

December 19, 2014

Diane Rowland, Chair
Medicaid and CHIP Payment and Access Commission
1800 M Street, NW
Suite 650 South
Washington, DC 20036

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 children's coverage.

Any examination of the future of children's coverage must consider and work to improve all coverage sources that serve children's, including recognition of the foundational role of Medicaid and CHIP. We appreciate your interest in examining the current and potential role of marketplace coverage in meeting children's health care needs at an affordable cost. A detailed examination of the marketplaces 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, 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 exchanges 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.

1. *Affordability of coverage and out-of-pocket costs, including premiums and cost sharing (e.g., copayments, coinsurance, and deductibles) in exchanges.* Evidence is clear that nearly all families would pay more out-of-pocket if their children move from CHIP to exchange plans available today, even with available tax credits and cost-sharing reductions.³ And as MACPAC has noted, the families of up to an estimated 2 million children covered by CHIP today would be locked out of access to any federal subsidies because of the family glitch. To ensure exchange coverage does not leave families worse off financially, premiums and cost-sharing in exchange plans must be comparable to CHIP. Additionally, the “family glitch” must be addressed.
2. *Adequacy of covered benefits in exchanges.* Recent research, most notably that of Wakely Consulting, has shown gaps in exchange benefits for children, both in services covered and utilization limits.⁴ This is not surprising considering the process for developing the essential health benefits. While the ACA requires the EHBs to include pediatric services, the plans that serve as the EHB benchmarks are nearly all small employer plans, not plans developed specifically to serve children. A recent study suggested, that wide interpretations of the regulations with regard to pediatric coverage have led to gaps in coverage.⁵ By contrast, CHIP and Medicaid provide benefits packages specifically created to meet children’s needs. Medicaid’s EPSDT requirement offers children comprehensive services and 38 states use Medicaid as the benefits package for CHIP or use Medicaid benefits as the basis for their CHIP packages for some or all enrolled children.⁶

Without CHIP, many children—especially those with special health care needs—would not only pay more for exchange coverage, they would not be able to get the full set of services necessary to aid in their successful development. For example, Wakely found that 100 percent of the CHIP plans it examined covered hearing exams, while marketplace plans did in only 37 percent of states. Even when services are available, coverage limits were more frequently reported in marketplace plans than in CHIP for autism services, habilitation, and physical, occupational, and speech therapies. These benefit limits combined with higher cost-sharing make marketplace plans particularly inadequate for children with special health care needs. One recent study looking at the state of Arizona estimated that the family of a

child with special health care needs would pay between 8 and 38 times more for coverage and care in a marketplace plan compared to CHIP.⁷

3. *Adequacy and appropriateness of provider networks for children in exchanges.* Network consistency between CHIP and exchange plans networks and whether these networks will be adequate to meet the pediatric care needs of these children remains unclear. This variability and uncertainty around network adequacy for children under exchange plans raises concerns that children who are currently enrolled in CHIP may have difficulty maintaining continuity of care with their providers if these children have to transition to an exchange plan. Network adequacy is difficult to assess because, to date, we lack a generally-accepted standard for adequate networks, particularly for pediatric services against which to assess networks. Furthermore, available information on exchange plan networks is volatile, difficult to ascertain and inconclusive. Much more research is needed to understand how networks are serving children, in exchange plans as well as in Medicaid and CHIP.

Network adequacy standards are needed that assure access for children, especially those with special health care needs, serious or chronic health conditions, limited English proficiency and other challenges. These standards must ensure that provider networks include the full range of pediatric primary, ancillary, specialty and subspecialty providers who typically care for children to ensure access to all covered benefits. Provider networks must be capable of providing services for all levels of complexity, including for rare conditions, without administrative or cost barriers for consumers. In the rare event that there is no provider in-network to treat a particular rare condition, children must have access to out-of-network providers at no additional cost and in a timely manner. QHPs should include in their networks 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 CHIP funding is necessary to also 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 the 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. To identify the best improvements, it is also important to strengthen available data. 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.

Children with special health care needs, children in mixed immigration status families, and children in 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. In addition, families with immigrants have faced grave and persistent barriers to enrolling in the marketplace.

We are grateful for the opportunity to suggest the best ways to improve coverage for children. As we learn more about how exchange plans can best serve children, CHIP must remain viable until necessary changes are made. Our nation's children cannot afford for us to end a successful, popular, and well-known program without full confidence that they will receive comparable coverage elsewhere. Hasty assumptions or surface-level analyses of available coverage pose the 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 access the services necessary to help them develop into healthy, productive adults.

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

Sincerely,

AASA – The School Superintendent's Association
ACCSES
AIDS Alliance for Women, Infants, Children, Youth & Families
Alliance for Strong Families and Communities
America's Essential Hospitals
American Academy of Pediatrics
American Academy of Physical Medicine and Rehabilitation
American Association of Child and Adolescent Psychiatry
American Association on Health and Disability
American Association for Marriage and Family Therapy
American Cochlear Implant Alliance
American Dental Hygienists' Association
American Heart Association

American Music Therapy Association
American Public Health Association
American Speech-Language-Hearing Association
American Thoracic Society
Ascension Health
Association of Maternal & Child Health Programs
Brain Injury Association of America
Children's Defense Fund
Children's Dental Health Project
Children's Health Fund
Children's Hospital Association
The Children's Partnership
Child Neurology Society
Community Catalyst
Easter Seals
Enroll America
Epilepsy Foundation
Families USA
Family Voices
First Focus
Georgetown University Center for Children and Families
LEAnet
March of Dimes
NAMI (National Alliance on Mental Illness)
The National Alliance to Advance Adolescent Health
National Association of County Behavioral Health & Developmental Disability Directors
National Association of Pediatric Nurse Practitioners
National Association of Rural Health Clinics
National Coalition on Health Care
National Council for Behavioral Health
National Health Care for the Homeless Council
National Health Law Program
PolicyLab at The Children's Hospital of Philadelphia
School-Based Health Alliance
United Cerebral Palsy
United Way Worldwide

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 C. Ryan, and S. Kim, "Who Still Needs CHIP?," American Action Forum (September 15, 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 CHIP to Qualified Health Plans](#)," (July 2014); 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).

⁴Wakely Consulting Group, "[Comparison of Benefits and Cost Sharing in CHIP to Qualified Health Plans](#)," (July 2014). Also see, for example, McManus, M. A. and H. B. Fox, "[Lack of Comparability Between CHIP and ACA Qualified Health Plans](#)," The National Alliance to Advance Adolescent Health (July 2014)

⁵ 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.

⁶ Georgetown Center for Children and Families and National Academy for State Health Policy, "[Benefits and Cost Sharing in Separate CHIP Programs](#)," (May 2014).

⁷ 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).