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Policy Brief #6:

From SCHIP Benefit Design to Individual Coverage Decisions

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ABSTRACT

The majority of states have implemented separate SCHIP (S-SCHIP) programs that significantly depart from Medicaid and resemble less comprehensive commercial products. This difference in program design may result in S-SCHIP potentially being less responsive to children with special needs (CSHCNs). This study explores how responsive insurers are to these higher than average needs. We found that, with one exception, insurers did not agree on the coverage of any specific service, but overall they provided coverage beyond state limits and exclusions. Second, the less acute the childhood condition, the more frequently insurers imposed exclusions. Finally, in the majority of states, some insurers excluded services that arguably should have been covered according to the plan/contract language. We conclude that SCHIP coverage at current levels may not be sufficient to care for CSHCNs, making external reviews of insurers' coverage decisions and coordination with other sources of care important components of SCHIP program design.

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INTRODUCTION

How do private insurers that administer both the Medicaid and the separate State Children's Health Insurance Program (SCHIP) programs make coverage decisions for SCHIP-enrolled children who have special health care needs (CSHCNs)? Are there any differences between the benefits mandated under SCHIP and the implemented benefits as illustrated by insurers' coverage decisions? What is the potential impact of these decisions for children's access to care, particularly in comparison to the more comprehensive benefits provided to children enrolled in Medicaid? This paper presents key findings from a study designed to answer these core questions.

Enacted in 1997, SCHIP gives states the option to extend coverage to low-income children through a Medicaid expansion program, a separately-administered SCHIP program, or both.¹ If a state chooses to implement a Medicaid expansion (M-SCHIP), all Medicaid rules apply.² Alternatively, if a state elects to establish a separately-administered program (S-SCHIP), it enjoys some flexibility in designing the program: it may follow Medicaid rules, or it can depart from these rules as long as the departure is within the broad limits of the law.³ As of FY 2003, all states participated in SCHIP.⁴ Fifteen states had separately-administered SCHIP programs, 16 states (including D.C.) had Medicaid expansions, and 20 states had combination plans, covering a total of 5.9 million children.⁵ Of those, two-thirds (4.4 million children) were enrolled in 35 S-SCHIP programs.⁶

By design, Medicaid aims at covering the "uninsurable" and thus attracts CSHCNs.⁷ Research shows that children who have Medicaid are more likely to be only in fair or poor health, as reported by their parents, have asthma, learning disorders, or medical conditions that require regular treatment with prescription drugs.⁸ The program has characteristics that make it, at least in theory, a great policy for children, particularly CSHCNs, even though access to physicians willing to participate in the program has been problematic since the program's inception due to reimbursement levels that are low relative to what other payers, such as Medicare and commercial insurers, pay for the same service. Medicaid law creates an individual entitlement to a federally-defined comprehensive set of benefits with no cost-sharing allowed. It requires coverage of medically necessary services for children even if they do not restore these children's normal functioning, but rather maintain current functioning or prevent further deterioration from normal functioning, and even if they are not specifically listed in the state Medicaid plan. When benefits are further denied, beneficiaries can rely on a federally-determined fair hearing process to seek redress. When state agencies deliver services through managed care organizations or MCOs (as is the case for the majority of women and children), services not provided by the insurer remain the responsibility of the Medicaid agency.⁹

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In contrast, by design, S-SCHIP functions more like a private insurance policy and thus addresses the needs of generally “healthy” children.¹⁰ It is not an entitlement to individual children, and benefits may be less comprehensive in scope, amount and duration than Medicaid benefits, with some cost-sharing allowed. The medical necessity standard can be more restrictive than the “preventive” medical necessity standard used in Medicaid, limiting coverage of services to those that are restorative. Grievances and appeals may be less defined. And services not provided by MCOs must be found elsewhere in the system, e.g., through state public health agencies.¹¹

While SCHIP is still in the early years of implementation, the literature on its design and its impact on access and use of services is growing. Early national benefit design studies conducted under the auspices of the Children’s Health Insurance Initiative (CHIRI)¹² and elsewhere document that S-SCHIP programs tend to cover a range of benefits somewhat less broad than that available through Medicaid (particularly with respect to long-term care services) and employ coverage limits (such as limits on the number of visits for services to treat mental illness or developmental disabilities) that would not be permissible under Medicaid in the case of children.¹³ These studies suggest that the departure of S-SCHIP programs from the more generous coverage principles of Medicaid may mean that these programs may not be as responsive to the needs of CSHCNs as Medicaid can be.

