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CHILDREN'S HEALTH INSURANCE

Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance

GAO-14-40

GAO Highlights

Highlights of GAO-14-40, a report to the Chairman, Subcommittee on Health Care, Committee on Finance, U.S. Senate

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Why GAO Did This Study

More than 8 million children were enrolled in CHIP—the federal and state children's health program that finances health care for certain low-income children—in 2012. PPACA appropriated funding for CHIP through federal fiscal year 2015. Beginning in October 2015, any state with insufficient CHIP funding must establish procedures to ensure that children who are not covered by CHIP are screened for Medicaid eligibility, and if ineligible, are enrolled into a QHP that has been certified by the Secretary of Health and Human Services (HHS) as comparable to CHIP. Exchanges are marketplaces for QHP coverage effective in 2014. GAO was asked to review issues related to CHIP. This report provides a baseline comparison of coverage and costs to consumers in separate CHIP plans and benchmark plans in select states; describes how coverage and costs might change in 2014; and describes how access to care by CHIP children compares to other children nationwide.

For the coverage and cost comparison, GAO reviewed Evidences of Coverage from separate CHIP plans and benchmark plans (base and supplemental) from five states—Colorado, Illinois, Kansas, New York, and Utah—selected based on variation in location, program size, and design. GAO reviewed documents and spoke to officials from states' CHIP programs, exchanges, and benchmark plans, and from the Centers for Medicare & Medicaid Services. To describe access to care by children in CHIP compared to others with Medicaid, private insurance or without insurance, GAO analyzed nationwide data from HHS's MEPS from 2007 through 2010.

View GAO-14-40. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

In five selected states, GAO determined that the separate State Children's Health Insurance Program (CHIP) plans were generally comparable to the benchmark plans selected by states in 2012 as models for the benefits that will be offered through qualified health plans (QHP) in 2014. The plans were comparable in the services they covered and the services on which they imposed limits, although there was some variation. For example, in coverage of hearing and outpatient therapy services, the benchmark plan in one of the five states—Kansas—did not cover hearing aids nor hearing tests, while the CHIP plans in all states covered at least one of these services. Similarly, two states' CHIP plans and three states' benchmark plans did not cover certain outpatient therapies—known as habilitative services—to help individuals attain or maintain skills they had not learned due to a disability. States' CHIP and benchmark state plans were also similar in terms of the services on which they imposed day, visit, or dollar limits. Plans most commonly imposed limits on outpatient therapies and pediatric dental, vision, and hearing services. Officials in all five states expect that CHIP coverage, including limits on these services, will remain relatively unchanged in 2014, while QHPs offered in the exchanges will be subject to certain Patient Protection and Affordable Care Act (PPACA) requirements, such as the elimination of annual dollar limits on coverage for certain services.

Consumers' costs for these services—defined as deductibles, copayments, coinsurance, and premiums—were almost always less in the five selected states' CHIP plans when compared to their respective benchmark plans. For example, the CHIP plan in the five states typically did not include deductibles while all five states' benchmark plans did. Similarly, when cost-sharing applied, the amount was almost always less for CHIP plans, and the cost difference was particularly pronounced for physician visits, prescription drugs, and outpatient therapies. For example, an office visit to a specialist in Colorado would cost a CHIP enrollee $2 to $10 per visit, depending on their income, compared to $50 per visit for benchmark plan enrollees. GAO's review of premium data further suggests that CHIP premiums are also lower than benchmark plans' premiums. While CHIP officials in five states expect consumer costs to remain largely unchanged in 2014, the cost of QHPs to consumers is less certain. These plans were not yet available at the time of GAO's review. However, PPACA includes provisions that seek to standardize QHP costs or reduce cost-sharing amounts for certain individuals.

When asked about access to care in the national Medical Expenditure Panel Survey (MEPS), CHIP enrollees reported positive responses regarding their ability to obtain care, and the proportion of positive responses was generally comparable to those with Medicaid—the federal and state program for very low-income children and families—or with private insurance. Regarding use of services, the proportion of CHIP enrollees who reported using certain services was generally comparable to Medicaid, but differed from those with private insurance for certain services. Specifically, a higher proportion of CHIP enrollees reported using emergency room services, and a lower proportion of CHIP enrollees reported visiting dentists and orthodontists. HHS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

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Abbreviations

AHRQ	Agency for Healthcare Research and Quality
CHIP	State Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CMS	Centers for Medicare & Medicaid Services
EHB	essential health benefits
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
FEDVIP	Federal Employees Dental and Vision Insurance Program
FEHBP	Federal Employees Health Benefits Program
FPL	federal poverty level
HHS	Department of Health and Human Services
MEPS	Medical Expenditure Panel Survey
PPACA	Patient Protection and Affordable Care Act
QHP	Qualified Health Plan
SADP	stand-alone dental plan

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441 G St. N.W.
Washington, DC 20548

November 21, 2013

The Honorable John D. Rockefeller IV
Chairman
Subcommittee on Health Care
Committee on Finance
United States Senate

Dear Mr. Chairman:

