



December 19, 2014

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Medicaid and CHIP Payment and Access Commission
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Chairperson Rowland:

Thank you for the opportunity to provide input on the crucial topic of ensuring affordability and adequacy of health coverage for our nation's children. The U.S. has achieved its highest levels of coverage for children—nearly 93 percent—thanks to unwavering commitment at the national and state levels in recent decades through Medicaid and the Children's Health Insurance Program (CHIP).¹ As you know, the coming months and years will be a critical period for the future of children's coverage.

Any examination of the future of children's coverage must consider and work to improve all coverage sources that serve children, including recognition of the foundational role of Medicaid and CHIP. We appreciate your interest in examining the current and potential role of exchange (or marketplace) coverage in meeting children's health care needs at an affordable cost. A detailed examination of exchanges as well as other private and public coverage sources is imperative to understand how children are faring in the new coverage landscape, identify gaps in services or unaffordable costs, and make necessary improvements.

Yet in order to achieve the Commission's stated goal, to ensure "adequate and affordable coverage for low-income children and smooth transitions across sources of coverage," which we wholeheartedly share, the Children's Health Insurance Program (CHIP) must remain available for a number of years (beyond the minimum two-year extension recommended in the Commission's June 2014 report) in order to gain sufficient experience with marketplace coverage, allow improvements in such coverage, and provide sufficient time to fully assess the future role of CHIP. For example, as noted below, there is substantial evidence that as it currently stands, new marketplace coverage would cost low-income families more and provide their children less comprehensive benefits than CHIP. Until we can ensure that marketplace coverage is comparable to CHIP coverage, we respectfully submit that any assumption of discontinuing CHIP remains highly premature. Rather, additional time is needed to ensure:

- Existing benefit gaps in marketplace plans are addressed before they can be considered comparable to CHIP; Medicaid and CHIP's child focused benefit standards are considerably stronger.
- Any necessary legislation or regulations sufficiently address the current probability that many children and their families could face higher costs for less robust coverage in marketplace plans, as well as the "family glitch," which could swell the ranks of the uninsured by an estimated 2 million children;² and

- State officials and, in turn, marketplace plans have ample time and resources to respond to policy changes that will require a fundamental shift to child-focused and child-designed coverage that is lacking in marketplace plans today.

Our responses to your topic requests below reflect our strong belief that CHIP and Medicaid must be part of the conversation, setting a standard for affordability and adequacy of qualified health plans and other private coverage moving forward.

In addition to these four areas, we also highlight that children with special health care needs, children in mixed immigration status families, and families where parents have limited English proficiency are particularly vulnerable to receiving substandard care or even becoming uninsured if federal CHIP funding were to end.

1. Affordability of coverage and out-of-pocket costs, including premiums and cost sharing (e.g., copayments, coinsurance, and deductibles) in exchanges

Improving children’s health is a key goal of coverage, and ensuring family economic security is another crucial outcome that also affects children’s access to care. CHIP and exchange coverage approach affordability with different goals and standards. In creating CHIP, federal and state policymakers recognized that the program would serve uninsured children in families with limited incomes and sought to limit families’ overall health care costs. In contrast, financial assistance available for families shopping for marketplace coverage—premium tax credits and cost sharing reductions—was not only designed to improve coverage affordability, but also to facilitate flexibility and competition among private plans in exchanges. As a result, financial support provided for exchange coverage is intended to serve entire families and often requires much higher contributions from families than is allowed in CHIP (up to \$13,200 out-of-pocket maximum for a family in 2015, compared to a five percent cap on combined premiums and cost-sharing in CHIP). In addition, federal subsidies in exchanges are offered in a way that is fundamentally biased against affordability for some families—those who have higher-cost offers of coverage from employers are locked out of financial assistance in the exchanges entirely. The Affordable Care Act’s (ACA)’s affordability test pegs the threshold for affordability only to individual coverage rather than the full cost of family coverage, creating what is known as the ‘family glitch.’ As a result, the affordability of exchange coverage is not comparable to CHIP’s affordability. The following recommendations will help to ensure any policy changes to improve affordability of exchange coverage for children take into account important details and widely varying circumstances of children and their families.

- **Consider the affordability of exchange coverage versus CHIP for both healthy children as well as children with special health care needs.** Recent studies have shown that for both groups, the costs for exchange coverage are substantially higher, even when federal subsidies are available. Wakely Consulting Group used actuarial analysis to compute the average annual cost-sharing for a standard population, one that includes children with both high and low health needs. Looking only at states with cost-sharing (some CHIP programs do not require it), Wakely found the average annual cost-sharing for a child in CHIP to be \$66 for a family at 160 percent of the Federal Poverty Level (FPL) and \$97 for a family at 210 percent of FPL. This compares to \$446 and \$926 for exchange plans at the same income levels—six to nine times greater than CHIP.³

Wakely’s analysis considers cost-sharing, but not premiums, in part because premiums are not directly comparable between CHIP and subsidized exchange plans. CHIP premiums apply only to

enrolled children, while exchange plan premiums, after subsidies, purchase coverage for the whole family and may vary depending on the family's choice of plan. Nonetheless, premiums are limited in CHIP. At 151 percent of the FPL, only 13 states charge premiums or enrollment fees in CHIP, with a median amount of \$15 per child, or less than one percent of income for a family of two at this level. At 201 percent of FPL, 26 states charge premiums, with a median of \$20 per child, also less than one percent of income. For exchange coverage, the expected contribution to the premium for an entire family at 151 percent of FPL is approximately four percent of income and at 201 percent of FPL is roughly 6.34 percent of income.

