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What's Ahead for Children's Health Insurance?

The United States Senate and the House of Representatives in late September passed a compromise bill reauthorizing the State Children's Health Insurance Program (SCHIP). President Bush has said he will veto the bill, H.R. 976, which would provide an additional $35 billion in federal matching funds to states over the next five years, to enable states to add additional children to the insurance program. The President had asked for a much smaller increase in funds -- $5 billion -- which would have covered only children already in the program.

Apparently sure that the U.S. House of Representatives will uphold the promised veto, SCHIP supporters said last week that they will return to the table to work out new legislation. Meanwhile, Congress has approved an extension of the SCHIP program with existing rules and funding levels through the end of this calendar year.

If the compromise bill were enacted into law, it would make some changes in the very popular federal/state child insurance program. Here are some of the provisions of that legislation that may or may not make it into a new bill now expected to be crafted by House and Senate committees in the next session of Congress.

Under H.R. 976, the Children's Health Insurance Reauthorization Act of 2007,

- Pregnancy-related assistance would be provided to targeted low-income pregnant women (incomes up to 185 percent of the federal poverty level), with postpartum care through 60 days following the end of the pregnancy. Babies born to the women would be enrolled in SCHIP automatically.
- Coverage to non-pregnant childless adults would be phased out, with states that have waivers allowing such coverage given options for ending it.
- The federal matching rate for children from families earning more than 300 percent of the federal poverty level would be limited.
- There would be extensive studies of whether enrollment in SCHIP "crowds out" private insurance coverage—in other words, whether families move their children from private health plans to enroll them in SCHIP.
- Current requirements that SCHIP applicants present documentary evidence of citizenship would be replaced by other assurances of eligibility.
- There would be extensive examination of health quality improvements for children enrolled in SCHIP and improved availability of public information regarding enrollment of children in Medicaid and SCHIP.
- Dental benefits and mental health parity would be ensured under SCHIP plans.
- There would be demonstration projects relating to diabetes prevention.
- Provisions regarding school-based health centers would be clarified to say that nothing in the law prevents states from providing SCHIP payment for items and services provided by SBHCs.
- The program would be financed by an increase in the excise tax on tobacco products.
- There would be no federal funding for illegal aliens.

The State Children's Health Insurance Program was passed by Congress 10 years ago, in 1997, and the original authorization expired at the end of September this year. The reauthorization proposal now before President Bush inspired heated debate in both the House and Senate, with critics charging that the bill's provisions for child health insurance are an opening wedge to government-financed universal health coverage, and advocates arguing that the program should be extended to cover at least 10 million children, up from

the 6.6 million currently enrolled in SCHIP.

The compromise bill was supported by organizations including the American Medical Association and the AARP, and by many state governors. Supporters of the bill warned during debate that congressmen who vote to sustain the President's veto will face the issue when they stand for reelection next year.

School-Based Health Centers Found to Improve Access, Quality of Care for Low-Income Adolescents

Judged by visit rates, emergency care use, and markers of quality care, researchers who looked at a Denver, Colorado, safety-net system found that school-based health centers (SBHCs) served uninsured or underinsured adolescents better than traditional outpatient care sites such as community clinics. Using Denver Public Schools enrollment data and electronic medical chart data and immunization registries from Denver Health, investigators examined the experiences over a one-year period of a cohort of 14- to 17-year-old high school students who were either uninsured or insured by Medicaid or the State Children's Health Insurance Program (SCHIP).

Noting that children of racial or ethnic minorities, low-income children, and children who are underinsured or uninsured may lack a usual source of health care, the report describes the development of school-based health centers as a potential solution to improving access to care. "Based on evidence that SBHCs improve access to health care and a belief that they may also result in improved quality of care and better long-term outcomes, the number of SBHCs has increased over the past decade from fewer than 200 centers to 1500 centers nationwide. Approximately one-third of these centers are located in high schools and the majority are in urban locations." Intended to provide primary care, SBHCs are usually staffed by health care professionals such as nurses, nurse practitioners, physician assistants, behavioral health specialists, and physicians who provide physical and mental health services with an emphasis on prevention.

In Denver, a health safety-net system that serves one-fourth of the city's population is made up of 11 SBHCs, 9 community clinics, 2 urgent care centers, and a tertiary care hospital with an emergency department. At the time of the study--August 1, 2002, to July 31, 2003—SBHCs existed in 7 of the 11 Denver public high schools targeted as serving racial or ethnic minorities or low-income families. In its annual report, the Denver SBHC said 94 percent of students attending a school with a SBHC were enrolled and 35 percent to 60 percent of them actually used the center during the school year.

