



# Children's Health Care Benefits

*A Key Issue in SCHIP Reauthorization*

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## Introduction

As Congress faces reauthorization of the State Children's Health Insurance Program, it is grappling with several contentious issues, including funding levels, formula allocations, enrollment requirements and program eligibility. The SCHIP benefit design, including covered benefits and cost-sharing structures, was an important issue during initial authorization in 1997 but has received relatively little attention in this year's debate.

Several parties, including conservative think tanks and insurance industry stakeholders, have advanced proposals that would have a significant impact on the benefits low-income children may receive.<sup>1</sup> In particular, two of their suggestions should prompt a reconsideration of how Medicaid, SCHIP and private coverage benefit packages meet low-income children's health care needs to various degrees: that some portion of SCHIP reauthorization funding should be used for tax credits or other mechanisms to finance private coverage; and that state SCHIP programs should place more emphasis on enrolling children in private or employer-based coverage.

Neither of these approaches will strengthen the SCHIP program's ability to provide low-income children with critical health coverage. Policy choices that would use SCHIP funding for tax credits or programs to purchase private coverage would leave low-income children and their families with coverage that does less to meet their needs yet requires greater out-of-pocket contributions from these families. Instead, policymakers should seek to bolster efforts to provide children with appropriate coverage that meets their medical and developmental needs.

## Benefit Design and SCHIP Reauthorization

The American Academy of Pediatrics periodically updates its recommendations on the scope of children's health care benefits. The AAP recommendations apply to all children, not merely low-income children, but they provide a starting point for considering coverage policy for children in public programs and private insurance. The AAP recommendations include medical care, critical care, pediatric surgical care, behavioral health services, specialized services for children with special needs, and pediatric oral health. (See box on next page for more detailed information.)

The comprehensive nature of these recommendations reflects the significant role health services play in a child's life—including lifelong skills such as speech and physical activity

and enhanced school performance through amelioration of hearing and vision problems. These recommendations generally do not address benefit limits, which appear in both public and private coverage and affect children's access to services across the income spectrum. Nor do they address appropriate cost-sharing schedules for these services—and significant deductibles or co-payments are likely to affect lower-income children's access to covered benefits.<sup>2</sup>

The majority of American children (56 percent) receive health insurance through employer-sponsored health plans, which are generally designed to provide health coverage to adult workers.<sup>3</sup> While we know there is wide variation in plan benefits and cost-sharing structures, including benefits of particular importance to children and adolescents, it is difficult to pinpoint these variations because group health plan contracts are typically not available for analysis.

As Professors Sara Rosenbaum of George Washington University and Dr. Paul H. Wise of Stanford University have noted, however, an examination of judicial decisions related to coverage disputes demonstrates that private insurance products offer narrow coverage terms that “seek to avoid” financing the broad range of developmental conditions children may experience. They particularly cite cases that suggest private coverage seeks to exclude coverage of chronic and developmental conditions by providing broad discretion to plan administrators to approve or deny coverage. Rosenbaum and Wise also note that private coverage also excludes coverage on the basis of service setting, diagnosis or “hard” limits on certain services.<sup>4</sup>

A few health care research surveys provide details about employer-based coverage for certain categories of benefits, including services such as behavioral

## Recommended Child Health Care Benefits

### *Guidelines from the American Academy of Pediatrics*

- Medical care, including: health supervision for prevention, diagnosis and treatment for acute and chronic conditions; pediatric subspecialty care; family planning and reproductive health services; newborn care; vision services; audiology services; phone- and Internet-based medical information for established patients; laboratory and pathology services; metabolic and genetic disorder screening; diagnostic and therapeutic radiology services; and prescription drug coverage.
- Critical care, including: emergency medical and trauma care specific to children; pediatric inpatient hospital and critical care services; and emergent and non-emergent transfer or transport.
- Pediatric surgical care, including: comprehensive repair of congenital anatomic malformations; pediatric surgical subspecialty services; and anesthesia.
- Behavioral health services, including: mental health services; services for substance use disorders; and comprehensive inpatient and outpatient evaluation and treatment for physical, emotional, and sexual abuse and neglect.
- Specialized services for children with special needs, including: care coordination; nursing home care; physical, occupational, speech and respiratory therapy; home health care; nutrition and counseling services; special diets; disposable medical equipment; respite services; and palliative and hospice care.
- Pediatric oral health, including: preventive and restorative pediatric dental care; and functional orthodontia.<sup>5</sup>

health and prescription drugs, which may be important to children and adolescents. Some of these surveys have also shown that while most workers and their dependents have coverage for these services, the large majority of enrollees face considerable limitations on these benefits.