Wakely's calculation of an average for cost-sharing provides a useful overall measure, but masks the greater differences in affordability for families whose children need more frequent health care services. The costs for any individual family can vary greatly depending on children's specific health needs and many other factors. Examining the plans available in one location using a standard set of health needs can provide a helpful illustrative example.

Working with Arizona's Children's Action Alliance, the Georgetown University Center for Children and Families estimated the costs under a variety of scenarios for three of the lower cost Silver exchange plans and CHIP in one county in Arizona. For a child with special health care needs (calculations were based on a child who was born prematurely and has cerebral palsy, requiring a broad range of acute and habilitative services), the differences in costs are dramatic. In Arizona's now-closed CHIP program, the costs for such a child were limited to premiums--\$120 per year for a family at 140 percent of FPL and \$600 per year for a family at 190 percent of FPL. In an exchange plan, families are required to pay deductibles, co-pays, and the full cost of benefits that are not covered by the exchange plan or go beyond the plan's limits. At the lower income level, costs in the exchange plans would be 35 to 38 times higher than CHIP, between \$4,256 and \$4,572. At the higher income level, costs would be 8 to 9 times higher than CHIP, from \$4,986 to \$5,331.⁴ All of these totals take into account the cost-sharing reductions that are available in exchange plans for eligible families who earn below 250 percent of FPL.

- **Fix the family glitch.** The studies mentioned above compare subsidized exchange plans, but not all families who benefit from CHIP would qualify for federal subsidies, due to the family glitch. Millions more children would be impacted in the absence of CHIP. The ACA's affordability test permits federal subsidies only for families who do not have an affordable offer of employer coverage. Under the family glitch, the affordability of an employer's offer is evaluated only with consideration of the cost of self-only coverage, not the cost of family coverage that would extend to all of the members of a family. Family coverage is much more expensive than self-only coverage (workers contribute an average of \$4,565 for family coverage, on average, versus \$999 for self-only⁵), so many households are deemed to have "affordable" employer offers even if the cost of family coverage is out of reach.

The family glitch affects both children and other family members, like spouses. The estimate of how many are currently prevented from accessing subsidies varies widely, from 2 to 4 million.⁶ The number is sure to grow should CHIP funding expire. As MACPAC itself has estimated, 56 percent of children in separate CHIP programs could be subject to the family glitch if their CHIP coverage were no longer available, with other analyses estimating as many as 2 million children subject to this glitch.⁷ Families without access to CHIP or federal subsidies for exchange plans are unlikely to find an affordable source of coverage; many of the children in such families can be expected to become uninsured.

- **Improve affordability of dental benefits.** The lack of aggregated federal subsidies for medical and dental benefits also makes exchange coverage less affordable for families than CHIP. All CHIP programs cover dental benefits and cost-sharing for them is included under CHIP’s overall five percent cap on family costs. Exchange plans sometimes include pediatric dental benefits, but they are not required to do so when stand-alone dental plans are available in a marketplace. When families purchase dental benefits separately, no federal cost-sharing reductions are available and premium tax credits are only available if the family chooses a particularly low-cost health plan that leaves some of their tax credit “left-over” to apply to the dental plan. Thus, most families with exchange coverage face separate premiums and cost sharing for their children’s dental benefits, including a separate and additional out-of-pocket maximum, with no affordability assistance. These affordability challenges likely contribute to the very low rates of take-up for pediatric dental coverage in exchanges and make ineffective the ACA’s requirement that the EHBs include pediatric dental services.⁸

2. Adequacy of covered benefits in exchanges

Exchange plans are intended to serve both adults and children, but the design of their benefits to date has fallen short of providing the comprehensive coverage that many children need. Unlike CHIP and Medicaid’s pediatric benefit, exchange plans simply were not created to specifically address children’s needs. Because of their continuous growth and development, children’s need for comprehensive benefits is particularly acute. Children need a set of health care benefits that are distinct from those provided to adults to ensure their healthy development. Failure to ensure an adequate scope and design of benefits for children can result in life-long health consequences that generate extensive and avoidable costs. Exchange plans should assure affordable access to care for the vast majority of relatively healthy children and, at the same time, provide the benefits needed by children with serious and/or chronic health needs.

The minimum set of benefits for exchange plans is defined by each states’ package of essential health benefits (EHBs). Congress included “pediatric services, including oral and vision care” as a separate and distinct category within the EHBs to ensure that children receive an additional set of benefits beyond those provided under the other nine EHB categories. The ACA’s legislative history makes it clear that oral and vision care were added to supplement other pediatric services provided under the category, not to limit pediatric services to oral and vision care.

However, numerous studies have shown that the process for defining EHBs has failed to assure that all pediatric services are covered for children enrolled in exchange plans.⁹ Under the approach that the Department of Health and Human Services (HHS) developed to define the EHBs, employer-based small group plans from 2012 serve as the benchmark for EHBs in all but a few states. These plans were not developed with adequate consideration of children’s needs. In contrast, Medicaid’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit standard and the benefits in state CHIP plans were specifically developed to serve children, particularly those in low and moderate-income families.

