

**THE STRENGTHS AND WEAKNESSES OF
PRIVATE HEALTH INSURANCE COVERAGE FOR
CHILDREN WITH SPECIAL HEALTH CARE NEEDS**

**by
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EXECUTIVE SUMMARY

The majority of children in the United States have health insurance coverage through their parents' employers, who for the most part rely on health maintenance organization (HMO) or preferred provider organization (PPO) plans. Yet, the available literature tells us little about the adequacy of employer-based coverage for services important to children, particularly those with special health care needs who represent almost one-fifth of all children.

This study was intended to provide an in-depth picture of the health insurance commonly available to children through their parents' place of employment. It was based on information obtained from the most commonly sold HMO and PPO products in 1998 in each state and the District of Columbia. We wanted to know the extent of coverage for a wide range of services needed by children with chronic physical, developmental, behavioral, and emotional conditions, and, among these services, which ones were most likely to be limited in amount and scope and subject to cost-sharing requirements. For each of the 22 benefits we selected, the following items were abstracted: the availability of the benefit; day, visit, or monetary limits on coverage; limits on the nature and scope of coverage; applicable condition or treatment exclusions; and any special provisions that would benefit children with special health care needs. For our six hypothetical children, we selected the following conditions: asthma, cerebral palsy, spina bifida, attention deficit hyperactivity disorder, depression, and substance abuse with bipolar disorder. A medical history and recommended service utilization profile were constructed for each child based on expert medical advice and a review of clinical guidelines and other medical literature. The analysis for each child was conducted so as to take into account all of the elements affecting the availability of coverage by each plan for each of the recommended services.

This study has several limitations. Its findings only pertain to the most commonly sold HMO and PPO products and do not enable us to generalize about the insurance that all American workers and their families have. In addition, since the findings are based on analysis of contract documents, we have no way of knowing whether plans might be more generous or flexible in their authorization of coverage for certain patients.

Similarly, for our hypothetical case analysis, we cannot know whether plans might apply contract language more restrictively than we did.

Our findings on the availability of coverage for the various services required by our six hypothetical children reveal that they would have access to benefits for most basic medical services but that they would be unable to have their extended needs met for behavioral health and most specialized health care services.

- With the exception of the child with step 3 asthma, the hypothetical children in our study would rarely have access to coverage for all of their recommended services.
- Ancillary therapy and mental health services were the benefits least likely to be available in the amounts considered necessary by medical experts who routinely treat children with special needs.
- The hypothetical children requiring ancillary therapy and mental health services, as well as those requiring home health care, would confront not only benefit limits but also specific condition and treatment exclusions (such as exclusions for developmental disorders, behavioral conditions, or conditions not caused by illness or injury) that would preclude them from receiving otherwise available benefits in many plans.
- Coverage for other services needed by these hypothetical children would sometimes be unavailable simply because plans do not provide benefits for them. Even prescription drugs, required by each of the six hypothetical children, were not a covered benefit in about 20% of plans. Neuropsychological exams, residential treatment, and partial hospitalization were excluded from plan contracts slightly more often. For certain types of medical equipment and supplies, the lack of benefits was even more common.

Overall, our findings show that the vast majority of plans provide coverage for the 22 services we analyzed but that they restrict the amount and scope of coverage for most services not only through visit or monetary limits but also through condition and treatment exclusions.

- The majority of plans offered coverage for almost all of the 22 services we examined. Only a handful of services – audiology and optometry services, mental health and substance abuse partial hospitalization services, nutritional counseling services, and medical supplies – were not covered in a quarter or more of plans.

- Benefits for basic medical services were usually offered without visit, day, or monetary limits. In contrast, benefits for behavioral health and specialized services typically were typically limited. Moreover, mental health, substance abuse, and ancillary therapies limits often applied to two or more services combined -- for example, all types of mental health services (outpatient, inpatient, and partial hospitalization) or all types of ancillary therapy (physical therapy, occupational therapy, and speech therapy). When expressed as visit or day limits, as they were in most cases, amounts for a combination of services did not differ significantly from those applicable to a single service. They were often set at 20 or 30.
- Most plans imposed condition or treatment exclusions on mental health services and certain specialized services important to children. For mental health services, the most common exclusions were for certain modes of treatment, such as family therapy, and for specific conditions, such as attention deficit hyperactivity disorder. Overall, two-thirds of plans imposed one or more access restrictions on outpatient mental health services. For physical, occupational, and speech therapy services, the most frequent exclusions were for conditions not caused by an illness or injury and for requirements for significant improvement within a short period of time. Overall, more than four-fifths of plans imposed one or more access restrictions on the three ancillary therapies.
- A minority of plans established access protections or special provisions beneficial to children with special health care needs. The special protections that plans were most likely to allow were lower cost sharing or benefit expansion for younger children for preventive care, immunizations, mental health outpatient care, and ancillary therapies.
- Overall, we found that HMOs offered a more comprehensive set of benefits than PPOs with somewhat fewer benefit limits than PPOs. In addition, HMOs were less likely than PPOs to impose cost-sharing requirements, and when cost sharing was imposed, HMOs were more likely than PPOs to rely on copayments.
- Monetary limits were much less often used than visit limits, but certain services were more likely to be subject to annual or lifetime dollar caps, including eyeglasses, hearing aids, all substance abuse services, medical equipment, and home health services.
- The vast majority of benefits carried either copayment or coinsurance obligations, and, in a few instances, separate deductibles. Copayments were the predominant cost-sharing method for basic medical services and coinsurance was the predominant method for behavioral services, while for specialized services neither coinsurance nor copayments were more common. Cost-sharing amounts often varied by service, particularly when copayments were used, but the highest cost-sharing charges were imposed on behavioral services.
- At least one-fifth of plans imposed no cost sharing on immunizations, inpatient and outpatient hospitalizations, mental health and substance abuse

inpatient and partial hospital services, ancillary therapies, home health care, skilled nursing facilities, eyeglasses and vision therapy, and medical equipment and supplies.

This study provides a basis for understanding which services private health insurance typically covers and how well. It also sheds light on those coverage areas that need to be strengthened for children with special needs. A variety of options to improve health insurance coverage for these children could be explored. Recognizing that both employers and states may be hesitant to undertake costly initiatives, it might be appropriate for a national commission to examine how best to achieve improvements for special-needs children. Both insurance and programmatic reforms could be considered.

I. INTRODUCTION

Employer-based plans are the most important source of health care coverage in the United States. The majority of children today have insurance coverage through their parents' employers. In 1999, approximately 44.5 million children under age 18, 61.5% of the child population, were insured through employer-based plans. Earlier there had been a significant decline in employer-based health insurance among children, but over the last six or seven years that trend appeared to be reversing itself.¹

Employers, for the most part, now furnish health insurance to employees and their dependents through managed care plans -- either preferred provider organizations (PPOs) or health maintenance organizations (HMOs) and their more flexible variant, point-of-service plans.² In 2000, 92% of workers receiving employer-based health insurance were enrolled in managed care plans; only 8% were in traditional plans. Among those in employer-based managed care plans, about 55% were in some type of HMO; about 45% were in PPOs.³ The movement away from traditional plans happened quickly; in the two-year period between 1993 and 1995 alone, managed care enrollment among employees with health coverage increased three-fold, from 22% to 73%.⁴

With so many children participating in employer-based managed care plans, it is important to know how well this coverage provides protection for the kinds of services that children, particularly children with special health care needs, often require. Children with special health care needs, according to the federal Maternal and Child Health Bureau are those "who have or are at increased risk for a chronic physical,

¹ Fronstin, Paul. *Sources of Health Insurance and Characteristics of the Uninsured: Analyses of the March 2001 Current Population Survey*. Washington, DC: Employee Benefit Research Institute, 2001.

² An HMO is a managed care plan in which enrollees are required to receive their care from providers participating in the HMO network, and their access to services is controlled by their primary care provider. No benefits are available for services obtained out of network. A point-of-service plan is an open HMO in which enrollees are offered a financial incentive to use providers in the network but are able to use non-network providers if they pay more for these services. A PPO is a managed care plan in which enrollees are able to decide each time they receive a service whether they wish to use providers on the preferred list or go outside the preferred network and pay a higher contribution for services furnished by non-participating providers. There is no primary care gatekeeping arrangement.

³ Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits:2000 Annual Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation, 2000.

⁴ Mercer/Foster Higgins. *National Survey of Employer-Sponsored Health Plans--1997*. New York: Mercer/Foster Higgins, 1998.

developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”⁵ National estimates show that 18% of children under 18 years old have an existing special health care need, and many more are at-risk.⁶

The available literature tells us little about the adequacy of employer-based coverage for services important to children with special needs. Studies of health insurance coverage have been of two types: surveys conducted by private employee benefit research firms and surveys conducted by the federal Bureau of Labor Statistics (BLS). Both types of surveys have focused primarily on broad industry trends in plan arrangements and on coverage of basic medical and other selected health care services.⁷ Typically, the examination of benefits has been reported in terms of the proportion of employers who offer, or the employees who receive, coverage for basic medical and other selected health care services. Historically, only BLS has reported even basic information about whether benefit limits or cost-sharing requirements are applied. More recently, though, two private surveys have furnished some detail about the amount of coverage and reimbursement available for mental health⁸ and prescription drug services.⁹

In addition, certain types of benefits of particular importance to children with special health care needs, such as physical therapy, occupational therapy, speech language pathology services, and durable medical equipment are not included at all in large-scale employer surveys. The only study of employer-based coverage that focused

⁵ McPherson M, Arango P, Fox HB et al. A new definition of children with special health care needs. *Pediatrics*. 102:137-140, 1998.

⁶ Newacheck PW, Strickland B, Shonkoff JM et al. An epidemiologic profile of children with special health care needs. *Pediatrics*. 102(1):117-123, 1998.

⁷ See, for example, Mercer/Foster Higgins. *National Survey of Employer-Sponsored Health Plans--2000*. New York: Mercer/Foster Higgins, 2001; The Hay Group. *2001 Hay Benefits Report*. Philadelphia: The Hay Group, 2001; Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits:2000 Annual Survey*. Menlo Park, CA: Henry J. Kaiser Family Foundation, 2000; Bureau of Labor Statistics. *Employee Benefits in Medium and Large Private Establishments,1997*. Washington, DC: U.S. Department of Labor, September 1999.

⁸ See Kaiser/HRET. *Employer Health Benefits: 2000 Annual Survey*; Gabel J, Levitt L, Pickreigh J et al. Job-based health insurance in 2000: premiums rise sharply while coverage grows. *Health Affairs*. 19(5): 144-151, September/October 2000.

⁹ Kaiser/HRET. *Employer Health Benefits: 2000 Annual Survey*; Buck JA, Teich JL, Umland B, Stein M. Behavioral health benefits in employer-sponsored health plans, 1997. *Health Affairs*. 18:67-78, 1999.

on the full range of benefits important to children with special health care needs was conducted in 1987,¹⁰ when traditional insurance arrangements were most prevalent.

The purpose of this study was to obtain a more complete picture of the health insurance coverage commonly available to children through their parents' place of employment. Specifically, we wanted to know the extent of coverage for a wide range of services needed by children with chronic physical, developmental, emotional, and behavioral conditions, and, among these services, which ones were most likely to be limited in amount and scope and subject to cost-sharing requirements. We also wanted to know if there were differences in the comprehensiveness of coverage for children with special health care needs in HMO versus PPO plans. In addition, we wanted to identify the implications of the health insurance benefit policies for children with various types of chronic conditions.

Four sections follow this introduction. In Section II, we describe our methodology for the study. In Section III, we present our analyses of the extent of plan coverage potentially available to six hypothetical children with special health care needs. Brief case profiles are presented for each child with a description of the child's condition and a snapshot of health services previously used and currently required. Each is followed by an assessment of private health insurance coverage available for each child's condition under the plans in our study. Detailed tables are also presented for each child displaying the recommended services and the proportion of plans with full, partial, and no coverage for HMOs, PPOs, and overall. In Section IV, we review the availability of coverage for 22 services important to children with special health care needs. The information is presented in three subsections -- one on basic medical services, one on behavioral services, and one on specialized services -- each followed by tables. The 22 services are analyzed in a uniform way, looking at actual benefit coverage, benefit amounts, cost-sharing requirements, access restrictions, access protections, and HMO/PPO differences. Section V presents our conclusions and recommendations.

¹⁰ Fox HB and Newacheck PW. Private health insurance of chronically ill children. *Pediatrics*. 85:50-57, 1990.

II. METHODOLOGY

We chose to use a research methodology that would allow us to examine benefit policies in an in-depth and standardized (non-biased) fashion. Rather than relying on telephone interviews with employers, we elected to collect and analyze health insurance contract documents that would be representative of the coverage sold to most employers and that would be potentially available to us, that is, not restricted by proprietary concerns.

We based our study, therefore, on the benefit policies stipulated in the most commonly sold product of the largest HMO and the largest PPO insurer in each state and the District of Columbia. For each state, we identified the insurer with the largest number of enrollees in an HMO and the insurer with the largest number of enrollees in a PPO through information provided to us by the state insurance commissioner's office. All states except Alaska had HMO products (or POS counterparts) and all states had PPO products (or managed indemnity counterparts),¹¹ bringing the total number of plans requested to 101 (50 HMOs and 51 PPOs). In some instances, the insurance commissioners were able to furnish us with all documents necessary for the analysis, including the certificate of benefits, the schedule of benefits, and any supplemental riders that were commonly purchased. In most cases, however, we obtained the necessary documents directly from the plans, through a series of telephone calls and written communications. Our final response rate was 97% and included 49 HMOs and 49 PPOs.¹² The contract documents were collected in 1999 and were in effect at the end of 1998.

We developed an analytic plan based on an initial in-depth review of contract documents. We selected benefits important to children with special health care needs: physician and hospital services, mental health and substance abuse services, ancillary therapies, in-home and other skilled nursing services, prescription drugs, durable

¹¹ In three rural states, conventional insurance was provided through managed care companies that did not require greater cost sharing for out-of-network providers, since most providers were within the managed care provider network.

¹² For some plans, it was not possible to obtain all riders, but we elected to include all of the coverage information provided and not exclude these plans totally from our analysis. Complete plan information was obtained from 90% of the plans (91 plans; 44 HMOs and 47 PPOs).

medical equipment and supplies, optometry and audiology services, and nutritional counseling services.¹³ We used the same basic approach to abstracting information for each of the selected benefits. We thoroughly reviewed all language related to coverage and cost sharing and also examined the plans' general exclusion sections and medical necessity definitions. Based on this analysis, we coded the following items for each benefit: the availability of the benefit; day, visit, or monetary limits on coverage; limits on the nature and scope of coverage; applicable condition exclusions; and any special provisions that would benefit children with special health care needs. We also coded in- and out-of-network cost sharing associated with the benefit,¹⁴ including overall plan deductibles, coinsurance maximums, copayment maximums, as well as coinsurance, copayment or deductible requirements specific to the benefit. When the intent of the plan's language was unclear, we sought to obtain clarification from the plan and also consulted with various health insurance and medical experts.

Much of this work required the formulation of strict decision rules in order to ensure the validity of the analysis. We established decision rules for interpreting the implications of medical necessity definitions and general condition exclusions for specific benefits. We sometimes also were able to establish decision rules that enabled us to code as a single category the different language insurers used to articulate comparable access restrictions. In establishing these rules, we made the assumption that insurers would be lenient in coverage, rather than restrictive. Our findings, therefore, should be taken as the "best case scenario."