More recent studies of nationally representative data examine the effect of SCHIP on coverage and utilization,¹⁴ but few focus specifically on CSHCNs.¹⁵ For example, one study found that unmet need for dental care decreased and the probability of having a dental care visit increased for CSHCNs after their enrollment into SCHIP, consistent with the findings of similar studies on children generally.¹⁶ Such associations were not found to be statistically significant for specialty care and other services, again consistent with the findings of similar studies on children generally.¹⁷ Although this and other nationally representative studies did not distinguish between children’s enrollment in a SCHIP Medicaid expansion program and in a separately-administered SCHIP program, state-based studies on S-SCHIP programs also suggest significant gains in dental care for children generally.¹⁸

Other, state-based CHIRI studies of S-SCHIP programs examining the characteristics of the children enrolled in these programs, key indicators of access to care, disenrollment patterns, and reasons for leaving the programs, found that the prevalence of CSHCNs ranged from 17 to 25 percent in Florida, Kansas, and New York.¹⁹ The authors conclude that this prevalence is slightly higher than the estimate of 13 to 18 percent of the general child population who is at risk of a chronic condition or has a higher than average need for services, and somewhat lower than the prevalence of special needs in Medicaid, confirming the need to take a closer look at access to services and quality of services rendered to these children under programs such as S-

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SCHIP that typically limit or exclude the types of services they need to maintain their functioning or prevent further deterioration of their health status.²⁰

Although national expenditure data on SCHIP-enrolled CSHCNs are not yet widely available, one would expect to find that, while these children constitute only a small proportion of enrolled children as is the case in any public or private plan, they nevertheless generate a disproportionate amount of the expenses incurred, further underscoring the importance of studying state efforts to monitor the quality of care received by CSHCNs.²¹ One study comparing two state separate SCHIP programs suggests this inverse relationship to be the case, showing that CSHCNs made up approximately 15% of the total enrollment but accounted for about 60% of the program expenditures.²²

Similarly, few studies have examined private and public insurers' coverage decisionmaking and how it affects children generally and CSHCNs specifically,²³ and none have studied this aspect of the SCHIP program, except for a handful of studies describing the medical necessity standards used in the program.²⁴ Past studies focused on discrete aspects of the process: the use of information in the process;²⁵ the process used by private and public payors to remedy lack of consensus on the evidence;²⁶ the role of courts in reviewing coverage decisions;²⁷ and the coverage of new technologies.²⁸ But most relevant to this study are studies that explored the variation among private and public insurers in the coverage of specific treatments in relation to existing evidence, although very few focused on children's health services. For example, Finkelstein *et al.* found variations among private and public insurers and physicians regarding the coverage of growth hormone therapy for childhood short stature.²⁹ Existing studies generally conclude that there is a high variation in decision outcomes among and within types of insurers (i.e., private insurers, Medicaid agencies).

In this study, we explore how the variability in coverage and benefits found in S-SCHIP programs may influence children's access to care by examining insurers' coverage decisionmaking of a select number of services most needed by CSHCNs, including long-term therapies and support services. The differences in insurance design between Medicaid and SCHIP were the rationale for the study and we assumed that the limits (e.g., scaled back benefit packages, coverage limitations and exclusions, etc.) found in S-SCHIP programs would disproportionately affect CSHCNs. We assumed a disproportionate effect on CSHCNs because, even though they constitute a fairly small proportion of all SCHIP enrollees, they are higher users of care and particularly of expensive services, so that restrictions would affect them more than the majority of children who are generally healthy.