As they develop, children require many of the services in the first nine EHB categories and they also need additional pediatric services. These include developmental assessments and screenings as well as preventive and supportive services to ensure they have the tools to maintain and/or improve their health into adulthood. Additionally, a segment of children suffer from chronic conditions that affect their development and require other services in order to generate, maintain, and restore age-appropriate functioning. These services include, for example, audiology screenings and hardware, durable medical equipment, special therapies (physical, speech and occupational), education, counseling, and services such as anticipatory guidance, nutritional counseling, and treatment of pediatric obesity. Furthermore,

children often need services with greater frequency and intensity than adults, so certain benefit limits (for instance, limits on numbers of visits, etc.) established for adults may be inappropriate for children.

For children with chronic conditions, the small group EHB benchmark plans are particularly inadequate. For example, many plans only cover intermittent, short-term home health care. In some instances, plans only cover a few hours each day with a limit on the total number of visits each year even though many children with special needs may require ongoing and long-term home health care. In addition, the benchmark plans often only cover equipment that serves a therapeutic purpose in the treatment of an illness or injury. As a result, children with chronic conditions who, for example, require a customized wheelchair as they grow could be denied coverage for that equipment. Many children and families who face serious and long-term medical challenges also need case management and coordination services. However, those services are typically not covered by private insurance.

Unlike the EHB benchmark plans, the benefits in state CHIP plans were developed specifically to provide pediatric services to children. States frequently choose a robust package of benefits for the low- and moderate-income children covered by CHIP: 38 states use Medicaid or Medicaid-based benefits for some or all of their CHIP enrollees, according to a recent study.¹⁰ Medicaid's EPSDT benefit standard is intended to assure that children receive all the services they need to maintain and improve health as they grow and develop. The following steps must be taken to ensure exchange coverage is fully comparable to what CHIP provides today.

- **Address pediatric benefit gaps and limits in exchange plans.** Recent studies of current EHBs reveal many gaps in pediatric services, especially when compared to the benefits offered by state CHIP plans. The Wakely Consulting Group analysis found that EHB benchmark plans cover fewer of the benefits particularly relevant to children's health and well-being than do CHIP plans.¹¹ Wakely considered child-specific benefits to include dental benefits, vision benefits, audiology benefits, autism services, and habilitation benefits. If and when such benefits are covered by a state's EHB benchmark, there tend to be more limits imposed than in CHIP. CHIP also frequently provides children with the enabling services they need to have meaningful access to medically necessary treatments. Some CHIP plans cover services like translation and non-emergency transportation, while Wakely found no benchmark plans that cover these services.

The Wakely comparison found that 82 percent of CHIP plans cover child-specific benefits, sometimes with limits. Only 52 percent of EHB benchmark plans offer the same level of coverage. For instance, 95 percent of CHIP plans cover medically necessary audiology exams with no limits, but only 37 percent of EHB benchmark plans do so. In addition, CHIP covers hearing aids with or without some sort of limit in 95 percent of the states included in the Wakely analysis, while EHB benchmark plans offer that coverage in only 55 percent of those states.

Wakely's review of child-specific services also provides a closer look at pediatric benefits in specific states:

- In Iowa, CHIP covers hearing aids (1 per ear every 36 months) but there is no coverage for hearing aids in the state's EHB benchmark plan. We know that as children grow, they will frequently outgrow their hearing aids and need new ones. However, the cost to families for these medically necessary devices when insurance coverage is inadequate can be in the thousands of dollars.
- In Colorado, a child who is covered by CHIP has unlimited coverage for medically necessary speech, occupational, and physical therapy from birth to the age of three. These are the critical years for learning to speak, walk, and develop fine motor skills. However, the EHB

benchmark plan in Colorado limits these services to 20 visits per year per type of therapy. A child who needs speech therapy three times a week would exhaust this benefit in less than two months.

- In Florida, Applied Behavior Analysis services for treatment of autism are covered under CHIP but are not covered under the EHB benchmark plan.
- In Indiana, CHIP covers 50 visits per year per type of therapy for outpatient speech, occupational and physical therapy to ensure that children’s developmental needs are met. However, the state’s EHB benchmark plan offers only 20 visits per type of therapy.

The coverage limits found to be more prevalent in exchange plans than in CHIP are particularly challenging for children with special health care needs. Wakely shows that benchmark plans in 80 percent of states employ utilization limits for physical, occupational, and speech therapies, while only 42 percent of state CHIP plans do so. Children with serious conditions, such as spina bifida, cerebral palsy or neuro-development disabilities, require multiple therapies over the course of a year and throughout their lifetime. Arbitrary limits on the number of visits to those therapies threaten access to the necessary services that will assist these children in achieving and maintaining their highest level of functioning.