Overall, the task of coding mental health, substance abuse, and ancillary therapy benefits presented the greatest challenge. Benefit amounts for these services were expressed in terms of visits, days, or dollars, but, depending on the plan, these might be established per year, per lifetime, per condition, or per episode and might apply to several services combined. In addition to benefit limits, insurers typically restricted access to coverage by excluding treatment based on the purpose or mode of treatment and by the nature of the condition necessitating treatment -- restrictions which could be

¹³ Educational therapies, custodial services, and maintenance treatment were not analyzed as part of the benefit information.

¹⁴ HMOs provide benefits within their networks only, while PPOs allow patients to receive care outside of their networks for a higher cost-sharing burden. For PPOs, both in- and out-of-network benefits were analyzed.

found in the benefit language or service definition or extrapolated from medical necessity or general condition exclusion language.¹⁵

With respect to mental health services, for example, we had to address restrictions relevant to the mode of treatment, such as exclusions for family therapy, psychological testing, or evaluations for mental retardation and developmental disabilities. We also had to address general condition exclusions, such as those for autism, learning disorders, or mental retardation, as well as condition exclusions specific to the mental health benefit itself. These ranged from broad categories intended to capture chronicity or severity, such as “conditions that could not improve within a short period of time,” to categories that grouped various diagnoses, such as “inorganic disorders,” “biologically based disorders,” and “nervous disorders,” to specific diagnoses such as affective or personality disorders.

Since part of the study involved analyzing coverage for six hypothetical children with special health care needs, we also had to select the physical and mental health conditions that would permit us to analyze the potential availability of coverage for a broad array of services and then construct reasonable medical histories and recommended service utilization profiles for children with such conditions. We did this by researching the medical literature, reviewing clinical guidelines, and drawing upon the expertise of numerous medical specialists, many of whom were identified by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry.

We then analyzed our data to determine the extent of coverage that would be available from each plan for each of the hypothetical children. The analysis considered all relevant access restrictions, benefit limits, and access protections. For each child, a separate database was created, containing each plan’s specific coverage provisions for each recommended service. Multiple factors were considered in determining the amount of coverage a plan would provide: 1) whether the plan had the relevant benefit;

¹⁵ Exclusions for services needed for the treatment of mental retardation, for example, were often stipulated as part of a specific benefit description but were sometimes found in the general exclusions section. Exclusions related to mental retardation could also be extrapolated from a broader categorical exclusion, such as “mental disorders,” or from medical necessity language that limited coverage to services “to diagnose or treat an injury or illness.”

2) whether there was an access restriction in the contract that would specifically exclude coverage for this child because of his or her condition, treatment history, or service needs; 3) how the benefit was structured; 4) whether and how the benefit was limited; and 5) whether the plan had a special provision that would allow the child to receive more or full coverage for a specific service. Where benefits were expressed as dollar amounts, we converted them into visit or day limits. This was accomplished by using fees comparable to the average rates paid by private insurers.¹⁶ Where benefits were combined for two or more services -- as was often the case for outpatient mental health and substance abuse treatment or for physical, occupational, and speech therapy -- we apportioned the amount of the benefit among these services based on the specific service requirements of the hypothetical child.

There are several limitations to this study that must be acknowledged. Although our method of data collection enabled us to analyze in great detail the extent of benefits available through the most commonly sold HMO and PPO products in each state, it did not permit us to report on the actual health insurance coverage that the majority of employees in each state have or even to report on the actual coverage offered to them. We know from our discussions with insurance administrators that employer modifications to standard plan products are far more likely to center around deductibles and other cost-sharing features than around benefit provisions. We do not know, however, the extent to which employer-based self-insured plans -- in which just over a third of workers participate¹⁷ -- resemble plans that employers purchase from insurers, although one study found that self-insured plans and fully-insured PPO plans are actuarially similar and fully-insured HMO plans are somewhat more generous.¹⁸

¹⁶ These are the fees used by the Texas Medicaid program, which contracts with BlueCross BlueShield of Texas to serve as a health insuring organization. The specific reimbursement rates used for each service can be obtained by contacting the authors directly.

¹⁷ In 1997, 36% of employees were covered by self-insured plans. In the largest firms, those with 500 or more employees, the proportion rises to 60%; and in the smallest firms, those with fewer than 50 employees, it is only 4%. Employee Benefits Research Institute. *Employment-Based Health Care Benefits and Self-Funded Employment-Based Plans: An Overview*. Washington, DC: EBRI, April 2000.

¹⁸ Acs G, Long SH, Marquis SH, Short PF. Self-insured employer health plans: prevalence, profile, provisions, and premiums. *Health Affairs*. 15: 266-278, 1996.

III. PLAN COVERAGE POTENTIALLY AVAILABLE TO SIX HYPOTHETICAL CHILDREN WITH SPECIAL HEALTH CARE NEEDS

In this section, we provide the results of our analysis of the coverage that would be available under the 98 plans to six hypothetical children -- three with complex physical conditions and three with significant mental health problems. The three with physical conditions include a 3 year-old with cerebral palsy and seizure disorder, a 5 year-old with spina bifida, and a 10 year-old with asthma. Those with mental health conditions include a 7 year-old with attention deficit hyperactivity disorder (ADHD) and sensory integration and motor planning dysfunction, a 15 year-old who has major depressive disorder and is suicidal, and a 17 year-old with both substance abuse problems and bipolar disorder.

The analysis was conducted so that our findings would represent the best case coverage scenarios for each child. Plan coverage policies presented in the tables assume that, without specific condition or treatment exclusions that would deny coverage in a hypothetical case,¹⁸ plans in our study would authorize all of the benefits for services provided in their contracts. In actual practice, however, plans commonly exercise their discretion in authorizing the full amount of coverage and negotiate with providers about the extent of intervention needed to achieve an acceptable outcome. Plans typically exercise this discretion for mental health, home health, ancillary therapy, and other services needed over an extended period of time. In making their determinations, plans give strong weight to contract language establishing the criteria for coverage, such as language requiring significant improvement within a short period of time or limiting coverage to crisis intervention until a patient is stabilized. They also rely on internally developed guidelines.

Nevertheless, even assuming approval of the maximum covered benefits, we found that with the exception of the child with step 3 asthma, the hypothetical children would rarely have access to coverage for all of their recommended services. Ancillary and mental health therapies were the services for which benefits were least likely to be available in the amounts considered necessary by medical experts who routinely treat

¹⁸ We counted specific condition and treatment exclusions only when there would be no question as to their applicability. Chronic condition exclusions for mental health services, for example, were counted only when they were very broadly stated and then only for children with ADHD. Plans verified this interpretation.

children with special needs. The child with cerebral palsy, the only one of our six hypothetical cases requiring extensive ancillary therapy services, would have either previously exhausted her benefits or lacked sufficient current benefits for her occupational therapy, physical therapy, or speech therapy services in a significant number of plans. Moreover, each of the three children with mental health diagnoses who required outpatient mental health or substance abuse therapies would have insufficient benefits to meet their ongoing treatment requirements in most plans.

The hypothetical children requiring ancillary therapy and mental health services, as well as those requiring home health care, would confront not only benefit limits but also specific condition and treatment exclusions that would preclude them from receiving otherwise available benefits in many plans. The children with cerebral palsy and with motor planning deficits would be prevented from accessing ancillary therapy benefits because of exclusions for developmental disorder or for conditions not caused by an accident or illness. The child with ADHD would be denied mental health therapy, and in some cases medications as well, because of exclusions for the treatment of ADHD, behavioral conditions generally, or chronic mental health conditions broadly defined. The child with spina bifida would be unable to access home health benefits because of exclusions for developmental disorders or care requirements below the hospital level.

Coverage for other services needed by these hypothetical children would sometimes be unavailable simply because plans did not provide benefits for them. Even prescription drugs, which are part of the proposed treatment plan for each of the six hypothetical children, were not a covered benefit in about 20% of the plans we examined. Neuropsychological exams, residential treatment, and partial hospitalization, one or more of which were needed by two of the hypothetical children with mental health diagnoses, were excluded from plan contracts slightly more often. For certain types of medical equipment and supplies, which were recommended for two of the children with complex physical conditions, the lack of benefits was even more common.

We found, overall, that there would be few differences between HMOs and PPOs in the nature and extent of the coverage they would provide for the six hypothetical children. Still, the hypothetical children would be more likely to obtain full coverage for certain services in HMO plans. Preventive services and immunizations, predictably, would more often be available from HMOs. Full coverage for the recommended number

of speech therapy visits, occupational therapy visits, and partial hospitalization days would be available more often in HMOs as well. By contrast, PPOs would only be more likely to provide coverage for the recommended number of physical therapy visits.

There are two significant limitations to the analysis of coverage for hypothetical children that should be noted, however. One limitation is that the analysis does not take cost-sharing policies into account and, as a result, fails to capture differences in the value of coverage among plans. The reader cannot know that one plan may offer benefits for fewer visits or apply more condition or treatment exclusions but require less cost sharing, while another may provide more generous benefits but place greater financial obligations on families. The other limitation is that the analysis does not account for any changes in individual benefits that might be authorized through the intervention of plan case managers for high-cost patients. In such situations, additional outpatient or home care services might be approved in order to avoid a more costly hospitalization. Case managers might in some instances also be able to arrange for a waiver of benefit limits or, more often, for access to community-based health care services supported with public funding rather than plan resources.

A. ANNA, AGE 30 MONTHS WITH CEREBRAL PALSY AND SEIZURE DISORDER

Anna, who was born 7 weeks prematurely weighing 4.25 pounds, was diagnosed early in infancy with moderate cerebral palsy of the mixed form, including spasticity and athetoid movements. Anna's arm and leg muscles were stiffly and permanently contracted and her arms, hand, and facial muscles periodically moved uncontrollably in slow, writhing motions. She also had periodic seizures. From the time of her diagnosis, Anna's pediatrician at the children's hospital coordinated her care with a pediatric neurologist and a pediatric orthopedist. Anna has taken medication regularly to relax her muscles and control her seizures. She also has received physical therapy twice a week to prevent muscle atrophy and avoid contracture -- a total of 192 sessions by the time she was 2_ -- and her mother has done patterning exercises with her on a daily basis. In addition, she has been wearing braces to help correct her inward-turned knees. Anna participates in an early intervention program that provides training in therapeutic strategies to her mother at home and to her teacher at pre-school.

At 30 months, Anna's mother scheduled a visit with the pediatrician to reassess Anna's service requirements for the upcoming year. It was decided that because of Anna's age and the need to improve her readiness for school, Anna would now begin a program of speech therapy to develop her communication skills and occupational therapy to promote her fine motor skills and skills in feeding, dressing, and toileting. In addition, she would require new braces and a fitted stroller. Her medications for muscle relaxation and seizure control would remain unchanged, and she would continue to have her blood tested twice annually to monitor her medication levels. In addition, Anna would continue to receive physical therapy, in part to promote the beneficial effects of the chemodenervation treatments.

Anna, the second-born child in her family, lives with both parents. Her mother, who does not work outside the home, is her primary caregiver. She has been covered under her father's health insurance plan since birth.

Even excluding the fitted stroller, which no plan in our study would cover, Anna would have full coverage for all of her recommended services in 3% of plans. Her various medical services would be covered by all or mostly all of the plans. All would cover her laboratory tests, her primary care visits for acute conditions, and her neurologist visits; nearly all would cover her annual preventive check-up; and the vast majority would cover her medications. Most of her other service requirements, however, would be fully covered by all plans far less often. Orthotic replacements would be covered in less than half the plans, while benefits to fully meet her needs for physical therapy, occupational therapy, and speech/language therapy services would be available to her only rarely.

Among the ancillary therapy services, it was Anna's physical therapy that would most often be uncovered. Although physical therapy benefits were included in all but two plan contracts, Anna would be subjected to a lifetime benefit limit that would have been already exhausted in about 20% of plans. In addition, she would confront specific condition exclusions that would preclude her from receiving benefits in almost the same proportion: seven plans included language under the physical therapy benefit that excluded treatment for developmental disorders, chronic conditions, or congenital anomalies and conditions, and 12 -- including one of the seven -- stipulated that treatment for developmental disorders was excluded in general. Among the remainder of plans in which physical therapy coverage would be available to her, three-quarters would provide Anna partial coverage, and, of those, most would cover half or fewer of the visits she required. This would be due largely to the frequency of combined benefits for physical therapy with one or both of the other ancillary therapies.

Yet, Anna would find that, compared to physical therapy, a slightly larger proportion of plans did not provide any benefits for occupational therapy and speech therapy, 13% and 10% respectively.¹⁹ In addition, the same kinds of condition exclusions that would apply to Anna for physical therapy would apply for the other ancillary therapies. For speech therapy, in fact, exclusions would be more common, would be more likely to be established under the benefit language, and would encompass impairments not caused by an injury. At the same time, however, there would be a much smaller proportion of plans -- 4% for occupational therapy and 1% for speech therapy -- in which Anna would have exhausted her benefits due to a lifetime benefit combined with physical therapy.

Depending on whether a plan considered cerebral palsy to be an illness, and how it defined significant improvement, Anna's access to ancillary therapy benefits might actually be greatly reduced. Among the relatively small number of plans that would cover all of Anna's recommended physical, occupational, or speech therapy visits, 60% had contract language for two or more of these services that would exclude benefits if impairments were not caused by an illness or injury. Thirty percent had language that would exclude benefits for coverage of two or more of these services when conditions could not improve significantly. Among those that would partially cover her recommended visits, an even larger proportion had the same criteria

¹⁹ The reader is reminded that detailed information on the availability of coverage for each service in the 98 plans is presented in Section IV.

for two or more of the services. These exclusions were almost always stipulated as part of the benefit language.

Table 1
Anna, Age 30 Months with Cerebral Palsy and Seizure Disorder

Recommended Services	All Plans (n=98)			HMOs (n=49)			PPOs (n=49)		
	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered
PCP visits for preventive care (1)	89%	0%	11%	92%	0%	8%	86%	0%	14%
PCP visits for acute condition (3)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Laboratory tests (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Neurologist visits (3)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Orthopedist visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Speech/language therapy visits (52: weekly for 1 year)	15%	47%	37%	8%	63%	29%	22%	33%	45%
Physical therapy visits (52: weekly for 1 year)	14%	44%	42%	6%	45%	49%	22%	43%	35%
Occupational therapy visits (52: weekly for 1 year)	12%	55%	33%	6%	67%	27%	18%	43%	39%
Durable medical equipment									
• Orthotic replacement	46%	0%	54%	42%	0%	58%	51%	0%	49%
• Fitted stroller	0%	0%	0%	0%	0%	0%	0%	0%	0%
Medications	81%	0%	19%	78%	0%	22%	84%	0%	16%

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

B. EMILY, AGE 5 WITH SPINA BIFIDA

Emily was born with spina bifida of the myelomeningocele (most severe) form, the effects of which included some paralysis in both legs and the left arm, loss of bowel and bladder control, and hydrocephalus -- a condition causing fluid accumulation in the brain. Surgery to relieve the build-up of fluid was performed within 48 hours of Emily's birth, when a ventriculopleural shunt was first implanted, and again at age 2. Emily is almost totally dependent on a wheelchair for mobility. Her urinary incontinence is managed through intermittent catheterization at home and at preschool, but she suffers from frequent urinary tract infections that have brought her to the emergency room on numerous occasions, and she takes suppressive antibiotics. Intellectually, Emily's development has been normal; however, she has been identified as having learning disabilities -- including difficulties with language processing, reading, and math -- and had received early intervention services at home and has since age 4 been attending a pre-school special education program.