Denver SBHC services include preventive and primary health care, including immunizations, mental health services, referrals to specialty services, and access to after-hours telephone advice and urgent care. The SBHCs provide pregnancy testing, diagnosis and treatment of sexually transmitted infections, and family planning and birth control counseling, but students are referred to community clinics for prenatal care and contraception management. The centers are open during hours of school operation and are closed on school holidays.

Analyzing their findings from the one-year study, researchers found that in comparison with community clinic users,

- SBHC users had higher visit rates, often for preventive services, possibly because there was no charge for the care, students did not require transportation since the centers were on school ground, and adolescents were able to visit the centers during school hours;
- SBHC users were less likely to have used emergency care;
- SBHC users were more likely to have received an influenza vaccine, a tetanus booster, and a hepatitis B vaccine.

The researchers commented, however, that the existence of a school-based health center on a school campus does not in and of itself overcome adolescents' barriers to health care access. In the study, many students did not use the service, possibly because they had other health care available or because they were not convinced that they needed health care. And the researchers pointed out that there have been few studies of the quality of care provided by SBHCs nationally. "SBHCs that are not part of an integrated system of care may not have the resources, such as an immunization registry, to perform as well on quality-of-care measures."

But because the Denver study was able to use a large data set with detailed information about visits and linkages to immunizations, it was able to make accurate comparisons between groups and subgroups and its conclusions were strengthened because the results were consistent across multiple outcome measures. On that basis, the researchers concluded, "SBHCs are an effective way for health care systems to improve access to health care and quality of care for underserved adolescents. In an era when health care funding is limited, these data may be used to advocate for increased resources for SBHCs."

The research report, "School-Based Health Centers: Improving Access and Quality of Care for Low-Income Adolescents," is published in the October 2007 issue of the journal Pediatrics. E-mail correspondence may be addressed to Mandy Allison at mandyallison@hsc.utah.edu.

Legal Battles over Vaccines and Autism

What was once a medical or scientific question—do childhood

vaccinations cause autism?—has now become a legal question. Increasingly, parents are turning to the courts to try to prove that their autistic children were damaged by the injections they were given as infants, with arguments often centering around one component of earlier vaccines, the mercury-containing preservative thimerosal. In two major articles in its September 27 issue, the *New England Journal of Medicine* takes on the troubled history of vaccines and autism and offers a cautionary tale about thimersosal.

As of now, the journal reports, 5000 families of autistic children have filed claims with the Vaccine Injury Compensation Program (VICP), a program that was created by Congress 20 years ago in response to a scare about the pertussis portion of the diphtheria-pertussis-tetanus (DPT) vaccine. The VICP provides compensation to children who have serious adverse effects from any childhood vaccination, with compensation intended to cover medical and related expenses, lost future income, and up to $250,000 for pain and suffering. There have been some 7000 claims so far for adverse effects other than autism, with payments in 2000 of those claims averaging about $850,000. The VICP frequently takes more than two years to process a petition, and approximately 700 claims remain unresolved.

Autism is not on the VICP's list of possible adverse reactions to vaccination, and families who make autism claims must prove in some way that there was injury. That's a significant barrier, since most medical and scientific experts have concluded that there is no proof of a causal tie between autism and thimerosal or the MMR vaccine, says Dr. Stephen Sugarman. So far, the VICP has rejected at least 300 autism claims outright.

With thousands of autism claims pending, however, the VICP announced in 2002 that it would examine the general causation question, using a few test cases. The first of nine test cases was heard this past summer, but judges on the so-called Vaccine Court are not expected to rule before next year. Meanwhile, families are bypassing the VICP process and going directly to other courts, where lawsuits "seem a long way from resolution," according to Sugarman.

On the specific question of whether thimerosal in vaccines caused autism, Dr. Paul Offit suggests in a second journal artricle that the campaign against thimerosal "has caused legal, political, and social harms." Although the preservative is now banned from most childhood vaccines, with the exception of some influenza vaccines, there has been no apparent decline in the incidence of autism and "the controversy continues to be emotionally charged,"

A lesson learned from the thimerosal scare came after the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) asked pharmaceutical companies in 1999 to remove the preservative from their vaccines. The AAP said parents should not be worried, since "The current levels of thimerosal will not hurt children, but reducing those levels will make safe vaccines even safer."

"Critics wondered," Offit says, "how removing something that hadn't been found to be unsafe could make vaccines safer. But many parents, frightened by the sudden change in policy, reasoned that thimerosal was targeted because if was harmful, and their faith in the vaccine infrastructure was shaken. Doctors were also confused by the recommendation."