A 2006 Kaiser Family Foundation/Health Research and Education Trust survey, for example, found that of the 97 percent of enrollees who have mental health benefits only 13 percent had unlimited coverage for outpatient visits, while 65 percent had coverage for 30 or fewer outpatient mental visits per year.<sup>6</sup> These limits are problematic for children and adolescents, given that the health problems of adolescents are largely attributable to conditions related to behavioral factors, and roughly 20 percent of children and adolescents may have a diagnosable mental health disorder.<sup>7, 8</sup>

In addition, private plans typically use cost-sharing requirements, including deductibles and co-payments, to reduce health care utilization and control premium costs. These cost-sharing responsibilities can be particularly burdensome for families with low-wage workers. For example, workers with preferred provider organization, or PPO coverage, the most common plan arrangement, face on average an aggregate family deductible of \$1,034 in 2006—nearly 10 percent of pre-tax income for a minimum wage worker at the time.<sup>9</sup> This amount does not include co-payments or co-insurance required at the point of service.

Historically, children's benefits under the Medicaid program have been specifically designed to address the developmental needs of lower-income children. In particular, through the Early, Periodic Screening Diagnosis and Treatment, or EPSDT benefit, Medicaid has reflected the professional standards for pediatric care, with emphasis on access to early and preventive care and comprehensive ameliorative services.<sup>10</sup> The EPSDT benefit requires states to cover all medically necessary items and services Medicaid-enrolled children require to address their health conditions, whether or not they are covered by the

state Medicaid plan for adults. Medicaid has also prohibited cost-sharing requirements for children.

In contrast, the SCHIP benefit was designed to more closely mirror private insurance models. States may design their SCHIP benefit package by modeling it on a “benchmark” package pegged to federal or state employee coverage plans, or the plan offered by the largest commercial health maintenance organization in the state. States may also design “benchmark-equivalent” packages that cover specified categories of services and are actuarially equivalent to a benchmark package, or obtain federal approval for an alternative package of benefits unrelated to a benchmark or benchmark-equivalent benefit design.

Under SCHIP, states can design cost-sharing schedules and premium charges for higher-income children—those living in families with income above 150 percent of poverty—that impose higher out-of-pocket costs than those allowed under Medicaid, although aggregate cost-sharing cannot exceed 5 percent of family income. Some states used this flexibility to develop SCHIP benefit packages that differ from the Medicaid program, while others used the Medicaid benefit package as the model for their separate SCHIP program. Finally, some states explicitly expanded their Medicaid program using SCHIP funding and therefore extended the Medicaid benefit package to all SCHIP enrollees.

Separate SCHIP programs are less likely to cover dental services, services related to long-term care, prosthetics, and hearing aids and eyeglasses than the Medicaid program and Medicaid-expansion programs in SCHIP. Separate SCHIP programs may also impose benefit limits on any service they cover that could not be applied to children covered by Medicaid.<sup>11</sup>

In addition, the Deficit Reduction Act of 2005 made several important changes to the Medicaid statute, including giving states greater flexibility to design their basic Medicaid benefit package and create alternative cost-sharing schedules. In general, states may now provide Medicaid benefit packages bench-

marked to private insurance coverage, as is the case with SCHIP, although the EPSDT benefit should wrap around this coverage for eligible children. States may also require some Medicaid populations to pay cost-sharing, including children with incomes above the poverty level.

As under SCHIP, total cost-sharing and premium amounts cannot exceed 5 percent of family income. During consideration of the Deficit Reduction Act, the Congressional Budget Office estimated that 4.5 million children would face cost-sharing for the first time.<sup>12</sup>

States have also used premium assistance programs to promote private coverage—partially financed with Medicaid and/or SCHIP funding—for low-income children through statutory authority and waiver authority. These efforts often enroll children in private coverage when available, with public programs helping to cover the family’s premium obligation and—when implemented without a waiver—additional services not covered by the private plan.