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METHODS

This study has two main objectives. The first is to summarize the coverage of benefits in separately-administered SCHIP programs¹³; the second is to present coverage decisions for two hypothetical cases of children with special needs by participating insurers in states with such S-SCHIP programs, relating the outcomes of these decisions back to what states required as a matter of benefits and coverage rules.

Study Design

The study design was qualitative and consisted of case studies of coverage decisions by private insurers regarding a select number of medically necessary services prescribed for two hypothetical children with special needs, using a semi-structured telephone survey complemented by documentary analysis, both conducted between March and June 2002. Main decision outcomes were: the insurer would have provided the service without limits; the insurer might have provided the service, but only with some limits; the insurer would not have provided the service. Insurers were also asked for the basis for their decisions, if they imposed limitations or excluded a service altogether.

Population Studied

Purposive sampling, which is a non-probability method of sampling based on the researcher's subjective selection, was used to select states that presumably represented the most significant departure from Medicaid. Their use of separate managed care contracting documents for Medicaid and SCHIP services was interpreted as signaling their intention to depart from the extensive specifications usually found in Medicaid managed care contracts and to more closely follow standard commercial contracts. Fourteen states fit this criterion as of 2002. Although these states constituted a non-representative sample of S-SCHIP programs, together they covered 66 percent of all S-SCHIP enrolled children and were spread across all four main regions of the country.³⁰ Within these 14 states, we identified 71 medical directors employed by plans participating in both Medicaid and SCHIP who may potentially provide similar or differential treatment to their Medicaid and SCHIP members.

Very few medical directors agreed to answer our short survey. Only 13 percent of medical directors participated for a total of 234 coverage decisions; 49 percent explicitly declined; and 38 percent did not respond after repeated requests. Six of the 14 states were represented, which combined covered 46 percent of all children enrolled in S-SCHIP programs and all four main regions of the country. The six states shared similar program characteristics to the other eight states not represented in the study in terms of their use of benefit exclusions and/or limitations (100%) and co-payments (50%), but they were more likely to use a restorative standard of

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medical necessity or not have defined the standard of medical necessity in their contract (66% versus 50%), offer fewer managed care options to children (66% versus 25%), and include states that had all of these characteristics combined (33% versus 12.5%). Insurers were represented at varying levels across the six states, from a low of 6 percent of all insurers in one state to a high of 100 percent of insurers in another state.

States are not named individually in order to protect the privacy of the respondents who agreed to participate in this study.³¹

Data Collection and Analysis

Data collection and analysis followed four main steps. First, researchers used a database of SCHIP plan and contract language to analyze the extent of coverage of benefits more likely to be needed by CSHCNs in the 14 study states and to fine tune this analysis in the six states represented in the study. These broad categories of benefits were: (1) medications; (2) speech and physical therapy; (3) durable medical equipment; (4) enabling (i.e., non-medical, non-emergency) transportation; and (5) case management to coordinate the children's care. The National Survey on Children with Special Health Care Needs found that almost all CSHCNs need prescriptions drugs, a quarter need physical and speech therapy, and 2-4% need communication and mobility aids.³² On average, the 14 states selected for participation in this study limited or excluded these benefits altogether.

Second, researchers developed a list of 13 services that fall under these broad categories of benefits (Table 1). Researchers also designed two vignettes (see boxes) of hypothetical children with conditions that are either long-term for which there is usually no return to a state of "normal functioning" (spina bifida) or very acute with the possibility of either long-term sequelae or a return to "normal functioning" (head trauma). In both cases, however, the children described had special needs requiring specialized, and often expensive, treatment. This information was the basis for the survey questions and for the analysis of findings across and within states, respectively.

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Patient Scenario A: Spina Bifida

Case of a six-year-old with spina bifida, hydrocephalus, shunt in the brain to treat the hydrocephalus, neuro-developmental delay, paralysis of the lower extremities, hearing loss, and failure to thrive.