The State Children's Health Insurance Program (CHIP), a joint federal-state program that was established by law in 1997, finances health insurance for over 8 million children whose household incomes are too high for Medicaid eligibility, but too low to afford private insurance.[1] States administer CHIP under broad federal requirements, and the programs vary, for example, in the services covered, costs to individuals and families, and eligibility requirements. The Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing CHIP, with states managing and administering the operations of their individual CHIP programs. States can operate CHIP as a separate program or include CHIP-eligible children in their Medicaid program.[2] Congress has appropriated federal CHIP funding at various times since the creation of the program. Most recently, the Patient Protection and Affordable Care Act (PPACA) appropriated federal CHIP funding through federal fiscal year 2015, thus requiring Congress to act again to extend funding in the future.[3] Among other provisions aimed at maintaining and increasing

[1]Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of lower-income individuals, including children. Most states' CHIP eligibility levels are between 200 and 300 percent of the federal poverty level (FPL), with the highest eligibility level being 400 percent of the FPL. We use FPL to refer to federal poverty guidelines issued by HHS each year in the *Federal Register*. These guidelines provide income thresholds that vary by family size and for certain states and are updated using the Consumer Price Index.

[2]As of January 14, 2013, 43 states operated separate CHIP programs (15 states had a separate CHIP program only and 28 states covered CHIP children through a separate program and a Medicaid expansion).

[3]Pub. L. No. 111-148, §10203, 124 Stat. 119, 927 (2010). In this report, references to PPACA include any amendments made by the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-52, 124 Stat. 1029 (2010), unless otherwise indicated.

access to affordable health insurance, PPACA requires the establishment of health insurance exchanges in each state—marketplaces where eligible individuals can compare and select among qualified health plans (QHP) offered by participating private issuers of health coverage, hereafter referred to as issuers, beginning in 2014. PPACA also requires that, if a state's CHIP funding is insufficient to cover all CHIP-eligible children, beginning in October 2015, the state must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility, and if ineligible for Medicaid, are enrolled into a QHP in an exchange in that state if the QHP has been certified as comparable to CHIP by the Secretary of HHS.[4]

To prepare for the offering of QHPs in 2014, HHS asked states to select benchmark health plans—plans intended as models for the benefits that will be offered through QHPs—by December 26, 2012. The most commonly selected base-benchmark plan by the states was the largest small group market health insurance plan by enrollment and product in the state, which reflected the scope of coverage available under a typical employer plan. If a state's base-benchmark plan did not meet applicable PPACA requirements—such as coverage of certain essential health benefits (EHB) categories—the state (or HHS in the case of a federally established default plan) generally was required to supplement it by using the relevant benefits in that EHB category from another one of the plan options to bridge coverage gaps.[5] To offer coverage starting in 2014, individual market and small group market insurance plan issuers must

[4]The QHP must be certified by the Secretary of HHS as offering benefits and imposing cost-sharing for children in a manner that is at least comparable to the covered services and cost-sharing protections provided under the state's CHIP plan. As of November 1, 2013, CMS had not issued any guidance on how comparability between QHPs and CHIP will be defined.

[5]PPACA does not explicitly define the services included in the EHB categories, rather it identifies 10 broad categories of essential benefits that QHPs must provide: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness and chronic disease management; and pediatric services, including oral and vision care. Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and its implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

offer QHPs that are substantially equal to their state's EHB-benchmark plan (base and supplemental, if necessary). In this report, we refer to states' EHB-benchmark plans as "benchmark plans."

You asked for baseline information about how health care coverage, costs, and access to services in separate CHIP programs compare to coverage provided to children and families through benchmark plans, and how this may change with QHPs offering coverage through the exchanges in 2014. In this report, we describe

1. how coverage in separate CHIP plans compares to benchmark plans in select states, and how coverage might change in 2014,
2. how costs to consumers in separate CHIP plans compare to benchmark plans in select states and how costs to consumers might change in 2014, and
3. how access to care by children covered by CHIP compares to other children.

To address the first two objectives—how coverage and consumers' costs in separate CHIP plans compare to benchmark plans in select states and how coverage and costs might change in 2014 when QHP coverage in the exchanges begins—we reviewed federal statutes and regulations governing CHIP-eligible services and the required EHBs to identify a range of health care services for further review. Based on variations in CMS region, CHIP program design, and size of enrollment in the separate CHIP program, we also selected five states for further review: Colorado, Illinois, Kansas, New York, and Utah.[6] In each of these five states, we contacted state officials to identify the plan within their separate CHIP program with the largest enrollment from late 2012 through early 2013. We also identified the base-benchmark and relevant supplemental plans

[6]CMS places states into one of 10 geographic regions. In this report, the term "state" includes the District of Columbia. Colorado, Kansas, and Utah operate separate CHIP programs. Illinois and New York operate both a Medicaid expansion and separate CHIP program; however, for our review, we only examined their separate CHIP programs.