At age 5, the multidisciplinary team of physicians at the spina bifida clinic where Emily had been treated since birth recommended that she be hospitalized for another shunt replacement. The expectation was that Emily would need to remain in the hospital for no more than 3 days but, since her mother was in the last trimester of a very difficult pregnancy, a home health nurse would assist in her care over the 3-month period following her discharge. Catheters, gloves, and other medical supplies would be needed. Emily would continue taking regular antibiotic medications. Also, sometime in the coming year, she would need a new wheelchair.

Emily lives with both parents and is covered under her father's health insurance plan. Her father works long hours and would like to change jobs but is unable to because he needs to assure that Emily is continuously insured. Her mother resigned from her job following Emily's birth.

Emily would have coverage for all of the services she required in 1% of the plans we analyzed. All would cover her emergency room visit, her inpatient hospitalization, and her shunt replacement as well as her visits to the neurologist, urologist, physiatrist, and orthopedist. Her preventive services -- the well child examination and immunizations required for her age -- would be covered by all but a handful of plans, and her medications would be covered by almost as many. The services for which Emily would be far less likely to receive coverage are her home health services, her wheelchair replacement, and, most often, her medical supplies.

For Emily the services that would be least often covered in full are also the ones for which partial coverage would rarely be available. Either these services would not be covered at all or Emily would confront service or condition exclusions that would preclude her from

receiving benefits. With respect to home health care, Emily would find that she would have all of her visits covered in almost half of the plans, and none covered by almost the same proportion: three plans offered no home health benefits, 25 stipulated that benefits could only be provided in lieu of hospitalization, eight excluded treatment for developmental disorders or conditions that could not be expected to improve within a short period of time -- usually as a general exclusion rather than one specific to the home health benefit -- and four others restricted home health coverage to hospital-level care and also had one of the above condition exclusions. With respect to medical supplies and equipment, Emily would find that if coverage was unavailable, it was usually because benefits were not offered, although in the case of the wheelchair replacement, it was the replacement rather than the original wheelchair that was typically not covered.

Table 2
Emily, Age 5 with Spina Bifida

Recommended Services	All Plans (n=98)			HMOs (n=49)			PPOs (n=49)		
	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered
PCP visits for preventive care (1)	88%	0%	12%	92%	0%	8%	84%	0%	16%
Routine immunizations (DtaP, polio, MMR)	93%	0%	7%	96%	0%	4%	90%	0%	10%
Neurologist visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Urologist visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Physiatrist visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Orthopedist visits (1)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Emergency room visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Inpatient hospital days (3)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Shunt replacement surgery	100%	0%	0%	100%	0%	0%	100%	0%	0%
Home health nurse visits (60: 5 days per week for 3 months)	48%	11%	41%	55%	8%	37%	41%	14%	45%
Medical Supplies									
• Catheters	24%	0%	76%	13%	0%	87%	35%	0%	65%
• Gloves	4%	0%	96%	2%	0%	98%	6%	0%	94%
Wheelchair replacements (1)	49%	0%	51%	46%	0%	54%	53%	0%	47%
Medications	81%	0%	19%	78%	0%	22%	84%	0%	16%

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

C. SAM, AGE 10 WITH ASTHMA

Sam, who is 10 years old, was diagnosed with asthma at age 5. His symptoms, consistent with step 3 asthma, have been moderate but persistent and tend to worsen in the presence of dust, mold, cigarette smoke, and pollen and also when the weather is cold. Since his diagnosis, his parents have made great efforts to keep his room free of allergens but, living in an older home without air conditioning, this has not always been possible. Over the years, Sam has used several medications to control his asthma and has been fairly successful. He typically has had only a few exacerbations a year and has been able to play in a recreational basketball league, although he usually misses some games and practices. Only recently has his asthma become more difficult to manage, causing Sam to have several acute episodes at home and at school.

At his next appointment with his primary care provider, Sam's mother described Sam's worsening condition. The physician recommended a reassessment of Sam's home and school environment, which would be conducted by the local health department. She performed spirometry to assess Sam's lung functioning and also recommended that Sam again be seen by the allergist who had evaluated him earlier. For the present she would increase Sam's current asthma medications. The physician anticipated, based on past experience, that Sam would likely require emergency room treatment at least once in the coming year and explained to his mother again how to determine if this might be necessary.

Sam lives with both parents and a younger brother. His mother has worked for the same employer for 15 years, and Sam has been covered under her same health insurance plan since birth.

All of Sam's recommended services would be covered by 60% of the plans we analyzed. His acute care visits to his primary care provider, his visits to the allergist, his spirometry test, and his visits to the emergency room would be covered by all of the plans. In addition, his durable medical equipment would be covered by nearly all of the plans, and his medications, preventive check-up, and immunization would be covered by the vast majority.

The reason that as many as 40% of plans would not meet all of Sam's service requirements is that different plans lacked coverage for different services. No plan lacked benefits for all four of the services not consistently covered for Sam, and only three plans lacked benefits for three of these services. Overall, PPOs were far less likely to provide coverage for preventive visits and immunizations for 10 year-olds.

Table 3

Sam, Age 10 with Step 3 Asthma

Recommended Services	All Plans (n=98)			HMOs (n=49)			PPOs (n=49)		
	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered
PCP visits for preventive care (1)	79%	0%	21%	90%	0%	10%	67%	0%	33%
PCP visits for acute condition (6)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Spirometry (1)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Allergist visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Immunizations (Influenza)	79%	0%	21%	90%	0%	10%	67%	0%	33%
Emergency room visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Medications	81%	0%	19%	78%	0%	22%	84%	0%	16%
Durable medical equipment (metered dose inhalers, a peak flow monitor, and spacers with mask)	97%	0%	3%	94%	0%	6%	100%	0%	0%

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

D. JOHN, AGE 7 WITH ADHD AND SENSORY INTEGRATION AND MOTOR PLANNING DYSFUNCTION

In the second grade, John's teacher notified his parents that he was having difficulty paying attention, following instructions, and sitting still in his seat, and that, although bright, he was having difficulty with his school work. He also was having problems interacting with peers, due largely to his impulsive behavior and the fact that he frequently got angry without provocation. In addition, John appeared extremely hypersensitive to touch, sound, and movement. His parents were not surprised, as they had been dealing unsuccessfully with these same behaviors for several years. At the teacher's suggestion, they decided to take John to a child psychiatrist, who performed a comprehensive biopsychosocial and developmental evaluation and diagnosed John with ADHD. The psychiatrist ruled out the possibility of autism, but referred John for an evaluation to an occupational therapist who determined that John had significant sensory integration and motor planning deficits. The psychiatrist also referred John to a psychologist for a neuropsychological evaluation to test for specific learning disabilities, but none were identified.

To treat John's ADHD, it was agreed that he would be placed on medication and that he would continue to see the psychiatrist to initiate and stabilize the medication and to provide periodic assessment and oversight. In addition, John would receive individual and group behavioral therapy to help him become more aware of his impulsivity and to teach him more effective social and organizational strategies, while his parents would receive family therapy to help them implement the behavioral treatment plans and reduce their stress and anger at home. John also would begin working with an occupational therapist to develop his neurological functioning.

John lives with both parents and has no siblings. He attends a local public school that provides limited special education services. John has had health insurance coverage since birth through his father's place of employment.

John would have health insurance coverage for all of the services he required in 1% of the plans we examined. All would cover his acute care physician visit. The vast majority would cover his preventive health visit -- although he would be far more likely to have coverage in an HMO than a PPO -- and almost as many would cover his neuropsychological evaluation. A smaller proportion, however, would provide coverage for his medication, and only a handful would cover all of his mental health or occupational therapy visits.

John's inability to obtain coverage for most of the services recommended for him would be due largely to contract exclusions relevant to his specific conditions. Prescription drug benefits, for example, were included in 80% of plans, but 20% of these plans would deny coverage for his medications because of a general condition exclusion for the treatment of

ADHD or of all behavioral conditions,²⁰ and one additional plan would deny him coverage because of an exclusion for all prescription drugs related to mental health conditions. Mental health therapy was always a covered benefit in the plans we examined, but almost a third had one or more exclusions that would preclude John from coverage: most established exclusions pertaining to either ADHD or all behavioral conditions under the mental health benefit, but some established the same policy as a general contract exclusion, and one plan had broad exclusionary language under the mental health benefit pertaining to all chronic conditions.²¹ John's restricted access to occupational therapy benefits would be even more dramatic. Seventy-nine percent of plans (92% of those that covered occupational therapy) had an exclusion -- usually under the occupational therapy benefit -- that would encompass his diagnosed functional impairments. In all but two of these plans, coverage would only be available for rehabilitative purposes -- to improve or restore a lost function due to an illness or injury, though a few would also treat congenital anomalies -- and exclusions for treatment of developmental delay were sometimes specified as well. In the other plans, John would be denied coverage because he was older than three or because the required intervention would not be limited to his upper extremities.

With respect to mental health therapy, specific treatment exclusions would also contribute to John's inability to access benefits. Among the 58 plans that would not exclude his condition, John would find that his psychotherapy visits would not be covered in three plans because of language excluding either all psychotherapy or all psychotherapy beyond crisis stabilization. He would also find that his family therapy visits would not be covered in 18 plans due to specific exclusions for this mode of treatment. These treatment exclusions, in combination with benefit limits, would leave John only rarely able to receive coverage for all of the mental health services recommended for him. John required a total of 50 outpatient visits; about 50% of the plans that would cover his therapy would have benefits for half or fewer of these visits.

²⁰ This exclusion was verified by several plans.

²¹ Many plans had language that would exclude coverage for chronic mental health conditions but these were more narrowly defined to imply conditions such as organic brain disorder, chronic psychosis, and mental retardation.

Table 4

John, Age 7 with ADHD and Sensory Integration and Motor Planning Dysfunction

Recommended Services	All Plans (n=97)*			HMOs (n=48)*			PPOs (n=49)		
	Covered	Partially Covered	Not Covered	Covered	Partially Covered	Not Covered	Covered	Partially Covered	Not Covered
PCP visits for preventive care (1)	78%	0%	22%	90%	0%	10%	67%	0%	33%
PCP visits for acute condition (1)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Outpatient mental health visits (50: 8 visits for evaluation and medication management; 30 individual and group psychotherapy visits -- weekly for 4 months, then biweekly for 7 months; and 12 family therapy visits -- biweekly for 1 month, then monthly for 10 months)	13%	57%	30%	15%	52%	33%	12%	61%	27%
Neuropsychological evaluations (1)	72%	0%	28%	71%	0%	29%	73%	0%	27%
Occupational therapy visits (32: twice a week for 2 months; then weekly for 4 months)	4%	3%	93%	0%	2%	98%	8%	4%	88%
Medications	64%	0%	36%	65%	0%	35%	63%	0%	37%

* One HMO plan was excluded from this analysis because it did not sell mental health coverage.

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

E. SALLY, AGE 15, SUICIDAL WITH MAJOR DEPRESSIVE DISORDER

Only a month into her sophomore year of high school, Sally was feeling anxious and alone. She was not sleeping well at night, often going several nights at a time without sleep. Her appetite was significantly decreased, and she frequently complained of headaches and stomachaches. Though she had always been a good student, she was unable to concentrate and her school performance declined steadily. Eventually, she missed 8 full days of school and withdrew from sports, social activities, and friends. Her parents had tried to get her into therapy, but she refused. By spring, Sally had attempted suicide by slashing her wrists and her parents had taken her to the emergency room. There is a family history for depressive illness; her father suffered a serious depressive episode 10 years ago and was hospitalized, though he never attempted suicide.

Emergency room doctors admitted her to the hospital's psychiatric unit, where she was treated for 7 days. With assistance from the hospital social worker, her parents arranged for her to see a community-based child and adolescent psychiatrist following her discharge. After several sessions, the psychiatrist referred Sally to a psychologist in his practice for ongoing psychotherapy that would include cognitive behavioral therapy and also family therapy. The psychiatrist maintained contact with her to oversee her medication.

Sally lives with both parents and 1 younger sibling. Both parents work, but the family has had health insurance under the father's plan for 6 years.

Sally would find that, of the plans we examined, 10% would cover all of the services recommended for her. Every plan would cover her acute care physician visits and her emergency room visit. The vast majority would cover her preventive visit and -- although one of the plans with prescription drug benefits excluded coverage for drugs to address mental health conditions -- a slightly larger proportion would cover her medications. With respect to her mental health treatment, coverage for Sally's total inpatient stay would be available in almost 90% of plans, but complete coverage for her outpatient therapy would be far less common. Moreover, the proportion of plans providing Sally coverage for all of her outpatient mental health treatment would be even lower, except for the fact that six plans permitted additional benefits for individuals with biologically based conditions.

Sally's inability to have her mental health treatment covered, either in whole or in part, would be due to specific condition exclusions, benefit limits, and service exclusions applicable to her. Five plans that provided inpatient mental health coverage -- there was one that excluded it -- had a specific exclusion for treatment of self-inflicted injuries. All plans had outpatient mental health benefits, but in one plan Sally would have already reached her monetary benefit limit for mental

health services as a result of her inpatient stay. Among the remaining plans, more than three-quarters would provide fewer visits than she required; two-thirds of these, in fact, would cover half or fewer. In addition, Sally would find that psychotherapy was excluded in one plan and family therapy in about a quarter of plans. Also, it should be noted that among some of the plans that would provide coverage for all of her outpatient mental health services, the actual amount of coverage authorized for her outpatient mental health treatment could be less, given that three plans' contract language stipulated that coverage was for crisis intervention only, in one case indicating clearly that services would be discontinued after crisis stabilization.

Table 5

Sally, Age 15, Suicidal with Major Depressive Disorder

Recommended Services	All Plans (n=97) *			HMOs (n=48) *			PPOs (n=49)		
	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered
PCP visits for preventive care (1)	76%	0%	24%	88%	0%	12%	65%	0%	35%
PCP visits for acute condition (1)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Emergency room visits (1)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Inpatient hospital days (7)	89%	5%	6%	92%	6%	2%	85%	4%	11%
Outpatient mental health visits (54: 8 visits for evaluation and medication management; 34 visits for individual psychotherapy (twice weekly for 1 month, weekly for 5 months, then biweekly for 3 months); and 12 family therapy visits (biweekly for 2 months, then monthly for 8 months))	22%	77%	1%	25%	73%	2%	18%	82%	0%
Medications	79%	0%	21%	77%	0%	23%	82%	0%	18%

* One HMO plan was excluded from this analysis because it did not sell mental health coverage.