Most frequently occurring permanently disabling birth defect; 1 out of every 1,000 newborns annually. Potential need for surgeries and extensive medical care; bowel and bladder complications, hydrocephalus, learning disabilities, physical limitations, emotional problems.

Patient Scenario B: Head Trauma

Case of an otherwise healthy seven-year-old critically injured in a motor vehicle crash, with multiple long bone fractures, pulmonary injuries, significant facial and dental injuries, hearing loss, and closed head injury.

Approximately 2 million per year, including 500,000 severe enough to require hospitalization, and 99,000 resulting in a lasting disability; traffic accidents account for 1/3rd-1/2; common among children. Potential changes in personality, emotions or mental abilities, speech and language problems, loss of sensation, hearing, vision, taste or smell,

Third, in telephone interviews, researchers used a structured interview script and presented the two patient scenarios to the medical directors who agreed to participate in the study, asking them to assume that each patient had SCHIP coverage and that her treating physician had recommended the provision of each of the 13 services listed in Table 1 as medically necessary and to make a coverage decision for each service based on these assumptions.

Fourth, researchers compiled the information gathered through the interviews to present coverage decision outcomes in the form of aggregate findings. Although some simple statistical analyses were planned, it was not possible to perform them due to the very low number of responses. However, researchers analyzed the results to delineate patterns across the interviews regarding potential similarities and differences in coverage decision outcomes.

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RESULTS

In this section, we integrate findings from the state plan and contract language analysis with findings from the telephone interviews. We found that the study states' separate SCHIP programs varied in the types of limits or exclusions they imposed on benefits but generally agreed on which benefits to limit or exclude. Insurers who participated in this study, on the other hand, exhibited tremendous variation in coverage decision outcomes. In addition, they would have exercised discretion in deciding whether SCHIP-enrolled CSHCNs would obtain coverage of services deemed essential to these children, which translated into both more generous and more limited coverage than state prescribed coverage depending on the service and the case scenario involved.

States' Coverage of Medically Necessary Services under S-SCHIP

State SCHIP programs were generally more restrictive than Medicaid for all services we examined. All agreed that enabling transportation should be excluded, and they all limited the other 12 services in some way. The only disagreement in coverage among states related to case management/care coordination, but the majority still limited (three states) or excluded (two states) this service. In contrast, all of the study states' Medicaid managed care contracts covered the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit (i.e. the child benefit under Medicaid) and used a preventive medical necessity standard to determine coverage of specific services under EPSDT. As a result of these broad coverage standards in the case of children, these state Medicaid programs cover medically necessary services regardless of whether they are specifically listed in the state Medicaid plan.

The majority of state SCHIP agencies in this study did not define the medical necessity standard that would apply to determine whether a covered service is medically necessary for an individual child, and thus delegated this responsibility to participating insurers. Our findings describe the coverage outcomes of insurers applying their internal standard of medical necessity to the services listed in Table 1 for two hypothetical children.

Insurers' Coverage of Medically Necessary Services under S-SCHIP

Variation in the Level of Agreement among Insurers. As in previous research, we found a high level of variation among insurers. This variation, however, was the exact opposite of states' variation in coverage. More specifically, unlike states, insurers were far from being in agreement on any specific service, with the exception of the coverage of a case manager to coordinate the care of the child suffering from head trauma where 100 percent of the interviewees agreed they would have covered it without any limitations. The second highest level of agreement was 89 percent for full coverage of speech and language evaluation for both

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children, and a case manager to coordinate the care of the child with spina bifida, and for limited coverage of speech therapy for the child with head trauma. The lowest level of agreement was for assistive communication devices and enabling transportation. Table 1 displays this variation in greater detail.

Breadth of Coverage. Despite the variation just described, the majority of insurers made up for the limitations of the S-SCHIP benefit package designed by states and reflected in their contracts and would have provided coverage beyond the limits and exclusions of S-SCHIP for the majority of services examined here. This was particularly true for case management/care coordination for both children, which almost all insurers would have covered without limitations, when states limited or excluded this service. This was also the case for both children for the three prescription drugs studied, speech and language evaluation, hearing aids, fitted wheelchairs, and pumps for overnight feedings, which two-thirds of the insurers would have covered without limits (compared to states that unanimously limited these services). Finally, insurers were also more generous in their coverage of enabling transportation than states, all of which excluded coverage of this service, albeit with some more variation (about a third would have covered it without limits and another fifth with some limits).