effective in each of these five states as of December 26, 2012.[7] We then reviewed the Evidences of Coverage from each of the plans identified to determine whether the services we identified were covered and whether there were any annual limits on those services in terms of days, visits, or expenditures.[8] Our analysis did not include other coverage limits, such as unspecified limits based on medical necessity, expected improvement deadlines (e.g., improvement must be expected within 2 months), and drug day limits (e.g., prescriptions filled 30 days at a time). We also reviewed plan Evidences of Coverage to identify cost-sharing amounts, including deductibles, copayments, and coinsurance, for each of the services and any stated out-of-pocket maximum cost amounts.[9] We contacted state officials in all five states to obtain historic and current CHIP premiums and relied on national survey data on private individual

[7]States' base-benchmark and supplemental plans were identified in the HHS Final Rule, *PPACA Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation,* 78 Fed. Reg. 12834 (Feb. 25, 2012). HHS directed states to select a benchmark plan from among the following options: one of the three largest plans in the state's small group health insurance market; one of the three largest health plans offered to state employees; one of the three largest national plans offered through the Federal Employees Health Benefits Program (FEHBP); or the largest commercial non-Medicaid plan offered by a health maintenance organization in the state. If a state did not select a benchmark plan, the default plan would be the largest plan by enrollment in the largest product by enrollment in the state's small group market.

[8]An Evidence of Coverage is a comprehensive guide to an enrollee's health care coverage. It explains the benefits, premiums, cost-sharing, conditions and limitations of coverage, and plan rules. We reviewed these plan documents to identify whether the plan covered each of the following services: ambulatory patient services (primary care physician and specialist office visits and outpatient surgery); emergency care; inpatient hospital services (facility, professional, and ancillary); maternity care; mental health services (inpatient and outpatient); substance abuse services (inpatient and outpatient); prescription drugs; preventive care (well-child care, immunizations, and chronic disease management); outpatient therapies (physical, speech, and occupational for rehabilitation and habilitation); pediatric dental services (routine, emergency, and other); pediatric vision services(exams and corrective lenses); laboratory services (inpatient and outpatient); pediatric hearing services (testing and hearing aids); durable medical equipment; hospice; and home and community-based health care.

[9]A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

market premiums to approximate benchmark plan premiums.[10] Our coverage and cost comparison was limited to these five states. Our results cannot be generalized to other states. Coverage and cost information for QHPs was not available at the time of our analysis. Therefore, to determine how coverage and costs might change in 2014, we reviewed federal statutes and implementing regulations, interviewed federal and state officials about their expectations regarding the coverage and costs for CHIP and QHPs, and reviewed preliminary information available on state QHP premiums.

To describe how access to care for CHIP children compares to other children, we analyzed data from the Medical Expenditure Panel Survey (MEPS), a nationally representative survey that collects data from a sample of non-institutionalized Americans on their health insurance status and service utilization, among other factors. Our analysis covered the period of 2007 through 2010, the most recent complete data available at the time we did our work. We compared responses to a series of questions related to health care access and utilization by respondents with children eligible for CHIP to respondents with children covered under private insurance, Medicaid, and those who were uninsured.[11] Although MEPS combines Medicaid- and CHIP-eligible respondents, we consulted with HHS's Agency for Healthcare Research and Quality (AHRQ) to develop an analysis that disaggregated these responses. We analyzed responses from respondents who were enrolled in the program for at least 8 months. To determine the reliability of MEPS data, we reviewed related documentation describing how these data are collected and processed, and examined other research that has used these data to report on access to health care services. We also discussed the data and our analysis with AHRQ officials. We determined that the data we used in this report were sufficiently reliable for the purposes of our engagement. (See app. I for additional information on our MEPS analyses.)

[10]At the time of our analysis, premiums for the benchmark plans were not readily available and were often not comparable. For example, the base-benchmark plan in the five states was a group plan, which does not reflect individual market premiums, which historically are higher for consumers and are the point of comparison for purposes of this report. In addition, while the national data we cite reflects individual market premiums, they may also have limited relevance because they are several years old and do not reflect coverage of the EHBs, which would result in more comprehensive—and likely more expensive coverage—than health plans represented in these data.

[11]We identified MEPS questions related to respondents' experiences obtaining care and their utilization of specific services, including office and dental visits.

We conducted this performance audit from September 2012 to November 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Consumers may obtain health insurance from a variety of public and private sources, which can help protect them from the costs associated with obtaining medical care. Health insurance typically includes costs to consumers, which may vary for a number of factors, including scope of coverage, cost-sharing provisions, and federal or state requirements. Recent federal laws —specifically, PPACA and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)—further define coverage and cost parameters for certain health insurance plans available to consumers now and in 2014, when exchanges are required to be operational, and include provisions to increase children's access to coverage.