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

F. RICKY, AGE 17 WITH SUBSTANCE ABUSE DISORDER AND BIPOLAR DISORDER

By the beginning of his freshman year of high school, Ricky had been turning to alcohol and marijuana whenever he felt sad or anxious. As a result, he had periodically gotten himself into serious trouble at school. In his sophomore year, the school nurse had referred him to a substance abuse counselor, but he successfully completed only 3 of the recommended 15 counseling sessions. At age 17, as Ricky progressed into his junior year, he began to realize that, although he was smart, his poor performance at school would preclude him from attending college and he had few prospects for his future. Feeling hopeless and angry, he began abusing alcohol and marijuana on a daily basis. His personality changed as well; he became more aggressive at home and at school -- arguing, initiating fights, and threatening his mother, teachers, also other students. He started staying out all night. Eventually, he was suspended from school for arriving intoxicated and was involved in 2 episodes of drunk driving, the second of which involved an accident that caused him to be brought to the emergency room.

Doctors at the emergency room identified the severity of his substance abuse problem and arranged for him to be admitted to the hospital for an assessment over a 3-day period and then to receive residential substance abuse treatment. They presumed that he would remain in the treatment facility for approximately one month. Three weeks into his treatment at the facility, many of his behavior problems persisted and he was subsequently identified as having bipolar disorder based on his symptoms of irritable mood, depression, and angry outbursts. Discharged from the facility after a month, he would return home but would participate in a 2-week partial hospitalization program where he could be stabilized on appropriate medication and receive intensive individual and group therapy. After completing the program, Ricky would continue to receive some mental health therapy, both alone and with his mother, and he would periodically be seen by the hospital psychiatrist who would monitor his progress and medication. In addition, he would be seen by a substance abuse counselor and referred to Alcoholics Anonymous.

Ricky lives with his mother. He has been covered by her employer-sponsored health insurance plan, since he was 4 years old.

Benefits would be sufficient for all of the services recommended for Ricky in 2% of the plans we examined. All or virtually all of the plans would cover his acute care visit to his primary care provider, his medication management visits to the psychiatrist, his emergency room visits, and his short-term inpatient mental health stay. The vast majority would cover his annual preventive visit and prescription drugs, and a significant majority would cover his mental health treatment in a partial hospitalization program -- although for preventive care and partial hospitalization, complete coverage would be available far more often under HMOs than PPOs. By contrast, the proportion of plans that would cover all of Ricky's recommended outpatient

mental health therapy and substance abuse therapy would be much smaller, particularly for his mental health therapy. Coverage of his residential treatment for substance abuse would be even rarer, since typically plans in our study did not provide any coverage for this service, and in two instances where they did, substance abuse coverage was limited to crisis intervention and detoxification only.

Ricky would find that, with the exception of family therapy, for which coverage was expressly excluded in about a quarter of plans, outpatient mental health therapy was a standard component of plans' benefit packages; only in one plan would coverage for individual psychotherapy be excluded. Yet, in most cases, the amount of coverage offered would be insufficient to meet his service requirements. In more than 50% of the plans that would provide Ricky partial coverage, benefits would be equal to between half and three-quarters of the 29 visits recommended for him; in nearly all of the remainder, benefits would be less. This would be because of his dual diagnosis and the fact that mental health and substance abuse benefits were so often combined. Still, two additional plans would have provided less than full coverage if they did not offer additional therapy benefits to individuals with biologically based conditions.

With respect to outpatient substance abuse therapy, Ricky would find that benefits also were standard in plans' coverage. There would be only one plan without such coverage. In three plans, however, Ricky would be denied benefits because coverage was only available either for services related to medical complications or for services provided during the acute stage of a substance abuse disorder. Just over 40% of plans would provide Ricky complete coverage, but among those providing partial coverage, almost 50% would cover half or fewer of the number of visits required.

Using the discretion granted by their contract language, however, some plans could choose not to approve all available outpatient treatment benefits, particularly for mental health therapy. Of the 25 plans that would cover all of Ricky's outpatient mental health care, one had language requiring significant improvement within a short period of time and three had language -- in one case, very restrictive -- limiting coverage to crisis intervention only. Among plans that would provide partial coverage, similar provisions applied.

Table 6

Ricky, Age 17 with Substance Abuse Disorder and Bipolar Disorder

Recommended Services	All Plans (n=97) *			HMOs (n=48) *			PPOs (n=49)		
	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered	Fully Covered	Partially Covered	Not Covered
PCP visits for preventive care (1)	76%	0%	24%	88%	0%	12%	65%	0%	35%
PCP visits for acute condition (1)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Emergency room visits (2)	100%	0%	0%	100%	0%	0%	100%	0%	0%
Inpatient mental health days (3)	99%	0%	1%	98%	0%	2%	100%	0%	0%
Residential substance abuse treatment days (30)	11%	6%	83%	13%	8%	79%	10%	4%	86%
Partial hospital mental health days (14)	67%	1%	32%	75%	2%	23%	59%	0%	41%
Outpatient mental health visits (29: 3 visits for medication management; 16 individual psychotherapy visits -- weekly for 2 months, then biweekly for 4 months; 10 family therapy visits -- weekly for 1 month, then biweekly for 3 months)	26%	74%	0%	27%	73%	0%	24%	76%	0%
Substance abuse outpatient therapy visits (24: twice weekly for 2 months, then weekly for 2 months)	42%	54%	4%	42%	52%	6%	43%	55%	2%
Medications	79%	0%	21%	77%	0%	23%	82%	0%	18%

* One HMO plan was excluded from this analysis because it did not sell mental health coverage.

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

IV. PLAN COVERAGE FOR SERVICES IMPORTANT TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS

In this section, we summarize the benefit coverage policies available in the 98 private health insurance plans we examined. A total of 22 services were analyzed and are organized in three subsections to include seven basic medical services, six behavioral services, and nine specialized services, each followed by a set of tables. The services are analyzed according to coverage availability, benefit amounts, and cost-sharing provisions. We also examined plans' use of access restrictions, including condition or treatment exclusions, as well as plans' use of access protections involving special provisions that could benefit special-needs children. Finally, we compared differences between HMO and PPO policies.

Overall, we found that the majority of the plans offered coverage for almost all of the basic medical, behavioral, and specialized services. Only a handful of services -- audiology and optometry services, mental health and substance abuse partial hospitalization services, nutritional counseling services, and medical supplies -- were not covered in a quarter or more of the plans. Despite the broad scope of benefits offered in most of the plans, benefit limits, cost-sharing requirements, and condition and treatment exclusions commonly narrowed the nature, extent, and sometimes even the availability of coverage.

With respect to benefit amounts, basic medical services were usually offered without visit, day, or monetary limits. In contrast, coverage for behavioral health and specialized services typically was limited. Limits for mental health, substance abuse, and ancillary therapies often applied to two or more services combined -- for example, all types of mental health services (outpatient, inpatient, and partial hospitalization) or all types of ancillary therapy (physical therapy, occupational therapy, and speech therapy). When expressed as visit or day limits, as they were in most cases, amounts for a combination of services did not differ significantly from those applicable to a single type of service. They were often set at 20 or 30. Monetary limits were much less often used than visit limits, but certain services were more likely to be subject to annual or lifetime dollar caps, including eyeglasses, hearing aids, all substance abuse services, medical equipment, and home health services.

With respect to cost-sharing provisions, nearly all benefits carried either copayment or coinsurance obligations, and in a few instances, separate deductibles. Copayments were the predominant method for basic medical services and coinsurance was the predominant method for behavioral services, while for specialized services neither coinsurance nor copayments were more common. Cost-sharing amounts often varied by service, particularly when copayments were used, but the highest cost-sharing charges consistently were imposed on behavioral services. Importantly, however, we found that at least 20% of plans imposed no cost sharing on immunizations, inpatient and outpatient hospital services, mental health and substance abuse inpatient and partial hospital services, ancillary therapies, home health care, skilled nursing facilities, eyeglasses and vision therapy, and medical equipment and supplies.

With respect to access provisions, restrictions were far more common than protections. We found the vast majority of plans imposed condition or treatment exclusions on mental health services and certain specialized services. For mental health services, the most common exclusions were for certain modes of treatment, such as family therapy, and for specific conditions, such as attention deficit hyperactivity disorder. For physical, occupational, and speech therapy services, the most frequent exclusions were for conditions not caused by an illness or injury and for requirements for significant improvement within a short period of time. By contrast, we found that a minority of plans established access protections or special provisions beneficial to children with special health care needs. The special protections that plans were most likely to allow were lower cost sharing or benefit expansions for younger children for preventive care, immunizations, mental health outpatient care, and ancillary therapies.

Overall, our analysis revealed that HMOs offered a more comprehensive set of benefits than PPOs with somewhat fewer benefit limits than PPOs. We found that HMOs were more likely to offer preventive care for children through age 21, mental health and substance abuse partial hospitalization, ancillary therapies, most audiology and optometry services, nutritional counseling, and skilled nursing facilities. In addition, HMOs were less likely than PPOs to impose cost-sharing requirements; specifically for inpatient and outpatient hospitalization, substance abuse inpatient hospitalization, ancillary therapies, audiology and optometry services, nutritional counseling, home health care, skilled nursing facilities, and durable medical equipment and supplies.

When cost sharing was imposed, HMOs were more likely than PPOs to rely on copayments.

A. BASIC MEDICAL SERVICES

1. PHYSICIAN SERVICES

Coverage. Physician services were covered in 100% of plans.

Benefit Limits. None.

Cost-Sharing Requirements. Almost all plans (96%) required cost sharing for primary and specialty physician services. Although most plans had a single cost-sharing requirement that applied to all physicians, 9% of plans imposed higher cost-sharing charges for specialist physicians than for primary care physicians. Copayments for physician services were far more common than coinsurance and, though they ranged from \$5 - \$25, they were most likely to be set at \$10. Among plans using coinsurance, rates ranged from 10% to 40%, with 20% being the most common rate.

Access Restrictions. None.

Access Protections. One plan specified that a specialist could serve as a primary care provider for those with degenerative, disabling, or lifelong conditions.

HMO/PPO Differences. All HMOs relied on copayments, while some PPOs used coinsurance.

2. PREVENTIVE EXAMS

Coverage. Preventive exams were covered in almost all plans (97%). Two-thirds of these plans covered children through age 21.²² Among those that did not, almost a third covered preventive care only for young children, most often infants and toddlers.²³

Benefit Limits. Visit limits could not be calculated for preventive care because only a third of plans specified the periodicity of preventive care visits. Only 3 of these plans used schedules that were consistent with the American Academy of Pediatrics (AAP) current recommendations for preventive health care.²⁴ Another 4 plans almost met the

²² When plans covered routine preventive care but did not specify age limits we presumed coverage would extend through age 21.

²³ Almost half of these plans restricting preventive care to younger children only covered children ages 2 or under.

²⁴ Academy of Pediatrics, Committee on Practice and Ambulatory Medicine. Recommendations for Preventive Pediatric Health Care. *Pediatrics*. 105: 645-646, 2000.

AAP's standards.²⁵ Monetary limits, used in 15% of plans, varied from a low of \$100 to a high of \$500, and were most frequently set at \$200.²⁶

Cost-Sharing Requirements. Eighty-five percent of plans that covered preventive care required cost sharing, typically in the form of copayments rather than coinsurance. Copayment amounts ranged from \$5 to \$20, with \$10 being the most common. Coinsurance rates were set at either 10% or 20%, but were more frequently 20%.

Access Restrictions. None.

Access Protections. Twenty-seven plans with coverage had special provisions that could benefit children with special health care needs. More than a third of these had lower cost sharing for preventive care visits than for office visits, either deductibles were not applied or cost sharing for younger children was eliminated. Almost two-thirds offered health education programs,²⁷ and while few specified program content, 1 described health education classes to teach self-care skills for specific conditions.

HMO/PPO Differences. HMOs were much more likely than PPOs to offer a preventive care benefit to children through age 21, and they were much less likely than PPOs to impose monetary limits on preventive care. HMOs and PPOs also varied somewhat with respect to the form of cost sharing; some PPOs relied on coinsurance while no HMOs did.

3. IMMUNIZATIONS

Coverage. Immunizations, like preventive care, were covered in almost all plans (98%), but 38% of these plans did not extend coverage through age 21. Interestingly, 7 plans had higher age cut-offs for immunizations than for preventive care, and 2 plans had lower age cut-offs.

Benefit Limits. Plans seldom specified their immunization schedules, making it impossible to assess benefit amounts, except for monetary limits. In a handful of plans (4%), monetary limits were imposed²⁸ and ranged from \$250 every 2 years to \$350 each year.

Cost-Sharing Requirements. Almost three-quarters of plans with coverage (70%) required cost sharing for immunizations. The vast majority of plans required copayments, which ranged from \$5 to \$20, but were almost always set at \$10. Plans set coinsurance rates at either 10% or 20%, with 20% being the more frequent charge.

²⁵ These 3 plans allowed between 23 to 26 preventive care visits from 0 through 21. The AAP recommends 28 visits.

²⁶ Four plans with monetary limits for preventive care also applied them to immunizations.

²⁷ When plans offered asthma or diabetes health education programs only, we did not include them as offering access protections. We also did not count health education as an access protection if it was described as a component of the preventive care visit.

²⁸ These limits applied to both immunizations and preventive care.

Access Restrictions. None.

Access Protections. Thirteen plans reduced or eliminated cost sharing for immunizations, mostly for children ages 6 or under.

HMO/PPO Differences. HMOs relied exclusively on copayments; the majority of PPOs that required cost-sharing used copayments, although some used coinsurance.

4. INPATIENT HOSPITAL SERVICES

Coverage. Inpatient hospital services were covered in all plans.

Benefit Limits. None.

Cost-Sharing Requirements. Sixty percent of plans required cost sharing for inpatient hospital services. Plans requiring cost sharing were more than twice as likely to use coinsurance as copayments. While coinsurance rates ranged from 10% to 20%, most frequently they were 20%. Copayment amounts ranged from a low of \$50 to a high of \$300, but were most often \$100 per day. Interestingly, about a third of plans set a cap on copayments, which ranged from \$200 to \$500, with \$500 being the most common. A small proportion of plans (7%) also imposed a separate inpatient hospital deductible that a family would have to pay before the plan provided reimbursement. Deductible amounts were evenly split between \$50 per day, \$100 per admission, and \$300 per admission.

Access Restrictions. None.

Access Protections. None.

HMO/PPO Differences. HMOs were significantly less likely than PPOs to impose cost-sharing requirements on inpatient hospital services, and they were more likely to rely on copayments, while PPOs relied almost exclusively on coinsurance.

5. OUTPATIENT HOSPITAL SERVICES

Coverage. Outpatient hospital services were covered in 100% of plans.

Benefit Limits. None.

Cost-Sharing Requirements. Fifty-one percent of plans imposed cost sharing on outpatient hospital services. As with inpatient hospital care, plans were almost twice as likely to rely on coinsurance than on copayments. Coinsurance charges were either 10% or 20%, with 20% being the more frequently applied charge. Copayment amounts ranged from \$5 to \$50, and were most often set at either \$5, \$10, or \$15.

Access Restrictions. None.

Access Protections. Three plans offered coverage of medical social services to assist families in coping with a medical condition.

HMO/PPO Differences. HMOs were far less likely than PPOs to require cost sharing, but when they did they relied primarily on copayments, while PPOs relied primarily on coinsurance.

6. EMERGENCY ROOM SERVICES

Coverage. Emergency room services were covered in all plans.