All of that has led to drops in vaccination compliance, and, in the case of autistic children, a "cottage industry of charlatans" offering chelating agents that are supposed to remove traces of mercury from a child's body. Physicians, government scientists and others who have said publicly that vaccines don't cause neurological problems or autism have received hate mail and occasionally death threats. "The CDC, in response to planned protests at its gates, recently beefed up security and instructed personnel about how to respond if physically attacked."

"During the next few years," Offit writes, "thimerosal will probably removed from influenza vaccines, and the court cases will probably settle down. But the thimerosal controversy should stand as a cautionary tale of how not to communicate theoretical risks to the public; otherwise, the lessons inherent in the collateral damage caused by its precipitate removal will remain unlearned."

The articles, "Cases in Vaccine Court—Legal Battles over Vaccines and Autism," and "Thimerosal and Vaccines—A Cautionary Tale," were published in the September 27, 2007, issue of the New England Journal of Medicine.

The Continuing School Food Controversy

The National Alliance for Nutrition and Activity—whose members include the Center for Science in the Public Interest, the American Dietetic Association, the National PTA, and the American Heart Association—is calling on its members to try to persuade the Department of Agriculture (USDA) to update standards for foods sold in schools outside the federally subsidized lunch and breakfast programs.

Pointing out that while nutrition standards in the federal programs are updated periodically in accordance with the Dietary Guidelines for Americans, there has been no change for 30 years in the USDA's standards for foods sold outside of school meals, the alliance says that makes for some arbitrary rules for what can and can't be sold.

For instance, the alliance notes, current USDA standards allow sales of French fries, ice cream, candy bars, cookies, chips, snack cakes, and doughnuts, while prohibiting less ubiquitous items such as seltzer water, caramel corn, Popsicles without fruit juice,

jelly beans, chewing gum, lollipops, cotton candy, and breath mints. "As a result, while children receive sound nutrition from federally reimbursed school meals, foods such as soft drinks, candy, and fried snack foods are readily available at school, undermining child health and wasting taxpayer dollars invested in the school food program."

It's not, the alliance points out, that schools are making a lot of money from the unhealthful foods they are dispensing in cafeterias or vending machines. Contracts that schools negotiate with vendors, for example, which are an attractive discretionary source of funding for administrators, generate an average of $18 per student per school year for schools and/or school districts. In an average school beverage contract, that would be approximately one-fourth of one percent of the cost of a student's education.

Also, the alliance notes, money that flows to vending machines and cafeteria ala carte service comes out of the pockets of children; in effect, students and their parents make up with their own money for the revenue schools lose in federal payments for reimbursable meals that are not served when students opt for the alternatives.

As to how all of this affects the bottom line, the alliance reports that a recent survey of 17 school districts found that 12 had increased food revenues after improving their school food options, and four reported no change. That seems to show that, as claimed by the Department of Agriculture and the Centers for Disease Control and Prevention, "Students will buy and consume healthful foods and beverages—and schools can make money from selling healthful options."

A recent Institute of Medicine report called for specific standards for school foods outside the federal programs, and bipartisan bills currently before Congress would "provide children with nutritious food and beverage choices at school, model healthy choices, reinforce nutrition education, and support parents' ability to feed their children a healthy diet." The Child Nutrition Promotion and School Lunch Protection Act calls on the U.S. Department of Agriculture to update its definition of "Foods of Minimal Nutritional Value" to conform to current nutrition science—"for the whole campus, the whole day."

The child nutrition bills, S. 771 in the Senate and H.R. 1363 in the House, can be read and tracked at website http://thomas.loc.gov.

WORTH NOTING

Survey Finds Allergies Major Cause of Asthma

More than half of current asthma cases can be linked to allergies, and approximately a third of them result from cat allergy, according to data from the Third National Health and Nutrition Examination Survey (NHANES 111). In the study, researchers from the National Institute of Environmental Health Sciences (NIEHS) and the National Institute of Allergy and Infectious Diseases (NIAID) in the National Institutes of Health looked at skin test data for 10 allergens—cat, the fungus Alterneria, white oak, ragweed, dust mites, Russian thistle, Bermuda grass, peanuts, perennial rye, and German cockroach, all of which are "strongly associated" with asthma. Scientists noted, however, that many people who get asthma have no known allergies. "This study tells us that allergy is a major factor in asthma. But it also tells us that there are many people who get asthma who do not have allergies. We need to do more research to understand what is causing the asthma that is not related to allergies," said Dr. Peter George of NIAID.