Coverage and Cost Requirements for CHIP

Unlike states that opt to include coverage for eligible children under a CHIP-funded expansion of Medicaid, and therefore, must extend Medicaid covered services to CHIP-eligible individuals, states with separate CHIP programs have flexibility in program design and are at liberty to modify certain aspects of their programs, such as coverage and cost-sharing requirements. For example, federal laws and regulations allow states with separate CHIP programs to offer one of four types of health benefit coverage and, regardless of the benefit coverage option states choose, require states' separate CHIP programs to include coverage for routine check-ups, immunizations, and emergency

services.[12] States typically cover a broad array of services in their separate CHIP programs and, in some states, adopt the Medicaid requirement to cover Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.[13] Effective October 1, 2009, CHIPRA required CHIP plans to cover dental services defined as "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." CHIPRA also required states to comply with mental health parity requirements—meaning they must apply any financial requirements or limits on mental health or substance abuse benefits under their separate CHIP plans in the same manner as applied to medical and surgical benefits. States covering EPSDT services under separate CHIP plans were deemed to comply with these requirements.

With respect to costs to consumers, CHIP premiums and cost-sharing may not exceed minimum amounts as defined by law. States may vary CHIP premiums and cost-sharing based on income and family size, as long as cost-sharing for higher-income children is not lower than for lower-income children. Federal laws and regulations also impose additional limits on premiums and cost-sharing for children in families with incomes at or below 150 percent of the federal poverty level (FPL). For example, the range of copayments was $1.15 to $5.70 per service in 2009 for children in families with incomes between 100 and 150 percent of FPL. In all cases, no cost-sharing can be required for preventive services—defined as well-baby and well-child care, including age-

[12]Federal law defines four types of allowable coverage for separate CHIP plans: (1) benchmark health plan coverage, which must be one of the following plans: (i) Blue Cross Blue Shield FEHBP, (ii) a health benefits plan that is offered and generally available to state employees, or (iii) a health plan with the largest commercial enrollment in the state; (2) benchmark-equivalent health benefit coverage, which is a plan that must have an aggregate actuarial value that is at least equivalent to coverage under one of the benchmark plans identified above and must include inpatient and outpatient hospital services, physician surgical and medical services, laboratory and x-ray services, and routine check-ups; (3) comprehensive state-based coverage, which was offered by Florida, New York, and Pennsylvania as of August 5, 1997; and (4) Secretary–approved coverage, whereby the Secretary of HHS determines whether the coverage proposed by the state is appropriate for CHIP-eligible children. Actuarial value refers to the proportion of medical expenses an insurance plan is expected to cover.

[13]State Medicaid programs are required to cover EPSDT services for children under age 21. EPSDT services include comprehensive screenings, preventive health care services, and other services necessary to correct illnesses or conditions identified by the screenings.

appropriate immunizations and pregnancy-related services. In addition, states may not impose premiums and cost-sharing, in the aggregate, that exceed 5 percent of a family's total income for the length of the child's eligibility period in CHIP.[14]

Children's access to affordable health insurance and health care can be affected by many different factors, and CHIPRA and PPACA also contain provisions to facilitate eligible children's access to CHIP.[15] For example, CHIPRA appropriated funding for state and other organization outreach grants to help increase enrollment of CHIP-eligible children for federal fiscal years 2009 through 2013 and performance bonuses for simplifying CHIP enrollment and retention by applying certain program reforms. PPACA provisions that aim to facilitate eligible children's access to CHIP include appropriating additional funding for CHIPRA outreach grants through federal fiscal year 2015. PPACA also requires states to maintain CHIP eligibility standards for children through September 2019. In accordance with this requirement, states are prohibited from increasing existing premiums or imposing new premiums except in limited circumstances.[16]

Coverage and Cost Requirements for QHPs

PPACA requires the establishment of exchanges in all states by January 1, 2014, to allow consumers to compare health insurance options available in that state and enroll in coverage.[17] The exchanges will offer

[14]This annual cumulative cost-sharing maximum applies to all services with cost-sharing requirements, irrespective of the number of children in the family that are enrolled in CHIP.

[15]We have previously issued reports related to children's access to affordable health insurance and to health care services, including reports on the extent uninsured children would be eligible for Medicaid, CHIP, or the premium tax credit under PPACA; children's access to primary, specialty and dental care by type of coverage; providers' willingness to serve children in CHIP and Medicaid, and on the association between parent and child insurance coverage. For a list of these and other related reports, see the Related GAO Products page at the end of this report.

[16]There are certain circumstances when states may increase CHIP premium levels. For example, states can routinely increase CHIP premiums if they obtained CMS approval prior to March 23, 2010, states can adopt certain types of inflation-related adjustments to CHIP premium levels, and states can impose new premiums for CHIP coverage offered after March 23, 2010.

[17]In states electing not to establish and operate their own state-based exchange, PPACA requires the federal government to establish and operate an exchange in the state, referred to as a federally facilitated exchange. Pub. L.No.111-148 §§ 1311(b)(1), 1321 (c), 124 Stat. at 173, 186.

