

PRIVATE SECTOR SERVICES

OVERVIEW OF MAJOR SYSTEMS AND THEIR COMPONENTS IN THE PRIVATE SECTOR



PRIVATE COVERAGE

The majority of CYSHCN in California have private insurance only (63.6%), and another 7.1% have both private and public insurance (CAHMI, NS-CSHCN, 2005-06). Thus, private insurance is the predominant payer for health services for children with special health care needs in the state.

Privately funded health insurance comprises two main categories: employer sponsored insurance and individual insurance. The majority of children and youth with special health care needs in California are served by employer-sponsored insurance, usually through their parent's employer. Employer-sponsored insurance is offered to employees and their dependents; however, employees usually have to bear a greater financial burden in order to add dependents to their policies. With employer-sponsored insurance, all employees and dependents are included in a risk pool so no one is held financially responsible for their individual health care costs.

Individual insurance is purchased directly from an insurance plan (or through an insurance broker) and the individual must undergo underwriting where health conditions are enumerated and premium amounts determined accordingly. Thus, for children with special health care needs, the premiums would be considerably higher and likely unaffordable for most families in an individual plan.

The specific plan offered by employers or purchased by individuals can take on many forms. Most individuals are enrolled in some form of managed care; very few have indemnity insurance where providers are reimbursed at "usual and customary" rates for services provided. The majority of children with special health care needs are enrolled in a health plan with a managed care arrangement. A common characteristic of managed care includes utilization review where the health plans monitor services provided and authorized by health providers. Some also provide case management or disease management, although aside from asthma, disease management programs usually focus on adult-onset diseases such as Type II diabetes.

The three major types of managed care are health maintenance organizations (HMO), preferred provider organization (PPO) plans, and point-of-service

Dr. Thomas had to drop his Blue Cross contract because the reimbursement rates were too low to keep his pediatric specialty care practice solvent. At the same hospital, two other pediatric specialists followed his example for the same reason. Now the patients have to choose to: (1) pay cash and keep those services, (2) take their children to specialists unfamiliar with children's diseases, or (3) not get those services at all.

The Smith family is raising three daughters with mitochondrial disease. Each child is followed by six pediatric subspecialists, plus a pediatrician. On April 15, 2009, the family reported spending \$25,642 on out-of-pocket medical expenses during that year (after taxes, making actual cost substantially higher). Despite the fact that there is a \$1,000 deductible and \$8,000 “stop loss” on their plan, there were clauses in the policy that allowed the company to avoid payment. Since the girls have a chronic life threatening illness, and both parents are self-employed, they have no opportunity to change insurance carriers.

(POS) plans. These three general categories represent a diversity of plans, and within each type there is large variability with regard to referral requirements, reimbursement, co-payments, and a variety of other factors.

In a health maintenance organization, the health plan only pays for services provided within a contracted network of providers. Most HMOs require that members select a primary care provider who, in some cases, acts as a gatekeeper to more specialized medical services.

In a preferred provider organization, individuals seek care within a network of preferred providers who accept reimbursement at a discounted rate; however, the individual may seek care outside of the network and pay more. Unlike a HMO, PPOs do not require a referral to access specialist care.

A point-of-service plan is a hybrid in which patients may decide whether to receive care inside or outside the network at the point of service, but they will pay much larger fees for services outside the network and for services for which they do not have a referral.

Private insurance presents a fluid and changing set of benefits as, unlike public insurance programs, there is no defined set of benefits, other than those mandated by the legislature (e.g., maternity stays of at least 48 hours, contraceptives, and cancer screenings). In addition, one insurer may offer various plans from which employers may choose to offer their employees, with differing benefits in each.

Often, parents struggle to effectively navigate the system because of multiple layers of administration, resulting in uncertainty for families in understanding whom to talk to about services—the doctor’s office, the medical group, the independent practice association (an organization of physicians that negotiates on their behalf with managed care plans), or the health plan itself. Conflicting and confusing information, as well as varied coverage levels, can leave children with special health care needs without adequate coverage. Parents of children with special health care needs often report inadequate insurance coverage even when they are insured. Among CYSHCN with private insurance, 31.8% of parents reported that the insurance was inadequate, compared to 45% of children with public insurance and 23.3% of children with both public and private insurance (CAHMI, NS-CSHCN, 2005-06).

Similarly, in California, parents of children with private insurance pay more out of pocket for health services than those with public insurance, at least partly because public insurance programs have a more generous benefit package and lower cost-sharing requirements than private insurance plans. Nearly one quarter (23%) of parents of children with private insurance pay more than \$1,000 out of pocket. There is indication that a lower percentage of those with public insurance paid more than \$1,000 out of pocket; however these estimates do not meet standards for reliability or precision (4.5% of children with public insurance, 18.7% of children with both private and public insurance, and 21.3% of children who are uninsured) (CAHMI, NS-CSHCN, 2005-06).

FOUNDATIONS/SUPPORT ORGANIZATIONS

Some foundations and support organizations may help to pay for certain services that children with special health care needs and their families need. For example, some may pay for specialized equipment, such as van or home modifications that insurance does not cover, specialized summer camps with medical supports in place, or nonemergency medical transportation for appointments.

Two larger such organizations help families access services for their children when they are either uninsured or underinsured. First, the Kaiser Cares for Kids Health Plan is an insurance plan for children under age 19 who are uninsured and ineligible for Medi-Cal or CHIP. Cost for the program varies by county and children must live in families with incomes between 250% and 300% of the federal poverty level. There are caps on enrollment; for example, enrollment is currently closed in Los Angeles County (Children's Health Access and Medical Program).

Second, the United Health Care Foundation helps children who are either uninsured or underinsured by providing funding for needed medical services (United Healthcare) that are not covered by commercial insurance plans.

These services fill some of the gaps in services not provided by insurers or that uninsured children do not have access to. However they are not comprehensive and in no way cover all care required by children generally and children with special health care needs specifically.