Benefit Limits. No plan set limits on the number of emergency room visits, but a handful (4%) imposed dollar limits of \$500 for each emergency room visit.

Cost-Sharing Requirements. Nearly all plans (94%) imposed cost-sharing requirements on emergency room services. Of these, the majority required copayments rather than coinsurance, the amount of which ranged from \$10 to \$100, and was most frequently set at \$50. Coinsurance rates were typically 20%, and ranged from 10% to 20%.

Access Restrictions. None.

Access Protections. None.

HMO/PPO Differences Almost all HMOs relied on copayments, while PPOs were evenly split in their use of copayments and coinsurance.

7. PRESCRIPTION DRUGS

Coverage. Prescription drugs, including brand-name and generic drugs, were covered in 81% of plans, and non-formulary drugs were covered in 80% of these plans. More than half of plans (60%) with a drug benefit offered a mail-order option.

Benefit Limits. Only a few of the 79 plans with a pharmacy benefit imposed monetary limits on coverage -- 2 plans set a \$2,500 annual benefit limit and 1 plan set a \$10,000 lifetime limit.

Cost-Sharing Requirements. Almost all plans covering prescription drugs (99%) required cost sharing, typically in the form of copayments. Amounts varied by drug category (brand-name, generic, and non-formulary) and by purchase source (pharmacy and mail order). For each prescription drug category, the range of copayments differed - \$2 to \$11 for generic drugs, \$2 to \$20 for brand-name drugs, and \$2 to \$50 for non-formulary drugs. Although \$10 was the most common copayment charge for both brand-name and generic drugs, the average copayment charge for brand-name drugs was \$13 compared to \$7 for generics. Non-formulary drug copayments were most commonly set at \$25, with the average copayment being \$20 compared to \$7 for generics. Compared to pharmacy-purchased drugs, mail-order drug copayments varied more and were higher on average for brand-name drugs.

Access Restrictions. Almost one-third of plans with a prescription drug benefit (24) had 1 or more general exclusions for coverage of specific mental health conditions that would apply to prescription drugs. Most often the exclusions were for behavioral disorders (in 14 plans) and ADHD (6). Other mental health condition exclusions

applicable to prescription drugs included conduct disorders (4), psychoneurotic disorders (2), mental conditions with no known cure (2), and oppositional defiant disorder (1). In addition, 1 plan excluded prescription drug coverage specifically for adolescents with behavior disorders.

Access Protections. Three plans had special provisions allowing greater access to prescription drugs for children with chronic conditions. One plan enrolled children with diabetes and asthma into disease management programs and exempted them from any cost-sharing requirements and benefit limits. Another waived its pre-existing condition restriction for prescription drugs. The third eliminated its experimental or investigational drug restriction for children with terminal diseases.

HMO/PPO Differences. HMOs used only copayments; PPOs used primarily copayments but also coinsurance.

TABLE 7A
BENEFIT COVERAGE OF BASIC MEDICAL SERVICES

Basic Medical Services	Extent of Coverage		
	Total	HMO	PPO
1. Physician Services	(n=98)	(n=49)	(n=49)
Covered	100%	100%	100%
With Limits	0%	0%	0%
Without Limits	100%	100%	100%
Not Covered	0%	0%	0%
2. Preventive Exams	(n=98)	(n=49)	(n=49)
Covered	97%	100%	94%
With Limits*	15%	2%	28%
Without Limits	85%	98%	72%
Not Covered	3%	0%	6%
3. Immunizations	(n=98)	(n=49)	(n=49)
Covered	98%	100%	96%
With Limits*	4%	0%	9%
Without Limits	96%	100%	91%
Not Covered	2%	0%	4%
4. Inpatient Hospital Services	(n=98)	(n=49)	(n=49)
Covered	100%	100%	100%
With Limits	0%	0%	0%
Without Limits	100%	100%	100%
Not Covered	0%	0%	0%
5. Outpatient Hospital Services	(n=98)	(n=49)	(n=49)
Covered	100%	100%	100%
With Limits	0%	0%	0%
Without Limits	100%	100%	100%
Not Covered	0%	0%	0%
6. Emergency Room Services	(n=98)	(n=49)	(n=49)
Covered	100%	100%	100%
With Limits	4%	0%	8%
Without Limits	96%	100%	92%
Not Covered	0%	0%	0%
7. Prescription Drugs	(n=98)	(n=49)	(n=49)
Covered	81%	78%	84%
With Limits	3%	3%	5%
Without Limits	97%	97%	95%
Not Covered	19%	22%	16%

* Limits were expressed only as monetary limits.

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

TABLE 7B
COST SHARING FOR BASIC MEDICAL SERVICES

Basic Medical Services	Extent of Cost Sharing		
	Total	HMO	PPO
1. Physician Services	(n=95)	(n=47)	(n=48)
Primary Care Physicians			
Cost Sharing	96%	91%	100%
Copayments	84%	100%	69%
Coinsurance	18%	0%	33%
No Cost Sharing	4%	9%	0%
Specialist Physicians			
Cost Sharing	96%	94%	98%
Copayments	84%	100%	68%
Coinsurance	19%	0%	36%
No Cost Sharing	4%	6%	2%
2. Preventive Exams	(n=92)	(n=47)	(n=45)
Cost Sharing	85%	85%	84%
Copayments	87%	100%	74%
Coinsurance	13%	0%	26%
No Cost Sharing	15%	15%	16%
3. Immunizations	(n=93)	(n=47)	(n=46)
Cost Sharing	70%	68%	72%
Copayments	85%	100%	70%
Coinsurance	15%	0%	30%
No Cost Sharing	30%	32%	28%
4. Inpatient Hospital Services	(n=95)	(n=47)	(n=48)
Cost Sharing	60%	40%	79%
Copayments	30%	79%	5%
Coinsurance	74%	32%	95%
No Cost Sharing	40%	60%	21%
5. Outpatient Hospital Services	(n=93)	(n=45)	(n=48)
Cost Sharing	51%	27%	73%
Copayments	32%	75%	17%
Coinsurance	72%	25%	89%
No Cost Sharing	49%	73%	27%
6. Emergency Room Services	(n=95)	(n=47)	(n=48)
Cost Sharing	94%	91%	96%
Copayments	78%	98%	59%
Coinsurance	29%	5%	52%
No Cost Sharing	6%	9%	4%
7. Prescription Drugs	(n=77)	(n=36)	(n=41)
Brand-Name Drugs			
Cost Sharing	99%	100%	98%
Copayments	87%	100%	75%
Coinsurance	13%	0%	25%
No Cost Sharing	1%	0%	2%
Generic Drugs			
Cost Sharing	99%	100%	98%
Copayments	88%	100%	78%
Coinsurance	12%	0%	22%
No Cost Sharing	1%	0%	2%

Note: Totals do not always add up to 100% because some plans use both copayments and coinsurance.

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

B. BEHAVIORAL HEALTH SERVICES

1. MENTAL HEALTH OUTPATIENT SERVICES

Coverage. Outpatient mental health services were covered in all plans.

Benefit Limits. Visit or monetary limits²⁹ were imposed on outpatient mental health services in 88% of plans. Visit limits, which were far more common, ranged from 8 to 60 but were most frequently set at 20. In about half of these plans, however, the visit limits applied to outpatient substance abuse and mental health services combined. Conversion options, which allow inpatient hospital days to be converted to outpatient visits, were available in 4 plans. Monetary limits, imposed in about 10% of plans, ranged from a low of \$750 per year to a high of \$25,000 per lifetime, but in plans with more generous coverage, monetary limits typically applied to all mental health services or to all mental health and substance abuse services, not just mental health outpatient care.

Cost-Sharing Requirements. Almost all plans (96%) required cost sharing for outpatient mental health services. Coinsurance and copayments were used with equal frequency. Coinsurance rates ranged from 10% to 50% but were most often 20%, while copayment amounts ranged from \$5 to \$50, but were most often \$20. In about a dozen plans cost-sharing amounts increased with the number of visits.

Access Restrictions. Two-thirds of plans (64) imposed at least 1 or more access restrictions concerning types of conditions or modes of treatment.³⁰ The vast majority of these plans imposed condition exclusions pertaining to V-codes (in 18 plans),³¹ personality disorders (17), conduct disorders (14), behavior disorders (13), ADHD (11), impulse control disorders (7), chronic conditions (6), self-inflicted injuries (5), emotional disorders (3), or eating disorders (2), as well as conditions that would not improve significantly within a short period of time -- usually 2 to 3 months (11). More than half excluded specific modes of treatment, including family counseling (in 22 plans), services not for evaluation and crisis intervention (9 plans), psychological testing (6), and behavior modification (7).

Access Protections. Fourteen plans included 1 or more special provisions that could benefit children with special health care needs. Of these, 8 treated serious

²⁹ In 1998, the Mental Health Parity Act required that plans no longer set annual or aggregate lifetime dollar limits on mental health benefits lower than any such dollar limit for medical/surgical benefits. In addition, a plan that did not impose an annual or aggregate lifetime dollar limit on medical/surgical benefits might not impose such a limit on mental health benefits. However, a group plan could claim an exemption from these requirements if the plan's costs increased 1% or more due to the application of the Mental Health Parity Act's requirements. In *Federal Register*, Vol. 62, No. 245, December 22, 1997.

³⁰ Almost all plans with access restrictions on mental health services applied them to inpatient care, partial hospital care, and outpatient care. We, however, reported on each mental health access restriction under the most relevant benefit category. For example, we report on attention deficit hyperactivity disorder restrictions under the outpatient mental health benefit.

³¹ These conditions include, but are not limited, to psychological factors affecting medical conditions and problems related to abuse or neglect. In American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. Washington, DC: APA, 1994.

mental illness³² like other medical conditions, 1 doubled the number of outpatient visits for treatment of serious mental conditions, and another covered 20 additional visits if certain criteria were met. Six plans covered medication management visits without limits, and 2 others covered them on an unlimited basis for those with serious mental illness. Finally, 2 plans covered psychological counseling for families with young children as part of an early intervention benefit.

HMO/PPO Differences. HMOs were more likely than PPOs to provide a separate benefit limit for outpatient mental health services rather than a benefit limit combined with other services. In addition, HMOs relied predominantly on copayments, while PPOs relied on coinsurance.

2. MENTAL HEALTH INPATIENT HOSPITAL SERVICES

Coverage. Mental health inpatient hospital services were covered by almost all plans (98%). All of these plans covered inpatient mental health treatment in a general hospital, nearly all (96%) provided coverage in a psychiatric facility, while almost a quarter (22%) provided coverage in a residential treatment facility. Only 1 plan allowed treatment in a halfway house.

Benefit Limits. Among these plans, 92% imposed day limits or sometimes monetary limits. Day limits ranged from 3 to 76 days, with 30 days being most common, but in about half of the plans, limits applied to inpatient substance abuse services as well as mental health services. Monetary limits, used in just over 10% of plans with limits, varied from \$3,000 per year to \$25,000 per lifetime, and, as was the case for outpatient mental health services, the more generous monetary caps applied to all mental health services combined or all mental health and substance abuse services combined. Several of the plans with monetary limits had day limits as well.

Cost-Sharing Requirements. Seventy percent of plans that covered inpatient mental health services had cost-sharing requirements. Coinsurance, by far, was most common. Rates were most often set at 20%, but ranged from 10% to 50%. Copayments also varied widely from \$40 to \$300. Half of the plans imposed a per-day copayment, typically \$50, and the other half required a per-admission copayment, usually \$200. Additionally, 2 plans imposed separate deductibles for inpatient mental hospitalization of \$50 and \$300.

Access Restrictions. Almost half of plans that covered inpatient mental health services (43) had at least 1 access restriction. Condition exclusions were found in more than three-quarters of these plans for conduct disorders (in 14 plans), behavior disorders (13), chronic conditions (6), oppositional defiant disorders (5), self-inflicted injuries (5), and eating disorders (4), and also for conditions that would not improve significantly within a short period of time (11). Exclusions pertaining to modes of treatment were less common; 8 plans covered inpatient treatment only for evaluation and crisis intervention.

Access Protections. Nine plans had 1 or more provisions that could improve access to care for children with mental health problems. Five plans, all in states with mandated

³² Serious mental illness was often defined as schizophrenia, schizoaffective disorder, major depression, and obsessive compulsive disorder.

mental health parity requirements,³³ applied no day limits for individuals with serious mental illnesses. An additional 5 plans allowed individuals with serious mental illness longer lengths of stay, and 1 plan allowed extra hospital days for children under 19.

HMO/PPO Differences. HMOs were more likely than PPOs to have a separate inpatient mental health benefit limit rather than a combined limit that included substance abuse services as well, but they were also more likely to require cost sharing. In addition, PPOs relied almost exclusively on coinsurance, while HMOs used either coinsurance or copayments.

3. MENTAL HEALTH PARTIAL HOSPITAL SERVICES

Coverage. Mental health partial hospital services were covered in 70% of plans.

Benefit Limits. Ninety percent of the 68 plans covering mental health partial hospitalization imposed day or monetary limits, but of these the vast majority (92%) set limits that included other services as well. Almost half had a single benefit limit for mental health inpatient and partial hospital services combined, nearly as many had a single benefit limit for both substance abuse and mental health inpatient and partial hospital services combined, while 5 had a single benefit limit that included substance abuse treatment but only for partial hospitalization. Day limits, which were used in all but a handful of plans, were usually set at 60 days but ranged from 7 to 120 days. Plans that imposed a day limit on partial hospitalization for both mental health and substance abuse treatment tended to be somewhat less generous than those with day limits applying to partial hospitalization for mental health treatment only. Where monetary limits were imposed, they ranged from \$1,000 per 2-year period to \$25,000 per lifetime, with the higher amounts typically available for all mental health and substance abuse services combined.

Cost-Sharing Requirements. Cost sharing was required in 68% of plans with partial hospitalization benefits, typically in the form of coinsurance charges. Like inpatient mental hospital services, coinsurance rates ranged from 10% to 50%, and were most commonly set at 20%. Among the plans using copayments, most charged a per-day copayment, ranging from \$10 to \$150. Three plans charged a per-admission copayment, ranging from \$100 to \$300.

Access Restrictions. Half of the plans that covered mental health partial hospitalization services (33) imposed at least 1 access restriction. More than three-quarters of these plans excluded coverage for conditions, including conduct disorders (11 plans), behavior disorders (10), impulse control disorders (7), chronic conditions (6), and oppositional defiant disorder (5), and also conditions that would not show significant improvement over a short period of time (9). Almost a third of plans with restrictions excluded particular modes of treatment: 6 limited coverage to intervention only, and 4 did not cover behavior modification.

Access Protections. Five plans had special access provisions unique to partial mental health hospitalization. Four offered additional partial hospital days for those with serious

³³ These states required that plans apply the same limits for mental health conditions as for general medical conditions.

mental illness, and 1, at its discretion, allowed inpatient partial hospital days if an inpatient stay could be avoided.

HMO/PPO Differences HMOs were much more likely than PPOs to cover mental health partial hospitalization and to require cost sharing, either in the form of coinsurance or copayments, while PPOs imposed cost-sharing requirements less often but relied almost exclusively on coinsurance.

4. SUBSTANCE ABUSE OUTPATIENT SERVICES

Coverage. Outpatient substance abuse services were covered in almost all plans (97%).

