

# A CROSS-INSURANCE COMPARISON OF NORTH CAROLINA CHILDREN WITH SPECIAL HEALTH CARE NEEDS

## EXECUTIVE SUMMARY

**Victoria A. Freeman, R.N., Dr.P.H., Rebecca T. Slifkin, Ph.D.,  
Robert Schwartz, M.A., and Anita M. Farel, Dr.P.H.**

Children with special health care needs (CSHCN) by definition have on-going health problems that frequently require health care services beyond periodic visits for health maintenance or acute health problems. For any new insurance program, the extent to which services used by CSHCN are covered benefits is an important consideration. The State Children's Health Insurance Program (SCHIP), a federal-state partnership, was authorized in 1997 to provide health insurance for the nation's poor children who reside in families with incomes that exceed Medicaid eligibility guidelines. In the fall of 1998, North Carolina implemented its SCHIP, North Carolina Health Choice for Children (NCHC or NC Health Choice) as a stand-alone, fee-for-service health insurance program. The study described here is one method the Women's and Children's Health Section of the North Carolina Division of Public Health is using to assess the ability of NC Health Choice to meet the needs of CSHCN.

In funding this study, the Division supported the inclusion of a sample of Medicaid children and a sample of children insured by the State Employees' Health Plan (SEHP). This allowed examination of the difference in experience among two groups of publicly insured children and children covered by an employment-based insurance program. A written survey was mailed to parents of children with special health care needs, as identified through ICD-9 codes on insurance claims. Fifteen hundred children were sampled from each of the three insurance plans. Within each insurance group, the sample was stratified on five diagnosis categories: asthma, other chronic diseases, developmental delay, attention deficit disorder or attention deficit hyperactivity disorder (ADD/ADHD), and mental health. The survey response rate for all insurance groups combined was 61.6%.

Through analysis of survey responses, this study examines the health care and ancillary services that North Carolina parents report that their children require, across the three insurance plans and different diagnosis categories. It also examines the extent to which reported health care needs are being met, and the barriers that limit access to needed services.

## **Access to Medicare**

Differences across insurance plans are consistent throughout the survey results and support a gradient of need and access to care that ranges from more need and less access for Medicaid children to less need and more access for SEHP children, with NCHC children falling in the middle. Although reported access to medical care, both general and specialty care, was relatively good for children in all three insurance programs, and unmet need for both general medical care and specialty care was relatively low overall, 10% of Medicaid parents reported unmet need for both types of care, double that of children in the other two insurance groups. Similarly, children on Medicaid were significantly more likely to have problems accessing ADD/ADHD or mental health/substance abuse services, with rates of unmet need twice as high as those for NCHC children for both types of services and three times that of SEHP children for ADD/ADHD services.

The encouraging news is that there do not appear to be major areas of unmet need for medical care. However, even though the percent of parents of children on Medicaid or NCHC who reported unmet need was relatively small, if these percentages are applied to large numbers of enrollees in the programs the absolute number of children with unmet need is large.

While most children have access to providers for care, children on Medicaid in particular – and to a lesser extent, those on NCHC – were reported to be less likely to receive medical care in the private sector. This finding is problematic to the extent that some public providers do not offer comprehensive services. Consistent with differences in site of medical care, Medicaid children were most likely to receive special services at school or day care for their health or developmental condition, followed by NCHC children and children on SEHP. Also, children on Medicaid were more likely to receive ADD/ADHD and mental health services in the public sector than were children in either of the other insurance groups. The greater use of public providers by Medicaid children compared to NCHC children suggests that, should NCHC reimbursement levels decrease to Medicaid levels, there would be a movement of NCHC children away from the private sector, and the need to maintain a strong public safety net would increase.

## **Use of the Emergency Room**

Children in the Medicaid group used the emergency room (ER) more frequently than children in the other two insurance groups, with use being the lowest among children enrolled in SEHP. Parents of 34% of Medicaid children reported that they had taken their child to the ER at least once in the previous six months, compared to 25% of NCHC children and 15% of those covered by SEHP. Only two-thirds of ER visits were made because the parent believed their child's condition to be an emergency or they had been advised by a health care professional to seek care in the ER. One-third of parents sought ER care for other, presumably non-emergent problems. The

percentage of parents who reported using the ER for non-emergent problems did not differ across insurance plans. Parental reports of the reasons for use of the ER indicate the need for more extensive primary care coverage, parental education, and family-friendly office policies.