QHPs that are certified and are offered by participating issuers of coverage.[18] PPACA further requires QHPs offered through an exchange to comply with applicable private insurance market reforms, including relevant premium rating requirements, the elimination of lifetime and annual dollar limits on essential health benefits, prohibition of cost-sharing for preventive services, mental health parity requirements, and the offering of comprehensive coverage. With respect to comprehensive coverage, PPACA requires QHPs offered through an exchange to cover 10 categories of EHBs, limit cost-sharing associated with this coverage, and provide one of four levels of coverage determined by the plan's actuarial value.[19]

By the end of December 2012, states had either selected a base-benchmark plan or been assigned the default base-benchmark plan by HHS. In over 80 percent of states, the largest plan by enrollment in the largest product by enrollment in the state's small group market was established as the base-benchmark plan. In addition, in states where the base-benchmark plan did not include coverage for pediatric dental or vision services, the state (or HHS, in the case of a federally established default benchmark plan) was required to supplement coverage with the addition of the entire category of pediatric dental or vision benefits from either (i) the Federal Employees Dental and Vision Insurance Program (FEDVIP) dental or vision plan with the largest national enrollment of federal employees, or (ii) the benefits available under the plan in the state's separate CHIP program with the highest enrollment, if a separate CHIP program existed. PPACA also allows exchanges in each state the option of providing pediatric dental services using a stand-alone dental plan (SADP). In exchanges with at least one participating SADP, QHPs

[18] In order to become certified, the QHPs offered through the exchanges are required to meet certain criteria such as benefit design, marketing, and other consumer protections, and issuers offering plans must meet requirements, such as being licensed in the state where the plan is being offered.

[19] PPACA requires non-grandfathered health plans in the individual and small group markets, both inside and outside of the exchanges, to comply with these requirements. These requirements do not apply to CHIP. In implementing regulations, HHS has also defined EHB to include any state-mandates to cover benefits that were enacted on or before December 31, 2011, even if the mandated benefit has a later effective date. Actuarial value indicates the proportion of allowable charges that a health plan will pay, on average. Actuarial values will assist consumers in comparing and selecting health plans by allowing a potential enrollee to compare the relative payment generosity among plans.

will have the option of excluding pediatric dental benefits from their covered services.

In Five States, Coverage in CHIP and Benchmark Plans Was Generally Comparable; These States Expect Minimal Changes to CHIP and QHPs to Reflect PPACA Requirements in 2014

In our five selected states, CHIP and benchmark plans generally covered the services we reviewed and were similar in terms of the services on which they imposed day, visit, or dollar limits. CHIP officials in our selected states expected minimal or no changes to CHIP coverage in 2014, and that the QHPs offered through the exchanges would reflect states' benchmark plans and PPACA requirements.

Coverage in CHIP and Benchmark Plans Was Generally Comparable, with Some Variation in Hearing and Outpatient Therapy Services in Five States

We determined that the CHIP and benchmark plans in our five selected states were comparable in that they included some level of coverage for nearly all the services we reviewed. Exceptions were hearing-related services, such as tests or hearing aids, where both were not covered by the benchmark plan in Kansas, and outpatient therapies for habilitation, which were not covered by CHIP plans in Kansas and Utah or by the benchmark plans in Colorado, Kansas, or New York.[20] (See app. II for a detailed list of selected services covered by each state.) The benchmark plan coverage for pediatric dental and vision services was often the same as that in the CHIP plan because the base-benchmark plan, which was typically based on the largest plan by enrollment from each state's small group market, did not cover these services, and the states often selected CHIP as the supplementary coverage model. In particular, the base-benchmark plan in four states did not cover pediatric dental services and

[20]Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

in three states did not cover pediatric vision services.[21] Because pediatric dental and vision services are EHBs, these states were required to select supplemental benchmark plans to bridge the coverage gaps, and often selected CHIP as the supplement.[22] National data from HHS suggests that nearly all states supplemented the base-benchmark plan with pediatric dental and vision plans. According to HHS, 50 and 46 states had to identify supplemental pediatric dental and vision plans, respectively, and more than half of the states selected the FEDVIP plan as the supplement for each service.[23]

The CHIP and benchmark plans we reviewed were also generally similar in terms of the services on which they imposed day, visit, or dollar limits. For example, the plans we reviewed were similar in that they typically did not impose any such limits on ambulatory patient services, emergency care, preventive care, or prescription drugs, but commonly did impose limits on outpatient therapies and pediatric dental, vision, and hearing services.[24] One notable difference between CHIP and benchmark plans we reviewed was the frequency by which they limited home- and community-based health care services. While the benchmark plans in four states imposed day or visit limits on these services, only one state's CHIP plan did so. (See fig. 1.)

