Economic Woes May Not Slow SCHIP Expansion

BY ALICIA AULT
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Even though the Bush administration has made it nearly impossible to expand the State Children's Health Insurance Program, and the economic downturn has put a squeeze on Medicaid budgets, many states are keeping children covered and some are even expanding eligibility, according to two new studies by Families USA.

Officials at the advocacy organization, based in Washington, D.C., said that at the end of 2007, 17 states were considering expanding coverage for children under SCHIP and Medicaid. But those plans were largely put on hold or scaled back because of President Bush's vetoes of the original SCHIP reauthorization package. A law authorizing the program at 2007 levels expires in March 2009.

Another setback for states came last August, when the Bush administration issued a directive that limited the SCHIP eligibility, going forward, of families with incomes at or below 250% of the federal poverty level.

That directive has remained essentially unchanged, although the Centers for Medicare and Medicaid Services announced in May that it would look at expansion programs on a case-by-case basis.

Expansion plans by New York and Ohio were rejected by CMS, but New York used state funds to expand coverage to children living in families with incomes up to 400% of the poverty level. Ohio is using state money to cover children who can't get private health coverage, but the expansion is not through Medicaid or SCHIP, according to the Families USA report, "Detour on the Road to Kids Coverage: Administration Creates Roadblocks, So States Seek Alternative Routes."

Ohio also raised eligibility to the federal ceiling (250% of the poverty level).

Indiana, Louisiana, Oklahoma, and Wis-

consin had planned to raise eligibility for their programs to 300% of the poverty level, but have now scaled that back to 250%, according to the Detour report. Finally, North Carolina, Washington state, and West Virginia also had expansion plans, but have not yet submitted them to CMS, according to the report. It is not clear yet how those states will proceed.

Despite the CMS directive and the bleak economic outlook, some states—including Colorado, Florida, Iowa, and Kansas—are planning to expand coverage next year. The expansions in Iowa and Kansas, however, depend on a reauthorization of the SCHIP program, according to the Detour report.

There also may be a ballot measure in Montana this fall aimed at increasing eligibility from 175% to 250% of poverty level.

California is currently wrangling over the state's budget, which included an increase in cost sharing for SCHIP (which is called "Healthy Families" in California) as well as reduced Medicaid coverage for parents. Rhode Island is also looking at paring back its SCHIP coverage in fiscal 2009 and increasing cost sharing for families.

"States are committed to covering kids, but they are clearly hampered by the roadblocks the administration has put up," said Families USA senior policy analyst Jenny Sullivan in a briefing with reporters.

Most states are also feeling the pinch as tax revenues recede while Medicaid costs—increasingly a larger proportion of most state budgets—continue to rise, according to the second Families USA report, "Precarious Position: States Must Balance Declining Revenues With a Growing Need for Medicaid." The report found that 16 states and Puerto Rico are looking at budget deficits in fiscal year 2008, and 29 states and the District of Columbia are looking at shortfalls in fiscal 2009.

Increasing unemployment means more Americans will turn to Medicaid for health coverage for them and their children, said the organization. The Medicaid report cited a study by the Kaiser Family Foundation showing that a 1% rise in unemployment increases Medicaid and SCHIP enrollment by 1 million, leaving states with an additional $1.4 billion obligation.

In California, Gov. Arnold Schwarzenegger (R) has proposed $1 billion in Medicaid and SCHIP cuts. That means the state would lose an additional $1 billion in federal matching funds—a danger that all states face as they look to balance their budgets through Medicaid cuts, according to the Medicaid report. Mississippi is also considering Medicaid cuts in a special legislative session. Maine instituted some cost-sharing measures; New Jersey is considering shifting more of the burden onto Medicaid recipients. In Rhode Island's 2008 budget, eligibility was reduced for parents and cost sharing was increased; premium payments based on income are required, and the state is looking at further cuts in 2009, according to the report.

Families USA is pushing for federal relief, such as a temporary increase in the matching rate given to states for Medicaid. Congress passed such a fix in 2003, but it is unclear whether a proposed fix could make it out of Congress this year, said a Families USA staffer in the briefing. ■

International Graduates Fill Gaps in Physician Supply

BY JOYCE FRIEDEN
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ARLINGTON, VA. — International medical graduates have become an integral part of providing medical care in federally designated physician shortage areas, according to results from a recent study.

"Compared to U.S.-trained physicians, IMGs provide more primary care and more [overall] medical care to populations living in primary care shortage areas" as well as to minorities, immigrants, patients in poor areas, and Medicaid recipients, said Esther Hing of the National Center for Health Statistics, in Hyattsville, Md.

Ms. Hing and her colleague Susan Lin, Dr.P.H., studied 2005-2006 data from the National Ambulatory Medical Care Survey. The survey was nationally representative, and the data used by the researchers included information from 2,390 physicians in office-based practices. Ms. Hing presented the survey results at the 2008 Physician Workforce Research Conference.

The survey showed that IMGs make up 25% of office-based physicians. They also tend to be a little older that U.S.-trained doctors, with an average age of 52 years, compared with 50 years for physicians trained in the United States. The racial and ethnic differences were more pronounced: 71% of U.S. medical graduates were non-Hispanic white, compared with 26% of IMGs. Asian/Pacific Islanders made up 32% of IMGs, compared with 5% of U.S. medical graduates. Hispanic and Latino physicians accounted for 7% of IMGs, compared with 2% of U.S. graduates.

More of the IMGs than U.S. medical graduates were working as primary care physicians—57% vs. 46%—a statistically significant difference, Ms. Hing noted.

IMGs also practiced more often in counties that included primary care shortage areas than did U.S.-trained physicians—87% vs. 79%. IMGs also were more likely to accept new patients and to accept Medicaid—nearly one-third of IMGs surveyed derived 20% or more of their incomes from Medicaid, compared with less than one-fourth of U.S.-trained physicians.

"This study illustrates how the U.S. health care system continues to rely on IMGs to address shortages in primary care," Ms. Hing said at the conference, which was sponsored by the Association of American Medical Colleges and Harvard Medical School.

"The U.S. health care system faces challenges if the future supply and use of IMGs is constrained by recent changes in visa policy that reduce the number of incoming" medical graduates, she said. ■