Other recent studies confirm these overall results. The National Alliance to Advance Adolescent Health compared CHIP benefits and those offered in the second-lowest cost qualified health plan in five states.¹² It found:

CHIP plans are far more likely to offer dental services, hearing aids and cochlear implants, residential treatment for mental health and substance abuse conditions, family therapy, and private duty nursing. In addition, CHIP plans in three of the five states provide more generous coverage for ancillary therapies and home- and community-based care than qualified health plans do. . . . These benefit differences would have their most significant impact on children and adolescents with special health care needs.

Another study published in *Health Affairs* concludes that the EHB approach has resulted in a “state-by-state patchwork of coverage for children and adolescents that has significant exclusions, particularly for children with developmental disabilities and other special health care needs.”¹³

- **Improve coverage of habilitation services.** Children with special health care needs also frequently require habilitation services. However, the flexibility afforded to states and issuers under the February 25, 2013, final EHB rule¹⁴ includes inadequate protections for children who need access to a range of services to enable them to acquire, improve, or retain a skill or level of functioning. A preliminary analysis¹⁵ of qualified health plan (QHP) rehabilitation and habilitation coverage and limitations in the 2014 plan year shows that habilitation services are not easily accessible or sufficient in many states. For example:
 - Rehabilitation, habilitation, physical therapy, and occupational therapy visit limits are often combined, which can reduce the number of needed therapy visits available to a child.
 - Applied behavior analysis services for autism-spectrum disorders are sometimes included in the habilitation benefit, potentially to the exclusion of other habilitation services.
 - Fewer than 10 percent of plans clearly identify all of the following: covered therapies, visit limits, and the applicability of the deductible.
 - More than half of plans do not specify which therapies are covered under the rehabilitation and habilitation benefits.

- **Ensure that ACA protections, such as benefits limits based on age, are upheld.** Other benefit limits further demonstrate exchange plans' lack of consideration for children's needs. The ACA makes several references intended to protect children's access to needed services, including prohibitions on discrimination based on age.¹⁶ Nonetheless, review of the EHB benchmark summaries available on the Center for Consumer Information and Oversight (CCIO) website reveals that these protections have been violated in several instances. For example:
 - Utah's benchmark plan provides eye exams and eyeglasses starting at age 5, not for younger children.
 - Maine's benchmark plan offers autism assessments only up to age 5, not for older children.
 - Massachusetts' benchmark plan excludes coverage for chiropractic services for individuals under age 16.
- **Improve pediatric dental benefits, such as access to restorative services, in exchange plans.** Children's access to dental coverage is another important way that exchange plans have fallen short, especially compared to CHIP. Many of the challenges with access to dental coverage involve affordability and the plan selection process, but in some cases benefits are also inadequate. Most states selected CHIP or the federal employees FEDVIP plan as the benchmark for their pediatric dental benefits. However, one state did not—Utah's EHB benchmark, as described in CCIO's summary, seems to offer children x-rays, cleanings, and sealants only. It excludes fillings for cavities or any other restorative services that many children need. By contrast, CHIP in Utah (and every other state) includes coverage for dental services necessary to restore oral structures to health.
- **Improve EHB selection and review at the federal and state levels to ensure gaps in pediatric coverage can be fully addressed.** Recently proposed rules from HHS could help address some of the EHB shortcomings for children, but greater changes to the EHBs will be necessary to make the benefits of exchange plans comparable with CHIP. The Notice of Benefit and Payment Parameters for Plan Year 2016 proposes to give states another opportunity to select an EHB benchmark plan, which would go into effect in 2017. Yet the choice of plans for states would remain among employer-based plans—states would not have authority to select Medicaid's EPSDT benefit or CHIP benefits as their EHB benchmark for pediatric services. The Notice further proposes a definition of habilitation services, but the federal definition would apply only when a state's benchmark plan does not already include habilitation services. Because states will be choosing from among the 2014 plans in effect today which often have inadequate coverage of habilitation services, there is a risk that many states will continue the inadequate benefit. Finally, the Notice's preface clarifies that plans may not discriminate based on age. However, state or federal regulators must provide robust review of plan provisions before certification as well as vigorous enforcement to ensure that discriminatory provisions are not applied. The existence of the three age-based limitations referenced above indicates that such review has not yet been achieved.

Until the benefits in exchange plans are truly comparable to those in CHIP, both in covered benefits and the application of limits and utilization controls, some children stand to lose needed services if they leave CHIP for exchange coverage.

3. Adequacy and appropriateness of provider networks for children in exchanges

In general, sufficient data does not exist to fully assess how children and consumers more broadly are faring in the provider networks available in QHPs. However, initial evidence suggests that in the environment fostered by the ACA's insurance market reforms, insurers are using narrow networks as a

way to control costs. These insurance market trends have potentially serious implications for the way in which children and families – especially those with special health care needs – access needed medical care and the cost of obtaining these services.

Though the ACA provides the first national standard for network adequacy in the commercial health insurance market, the standard is a qualitative one that gives insurers flexibility in how it is achieved. Under the ACA, plans sold through the exchange must maintain a provider network that is “sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”¹⁷ In addition, QHPs sold through the marketplace must include some, though far from all essential community providers that serve predominantly low-income, medically underserved patients.