Benefit Limits. Among plans with outpatient substance abuse benefits, 78% placed limits on either the number of visits or the value of coverage. Visit limits, imposed by almost two-thirds of these plans, ranged from 8 to 60 visits and were most often 20, but the limits applied to substance abuse and mental health services combined in about half the plans. A handful of these plans (7%), however, had conversion options, allowing the substitution of inpatient days for outpatient visits. Monetary limits, used by more than a third of plans with limits, ranged from \$550 per year to \$100,000 per lifetime, but in well over half the plans the limit applied not only to outpatient substance abuse services but to other services as well -- usually all substance abuse services combined but sometimes all outpatient mental health and substance abuse services combined or simply all mental health and substance abuse services combined. The more generous monetary limits were usually associated with combined coverage that included inpatient care.

Cost-Sharing Requirements. Cost sharing for outpatient substance abuse services was required in 90% of plans with coverage. Coinsurance, used in more than half these plans, was most often 20%, but ranged from 10% to 50%. Copayments were most commonly \$20, but ranged from \$5 to \$50. In 10% of plans, cost-sharing amounts increased with the number of visits.

Access Restrictions. More than a quarter of plans with outpatient substance abuse benefits (25) restricted access to coverage in some way.³⁴ The majority of these excluded particular modes of treatment, including family counseling (12 plans), services not for evaluation or crisis intervention (3), drug rehabilitation (1), and services furnished by substance abuse professionals other than physicians or psychologists (1). Others applied exclusions for specific types of conditions, including disruptive behavior (3 plans), substance abuse without dependence (2), chronic substance abuse (1), abuse of psychoactive substances (1), and lack of medical complications (1). In addition, 1 plan excluded coverage for individuals who had previously discontinued a prescribed course of treatment.

Access Protections. Special access protections beneficial to children with special health care needs were established in 4 plans. These included 2 that offered 20 extra visits for family members of substance abuse patients, 1 that allowed 8 extra visits for

³⁴ Many of these plans applied access restrictions to all substance abuse services, but we reported on each substance abuse access restriction under the most relevant benefit category.

alcoholism treatment, and 1 that eliminated cost sharing for the first 20 outpatient substance abuse visits.

HMO/PPO Differences. HMOs relied to a greater extent on copayments, while PPOs generally used coinsurance.

5. SUBSTANCE ABUSE INPATIENT HOSPITAL SERVICES

Coverage. Substance abuse inpatient hospital treatment was covered in almost all plans (98%), but, like mental health inpatient services, it was not usually covered in facilities other than a general hospital. Only 19% provided coverage of inpatient treatment in residential treatment centers; only 2 plans provided coverage for treatment in halfway houses.

Benefit Limits. Day, episode, or monetary limits were imposed in 80% of plans with inpatient substance abuse benefits.³⁵ Day limits, used by more than two-thirds of these plans, ranged from 3 to 60 days, with the most common being 30 days, but in about half of these plans, the limits applied to inpatient mental health services as well as inpatient substance abuse services. Episode limits, used by almost 20% of plans, were usually specified “per lifetime” and ranged from 2 to 10, but were most often 2. Monetary limits, used by about 40% of plans, sometimes along with day limits, ranged from \$550 per year to \$100,000 per lifetime, but in about 80% of these plans the monetary limit applied to services other than inpatient substance abuse services -- usually to all substance abuse services and sometimes to combinations that included all mental health or all mental health inpatient services as well. The more generous monetary limits were typically provided when all substance abuse services or all mental health and substance abuse services were combined under a single limit.

Cost-Sharing Requirements. Cost sharing was required in 67% of plans covering substance abuse inpatient services. The most common form of cost sharing was coinsurance, typically set at 20% but ranging from a low of 10% to a high of 50%. Copayments varied, from \$40 to \$300, with no specific amount used most frequently. Additionally, 2 plans applied a separate deductible of \$300 per admission or per year.

Access Restrictions. About 15% of plans covering inpatient substance abuse services (15) imposed 1 or more access restrictions. About half of these plans applied treatment exclusions: 5 plans covered substance abuse treatments for detoxification only and 2 provided coverage for evaluation and crisis intervention only. More than half excluded coverage for specific conditions: 3 plans for disruptive behavior, 3 for substance abuse without dependence, 2 for chronic substance abuse, 1 for abuse of psychoactive substances, and 1 for lack of medical complications. In addition, there was 1 plan that did not provide benefits if the patient had a history of non-compliance with treatment.

Access Protections. Six plans offered special protections that would benefit children requiring substance abuse inpatient treatment. In 5 plans detoxification was treated as a medical benefit and not subject to day limits, and in 1 plan cost-sharing requirements were eliminated for detoxification and for the first 30 days of inpatient care.

³⁵ In 1998, the Mental Health Parity Act did not restrict plans from imposing annual or lifetime dollar limits on substance abuse services.

HMO/PPO Differences. HMOs were much less likely than PPOs to impose cost-sharing requirements, but when they did they relied on either coinsurance or copayments, while PPOs relied almost exclusively on coinsurance.

6. SUBSTANCE ABUSE PARTIAL HOSPITAL SERVICES

Coverage. Substance abuse partial hospital services were covered in 63% of plans.

Benefit Limits. Eighty-seven percent of the 62 plans covering partial hospitalization for substance abuse treatment imposed day or monetary limits, and in the vast majority of these plans (87%) the limit applied to a combination of services. Most often substance abuse partial hospitalization services were combined with inpatient mental health and substance abuse services or with inpatient substance abuse services alone, but several other combinations were found as well. Day limits, which were used in 80% of plans with limits, ranged from 7 to 120 days, but were typically set at 60. Monetary limits, which were used in almost a third of plans and almost always applied to a combination of services, ranged from \$550 per year to \$100,000 per lifetime. The most generous monetary coverage was for plans using a single monetary limit for all substance abuse services or all substance abuse and mental health services combined. Monetary limits were sometimes used along with day limits.

Cost-Sharing Requirements. Sixty-nine percent of plans covering partial hospital services required cost sharing, most often in the form of coinsurance. Coinsurance charges were typically set at 20%, but were as low as 10% and as high as 50%. Copayment amounts also varied dramatically, from \$10 to \$300, with no specific amount used most frequently. One plan required a \$350 deductible for partial hospitalization services.

Access Restrictions. Among plans that covered partial hospitalization for substance abuse treatment, 15% (9 plans) restricted access to benefits. About half limited the mode of treatment to evaluation and crisis intervention only (3) or excluded drug rehabilitation (1). About half restricted coverage for specific conditions, including disruptive behavior (2 plans), chronic substance abuse (2), substance abuse without dependence (1), and abuse of psychoactive substances (1).

Access Protections. Two plans had special provisions unique to substance abuse partial hospitalization. One allowed additional partial hospitalization days if an inpatient stay could be averted; the other covered 20 extra partial hospitalization days.

HMO/PPO Differences. HMOs were far more likely than PPOs to impose cost-sharing requirements, using either copayments or coinsurance. PPOs relied primarily on coinsurance.

TABLE 8A
BENEFIT COVERAGE OF BEHAVIORAL HEALTH SERVICES

Behavioral Health Services	Extent of Coverage		
	Total	HMO	PPO
1. Mental Health Outpatient Services	(n=97)	(n=48)	(n=49)
Covered	100%	100%	100%
Separate or Part of Mental Health Benefit ¹	52%	58%	45%
With Limits	84%	82%	86%
Without Limits	16%	18%	14%
Combined with Substance Abuse Benefit ²	48%	42%	55%
With Limits	91%	90%	93%
Without Limits	9%	10%	7%
Not Covered	0%	0%	0%
2. Mental Health Inpatient Hospital Services	(n=97)	(n=48)	(n=49)
Covered	98%	98%	98%
Separate or Part of Mental Health Benefit ¹	53%	60%	46%
With Limits	88%	89%	86%
Without Limits	12%	11%	14%
Combined with Substance Abuse Benefit ²	47%	40%	54%
With Limits	96%	95%	96%
Without Limits	4%	5%	4%
Not Covered	2%	2%	2%
3. Mental Health Partial Hospital Services	(n=97)	(n=48)	(n=49)
Covered	70%	81%	59%
Separate or Part of Mental Health Benefit ¹	57%	62%	52%
With Limits	87%	92%	80%
Without Limits	13%	8%	20%
Combined with Substance Abuse Benefit ²	43%	38%	48%
With Limits	96%	100%	92%
Without Limits	4%	0%	8%
Not Covered	30%	19%	41%
4. Substance Abuse Outpatient Services	(n=98)	(n=49)	(n=49)
Covered	97%	96%	98%
Separate or Part of Substance Abuse Benefit ³	48%	55%	42%
With Limits	65%	62%	75%
Without Limits	35%	38%	25%
Combined with Mental Health Benefit ⁴	52%	45%	58%
With Limits	90%	90%	86%
Without Limits	10%	10%	14%
Not Covered	3%	4%	2%
5. Substance Abuse Inpatient Hospital Services	(n=98)	(n=49)	(n=49)
Covered	98%	96%	100%
Separate or Part of Substance Abuse Benefit ³	50%	57%	43%
With Limits	66%	65%	67%
Without Limits	34%	35%	33%
Combined with Mental Health Benefit ⁴	50%	43%	57%
With Limits	98%	95%	100%
Without Limits	2%	5%	0%
Not Covered	2%	4%	0%

TABLE 8A (Cont.)

Behavioral Health Services	Extent of Coverage		
	Total	HMO	PPO
6. Substance Abuse Partial Hospital Services	(n=98)	(n=49)	(n=49)
Covered	63%	76%	51%
Separate or Part of Substance Abuse Benefit ³	52%	57%	44%
With Limits	77%	75%	82%
Without Limits	23%	25%	18%
Combined with Mental Health Benefit ⁴	48%	43%	56%
With Limits	96%	94%	92%
Without Limits	4%	6%	8%
Not Covered	37%	24%	49%

- Notes:**
- ¹ "Separate or part of mental health benefit" means that benefit amounts are either for the specific service (outpatient, inpatient, or partial hospitalization) or for all mental health services combined.
 - ² "Combined with substance abuse benefit" means that the benefit amounts for the specific service are combined as a behavioral health benefit for that service.
 - ³ "Separate or part of substance abuse benefit" means that benefit amounts are either for the specific service (outpatient, inpatient, or partial hospitalization) or for all substance abuse services combined.
 - ⁴ "Combined with mental health benefit" means that the benefit amounts for the specific service are combined as a behavioral health benefit for that service.

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

TABLE 8B
COST SHARING FOR BEHAVIORAL HEALTH SERVICES

Behavioral Health Services	Extent of Cost Sharing		
	Total	HMO	PPO
1. Mental Health Outpatient Services	(n=94)	(n=46)	(n=48)
Cost Sharing	96%	96%	96%
Separate or Part of Mental Health Benefit ¹	96%	96%	95%
Copayments	60%	85%	29%
Coinsurance	40%	15%	71%
Combined with Substance Abuse Benefit ²	96%	95%	96%
Copayments	40%	61%	24%
Coinsurance	60%	39%	76%
No Cost Sharing	4%	4%	4%
2. Mental Health Inpatient Hospital Services	(n=93)	(n=45)	(n=48)
Cost Sharing	70%	58%	81%
Separate or Part of Mental Health Benefit ¹	53%	41%	68%
Copayments	12%	27%	0%
Coinsurance	88%	73%	100%
Combined with Substance Abuse Benefit ²	89%	83%	92%
Copayments	26%	47%	13%
Coinsurance	79%	53%	96%
No Cost Sharing	30%	42%	19%
3. Mental Health Partial Hospital Services	(n=66)	(n=37)	(n=29)
Cost Sharing	68%	57%	83%
Separate or Part of Mental Health Benefit ¹	53%	39%	73%
Copayments	15%	33%	0%
Coinsurance	85%	67%	100%
Combined with Substance Abuse Benefit ²	89%	86%	93%
Copayments	28%	50%	8%
Coinsurance	72%	50%	92%
No Cost Sharing	32%	43%	17%
4. Substance Abuse Outpatient Services	(n=93)	(n=46)	(n=47)
Cost Sharing	88%	85%	91%
Separate or Part of Substance Abuse Benefit ³	80%	77%	85%
Copayments	49%	75%	18%
Coinsurance	51%	25%	82%
Combined with Mental Health Benefit ⁴	96%	95%	96%
Copayments	42%	63%	27%
Coinsurance	58%	37%	73%
No Cost Sharing	12%	15%	9%
5. Substance Abuse Inpatient Services	(n=93)	(n=46)	(n=47)
Cost Sharing	69%	57%	81%
Separate or Part of Substance Abuse Benefit ³	52%	41%	67%
Copayments	20%	45%	0%
Coinsurance	80%	55%	100%
Combined with Mental Health Benefit ⁴	89%	79%	96%
Copayments	25%	47%	12%
Coinsurance	80%	53%	96%
No Cost Sharing	31%	43%	19%

TABLE 8B (Cont.)

Behavioral Health Services	Extent of Cost Sharing		
	Total	HMO	PPO
6. Substance Abuse Partial Hospital Services	(n=58)	(n=34)	(n=24)
Cost Sharing	69%	59%	83%
Separate or Part of Substance Abuse Benefit ³	50%	38%	73%
Copayments	19%	38%	0%
Coinsurance	81%	62%	100%
Combined with Mental Health Benefit ⁴	92%	92%	92%
Copayments	29%	50%	8%
Coinsurance	71%	50%	92%
No Cost Sharing	31%	41%	17%

Totals do not always add up to 100% because some plans use both copayments and coinsurance.

- Notes:**
- ¹ "Separate or part of mental health benefit" means that benefit amounts are either for the specific service (outpatient, inpatient, or partial hospitalization) or for all mental health services combined.
 - ² "Combined with substance abuse benefit" means that the benefit amounts for the specific service are combined as a behavioral health benefit for that service.
 - ³ "Separate or part of substance abuse benefit" means that benefit amounts are either for the specific service (outpatient, inpatient, or partial hospitalization) or for all substance abuse services combined.
 - ⁴ "Combined with mental health benefit" means that the benefit amounts for the specific service are combined as a behavioral health benefit for that service.

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

C. SPECIALIZED SERVICES

1. PHYSICAL THERAPY SERVICES

Coverage. Physical therapy services were covered in almost all (98%) plans.

Benefit Limits. Among plans with physical therapy coverage, 84% imposed visit, duration, or monetary limits. In almost half of these plans, however, limits applied either to physical and occupational therapy combined or to all ancillary therapies combined. Visit limits, applied in more than half these plans and used mostly by those with a combined service limit, ranged from 20 to 90 visits per year and from 10 to 40 visits per lifetime, with 30 visits per year being the most common. In 1 plan, additional outpatient therapy visits were available through conversion of its inpatient rehabilitation benefit. Duration limits, applied in more than a third of plans with benefit limits and used only by plans with a separate physical therapy benefit limit,³⁶ typically provided coverage over a 2-month period per illness or injury per lifetime.³⁷ Monetary limits, imposed in about 15% of these plans, ranged from \$800 to \$2,000 per year, with no particular amount used most often.

Cost-Sharing Requirements. More than three-quarters of plans with a physical therapy benefit (79%) imposed cost-sharing requirements. Coinsurance charges, which were somewhat more likely to be used than copayments, were set at 10% or 20%, but 20% was more common. Copayments ranged from \$5 to \$25, with \$10 being the most common.