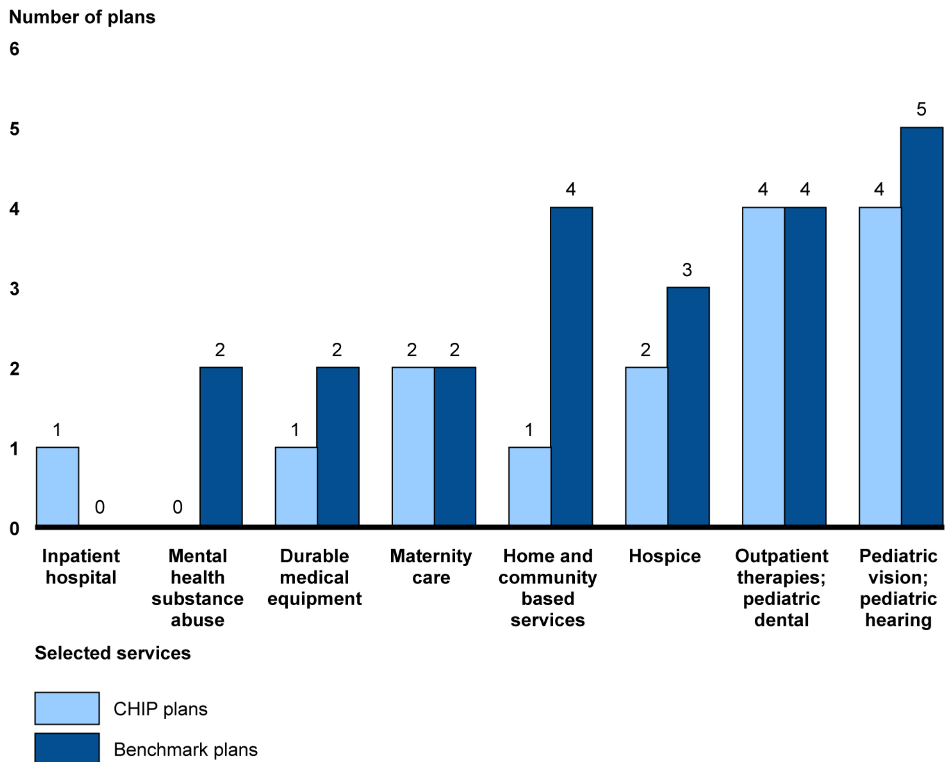
[21]Utah's plan was the only base-benchmark that included pediatric dental and vision services. The base-benchmark plans in the other four states did not include pediatric dental services, and these four states selected CHIP as the supplement. Three states—Illinois, Kansas, and New York— did not include pediatric vision services. While Kansas and New York selected CHIP as their supplemental vision plan, Illinois selected FEDVIP as the supplement.

[22]Benchmark plans must also include relevant state-mandated benefits as an EHB. Among our five states, the number of mandated benefits ranged from 9 to 49, and these mandated benefits were typically included within the services we reviewed. The state-mandated benefits that were not included among our services included services not associated with children, such as mammography, prostate cancer screening, osteoporosis screening, and shingles vaccinations.

[23]Nationally, for pediatric dental services, 26 states selected FEDVIP as the supplement, and 24 states selected CHIP. For pediatric vision services, 39 states selected FEDVIP as the supplement, and 7 states selected CHIP. For the full list of state selections, see Centers for Medicare & Medicaid Services, *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, accessed August 12, 2013, http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

[24]One state's CHIP plan specified limits on rehabilitative services received in an inpatient setting, but not the number of days allowed for an inpatient admission.

Figure 1: Number of State Children's Health Insurance Program (CHIP) and Benchmark Plans with Limits on Selected Services in Five States



Source: GAO analysis of CHIP and benchmark plan Evidences of Coverage and interviews with state CHIP and benchmark plan officials in Colorado, Illinois, Kansas, New York, and Utah.

Notes: CHIP plan data for Colorado and Utah was effective from July 1, 2012, through June 30, 2013, and for Illinois, Kansas, and New York, it was effective calendar year 2013. Benchmark plan data was effective as of December 26, 2012, the deadline for benchmark plan selection. There were no limits on the following services in the CHIP and benchmark plans we reviewed: ambulatory services, emergency care, prescription drugs, and preventive services.

For services where both plan types imposed limits, our review of plan Evidences of Coverage found that, except for dental and vision services, the comparability between plan types in terms of annual limits was less clear, but at times was more generous for CHIP. For example, Utah's benchmark plan limited home- and community-based health care services to 30 visits per year while the state's CHIP plan did not impose any limits on this service. Comparability between annual service limits in states' CHIP and benchmark plans was less clear for outpatient therapy services. For example, the Colorado CHIP plan limited outpatient therapy to 40 visits per diagnosis compared to 20 visits per therapy type in the benchmark plan. Similarly, the New York CHIP plan allowed a maximum

of six weeks for physical therapy while the benchmark plan allowed up to 60 visits per condition per lifetime. Limits on dental and vision services were largely comparable, due to the selection of CHIP as the supplemental benchmark for those services in most of the selected states. Table 1 provides examples of annual limits for select services between CHIP and benchmark plans, and app. III lists annual limits for all services we reviewed.