However, in practice states and insurers have wide latitude to determine what constitutes “sufficient” numbers and types of providers and “unreasonable” delay.¹⁸ Some states have enacted additional standards that go beyond the federal requirements under the ACA. While states have taken different approaches to enforcement of network adequacy provisions, state enforcement of these requirements has largely occurred after plans are certified and sold in marketplaces – regulators respond to consumer complaints and include network adequacy in state market conduct examinations.¹⁹ Regulators appear to do little to assure plans have adequate networks for children or others before they are offered to consumers.

Prior to the ACA, individual market insurers had a number of tools to control costs, including denying coverage based on pre-existing conditions, rating based on health status, and limited benefit packages that excluded key services such as maternity care, prescription drugs, and mental health services. With the ACA’s prohibition on discrimination based on health status and required benefit packages, narrow networks are an expected strategy for insurers to cut costs.²⁰

Early evidence suggests that insurers selling through the marketplace have narrowed their networks relative to what they previously covered.²¹ Further, state officials participating in a six-state case study expected insurers to narrow networks even further in 2015.²²

Though the ACA prohibits insurers from imposing out-of-network cost sharing on consumers for emergency services, the narrow networks of coverage available through QHPs could have important implications for how children access health coverage and the costs their families incur. This is especially true for children with special health care needs such as chronic or complex conditions. Should these children and their families require out-of-network care, they are likely to face higher cost-sharing and may be subject to balance billing (if these services are covered at all).²³ In addition, these expenses will not necessarily count towards their maximum out-of-pocket cost limits. Worse, families may forgo necessary care if they are unable to find an out-of-network provider or feel they would be unable to afford the cost if they do. Finally, the changing network landscape has sowed confusion among both consumers and providers about the composition of covered networks in QHPs,²⁴ which may also expose children and their families to unexpected costs should they unknowingly obtain out-of-network care. This confusion is likely to be compounded in families with limited English proficiency.

Even without going out-of-network, children with special health care needs and their families can also face challenges when insurers structure their networks in a discriminatory way. Plans can place most or all pediatric specialists into high-cost tiers within their network. This forces the families of children who require specialty services to pay more due to their children’s health status.

Policy makers should take the following steps to help shed light on and ameliorate this trend towards narrow provider networks in QHP coverage and ensure children can access needed care.

- **Collect data on QHP networks and consumers' experience using them.** First, as implied above, systematic data collection on both covered networks in QHPs and how consumers experience these networks is needed.
- **Strengthen and clarify network adequacy standards.** Improved standards for network adequacy in exchange coverage could help prevent consumers from facing problems accessing care or being exposed to unexpected and unaffordable costs in the first place. The National Association of Insurance Commissioners is updating the network adequacy model act, but final action is not expected for several months and, once adopted, would require state action for application to QHPs.
- **Take steps to ensure children can access the care they need without incurring additional cost.** Pediatric specialty services should be offered throughout a tiered network, rather than segregated into a high-cost tier. Further, establishing an exemption process that allows families to access out-of-network care at in-network rates when needed services are not available in-network would be helpful. Such a process, though, must seek to minimize the burden on families in pursuing coverage for out-of-network care. QHPs should provide easy access to essential community providers that care for children, including but not limited to children's hospitals, school-based health centers, and federally qualified health centers. Dental access and limitations should be included in any assessment of adequacy.

Given the fluid nature of both QHP networks and standards, moving children with CHIP coverage into QHP networks is premature. Extending funding for the CHIP program is needed to provide sufficient time to understand network adequacy for marketplace coverage and allow standards and enforcement develop in a way that make such coverage viable for children.

4. Greatest area(s) of concern with transitions between coverage in Medicaid, CHIP, exchanges, or employer sponsored insurance, and options to safeguard against them

Despite the intent of the Affordable Care Act, policy and program changes have not yet met the promise of seamless “no wrong door” enrollment. Improvements in eligibility and renewal processes, better coordination of account transfers between state or federal marketplaces and Medicaid/CHIP, more robust consumer assistance, and special attention to coverage transition processes will go a long way to help ensure children and their families do not experience gaps in coverage. While much can be done to ease transitions for children or other family members between Medicaid/CHIP and marketplaces, it is also important to assure the accuracy of eligibility determinations so that individuals are not erroneously transferred between programs. Specific recommendations below address areas of opportunity to improve enrollment, coordination, or eligibility determinations.

- **Adopt an alternative identify-proofing mechanism.** Use of a credit rating service for identity proofing has proven extremely challenging for applicants without a credit history, as well as families with members who are immigrants. While the Federally-Facilitated Marketplace (FFM) indicates that there are processes in place to overcome these limitations, individuals continue to encounter barriers to a timely enrollment process. The FFM should create and triage applicants to a dedicated unit that is specially trained to assist mixed status or immigrant families with the unique challenges they face in accessing coverage.