This finding would indicate that insurers may provide, perhaps routinely, extra-contractual services by overriding otherwise applicable limits in the case of higher needs children, even though the premium they receive is not calibrated to tolerate this type of practice.

On the other hand, certain services most needed by CSHCNs, such as speech and physical therapy, motorized wheelchairs, and assistive communication devices, were generally restricted under S-SCHIP by *both* states and insurers in ways permissible under S-SCHIP but not permissible under Medicaid in the case of children. In addition, several insurers also excluded these services, seemingly against what the SCHIP programs called for. Table 1 shows this in greater detail.

Coverage Exclusions. Because of the discrepancy between insurers and states in coverage levels, particularly in the area of exclusions, we examined exclusions only and how they varied by condition. A relatively small proportion of all coverage decisions (n=234) are exclusions (27 or 11.5 percent). And it appears that the less acute the condition suffered by the child, the more frequently insurers would have imposed exclusions. Nine percent of all decisions related to the care needed by the child with a head trauma were exclusions, compared to 14 percent of all decisions related to the care needed by the child with spina bifida.

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Services more likely to be targeted for exclusion included speech and physical therapy for the child with spina bifida. Insurers based their decisions on the fact that the therapies would not have been restorative and thus did not fit the criteria for coverage.

Because there were variations in exclusions within states also, we examined discrepancies between an individual insurer's decision to exclude a service and that insurer's state requirements to cover it, whether with limits or none at all, as spelled out in the managed care contract. In four states, there were four services, where this inconsistency was noted for one or both children: (1) assistive communication devices for both children (in four states for the child with spina bifida, and in three states for the child with head trauma), (2) speech therapy for the child with spina bifida in two states, (3) hearing aids for the child with spina bifida in two states, and (4) motorized wheelchairs for both children in one state. Thus, in these four states, it is possible that insurers would have excluded services when these services arguably should have been covered according to the language used in the contracting documents.

In one state in particular, the language leaves little doubt that the sole insurer in that state should have covered assistive communication devices for both children instead of excluding them because, the insurer explained, they are not covered in the SCHIP program and it has to administer the benefits "as is contracted." However, a closer examination of the contract in question shows that it stipulates that durable medical equipment should be covered when medically necessary, it does not contain any exclusions, and it provides a definition of medical necessity that follows the Medicaid pediatric preventive standard of medical necessity. Interestingly, this state is one of the only two states in this study that actually specified a preventive medical necessity standard in the contract.

In comparison, in the remaining three states, the language is somewhat ambiguous and subject to interpretation. In one of these three states, which imposes many limitations and exclusions on services, the contract includes an interesting provision on CSHCNs that would seem to override all limitations because it explicitly lists spina bifida and hydrocephalus as qualifying conditions and requires timely access to a number of services, including rehabilitation and durable medical equipment appropriate for the condition. But in this state, as in the other two states, the contract does not define medical necessity, in effect delegating that responsibility to insurers and thus relying on more normative insurance principles that emphasize standard coverage rules and support the exclusion of services for children with low prevalence conditions, and deemphasize the unique coverage principles of Medicaid for children, which favor the coverage of services for children with low prevalence problems.

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The question that remains unanswered by this research is whether, in these four states, the child would have obtained coverage for the service on appeal, and if not, whether the state remains obligated to furnish this service as is the case in Medicaid.

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DISCUSSION

This study of mandated versus implemented benefits for S-SCHIP-enrolled CSHCNs compares a selected number of benefits covered at the macro level in the state SCHIP plans and managed care contracts with the micro decisions of insurers, who decide on a case-by-case basis whether these benefits are medically necessary for a specific child.