Access Restrictions. Almost all plans covering physical therapy services (88) imposed 1 or more access restrictions, always in the form of condition exclusions. Coverage was commonly excluded for impairments not caused by an illness or injury³⁸ (in 78 plans). It was excluded for conditions that would not improve significantly within a short period of time, typically 2-3 months, in 41 plans, and for developmental disorders in 18 plans.

Access Protections. Sixteen plans had unique provisions that could benefit children with special health care needs. Six plans offered extended coverage for physical therapy sessions with plan approval. Four plans offered an early intervention benefit that included other services, such as nursing care and assistive technologies in addition to ancillary therapy, up to a certain dollar maximum (\$3,200 per year in 2 plans and \$5,000 per year in 2 plans). Three plans covered rehabilitative services provided by a multidisciplinary rehabilitation team. Also, 3 plans allowed maintenance therapy if significant deterioration would occur without treatment, while 1 plan allowed ongoing physical therapy for cerebral palsy, multiple sclerosis, and severe progressive rheumatoid arthritis as long as treatment was not for maintenance purposes.

³⁶ In the case of duration limits, even when plans expressed their coverage as being applicable to 2 or 3 ancillary therapy services, we counted the plans as providing the period of coverage for each of the therapies separately.

³⁷ Most plans with duration limits (71%) allow 2 months of other therapies per illness or injury per lifetime.

³⁸ One of the 78 plans excluded treatment for impairments not caused by an illness, injury, or congenital condition.

HMO/PPO Differences. PPOs were much less likely than HMOs to impose visit limits, but much more likely to require cost sharing, typically in the form of coinsurance. HMOs relied primarily on copayments.

2. OCCUPATIONAL THERAPY SERVICES

Coverage. Occupational therapy was covered in 87% of plans.

Benefit Limits. Eighty-six percent of the 85 plans covering occupational therapy services imposed at least 1 visit, duration, or monetary limit. These limits applied with equal frequency to occupational therapy services alone and to a combination of either occupational and physical therapy services or all ancillary therapies. Among plans with visit limits (37) -- mostly those with a combined service limit -- amounts ranged from 20 to 90 visits per year and from 20 to 40 visits per lifetime, with 30 visits per year being most common. Among plans with duration limits (26) -- those applicable to occupational therapy only -- coverage was typically provided over a 2-month period per illness or injury per lifetime.³⁹ Plans with monetary limits (8) usually provided coverage amounts of \$1,000 or \$2,000 per year.

Cost-Sharing Requirements. More than three-quarters of plans covering occupational therapy (78%) imposed cost-sharing requirements. Plans requiring cost sharing were almost evenly split in their use of copayments and coinsurance. Although copayment amounts ranged from \$5 to \$25, they were most frequently set at \$10. Coinsurance charges were either set at 10% or 20%, with 20% being the more common charge.

Access Restrictions. One or more access restrictions were applied to occupational therapy benefits by almost all plans that provided coverage (73). These were in the form of condition exclusions that always included impairments not caused by illness or injury.⁴⁰ They also pertained to learning disabilities (29 plans), mental retardation (24), pervasive developmental disorders or autism (16), developmental disabilities (15), and developmental delay (12), and to conditions that could not improve significantly within a short period of time (37).

Access Protections. Fifteen plans established 1 or more special provisions that would benefit children with special health care needs. Six plans allowed additional occupational therapy visits with plan approval. Four covered ancillary therapy services along with other nursing and assistive services, under an early intervention benefit up to \$3,200 per year in 2 plans and \$5,000 per year in 2 plans. Three plans covered rehabilitative services provided by a multidisciplinary team, and 3 allowed maintenance therapy to avoid significant deterioration.

HMO/PPO Differences. HMOs were more likely than PPOs to offer occupational therapy services, but also more likely to impose benefit limits. However, a much smaller proportion of HMOs required cost sharing than did PPOs. Similar to physical therapy, HMOs generally relied on copayments and PPOs, on coinsurance.

³⁹ Most of these plans (75%) allow 2 months of occupational therapy and 2 months of other therapies.

⁴⁰ Three of the 73 plans excluded treatment for impairments not caused by an illness, injury, or congenital anomaly; and 1 plan excluded treatment for impairments not caused by an illness.

3. SPEECH THERAPY SERVICES

Coverage. Speech therapy was covered in 90% of plans.

Benefit Limits. Among the 88 plans covering speech therapy services, 83% imposed 1 or more visit, duration, or monetary restrictions on the benefit. In a third of these plans, limits were applicable to more than 1 type of ancillary therapy. Visit limits, used in 35 plans (mostly plans with a combined benefit limit), ranged from 20 to 90 visits per year, and in 1 plan, 20 visits per lifetime. The most common visit limit was 30 visits per year. One plan permitted its inpatient rehabilitation benefit to be converted into additional outpatient therapy visits. Duration limits, used in 23 plans (all with a separate benefit limit for speech therapy), usually allowed for coverage over a 2-month period per illness or injury per lifetime.⁴¹ Monetary limits, used in 9 plans, ranged from \$500 to \$2,000 per year, with no particular amount being most common.

Cost-Sharing Requirements. More than three-quarters of plans covering speech therapy services (77%) had cost-sharing requirements. Among the half that relied on copayments, amounts ranged from \$5 to \$25, with \$10 being most common. Among the half that used coinsurance, the rate was either set at 10% or 20%, with 10% being the more frequently required rate.

Access Restrictions. Almost all plans covering speech therapy services (85) imposed 1 or more access restrictions, always in the form of exclusions for particular conditions. These included 42 plans that excluded coverage for learning disorders, 25 that excluded coverage for developmental delay, 22 that excluded coverage for developmental disability, 15 that excluded coverage for communication disorders, 4 that excluded coverage for hearing impairments, and 2 that excluded coverage for congenital conditions. In addition, 75 plans would not cover speech therapy for impairments not resulting in an accident or illness,⁴² and 36 plans would cover only conditions that would significantly improve within a short period of time, usually 2 to 3 months.

Access Protections. Fourteen plans had access protections relevant to children with special health care needs. Five plans allowed additional speech therapy visits with plan approval. Four plans, in states with mandated benefits, offered ancillary therapies as part of an early intervention benefit (up to \$3,200 in 2 states and up to \$5,000 in 2 states). Three plans covered rehabilitative services with a multidisciplinary team and 3 allowed speech therapy for maintenance purposes to prevent significant deterioration.

HMO/PPO Differences. HMOs were more likely than PPOs to offer speech therapy, but with visit limits. In addition, HMOs were less likely than PPOs to impose cost sharing. Again, HMOs relied on copayments for the most part, while PPOs relied on coinsurance.

⁴¹ In 80% of these plans, 2 months of speech therapy services and 2 months of other therapies are allowed.

⁴² Seventeen of the 75 plans excluded conditions not caused by illness, injury, or congenital condition, and 5 plans excluded conditions not caused by injury.

4. AUDIOLOGY SERVICES

Coverage. Thirty-seven percent of plans covered routine hearing exams, 17% covered audiology tests, and 7% covered hearing aids.

Benefit Limits. One-fifth of the 36 plans covering routine hearing exams imposed visit limits, ranging from once a year to once every 3 years, and 3 of these plans provided coverage only for children up to a specific age (6, 12, and 13). No plan that covered audiology tests specified a limit. By contrast, 4 of the 7 plans covering hearing aids limited the frequency of hearing aid purchases and usually also set a monetary cap. Among the plans that limited the number of hearing aids purchased over a given time period, 3 years was most common, although in 1 plan it was 5 years. Among the plans with monetary limits, maximum amounts ranged from \$800 per 3-year period to \$5,000 per year.

Cost-Sharing Requirements. The vast majority of plans covering routine hearing exams (85%) required cost sharing, and nearly all of these plans used copayments. The amount ranged from \$5 to \$15, with \$10 being the most common. The 1 plan using coinsurance required a 20% contribution. All but 1 of the plans that covered audiology tests required cost sharing, most frequently in the form of copayments, which ranged from \$5 to \$20 and were most commonly set at \$10. Coinsurance, when used, was always set at 20%. Almost two-thirds of plans covering hearing aids required cost sharing, and all charged either a 10% or 20% coinsurance rate but most often 20%.

Access Restrictions. No plan imposed access restrictions on routine hearing exams, but illness and injury restrictions were applied to audiology tests in 3 plans and to hearing aids in 2 plans.

Access Protections. Two plans exempted deductible requirements for audiology tests.

HMO/PPO Differences. HMOs were more likely than PPOs to cover routine hearing examinations and audiology tests and less likely to impose benefit limits, while no differences were found in coverage of hearing aids. Also, HMOs were less likely than PPOs to impose cost-sharing requirements on any of the audiology services.

5. OPTOMETRY SERVICES

Coverage. Routine eye exams were covered in 51% of plans, eyeglasses were covered in 9% of plans, and vision therapy was covered in 7%.

Benefit Limits. Half of the 50 plans that covered routine eye exams imposed visit limits, ranging from once a year to once every 2 years. Six of the 9 plans covering eyeglasses set limits, always monetary limits, which ranged from \$17.50 to \$1,500. One plan restricted vision therapy services in combination with speech and occupational therapy services to 30 visits per year.

Cost-Sharing Requirements. Among the 50 plans covering routine eye exams, cost sharing was required by more than 80%, and always in the form of copayments. Copayment amounts, typically set at \$10, ranged from \$5 to \$15. Two of the 9 plans covering eyeglasses imposed cost sharing; 1 plan required a \$50 copayment and the

other required a 10% coinsurance. Four of the 7 plans covering vision therapy required cost sharing, which was always in the form of copayments, ranging from \$5 to \$12.

Access Restrictions. None of the plans covering routine eye exams or eyeglasses imposed access restrictions. However, more than half (4) of plans with vision therapy benefits provided coverage only in the case of an illness or injury.

Access Protections. Three plans offered special protections pertinent to children with special needs. One plan offered vision training for children age 10 and older to treat amblyopia (wandering eye). Another offered vision therapy to maintain functional status. A third waived its cost-sharing requirements for optometry services provided to children under age 3.

HMO/PPO Differences. HMOs were much more likely than PPOs to cover routine eye exams and somewhat more likely to cover eyeglasses. They were also more likely to impose benefit limits on these services. In addition, HMOs were much less likely to require cost sharing for optometry services. The only other difference was in the method of cost sharing for eyeglasses, with HMOs relying on copayments and PPOs, on coinsurance.

6. NUTRITIONAL COUNSELING SERVICES

Coverage. Nutritional counseling services were covered in 20% of plans.

Benefit Limits. Among these 20 plans, 4 imposed visit limits, which ranged from 1 per lifetime to 3 per year to 4 visits for anorexia or bulimia per year.

Cost-Sharing Requirements. The vast majority of plans with nutritional counseling benefits (85%) required cost sharing, always in the form of copayments. Copayment amounts ranged from \$5 to \$15, and were most often \$10.

Access Restrictions. Nine plans imposed 1 or more access restrictions on nutritional counseling services, typically in the form of condition exclusions. Eight plans did not cover nutritional counseling for obesity, and 4 plans covered it only if the treatment was for a pathological state or if it was related to the medical management of a documented disease.

Access Protections. None.

HMO/PPO Differences. HMOs were much more likely than PPOs to offer nutritional counseling and to provide it without limits. They were also less likely than PPOs to require cost sharing for these services.

7. HOME HEALTH SERVICES

Coverage. Home health services were covered in almost all plans (97%). Fifty-five percent included coverage for home health aides, and 17% included coverage for private duty nursing, but almost two-thirds of plans covered physical, occupational, and speech therapy under the benefit.

Benefit Limits. Among the 95 plans covering home health services, 44% imposed visit, day, or monetary limits. The most common type of limit was an annual visit limit, used in more than half of plans. Visit limits ranged from 21 to 200, with the most common limit set at 60 and 100. Day limits, used in about one-fifth of plans, ranged from 21 to 60 days, and were most frequently set at 60 days. Monetary limits, used in almost as many plans, ranged from \$1,000 to \$10,000 per year, with \$5,000 being the most often used cap. One plan had a \$50,000 lifetime monetary limit.

Cost-Sharing Requirements. More than a third of plans with home health benefits (37%) required cost sharing. Nearly all used coinsurance, which ranged from a low of 10% to a high of 50%, with 20% being the most common. Among the plans that used copayments, amounts ranged from \$5 to \$15, with no most frequently used amount.

Access Restrictions. Two-thirds of plans covering home health services (63) imposed 1 or more access restrictions. Condition exclusions, used by the vast majority, included impairments not caused by an illness or injury (46), developmental disabilities (11), and nervous or mental disorders (10). In addition, 27 plans covered home health only in lieu of hospitalization, 1 plan excluded long-term home health services, and another excluded home health for conditions that would require less than 100 visits per year. Ancillary therapy restrictions, found in a third of plans covering home health, were the same as those described under physical and occupational therapy.

Access Protections. Three plans included special protections that could benefit children with special health care needs. In 2 plans, home health benefit extensions could be granted with plan approval. In the third plan, cost sharing was eliminated when home health services were required in lieu of hospitalization.

HMO/PPO Differences. HMOs were far less likely than PPOs to impose benefit limits and cost-sharing requirements.

8. SKILLED NURSING FACILITIES

Coverage. Skilled nursing facilities were covered in 92% of plans.

Benefit Limits. Among the 90 plans covering skilled nursing facility services, 70% imposed limits, typically annual day limits, which ranged from 28 to 180. The most common limit was 100 days. Additionally 4 plans had lifetime limits, ranging from 90 to 790 days, and 5 plans imposed monetary limits, which ranged from \$100 per admission to \$20,000 per lifetime.

Cost-Sharing Requirements. Almost half of plans with a skilled nursing facility benefit (46%) imposed cost sharing. Coinsurance, which was almost always used, was set at either 10% or 20%, but was more often 20%. Copayments ranged from \$200 to \$250 per admission, and from \$100 to \$200 per day, but were most commonly set at \$250 per admission.

Access Restrictions. Access restrictions for skilled nursing facility services appeared in most plans, with each establishing its own medical necessity requirements.

Access Protections. None.

HMO/PPO Differences. HMOs were more likely than PPOs to cover skilled nursing facility services, but were also more likely to set benefit limits. In addition, HMOs were far less likely than PPOs to impose cost-sharing requirements. Unlike PPOs, which relied almost on coinsurance, HMOs used either coinsurance or copayments.

9. MEDICAL EQUIPMENT AND SUPPLIES

Coverage. Almost all plans covered durable medical equipment (97%), prosthetic devices (96%), and orthotic devices (90%). Only 35% covered non-diabetic medical supplies.

Benefit Limits. The amount of coverage for medical equipment and supplies varied by service, but were most often in the form of monetary limits. Limits were applied to durable medical equipment in 23% of the 94 plans with coverage, to orthotic devices in 18% of the 87 plans with coverage, to prosthetic devices in 15% of the 93 plans with coverage, and to non-diabetic medical supplies in 9% of the 34 plans with coverage. Among plans that set limits specific to each service, amounts ranged from a low of \$500 to a high of \$30,000 per year. Among plans that set limits applicable to a broad category of services, amounts ranged from \$1,000 to \$6,000 per year and from \$10,000 to \$50,000 per lifetime.