- **Revise coverage effective dates to ensure children and their families do not experience gaps in coverage during transitions.** To eliminate gaps in coverage, individuals losing Medicaid or CHIP should be able to enroll in a QHP with a retroactive effective date up to the first of month in which they lose Medicaid or CHIP eligibility. This retroactive period will generally be no more than two months, given that individuals have a 60-day special enrollment period to secure marketplace coverage. Gaps in coverage could also be minimized if the enrollment cutoff of the 15th of the month was waived when someone is transitioning from other coverage.
- **Amend model application to ensure more accurate assessment of projected income.** A number of individuals may be enrolled in marketplace plans rather than Medicaid because they overestimate their projected income. This is particularly true for individuals who have pre-tax contributions deducted from their income. The problem is exacerbated because most states have not adopted a broader definition of reasonable compatibility for circumstances when the applicant reports income above the Medicaid/CHIP cutoff but the data source indicates income below the cutoff. In most states, the self-reported income is used and the applicant is denied Medicaid or CHIP. The single, streamlined model application should be amended to specifically ask about pre-tax deductions so that income is accurately assessed.
- **Ensure adequate resources and infrastructure for consumer assistance.** During transitions in coverage, individuals need additional assistance understanding the differences in how their plan works. This is particularly true for low-income families transitioning from Medicaid to QHPs in the marketplace. Current funding of consumer assistance is inadequate to address this need. Additionally, there is much that can be done to stretch limited consumer assistance services by strengthening the infrastructure that supports assisters. Creating a web portal for assisters with enhanced functionality, establishing a dedicated call center unit for assisters that is staffed with the most knowledgeable and seasoned representatives, and providing an expert policy technical assistance team to support assisters are among such opportunities to enhance consumer assistance.
- **Improve consistency and accuracy in state adoption of Modified Adjusted Gross Income (MAGI)-based rules.** A number of issues continue to surface in how states are determining MAGI-based eligibility. For example, although all social security benefits received by adults count toward MAGI, for children, social security income is counted only if the child has taxable income that requires the filing of a tax return. CMS should work with key eligibility and enrollment experts to identify and remedy these issues so that Medicaid and CHIP do not erroneously deny someone coverage.
- **Take steps to ensure successful transitions between QHPs and Medicaid/CHIP.** Families need clear protections to ensure continuity of care for individuals in the midst of a treatment period during transitions between Medicaid/CHIP and private insurance, both in minimizing coverage gaps as well as ensuring any treatment continues without placing undue financial or other burdens on families. For example, individuals enrolled in a QHP who are determined eligible for Medicaid or CHIP must proactively take action to cancel QHP coverage. If they do so after the 14th of the month, they must pay for an additional month of coverage even though their Medicaid is retroactive to the date their updated application was submitted. A better alternative would be for the marketplace to automatically disenroll the individual in their QHP as of the end of the month in which it receives notification of the Medicaid/CHIP enrollment, regardless of whether the action occurs before or after the 14th cutoff. Although enrollees may choose to pay the full cost to retain their QHP coverage, few low-income families are likely to have the ability or desire to do so. Notices

of the QHP disenrollment could inform them of this option and steps necessary to continue enrollment.

- **Eliminate CHIP waiting periods.** We applaud and agree with MACPAC's recommendation to eliminate CHIP waiting periods. While studies of substitution of private insurance by CHIP have produced mixed results, there is no concrete evidence that the problem is prevalent. This is supported by the fact that 90 percent of CHIP enrollees live in families with income less than 200 percent of the federal poverty level and are less likely to have access to affordable health insurance. Administering waiting periods post-ACA poses administrative burdens to marketplaces and state CHIP agencies, while creating gaps in coverage for children.
- **Improve data collection, transparency, and reporting.** It is important that federal and state officials work to strengthen data and information on transitions between sources of coverage. For example, Arizona recently eliminated KidsCare II, its CHIP program. To date, there has been no analysis of how many former KidsCare II children successfully transitioned to the federal marketplace or how they are faring after losing CHIP. Specific recommendations include:
 - **Strengthening account transfers information:** CMS requires states to acknowledge the receipt of an account transfer from the FFM, and to notify the FFM as to the disposition of the application. Although these data are available, there is no public reporting on the volume of transfers, processing times, or disposition. Such analysis and reporting is critical to identifying potential backlogs or delays in coverage that need to be addressed.
 - **Improving reporting and standardization of Medicaid and CHIP performance indicators:** CMS is working with states to collect accurate application and enrollment data required under the first phase of performance indicators that states report on a monthly basis. Only a subset of these data is being publicly reported. CMS should accelerate its efforts to validate the data collection and report all measures. However, these phase I measures are insufficient to fully assess the performance of our public coverage programs. CMS should move forward in identifying phase II indicators, with a particular focus on standardizing denial and disenrollment reasons, as well as capturing sufficient data to calculate retention rates separately at renewal and at other times.²⁵
 - **Developing and reporting performance indicators for marketplaces:** CMS should develop data reporting requirements for marketplaces that incorporate, to the greatest extent possible, similar measures to those required in Medicaid and CHIP. Additional measures to reflect unique aspects of marketplace coverage also should be included.
 - **Improving plan and coverage information.** Families need clear, easy-to-understand information regarding provider networks, plan benefits, and cost-sharing requirements. The summary of benefits and coverage, with improvements, provides a starting place to accomplish this.

Children with special health care needs, children in mixed immigration status families, and children in families where parents have limited English proficiency (LEP) are particularly vulnerable to receiving substandard care or even becoming uninsured if federal CHIP funding were to end. As described in detail above, families with children with special health care needs and/or chronic conditions would likely face additional costs and limits on services in exchanges that could be

detrimental to their children's healthy development as well as family finances. Children in LEP or mixed immigration families face additional and unique barriers to coverage. In particular, families with immigrants have faced grave and persistent barriers to enrolling in the marketplace.