This study is significant because it provides new knowledge on how the process works (or does not work) for CSHCNs who have public insurance that closely follows commercial rules and what it means for these children's access to care, which is based on information that is difficult to obtain in nationally representative surveys or at the state level because of the small number of cases involved and because of the need to distinguish between enrollment in Medicaid and S-SCHIP programs. It also illustrates what publicly-financing insurance programs may look like in the near future as federal and state policymakers discuss whether to reform Medicaid in the form of increased flexibility to states.

Overall, insurers would have provided coverage beyond the limits and exclusions of SCHIP when in fact payment received does not account for these extra-contractual services. This became apparent for services, such as prescription drugs and support services. There were some notable exceptions, however, which led to the exclusion of important services, such as therapies and durable medical equipment, which suggest that coverage at current levels may not be sufficient to care for CSHCNs. These findings support our assumption that the variability in coverage and benefits found in S-SCHIP programs as a result of states exercising their flexibility to depart from Medicaid can influence access to care by CSHCNs, and are consistent with previous research findings.

However, this study also has several limitations that require caution in interpreting the results. First, the sample of states is not a representative sample, and thus findings are not generalizable to all states with separate SCHIP programs. Although the findings may not be generalizable, they provide important insights for the future of the Medicaid and SCHIP programs, as more states can be expected to move toward a commercial insurance model for the provision of services to children. Second, the number of responses from the interviews is very small, raising issues of response bias and problems of analysis. Even with the small number of responses, however, some patterns were detectable and, as such, were interpreted as indicative of the larger picture. Third, the cases presented to the medical directors for a coverage decision described hypothetical cases of children with special needs. While this is obviously different from real-life cases, the scenarios aimed at representing realistic situations and capturing dilemmas

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encountered in the real world. Nevertheless, the results represent a qualitative indication of what may be happening on the ground. Furthermore, this type of research is the only one that can reach the level of analysis necessary to detect any differences. Large population-based and claims-based datasets may not capture sufficient data to address these questions due to the rarity of the medical conditions, the types of services, and the small numbers of decisions involved.

Our findings have two main implications. First, they point to the need to include protections for CSHCNs so that the potential for denial of treatment or serious undertreatment can be reduced or preferably avoided. The majority of our study states did not specify a standard of medical necessity in their SCHIP plan and contract and could include such a standard in these documents that either adopts the “preventive” definition of the Medicaid program or some similar definition.

However, as this research suggests, reinstating a preventive medical necessity standard in SCHIP may not be sufficient to ensure access to needed care, so that the availability of external reviews of insurers’ coverage decisions becomes an important component of SCHIP program design because some services denied may actually be covered on appeal. Among the study states, all but one state specified in their SCHIP plan, their managed care contract, or both, an external right of appeals, but none gave individuals a right to a fair hearing. Ensuring that SCHIP moves toward the adoption of rules similar to the Medicaid fair hearing rules would mostly affect CSHCNs, who would greatly benefit from improved access to services.

If benefits are further denied on appeal, the availability of, and the coordination with, other sources of care becomes all the more important so that CSHCNs can be referred to these other sources, which may be able to provide or reimburse needed care if eligible. States could lessen the impact of leaner benefit packages under SCHIP by establishing some kind of a wrap around system of services, which can be administered jointly by the SCHIP agency and other agencies in the state, such as public health agencies. In fact, two of the states represented in this study have already done so. One state has a specialty care carve-out (i.e., all specialty services are provided through a program separate from SCHIP), and another state has a person carve-out (i.e., the child is referred to a specialized system of care that provides the full range of services). A third alternative not represented in this study but adopted by a few other states consists of creating a benefit package that supplements the SCHIP benefit package and provides coverage beyond the limits and exclusions imposed in SCHIP. If unable to establish a wrap around system of services, states may want to consider strengthening their coordination efforts with these other public health agencies in the state that have traditionally cared for CSHCNs. These agencies include the state Title V CSHCNs agencies, a logical source of funding for children with extremely serious physical disabilities and conditions, and other agencies, such as those running special education programs, state block grants for mental illness and mental retardation, and

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other grant-style programs, which provide services for children with mental and developmental disabilities and delays not funded by most Title V programs. Several states, including at least one of the study states, have undertaken such efforts from the outset but they are far from being the overwhelming majority. Coordination between SCHIP and these other sources of care, both at the program design and program implementation stages, becomes of the utmost importance in ensuring that CSHCNs gain access to the services they need.