Small Diet, Activity Changes Found to Reduce Child Weight Gains

A family intervention program in which families were given pedometers to measure that they walked an added 2000 steps a day and were given cereal for breakfast and a sucralose sweetener to substitute for sugar in the family's diet was effective in reducing the rate of increase in body weight in the children, researchers reported in the October 2007 issue of the journal *Pediatrics*. The small-changes approach advocated by a group known as America on the Move "could be useful in preventing excess weight gain in families," researchers concluded. Families enrolled in the study had at least one child 7 to 14 years of age who was overweight or at risk of overweight; children were defined as overweight or at risk of overweight if they had body mass index at or more than the 85th percentile. Researchers pointed out that their goal was not to produce weight loss in children but to reduce the increase in body weight, and they said the six-months intervention was successful in doing that. "During a 6-month period children showed significant decreases in BMI for age."

SEPTEMBER NEWS ALERTS

The following information appeared during the month of September 2007 in the News Alerts section of the website of the Center for Health and Health Care in Schools, at www.healthinschools.org.

September 4, 2007
AMA Launches Campaign for Health Insurance

The American Medical Association (AMA) announced August 23 that it is launching a three-year, multi-million dollar campaign to give American families the means to purchase health care insurance. Timed initially to coincide with the 2008 election cycle, the initiative, called "Voice for the Uninsured," will feature radio, television, and print advertising, pharmacy bags printed with the AMA's message, billboards, placards at transit stations and

bus shelters, presentations at state fairs and football games, and a website, www.VoiceForTheUninsured.org. "The AMA is enlisting doctors and medical students in our campaign and asking them to become advocates on this important issue," said AMA President-elect Nancy Nielsen. In its proposal, the AMA is calling for tax credits or vouchers for the purchase of health insurance, individual choice of health plans, and insurance market regulation. The organization is also continuing to lobby Congress for continuance of SCHIP, the State Children's Health Insurance Program.

September 7, 2007
CDC Reports 'Significant' Increase in Youth Suicides

The federal Centers for Disease Control and Prevention (CDC) today reported the biggest annual increase in 15 years in suicides by females 10 to 19 years old and males 15 to 19 years old. The increase occurred between 2003 and 2004, and officials said they do not know if the rise in number of suicides was short-lived or represents the beginning of a trend. "Either way, it's a harsh reminder that suicide and suicide attempts are affecting too many youth and young adults. We need to make sure suicide prevention efforts are continuous and reaching children and young adults," said Dr. Ileana Arias, director of CDC's National Center for Injury Prevention and Control. The overall increase in suicides was 8 percent, with firearms the most common method for both boys and girls, followed by hanging/suffocation. Further information is available at www.cdc.gov/ncipc/dvp/Suicide/youthsuicide.htm.

September 10, 2007
New York Is Told Not to Add SCHIP Children

The state of New York, which had hoped to expand its State Children's Health Insurance Program (SCHIP) to include children from families that earn 400 times the federal poverty level, was told by the Centers for Medicare and Medicaid in the U.S. Department of Health and Human Services Friday that new federal restrictions bar expansions of SCHIP eligibility beyond 250 percent of the federal poverty level. Specifically, New York was told that it cannot extend SCHIP to higher income levels because it does not currently enroll at least 95 percent of all children in the state who have family incomes below 200 percent of poverty. That is one of several new restrictions on SCHIP eligibility set by the Bush administration August 17 in a letter to state governors. Current law allows state to set their own SCHIP eligibility levels, and New York Governor Eliot Spitzer said Friday that the state is preparing a lawsuit challenging the new policy. New York is the first state to test the federal restrictions, which include a mandatory one-year waiting period before children who previously had private health insurance can enroll in SCHIP, regardless of the reason for the child's loss of private coverage.

September 13, 2007
Senate Asked to Nullify New SCHIP Restrictions

Legislation introduced in the U.S. Senate yesterday would block implementation of guidance issued by the federal Centers for Medicare and Medicaid (CMS) August 17 that would block states from enrolling children with family incomes above 250 percent of the federal poverty level in the State Children's Health Insurance Program (SCHIP). Senate sponsors of a bill, the Better Health for Children Act, Sens. Ted Kennedy (D-MA), Gordon Smith (R-OR), Jay Rockefeller (D-WV), and Olympia Snowe (R-ME), said the CMS policy would have "a devastating impact" on states' ability to extend SCHIP to more children. Kennedy noted that a bill already passed by the Senate would allow states to cover children with family incomes up to 300 percent of poverty, and he noted that 18 states, including Massachusetts, already provide SCHP coverage to families with incomes above the CMS-proposed limit. The new Senate bill, S. 2049, can be read and tracked at http://thomas.loc.gov.