Non-English-speaking families have less experience with and lower awareness of the programs, more confusion about the eligibility requirements, and less knowledge about how and where to enroll for coverage.²⁶ At the same time about one-third of CHIP enrollees whose families were surveyed lived with a parent or guardian who was primarily Spanish speaking (32 percent).²⁷ LEP families whose children have CHIP coverage today would have added difficulty understanding why CHIP has ended and navigating where to go and how to enroll in other coverage.

Children in mixed immigration households are likely to experience gaps in coverage or go uninsured if CHIP funding were to end. This is not a small group. Nearly one quarter of U.S. children were living in immigrant families in 2010.²⁸ Hispanic children in particular are twice as likely to be uninsured as non-Hispanic white children.²⁹ Hispanic children also make up a large share of children enrolled in CHIP. More than half (54 percent) of children enrolled in CHIP in the states represented in the recent federal CHIP evaluation were Hispanic.³⁰

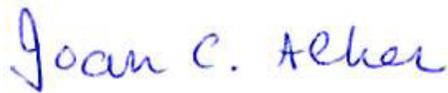
Families with immigrants have also faced grave and persistent barriers to enrolling in marketplace plans and receiving premium tax credits. These enrollment system problems need to be addressed for the long term before sending millions of children in immigrant families into the marketplace. Advocates have been urging HHS to improve enrollment for immigrant families for many months. Many of the barriers identified last year – identity verification, language access problems, immigration status inconsistencies, incorrect eligibility determinations for families under 100 percent FPL, and people stuck in the data matching process-- still have not been fixed in time for open enrollment this year. If children in these families are no longer enrolled in CHIP, they may not be able to make their way into the marketplace.³¹

A study by Action for Health Justice (AHJ), a network of national and community-based organizations working with Asian Americans and Native Hawaiians and Pacific Islanders, recently published an account of the first open enrollment period for these communities.³² AHJ found four primary barriers to enrollment, two of which—language access and concerns related to immigration status—are always high on the list when working with immigrant communities. The other two barriers—low health literacy and the lack of disaggregated data for different cultural and linguistic communities eligible for coverage—are less obvious, but equally instrumental in getting immigrant and mixed status families enrolled in coverage.³³ Even in California, many LEP families were left out of coverage in the state marketplace. While 40 percent of those eligible for enrollment in Covered California were limited English proficient, only 20 percent of those enrolled in Covered California were LEP. This is a substantial coverage gap of 20 percentage points.³⁴

We are grateful for the opportunity to suggest the best ways to improve coverage for children. Even as we learn more about how exchange plans can best serve children, CHIP must remain viable until lawmakers address critical issues regarding how children and families might obtain adequate coverage through the exchange. Our nation's children cannot afford for us to end a successful, popular, and proven program without full confidence they will receive comparable coverage elsewhere. Hasty assumptions or surface-level analyses of available coverage pose a real risk that millions of children could end up worse off than they are today – receiving inadequate coverage at a higher cost to their families or losing coverage altogether. To ensure we sustain and build on our nation's unprecedented success covering children, we must maintain CHIP even as we do the necessary work to improve alternative coverage sources and advance policies that ensure children can access the services necessary to help them develop into healthy, productive adults.

Thank you for allowing us to provide input on this important topic. If you have any questions, please contact Elisabeth Wright Burak at 202-687-0883 or Elisabeth.burak@georgetown.edu.

Sincerely,



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¹ J. Alker and A. Chester, “Children’s Coverage at a Crossroads: Progress Slows,” Georgetown University Center for Children and Families (November 2014).

² For examples, please see B. La Couture and C. Ryan, “The Family Glitch,” American Action Forum (September 18, 2014); United States Government Accountability Office, “Children’s Health Insurance Opportunities Exist for Improved Access to Affordable Insurance” (June 2012).

³ Wakely Consulting Group, “Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans,” (July 2014).

⁴ T. Brooks, M. Heberlein, & J. Fu, “Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child’s Health Care Costs,” Georgetown University Center for Children and Families and Children’s Action Alliance (May 2014), available at <http://ccf.georgetown.edu/wp-content/uploads/2014/05/Dismantling-CHIP-in-Arizona.pdf>.

⁵ T. Brooks, "Health Policy Brief: The Family Glitch," *Health Affairs* (November 10, 2014), available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129.

⁶ *Ibid.*

⁷ *Op. cit.* (2).

⁸ C. Yarbrough, K.Nasseh, & M. Vujicic, “Key Insights on Dental Insurance Decisions Following the Rollout of the Affordable Care Act,” American Dental Association Health Policy Institute (August 2014), available at http://www.ada.org/~/media/ADA/Science and Research/HPI/Files/HPIBrief_0814_2.ashx

⁹ For more information, see A. M. Grace, *et al*, “The ACA’s Pediatric Essential Health Benefit Has Resulted In A State-By-State Patchwork Of Coverage With Exclusions,” *Health Affairs*, 33, no.12 (2014):2136-2143.

¹⁰ Georgetown University Center for Children and Families and National Academy for State Health Policy, “Benefits and Cost Sharing in Separate CHIP Programs,” (May 2014), available at <http://ccf.georgetown.edu/ccf-resources/benefits-and-cost-sharing-in-separate-chip-programs/>.