Second, since insurance design seems to matter in terms of access to health care for CSHCNs and since insurance products that are limited in their coverage of treatment and management of chronic conditions and illnesses appear to affect the extent to which children with serious health problems use care, additional research on the actual use of services, comparing SCHIP-covered-CSHCNs with similarly situated children enrolled in Medicaid, is needed to examine how these children fare on the ground. This research could test for health care differences that can be linked to the nature, quality and structure of children's insurance coverage, and determine whether key indicators of access differ significantly depending on the type of coverage.

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CONCLUSION

In conclusion, SCHIP has advantages and disadvantages. On the one hand, the flexibility in program design under SCHIP allows states to extend coverage to higher family income levels and thus a higher number of uninsured children than they would have otherwise, had they not been able to exercise more control over the specific terms for providing that coverage. At the same time, the ability to use more limited benefit packages and higher cost-sharing, mandatory managed care enrollment for all children, and, when financially necessary, coverage waiting lists permits to exercise greater restraint over expenditures under the program.

On the other hand, this discretion has important implications for certain groups of children, i.e., those who find themselves on waiting lists for any coverage, as well as CSHCNs whose health conditions place them beyond the limits of the coverage they receive. It is this second group in which we were interested in this study because of concerns that shortfalls in coverage for care could lead to insufficient access to medically necessary treatment and management services. This concern with the impact of more limited SCHIP products on CSHCNs has taken on additional importance because of evidence of movement in the underlying Medicaid program toward more limited benefits and higher cost-sharing through legislative reform or the use of regulatory waiver demonstration authority. It is important to know whether supplemental services or insurance would be necessary for certain children were coverage to be curtailed and, if so, for which children coverage and treatment supplements would be most significant.

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TABLES AND FIGURES

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Table 1. Frequency Distribution

Benefit category	Service	Patient scenario	No. of states (n=6) that...			No. of insurers (n=9) that...		
			Cover with no limits	Cover with limits	Exclude from coverage	Cover with no limits	Cover with limits	Exclude from coverage
Prescription drugs	Medications for the treatment of an acute ear infection	Head trauma		6		5	3	1
		Spina bifida				6	2	1
	Both		6		7	1	1	
	Medications for the prevention of spasticity	Head trauma		6		6	2	1
		Spina bifida				7	1	1
Speech and physical therapy	Speech and language evaluation	Both		6		8	1	
	Speech therapy	Head trauma		6		1	8	
		Spina bifida				1	5	3
	Physical therapy to limit development of contractures in the lower extremities	Head trauma		6		3	6	
		Spina bifida				1	7	1
Durable medical equipment	Hearing aids	Head trauma		6		6	2	1
		Spina bifida				5	2	2
	Wheelchair specially fitted to child's size and capabilities	Both		6		5	4	
	Motorized wheelchair	Both		6		2	6	1

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Benefit category	Service	Patient scenario	No. of states (n=6) that...			No. of insurers (n=9) that...		
			Cover with no limits	Cover with limits	Exclude from coverage	Cover with no limits	Cover with limits	Exclude from coverage
	Assistive communication devices (such as computers with speech capacity)	Both		6		1	4	4
	Pump for overnight feedings	Both		6		6	3	
Enabling transportation	Transportation to medical appointments for wheelchair-bound child	Both			6	3(*)	2(*)	2(*)
Case management/ case coordination	A case manager to coordinate the child's care	Head trauma Spina bifida	1	3	2	9		
						8	1	

(*) Two states did not know whether enabling transportation was covered in their contract.

Source: CHSRP, 2002.

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