Table 1: Annual Limits on Outpatient Therapies, Pediatric Hearing, and Home- and Community-Based Services in the State Children's Health Insurance Program (CHIP) and Benchmark Plans of Five States

			CHIP plan	Benchmark plan
Outpatient therapies	CO	Rehabilitative	40 visits[a]	20 per therapy type[b]
		Habilitative	40 visits[a]	Not covered
	IL	Rehabilitative	None	None
		Habilitative	None	None
	KS	Rehabilitative	None	Physical and occupational: None Speech: max 90 days[c]
		Habilitative	Not covered	Not covered
	NY	Rehabilitative	Physical and occupational: 6 weeks Speech: None	60 visits per condition per lifetime
		Habilitative	Physical and occupational: 6 weeks Speech: None	Not covered
	UT	Rehabilitative	20 visits[d]	20 visits[d]
		Habilitative	Not covered	20 visits[d]
Pediatric hearing	CO	Testing	None	None
		Hearing aids	1 every 5 years	1 every 5 years
	IL	Testing	None	Not covered
		Hearing aids	None	Unknown[e]
	KS	Testing	None	Not covered
		Hearing aids	Various[f]	Not covered
	NY	Testing	1 exam	None
		Hearing aids	None	$1,500 1 every 3 years
	UT	Testing	1 exam	None
		Hearing aids	Not covered	Not covered
Home- and community-based services	CO		None	28 hours per week[g]
	IL		None	None
	KS		None	3 visits for home care education

	CHIP plan	Benchmark plan
NY	40 visits	40 visits
UT	None	30 visits

Source: GAO analysis of CHIP and benchmark plan Evidences of Coverage and information from CHIP and benchmark plan officials in Colorado, Illinois, Kansas, New York, and Utah.

Notes: CHIP plan data for Colorado and Utah was effective from July 1, 2012, through June 30, 2013, and for Illinois, Kansas, and New York, it was effective calendar year 2013. Benchmark plan data was effective as of December 26, 2012, the deadline for benchmark plan selection. Outpatient therapies consist of physical, occupational, or speech therapy. Rehabilitation is provided to help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]CHIP outpatient therapy visit limits are per diagnosis, per calendar year. Service is unlimited for children under 3 years of age and speech therapy is unlimited for those with a cleft palate or lip.

[b]Benchmark rehabilitative outpatient therapies are covered for children 3 to 6 years of age, and under 3 years of age if not participating in early intervention services. Service is unlimited for children with autism spectrum disorder who are under age 19.

[c]Speech therapy is limited to one service per day up to a maximum benefit of 90 daily services per insured per year.

[d]The limit is for all therapy types combined.

[e]The state official said there were no dollar limits but was unable to provide additional information on limits.

[f]Hearing aid batteries are limited to 6 batteries per month for monaural aids and 12 per month for binaural aids. Batteries for use with cochlear devices are limited to lithium ion (3 per 30 days) or zinc air (6 per 30 days). Batteries for cochlear devices are covered for CHIP-eligible beneficiaries only. Only one type of battery is allowed every 30 days.

[g]Home- and community-based services must not exceed 8 hours per day. Additional time up to 35 hours a week may be approved by the health plan on a case-by-case basis. Those in the Special Services Program (individuals with a terminal illness with a life-expectancy of 1 year or less who are not yet receiving hospice care or benefits) are limited to 15 home health visits per lifetime.

Selected States Expect CHIP Coverage Will Not Change and QHP Coverage Will Reflect PPACA Requirements in 2014

CHIP officials in all five states said that they expect the services we reviewed that were covered by their respective CHIP plans and any relevant limits on these services to remain largely unchanged in 2014. With respect to QHP coverage, state officials in all five states expect 2014 coverage to reflect PPACA and its implementing requirements, including being comparable to their respective benchmark plans. For example, QHPs must offer EHB services at levels that are substantially equal to their respective state's benchmark plans. With state approval, QHPs may substitute services that are actuarially equivalent and from the same EHB category as the service being replaced. The actuarial equivalence requirement also applies to dental benefits provided by SADPs, which are expected to be available in all five selected states, according to state

officials.[25] Exchange officials in three of the selected states—Colorado, Illinois, and Kansas—commented on the advantages and disadvantages of SADPs. While their availability could benefit consumers in terms of a broader set of options for dental services, their availability could also create confusion among consumers. For example, because QHPs are not required to include pediatric dental coverage in their plans if an SADP is available in their state's exchange, some officials expressed concern that a consumer who needs the pediatric dental benefit may mistakenly purchase a plan in the exchange without such coverage or, conversely, could have duplicate coverage if they purchased an SADP in addition to a QHP that may include pediatric dental coverage.

State officials said that they also expect QHPs to reflect additional PPACA requirements. For example, PPACA requires QHPs to include coverage for the categories of rehabilitative and habilitative services and devices. For benchmark plans that do not cover habilitative services, HHS's implementing regulations provide three options to comply with the requirement. States can opt to (1) require QHPs to cover habilitative services in parity with rehabilitative services; (2) select specific services that would qualify as habilitative or, if the state neglects to choose either of these choices, (3) allow the QHP issuer to determine which services qualify as habilitative. Each of the three selected states that did not cover outpatient therapies for habilitation—Colorado, Kansas, and New York—has opted to require QHPs to cover these services in parity with rehabilitative services. According to HHS, nationwide data show that in addition to these three states, 19 other states had benchmark plans that did not cover habilitation, and the majority chose to allow the issuers to determine which services would qualify as habilitative.[26]

[25]Data suggest that SADPs will be offered in most states. Specifically, on February 11, 2013, CMS reported that an SADP is expected to be offered in each of the states in which federally facilitated exchanges, including a state partnership exchange, will be operating. In a federally facilitated exchange, the state may pursue a state partnership exchange, where a state may administer and operate exchange activities associated with plan management and/or consumer assistance. QHPs are not required to include the pediatric dental benefit in their plans if an SADP is available in their state's exchanges. In such instances, consumers are not required to purchase an SADP if their QHP does not include the pediatric dental benefit.