¹¹ *Op. cit.* (3).

¹² M. A. McManus & H. B. Fox, “Lack of Comparability Between CHIP and ACA Qualified Health Plans,” The National Alliance to Advance Adolescent Health (July 2014) available at <http://www.thenationalalliance.org/pdfs/FS11-Lack of Comparability between CHIP and ACA Qualified Health Plans -FINAL.pdf>.

¹³ A.M. Grace, *et al*, “The ACA’s Pediatric Essential Health Benefit Has Resulted In A State-By-State Patchwork Of Coverage With Exclusions,” *Health Affairs*, 33, no.12 (2014):2136-2143.

¹⁴ Department of Health and Human Services. 45 CFR Parts 147, 155, and 156.

¹⁵ Preliminary analysis of QHP Summaries of Benefits and Coverage by the American Occupational Therapy Association.

¹⁶ Patient Protection and Affordable Care Act, H. R. 3590, 111th Congress, S. 1302(b)(4).

¹⁷ 45 CFR § 156.230.

¹⁸ S. Corlette, J. Volk, R. Berenson, & J Feder, “Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care,” Georgetown University Center for Health Insurance Reforms and the Urban Institute (May 2014) available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf413643.

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- ¹⁹ S. McCarty and M. Ferris, “ACA Implications for State Network Adequacy Standards,” The Robert Wood Johnson Foundation (August 2013) available at <http://www.statenetwork.org/wp-content/uploads/2014/02/State-Network-Georgetown-ACA-Implications-for-State-Network-Adequacy-Standards.pdf>.
- ²⁰ S. Corlette, K. Lucia, & S. Ahn, “Implementation of the Affordable Care Act: Cross Cutting Issues – Six-State Case Study on Network Adequacy,” Robert Wood Johnson Foundation (September 2014) available at <http://www.rwjf.org/content/dam/farm/reports/reports/2014/rwjf415649>.
- ²¹ McKinsey Center for U.S. Health System Reform. “Hospital Networks: Configurations on the Exchanges and Their Impact on Premiums.” New York: McKinsey & Company (2013). See also B. Herman, “Reform Update: More providers, insurers showing appetite for narrow networks,” *Modern Healthcare* (October 16, 2014) available at <http://www.modernhealthcare.com/article/20141016/NEWS/310169963>.
- ²² *Op. cit.* (18).
- ²³ *Ibid.*
- ²⁴ S. Hansard, “Confused by the ACA’s ‘Narrow Networks?’ Physicians Are Too,” *Bloomberg*, November 10, 2014, available at <http://www.bna.com/confused-acas-narrow-b17179911469/>.
- ²⁵ Suggestions on data points that should be included in phase I can be found in T. Brooks. “Tech Tuesday: The Wish List for Phase II of the Medicaid and CHIP Performance Indicators,” Georgetown University Center for Children and Families, (September 24, 2013), available at <http://ccf.georgetown.edu/all/tech-tuesday-the-wish-list-for-phase-ii-of-the-medicaid-and-chip-performance-indicators/>.
- ²⁶ M. Harrington, *et al*, “CHIPRA Mandated Evaluation of the Children’s Health Insurance Program: Final Findings,” Report submitted to the Office of the Assistant Secretary for Planning and Evaluation, Mathematica Policy Research (August 1, 2014), available at http://aspe.hhs.gov/health/reports/2014/CHIPevaluation/rpt_CHIPevaluation.pdf.
- ²⁷ *Ibid.*
- ²⁸ A. Chaudry and K. Fortuny, “Children of Immigrants: Family and Parental Characteristics,” The Urban Institute (May 2010) available at <http://www.urban.org/UploadedPDF/412132-children-of-immigrants.pdf>.
- ²⁹ S. Schwartz, *et al*, “Hispanic Children’s Coverage: Steady Progress, but Disparities Remain,” Georgetown University Center for Children and Families and National Council of La Raza (November 2014), available at <http://ccf.georgetown.edu/ccf-resources/hispanic-childrens-coverage-steady-progress-disparities-remain/>.
- ³⁰ *Op.cit.* (26).
- ³¹ S. Schwartz, “Advocates Urge HHS to Improve Enrollment for Immigrant Families,” Georgetown University Center for Children and Families (July 31, 2014) available at <http://ccf.georgetown.edu/all/200-organizations-urge-hhs-to-improve-enrollment-for-immigrant-families/>.
- ³² Asian and Pacific Islander American Health Forum, “Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities,” September 2014, available at <http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro?>
- ³³ N. Stark, “Seven Steps to Improve Enrollment for the Asian American, Native Hawaiian and Pacific Islander Community,” Georgetown University Center for Children and Families (July 23, 2014), available at <http://ccf.georgetown.edu/all/seven-steps-to-improve-enrollment-for-the-asian-american-native-hawaiian-and-pacific-islander-community/>.
- ³⁴ S. Schwartz, “Serious Enrollment Gap for Limited English Proficient Californians,” Georgetown University Center for Children and Families (June 30, 2014), available at <http://ccf.georgetown.edu/all/enrollment-gap-for-limited-english-proficient-californians/>.