are excluded from health insurance coverage built around adult health care models.

Developmental Surveillance. Particularly before children reach school age, health practitioners represent *the* nearly universal point of contact and opportunity to identify child developmental needs. A medical home provides the opportunity for continuity in providing parents information and anticipatory guidance about children's healthy development, identifying developmental issues and concerns, and linking children and their parents with needed and available resources, including early intervention services under Part C of IDEA. While an estimated 15-18% of all young children have identifiable developmental and mental health issues, less than half are identified prior to school entry. Connecticut's Help Me Grow program represents an exemplary, cost effective approach to identifying children's developmental and behavioral concerns in the primary care health practitioner's office, linking children and their families to existing community resources to address them, and providing feedback to the health practitioner for further follow-up.

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Nutrition and exercise. One of the greatest challenges to the child and adult health in America is obesity, which is growing even among the youngest children in society, when lifelong patterns of eating and exercise are being set. This is the case for all children, but it is a more pronounced problem within low-income and minority populations. The future health costs – through diabetes and other health conditions – are immense. Research indicates that parents who receive strong anticipatory guidance that focuses upon child eating, nutrition, and exercise can change nutritional practices and their children's health trajectories related to obesity. It is in the earliest years that these activities can be most effective.

The Need for Action: Building Upon and Extending the Medicaid EPSDT Base

Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program provides the authorization for coverage within the Medicaid program for many primary and preventive health services. It recognizes the need for a different approach to children's health insurance coverage than for adults and has been used effectively in many states to strengthen children's health and development. Medicaid's EPSDT program can further be strengthened, however, by building upon best practices and researched-based programs developed by specific states to better ensure that all health-related needs of children are identified early and then addressed through Medicaid. As Medicaid represents the country's poorest and most vulnerable children, including a large share of those with special health care needs, it is particularly crucial that EPSDT be supported and strengthened.

In addition, EPSDT-like provisions should be incorporated into state SCHIP programs, either through additional federal incentives or through explicit requirements. They also should be part of private child health insurance coverage systems. Finally, this should be coupled with expanded attention to supporting research directly focused upon strengthening children's health and development through well-child services.