In the Literature

CROSSING THE MEDICAID–PRIVATE INSURANCE DIVIDE: THE CASE OF EPSDT

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By providing children with preventive care that promotes their healthy development, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit has contributed significantly to the quality of care received by low-income children enrolled in Medicaid. Recent legislation, however, could threaten this benefit, warn the authors of a Commonwealth Fund–supported paper. The Deficit Reduction Act (DRA) of 2005 alters the structure of the EPSDT benefit and allows states to fundamentally redefine the meaning of Medicaid coverage for children.

"The potential de facto loss of EPSDT as Medicaid's pediatric coverage standard has major implications for the quality of pediatric care, particularly for children with special health care needs," write Sara Rosenbaum, J.D., and Paul H. Wise, M.D., Ph.D., of George Washington University and Stanford University, respectively. In "Crossing the Medicaid–Private Insurance Divide: The Case of EPSDT" (*Health Affairs*, Mar./Apr. 2007), Rosenbaum and Wise make a case for preserving EPSDT's scope and reach.

The ABCs of ESPDT

EPSDT was added to Medicaid in 1967 as part of comprehensive reforms responding to documented, widespread, and preventable mental and physical conditions among poor children. It was structured to reflect the professional pediatric standard of care, and emphasize early and preventive health care to optimize child development.

The earliest EPSDT rules, established in 1972, required periodic, comprehensive health exams; appropriate lab tests; developmental assessments; recommended immunizations; and vision, dental, and hearing care. In 1989, Congress enacted legislation to further strengthen EPSDT.

Threats to Children's Coverage

Created in 1997, the State Children's Health Insurance Program (SCHIP) represented a dramatic departure from Medicaid's pediatric coverage principles: states were now allowed to substitute private health insurance principles for EPSDT coverage design. Under SCHIP, states can link coverage to benchmarks drawn from the employer-sponsored health insurance market or build their own benchmark equivalents, which are subject only to a handful of cost-sharing, actuarial, and well-child coverage rules.

"[A]t its core, SCHIP is pegged to the prevailing market for third-party coverage rather than to child development principles; as health insurance products seemingly drift ever downward in scope and depth, so can SCHIP," the authors warn.

While Medicaid coverage design through EPSDT articulates financing principles that support a standard of care for child development, this "has never been equaled in other forms of health insurance." Private products are structured for "presumptively healthy workers with presumptively health children," the authors write. The two systems serve "fundamentally different" populations and provide "fundamentally different" coverage products.

Impact of the Deficit Reduction Act

The DRA essentially grafted SCHIP principles onto Medicaid as a state plan option, write the authors. EPSDT continues to supplement basic coverage for eligible children. "But as a result of either drafting clumsiness (seen in other DRA provisions) or deliberate drafting ambiguity, the legislation raises serious uncertainties regarding how well the EPSDT safeguard will function in practice," the authors write.

Saving EPSDT

EPSDT is the country's signature social policy effort to translate pediatric principles into health care financing, the authors write. "To sacrifice this vision for the sake of insurance markets is to lose not only coverage but the ethical basis of child health financing," they add. If EPSDT is to survive, careful thought must be given to the relationship between alternative benefit design and EPSDT's wraparound benefits.

In conclusion, the authors offer four recommendations to ensure that any state redesign retains a child health focus:

- Maintain the important periodic developmental assessment, pegged to pediatric milestones. This must remain a basic and routine aspect of benchmark coverage, without regard to medical-necessity decisions.
- Adhere to EPSDT's medical-necessity standard; in other words, coverage should not be delayed until a child is acutely symptomatic.
- Apply tiering selectively. EPSDT coverage principles should remain the touchstone of benchmark coverage, with high-cost treatments—as governed by developmental concepts of medical necessity—placed on an upper tier as a means of limiting insurer risk.
- Encourage flexibility in coverage. Health coverage for children must remain sufficiently flexible to be able to respond to new insights and new and effective strategies for ensuring optimal outcomes. Consequently, coverage protocols must be similarly flexible and responsive.

Facts and Figures

- Medicaid is the primary means of insuring low-income children and a principal source of pediatric health care financing.
- In 2005, Medicaid paid for more than one-third of all U.S. births and covered one of four children.
- In 2004, total per capita Medicaid spending for children under the EPSDT standard of coverage was $1,315, reflecting all screening, diagnostic, and treatment services.
- In 2001 dollars, risk-adjusted spending per child was $924 for all children and $1,344 for privately insured children.