## **Dental Care**

Parents of children covered by SEHP reported better access to dental care than did parents of children on Medicaid and NCHC despite the fact that the SEHP does not cover dental care and many children in SEHP probably do not have dental insurance. Medicaid children faced the greatest barriers, with 23% of parents reporting that their child had unmet needs, compared to 18% of NCHC children and 7% of SEHP children. The findings of poor access to dental care, especially for Medicaid enrollees, are consistent with other studies of access to dental care for low-income children in North Carolina. Although the increased access seen for NCHC children compared to Medicaid children suggests that raising provider reimbursement might improve access for children on Medicaid, the access levels of NCHC children are still not adequate.

Also, anecdotal reports suggest that there are a limited number of “slots” for dental care for low-income children, either because dentists will not see any publicly insured children or limit the number of these patients they will accept. It is not clear how much dentists limit the number of publicly insured patients they will see because of reimbursement rates or for other reasons. To the extent that these limits are based on multiple factors, an increase in reimbursement rates alone will not ensure access. Other methods need to be found that will encourage dentists to serve low-income children and support families to enable them to keep appointments.

## **Barriers to Health**

There were few reported barriers to receipt of prescription medication for any group of children. There were, however, significant differences in parents’ ability to get needed medical equipment and supplies, with parents of children in NCHC reporting the most difficulty. While the majority of CSHCN do not appear to need medical equipment and supplies, for those who do, the inability of many NCHC children to obtain these items is worrisome. The program has already addressed some of the barriers reported by parents. With the increase from \$250 to \$1,000 in the allowable cost for purchasing equipment without prior approval, some equipment such as nebulizers reported by respondents as not available would now be. There were also reports of barriers imposed by some vendors who required that parents pay out-of-pocket for some supplies. This access problem could be addressed by changing the relationship between vendors and the insurance plan, possibly requiring that vendors not charge the parent and ensuring that reimbursement to vendors is timely. Finally, some parents commented on the limited number of supplies such as test strips that they could get for their child each month. These comments are puzzling since there are no such limits under either Medicaid or NCHC. It is possible that the monthly limit comes from the number of

supplies indicated on the prescription written by the physician. If true, this is not a problem that can be addressed by changes to the insurance, but rather requires parental education regarding the necessity of contacting their physician for a new, larger prescription.

For all of the specialized therapies queried (respiratory, speech and physical/occupational therapy), parents of Medicaid children were significantly more likely to report that their child needed these services. Although the need was greatest among Medicaid children, SEHP children had more difficulty accessing therapy services, particularly speech therapy. Very few parents reported the need for either home health or respite care, but among parents with such need, unmet need was high.

In general, it appears that poverty creates access problems independent of insurance coverage as evidenced by reports of transportation barriers and barriers due to inconvenient office hours which reflect in part the often difficult and inflexible work schedules of the poor. Although Medicaid children are technically eligible for transportation services, it appears that not all families' needs are being met, possibly due to the differing methods of covering transportation needs in each county and the level of responsiveness to acute transportation needs.

## Conclusion

In summary, the North Carolina Health Choice program appears to provide better access to services for children with special health care needs than does the Medicaid program, and NCHC parents often report access that is comparable to that of SEHP. However, it is not possible to separate out the relative effects on access to care that come from the general willingness of providers to serve low-income children, the influence of provider reimbursement rates that affect provider willingness, and the effects of poverty on the daily life of families. Confounding the interpretation of these results is the socioeconomic gradient across the three insurance groups and the extent to which socioeconomic advantage contributes to good health in multiple facets of daily life. In addition, economically stressed parents may report less unmet need because of lowered expectations of the health care system and health insurance system, a factor that we were unable to measure in this study. Regardless, parents report that health insurance is an essential component in their efforts to keep their children healthy.

A report by the Cecil G. Sheps Center for Health Services Research  
at the University of North Carolina at Chapel Hill  
under contract with the North Carolina Department of Health and Human Services,  
Division of Public Health, Women's and Children's Health Section.

*For more information about the study, or to order a copy of the full report,  
contact Victoria Freeman or Rebecca Slifkin at (919) 966-5011.*