Cost-Sharing Requirements. Two-thirds of plans covering durable medical equipment, prosthetic and orthotic devices, and medical supplies required cost sharing, typically in the form of coinsurance, most often 20%. Three plans also required a separate deductible for durable medical equipment, either \$100 or \$200.

Access Restrictions. Most plans covering medical equipment and supplies (85) imposed at least 1 access restriction. The most common restriction, found in 76 plans, was the requirement that services were covered only for treatment associated with an illness or injury. In addition, 21 plans excluded both repairs and replacements of medical equipment, 6 excluded repairs only, and 5 excluded replacements only.

Access Protections. Three plans offered special access protections. Two plans, in a state with mandated early intervention services, provided durable medical equipment and assistive devices for children ages 0-3 “to attain or retain the capability to function age appropriately within his environment, including services that enhance functional ability without effecting a cure.” The third plan specified that durable medical equipment would be provided at no charge following hospitalization.

HMO/PPO Differences. PPOs were more likely than HMOs to cover medical supplies and prosthetic and orthotic devices. However, they were also more likely than HMOs to require cost sharing on all types of medical equipment and supplies.

TABLE 9A
BENEFIT COVERAGE OF SPECIALIZED SERVICES

Specialized Services	Extent of Coverage		
	Total	HMO	PPO
1. Physical Therapy Services	(n=98)	(n=49)	(n=49)
Covered	98%	100%	96%
With Limits	84%	96%	72%
Without Limits	16%	4%	28%
Not Covered	2%	0%	4%
2. Occupational Therapy Services	(n=98)	(n=49)	(n=49)
Covered	87%	96%	78%
With Limits	86%	96%	74%
Without Limits	14%	4%	26%
Not Covered	13%	4%	22%
3. Speech Therapy Services	(n=98)	(n=49)	(n=49)
Covered	90%	96%	84%
With Limits	83%	96%	68%
Without Limits	17%	4%	32%
Not Covered	10%	4%	16%
4. Audiology Services	(n=98)	(n=49)	(n=49)
Routine Hearing Exams			
Covered	37%	53%	20%
With Limits	19%	12%	40%
Without Limits	81%	88%	60%
Not Covered	63%	47%	80%
Audiology Tests			
Covered	17%	18%	16%
With Limits	19%	12%	25%
Without Limits	81%	88%	75%
Not Covered	83%	82%	84%
Hearing Aids			
Covered	7%	8%	6%
With Limits	71%	75%	100%
Without Limits	29%	25%	0%
Not Covered	93%	92%	94%
5. Optometry Services	(n=98)	(n=49)	(n=49)
Routine Vision Exams			
Covered	51%	69%	33%
With Limits	50%	53%	44%
Without Limits	50%	47%	56%
Not Covered	49%	31%	67%
Eyeglasses			
Covered	9%	16%	2%
With Limits	67%	75%	0%
Without Limits	33%	25%	100%
Not Covered	91%	84%	98%
Vision Therapy			
Covered	7%	8%	6%
With Limits	14%	0%	33%
Without Limits	86%	100%	67%
Not Covered	93%	92%	94%

TABLE 9A (Cont.)

Specialized Services	Extent of Coverage		
	Total	HMO	PPO
6. Nutritional Counseling Services	(n=98)	(n=49)	(n=49)
Covered	20%	37%	4%
With Limits	20%	11%	100%
Without Limits	80%	89%	0%
Not Covered	80%	63%	96%
7. Home Health Care Services	(n=98)	(n=49)	(n=49)
Covered	97%	100%	94%
With Limits	44%	29%	61%
Without Limits	56%	71%	39%
Not Covered	3%	0%	6%
8. Skilled Nursing Facilities	(n=98)	(n=49)	(n=49)
Covered	92%	98%	90%
With Limits	70%	75%	64%
Without Limits	30%	25%	36%
Not Covered	8%	2%	10%
9. Medical Equipment and Supplies	(n=97)	(n=48)	(n=49)
Medical Equipment			
Covered	97%	94%	100%
With Limits	23%	29%	18%
Without Limits	77%	71%	82%
Not Covered	3%	6%	0%
Medical Supplies			
Covered	35%	25%	45%
With Limits	9%	8%	9%
Without Limits	91%	92%	91%
Not Covered	65%	75%	55%
Prosthetic Appliances			
Covered	96%	92%	100%
With Limits	15%	25%	6%
Without Limits	85%	75%	94%
Not Covered	4%	8%	0%
Orthotic Devices			
Covered	90%	81%	98%
With Limits	16%	26%	8%
Without Limits	84%	74%	92%
Not Covered	10%	19%	2%

Source: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

TABLE 9B
COST SHARING FOR SPECIALIZED SERVICES

Basic Medical Services	Extent of Cost Sharing		
	Total	HMO	PPO
1. Physical Therapy Services	(n=91)	(n=45)	(n=46)
Cost Sharing	79%	69%	89%
Copayments	46%	87%	15%
Coinsurance	56%	13%	88%
No Cost Sharing	21%	31%	11%
2. Occupational Therapy Services	(n=81)	(n=44)	(n=37)
Cost Sharing	78%	68%	89%
Copayments	51%	87%	18%
Coinsurance	51%	13%	85%
No Cost Sharing	22%	32%	11%
3. Speech Therapy Services	(n=84)	(n=44)	(n=40)
Cost Sharing	77%	68%	88%
Copayments	51%	90%	17%
Coinsurance	51%	10%	86%
No Cost Sharing	23%	32%	12%
4. Audiology Services			
Routine Hearing Exams	(n=34)	(n=25)	(n=9)
Cost Sharing	85%	80%	100%
Copayments	97%	100%	89%
Coinsurance	3%	0%	11%
No Cost Sharing	15%	20%	0%
Audiology Tests	(n=17)	(n=9)	(n=8)
Cost Sharing	94%	89%	100%
Copayments	88%	100%	75%
Coinsurance	19%	0%	38%
No Cost Sharing	6%	11%	0%
Hearing Aids	(n=7)	(n=4)	(n=3)
Cost Sharing	86%	75%	100%
Copayments	0%	0%	0%
Coinsurance	100%	100%	100%
No Cost Sharing	14%	25%	0%
5. Optometry Services			
Routine Eye Exams	(n=50)	(n=34)	(n=16)
Cost Sharing	82%	79%	88%
Copayments	100%	100%	100%
Coinsurance	0%	0%	0%
No Cost Sharing	18%	21%	12%
Eyeglasses	(n=9)	(n=8)	(n=1)
Cost Sharing	22%	13%	100%
Copayments	50%	100%	0%
Coinsurance	50%	0%	100%
No Cost Sharing	78%	87%	0%
Vision Therapy	(n=7)	(n=4)	(n=3)
Cost Sharing	57%	25%	100%
Copayments	100%	100%	100%
Coinsurance	0%	0%	0%
No Cost Sharing	43%	75%	0%

TABLE 9B (Cont.)

Basic Medical Services	Extent of Cost Sharing		
	Total	HMO	PPO
6. Nutritional Counseling Services	(n=20)	(n=18)	(n=2)
Cost Sharing	85%	83%	100%
Copayments	100%	100%	100%
Coinsurance	0%	0%	0%
No Cost Sharing	15%	17%	0%
7. Home Health Services	(n=95)	(n=49)	(n=46)
Cost Sharing	37%	16%	59%
Copayments	9%	25%	4%
Coinsurance	91%	75%	96%
No Cost Sharing	63%	84%	41%
8. Skilled Nursing Facilities	(n=87)	(n=46)	(n=41)
Cost Sharing	46%	22%	73%
Copayments	15%	60%	0%
Coinsurance	88%	50%	100%
No Cost Sharing	54%	78%	27%
9. Medical Equipment and Supplies			
Medical Equipment	(n=94)	(n=44)	(n=49)
Cost Sharing	66%	46%	84%
Copayments	100%	100%	100%
Coinsurance	0%	0%	0%
No Cost Sharing	34%	54%	16%
Medical Supplies	(n=34)	(n=12)	(n=22)
Cost Sharing	65%	42%	77%
Copayments	9%	8%	9%
Coinsurance	91%	92%	91%
No Cost Sharing	35%	58%	23%
Prosthetic Appliances	(n=93)	(n=43)	(n=49)
Cost Sharing	66%	44%	86%
Copayments	2%	5%	0%
Coinsurance	98%	95%	100%
No Cost Sharing	34%	56%	14%
Orthotic Devices	(n=88)	(n=40)	(n=48)
Cost Sharing	64%	40%	83%
Copayments	2%	6%	0%
Coinsurance	98%	94%	100%
No Cost Sharing	36%	60%	17%

Note: Totals do not always add up to 100% because some plans use both copayments and coinsurance.

e: Information was obtained by the Maternal and Child Health Policy Research Center through an analysis of contract documents for each state's most commonly sold HMO and PPO product in effect at the end of 1998.

V. CONCLUSIONS AND RECOMMENDATIONS

This study on private health insurance benefits provides new information regarding the nature and extent of available coverage for services important to children with special health care needs. Our findings reveal that all of the most commonly sold HMO and PPO products in 1998 covered most basic medical services -- physician services and inpatient and outpatient hospital services -- and that nearly all covered preventive care and immunizations while a somewhat smaller proportion covered medications. Moreover, almost all covered most behavioral health services, including inpatient and outpatient mental health and substance abuse treatment, with about two-thirds providing coverage for partial hospitalization. More variability was found in coverage of specialized services, however. The vast majority of plans in our study covered home health care, skilled nursing facilities, medical equipment, and ancillary therapies, but half or fewer offered audiology and optometry services, nutritional counseling and medical supplies.

Despite the breadth of health care benefits offered by private insurers, particularly HMOs, coverage for behavioral health and specialized services was usually subject to visit or monetary limits and usually condition or treatment exclusions as well. Evidence of the impact of these restrictions was seen clearly in the hypothetical cases we analyzed. Children requiring ancillary therapy and behavioral health services, as well as those requiring home health care, were least likely to have their service needs met. Benefit amounts were typically less than what was recommended, and a variety of restrictive provisions, such as exclusions of treatment for developmental disabilities or behavioral conditions, often impeded these children's access to otherwise available coverage.

Moreover, requirements for cost sharing on most services were common, especially under PPO plans. Cost-sharing amounts often varied by service, particularly when copayments were used, but the highest charges consistently were imposed on behavioral health services. In addition, certain services were more likely to be subject to annual or lifetime dollar caps, including eyeglasses, hearing aids, all substance abuse services, medical equipment, and home health services.

This study was an attempt to understand the strengths and weaknesses of private health insurance coverage for children with special health care needs. It was not expected that all of the services needed by these children would be financed by employer-sponsored coverage, and our findings therefore are not surprising. Insurers operate under financial constraints and pressure to hold down premium costs, and if increases are not contained, they lead to larger numbers of uninsured. Moreover, in the absence of a satisfactory pediatric literature that would provide guidance about the effectiveness of extended ancillary or behavioral health therapies and the children who could benefit from them, insurers have limited scientific evidence for providing more generous coverage of these services. Also, for children who qualify as requiring special education, insurers may legitimately assume that certain therapeutic services ought to be financed through schools.

As previously discussed, there are several limitations to this study. Its findings only pertain to the most commonly sold HMO and PPO products and do not enable us to generalize about the insurance that all American workers and their families have. In addition, since the findings are based on an analysis of contract documents, we have no way of knowing whether plans might be more generous or flexible in their authorization of coverage for certain patients. Similarly, for our hypothetical case analyses, we cannot know whether plans might apply contract language more restrictively than we did.

Nevertheless, the study provides a basis for understanding which services private health insurance typically covers and how well. It also sheds light on those coverage areas that need to be strengthened for children with special needs. Employers are not likely in the near future, however, to expand their benefit offerings, especially given recent premium increases and economic uncertainties. Nor is it likely that states would enact additional benefit mandates. Reconfiguring publicly funded programs that serve children with special health care needs might achieve a more cost-effective result, but budgetary issues present obstacles here as well.

Congress or the Administration might consider establishing a national commission to examine the appropriate roles and responsibilities of employers, publicly funded health programs, schools, and families in financing basic medical, behavioral, and specialized services for children with special needs. A commission could be

charged with analyzing potential solutions and making recommendations for improving current arrangements.

Numerous ways to strengthen private health insurance could be explored. A commission might address, in addition to issues pertaining to the adequacy of benefit amounts, issues related to the appropriateness of access restrictions that appear to discriminate against children, particularly those with mental health and developmental conditions. We found that many private plans have, for example, exclusions of family therapy and treatment for individuals with behavioral disorders, attention deficit hyperactivity disorder, or developmental disabilities. We also found narrow medical necessity definitions that could further erode children's coverage because they typically fail to take into account their unique developmental needs and the importance of preventive therapeutic interventions. A commission might consider developing recommendations regarding reasonable access restrictions and protections for children. Many have already suggested the need for a pediatric medical necessity standard for use by private plans as well as independent pediatric expert peer review panels to guide purchasers in their coverage decisions when scientific evidence is inadequate for an individual child.

A commission might also address policy issues pertaining to the combined effects of coinsurance or copayments and deductibles on service utilization and the adequacy of reasonable catastrophic protections. Our study found that, with few exceptions, health insurance plans impose cost-sharing requirements on all covered services and that only 39% of plans had out-of-pocket maximum caps. Research has demonstrated that families, particularly those with little discretionary income, may forego needed services depending on the use and amount of copayments or coinsurance. Since many privately insured families with special-needs children purchase the most comprehensive coverage available to them and are paying higher premiums than ever before, they may lack the ability to afford rising copayments or coinsurance charges. A commission might consider tax incentives for employers to limit excessive out-of-pocket liabilities, which could result in fewer families dropping private coverage and either enrolling in Medicaid or S-CHIP or simply going without health insurance protection.

Despite the obvious value of the private health insurance system, the coverage it provides is inadequate for a significant proportion of children with special needs, presenting serious challenges for both families and health care providers attempting to finance their care. The various publicly funded programs providing medical, mental health, substance abuse, and developmental services could address these weaknesses. All of the programs, however, are currently underfunded and understaffed to achieve this purpose. They currently target carefully defined populations, usually those with the most severe conditions. As a result, many privately insured children with special needs are ineligible for publicly financed health care services because their conditions do not match the diagnostic or severity criteria established by categorical health programs or qualify as learning disabilities requiring a special education.

A number of public program strategies could be examined by a commission. One option it might want to consider is a specialized wraparound service plan for children. Under this option, private health insurers would continue to offer a comprehensive set of basic medical services and a limited set of behavioral and specialized services, but a state administered and funded wraparound plan would be established to finance developmental and extended services for eligible children with special needs, with cost-sharing requirements based on a family's ability to pay. Wraparound plan services could include some or all of these offered through all the existing publicly financed programs now serving special-needs children.

Assuring the adequacy of health insurance coverage to pay for the services required by all children with special needs is a goal shared by many in the maternal and child health community. Whether and how this goal can be achieved depends on the willingness of the public and private sectors to come together to explore with families reasonable insurance and programmatic solutions. At this time, employer-based coverage generally offers families a broad set of benefits that serve most children well. Still, some improvement appears necessary to address the coverage requirements of privately insured children with complex physical, developmental, emotional, or behavioral health problems.