Depending on the structure of the program, the state may provide a fixed amount to subsidize the private premium, leaving the family exposed to still-significant premium obligations that may grow as private sector premiums continue to increase at rates well in excess of wage growth. Enrollees may also face significant cost-sharing under these private/public arrangements that rely on private benefit packages, and may be purchasing private plans that offer limited benefits. There is little data on children’s access to services under these arrangements.<sup>13</sup>

## Discussion

For a variety of reasons—from statutory requirements to state policy choices, to contract language governing private health insurance arrangements—public programs offer low-income children health benefits that more fully meet their health care needs and family circumstances. Medicaid, in particular, requires states to provide comprehensive coverage with significant cost-sharing protections.

While the SCHIP program relies more heavily on private-sector plan design, most states offer important services such as dental, vision, and mental health care, which are often not offered or are heavily restricted by private plans. Private coverage is less responsive to children’s developmental needs, offers less comprehensive benefits, and typically includes cost-sharing obligations that represent a significant proportion of family income for low-wage workers.

These differences—less comprehensive and appropriate benefit packages, stricter limits on benefits that are covered, and cost-sharing schedules that make access to care less affordable for low-income families—raise significant concerns about efforts to shoehorn private plan arrangements into SCHIP reauthorization. Policy choices that would use SCHIP funding for tax credits or premium assistance programs to purchase private coverage would leave low-income children and their families with coverage that does less to meet their needs yet requires greater out-of-pocket contributions from these families.

Instead, policymakers should seek to bolster efforts to provide children with appropriate coverage that meets their medical and developmental needs. This can best be accomplished through three steps:

- Making necessary clarifications regarding EPSDT coverage
- Ensuring that benefits in separate SCHIP programs meet children’s developmental needs
- Creating new employer-based coverage options that ensure that children receive appropriate benefits.

The Deficit Reduction Act amendments to EPSDT coverage created confusion over states’ obligation to provide EPSDT benefits when they use new flexibility under Medicaid to create benchmark benefit packages. While the Department of Health and Human Services has confirmed in letters to State Medicaid Directors that children and young adults must

receive the full EPSDT benefit through a combination of the benchmark (or benchmark-equivalent) package and wraparound services, a clarification of statutory language would give greater security to families and greater certainty to the states.

Congress should also amend the existing SCHIP benefit standards to eliminate the option of HHS-approved benefit packages and ensure that commercial benchmark packages offer (to the extent possible) the most appropriate benefits for children. Under current law, states may design an SCHIP package without reference to Medicaid, commercial benchmarks, or standards for children's health coverage. This option provides little assurance that children will receive the coverage they need. In addition, Congress should amend the option to use a benchmark package pegged to state employee coverage to require states to use the health plan with largest family enrollment.

Finally, Congress should provide new flexibility for employers and families to buy into the SCHIP program itself, although Congress should reject calls for broad expansions of premium assistance waiver

programs, particularly given the little that is known about the benefits children receive and the cost-sharing they face under these arrangements. Such flexibility would maintain the public/private partnership that characterizes premium assistance efforts, while creating greater accountability for children's benefits. Alternatively, Congress could develop stronger standards for wraparound coverage for programs that support private coverage with public dollars.

## Conclusion

SCHIP reauthorization offers policymakers the opportunity to revisit the benefit-design decisions of 10 years ago, but this exercise should result in improvements to the adequacy of low-income children's health benefits. These children deserve coverage that meets their medical and developmental needs and makes services economically accessible. Policymakers should firmly reject proposals that seek to promote private coverage standards at the expense of children's health and well-being, and ensure, instead, that SCHIP builds upon its record of providing appropriate, high-quality coverage to our nation's children.

## About the Author

Karen Davenport is Director of Health Policy at the Center for American Progress, where she leads CAP's efforts to reinvigorate the national debate on health coverage for all Americans. Before joining CAP, she served as Washington Director for the Medicare Rights Center, coordinating the organization's national policy activities, partnership development and fundraising activities. As a Senior Program Officer at the Robert Wood Johnson Foundation, she developed and managed national programs dedicated to increasing health insurance coverage and improving long-term care financing and services for frail elders and people with disabilities. As a Legislative Assistant to Sen. Bob Kerrey (D-NE), she was responsible for staffing the senator's work on Medicare, Medicaid, public health, welfare and social issues. Her earlier federal experience includes serving as a specialist in Medicaid legislation for the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) and serving on the White House Health Care Reform Task Force. Davenport earned an MPA from the Maxwell School of Citizenship and Public Affairs at Syracuse University and a BA in political science from Whitman College in Walla Walla, Washington.



## Endnotes

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