September 17, 2007
Study to Look for Heart Risks from ADHD Medications

Two agencies in the federal Department of Health and Human Services (HHS) announced today that they are conducting the most comprehensive study to date of whether taking prescription medication to control attention deficit hyperactivity disorder (ADHD) increases the risk of heart attack, stroke, or other cardiovascular problems in children and adults. The Agency for Healthcare Research and Quality (AHRQ) and the Food and Drug Administration (FDA) will examine the clinical data of about 500,000 individuals who took ADHD medication during a seven-year period ending in 2005. The data will be analyzed by researchers at Vanderbilt University and will include all drugs currently marketed for ADHD. The study announcement describes ADHD as "a behavioral disorder that may have significant impact on school performance and social functioning" that is believed to affect approximately 3 percent to 5 percent of school-age children and 4 percent of adults. A recent AHRQ analysis found that the top five drugs prescribed for ADHD in children under 17 accounted for $1.3 billion in medical expenditures in the year 2004.

September 20, 2007
Flu Vaccination Urged for All Children

A coalition that includes almost all professional organizations involved in child and adolescent health has pointed out the importance of immunizing children--including infants 6 months to 5 years of age, schoolchildren, and adolescents--against influenza, starting early in the coming flu season and continuing through the fall and winter months. Although the main goal of vaccination is to protect children from an illness that caused 153 child deaths in the 2003-2004 flu season, there is also evidence to suggest that vaccinating children will provide additional benefits to society, the coalition said. "Widespread childhood vaccination can interrupt influenza transmission, since influenza outbreaks usually begin in children and then move on to the community at large."

Noting that well-informed health care professionals are best equipped to educate parents and guardians about the importance of influenza immunization, the coalition is urging that practitioners use every opportunity, including back-to-school visits, to encourage parents to get annual flu vaccinations for their children beginning as soon as vaccine becomes available in the fall and well into January and later, since the vaccine continues to be of benefit while the virus circulates.

In an unrelated development, the federal Food and Drug Administration announced September 19 that it has approved the use of the nasal influenza vaccine FluMist for children between the ages of 2 and 5. The nasal vaccine had previously been approved for children 5 years of age and older and adults up to age 49. The announcement noted, however, that FluMist should not be administered to anyone with asthma or to children under the age of 5 with recurrent wheezing.

The coalition's recommendations and a complete list of members are available at *www.preventchildhoodinfluenza.org.*

September 24, 2007
Senate Bill Cites Looming Shortage of Nurses

Noting that the federal Health Resources and Services Administration predicts a shortage of more than a million nurses in the United States by the year 2020, a bill introduced in the U.S. Senate last week would encourage career ladders to nursing for currently employed ancillary health care workers by providing English as a second language education, GED education, pre-college counseling, and support with entry-level college classes that are a prerequisite to nursing. The bill, S.2064, introduced September 18 by Senator Richard Durbin (D-IL), would also fund programs that would allow currently working nurses to return to school to take advanced degrees and would enable "bedside nurses" to take leave from their jobs to teach in nursing programs at colleges and universities. Durbin's bill is similar to legislation introduced in the House of Representatives September 19 that would amend the Higher Education Act to create a capitation grant program "to increase the number of nurses and graduate-educated nurse faculty to meet the future need for qualified nurses." The House bill, H.R. 3597, and the Senate bill can be read and tracked on the Congressional Record website at *http://thomas.loc.gov.*

September 26, 2007
Conference SCHIP Bill Allows Funds to SBHCs

A 300-page compromise between the U.S. House and Senate on reauthorization of the State Children's Health Insurance Program (SCHIP) that was approved by the House yesterday and is expected to pass the Senate today, includes language allowing states to use SCHIP funds for "items and services furnished through school-based health centers." Specifically, the conference bill reads:

"Section 2103(c) (42 U.S.C.1397(cc) c)) is amended by adding at the end the following new paragraph:
'(8) AVAILABILITY OF COVERAGE FOR ITEMS AND SERVICES FURNISHED THROUGH SCHOOL-BASED HEALTH CENTERS – Nothing in this title shall be construed as limiting a State's ability to provide child health assistance for covered items and services that are furnished through school-based health centers."

President Bush has said he will veto the SCHIP bill because it authorizes more spending that the administration wants over the next five years, and it is expected that House Republicans will sustain the veto, meaning the bill in its present form may not become law.

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