[26]Specifically, 12 states chose to allow the issuers to determine which services would qualify as habilitative, four states chose to cover these services in parity with rehabilitative services, and three states chose to define specific services as habilitative.

PPACA also eliminates the use of annual and lifetime dollar limits on any EHB services. The elimination of lifetime dollar limits was effective in September 2010 and the elimination of annual limits takes effect in January 2014.[27] Among our five selected states, four states had benchmark plans that imposed an annual dollar limit on at least one of the service categories we reviewed; with limited exception, none of these dollar limits were imposed on EHB services. For example, Kansas' benchmark plan limited hospice services to $5000 per insured person per lifetime. In general, state officials indicated that for these services, they expected that QHP issuers would eliminate the dollar limits.

PPACA also extends the mental health parity requirements, which require that any lifetime limits placed on mental health or substance abuse services be the same as those placed on physical health care services.[28] The benchmark plans in two selected states—New York and Utah—included such limits on mental health and substance abuse services. For example, both states' benchmark plans limited inpatient mental health service to 30 days a year, where similar limits did not exist for inpatient physical health services. Officials in both states said that they expected that QHP issuers would eliminate such limits.

[27] Issuers offering QHPs and group health plans, and issuers offering group or certain individual plans outside of the exchanges, are prohibited from applying lifetime or annual limits on EHBs. Issuers may apply annual limits for EHBs prior to 2014 subject to certain limitations.

[28] PPACA requires issuers offering QHPs and individual plans outside of the exchanges to comply with requirements established under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA specifies that the financial requirements (such as cost sharing) and treatment limitations (such as the number of visits covered) imposed on mental health and substance use disorder benefits cannot be more restrictive than those that apply to medical and surgical benefits.

In Five States, Costs to Consumers Were Almost Always Less in CHIP than in Benchmark Plans; CHIP Costs Are Expected to Remain the Same and QHP Costs to Reflect PPACA Limits in 2014

In our five selected states, consumers' costs were almost always less in CHIP plans when compared to the states' benchmark plans. While CHIP officials said that they expect CHIP costs to consumers to remain largely unchanged in 2014, the cost of QHPs to consumers is less certain, since benchmarks are not models for QHP cost-sharing. Instead, PPACA includes provisions that will standardize QHP costs and reduce cost-sharing for certain individuals.

Costs to Consumers in Five States Were Almost Always Less in CHIP Plans than in Benchmark Plans

Based on the review of plan Evidences of Coverage in our five selected states, costs to consumers were almost always less in the CHIP plans than in the states' benchmark plans. For example, the CHIP plans in four of the five selected states did not include any deductibles, which means that enrollees in those states did not need to pay a specified amount before the plan began paying for services. Utah is the only selected state that imposed a deductible on a portion of its CHIP population, which applied to about 60 percent of its CHIP enrollees—those with higher incomes.[29] In contrast, benchmark plans in all five selected states had deductibles, which ranged from $500 in Illinois and Kansas to $3,000 in Utah for an individual, and $1,000 in Kansas to $6,000 in Utah for a family.

Our review of plan Evidences of Coverage and information from state and plan officials also found that, for services we reviewed where the plan imposed copayments or coinsurance, the amount was almost always less

[29]CHIP enrollees in Utah with family incomes at or below 100 FPL were not subject to a deductible. Those with family incomes between 101 and 150 percent FPL—about 40 percent of enrollees—were subject to a deductible of $40 a year for the family. Those with family incomes between 151 and 200 percent FPL—about 20 percent of enrollees—were subject to an annual deductible of $500 and $1,500 for a child and family, respectively.

in a state's CHIP plan that in its benchmark plan.[30] For example, the CHIP plan in two of our five states—Kansas and New York—did not impose copayments or coinsurance on any of the services we reviewed. In two of the remaining three states, the CHIP plan imposed copayments or coinsurance on less than half of the services we reviewed, and the amounts were usually minimal and based on a sliding income scale. For example, for each brand-name prescription drug, the Illinois CHIP plan imposed a $4 copayment on enrollees with incomes between 134 and 150 percent of the FPL, which was increased to $7 for enrollees with incomes between 201 and 300 percent of the FPL. Utah's CHIP plan differed from the other states' plans in that it imposed either a copayment or coinsurance on all services we reviewed—except preventive and routine dental services—which varied by income level.

In contrast, the benchmark plans in all five states imposed copayments or coinsurance on most services we reviewed. Further, the amounts did not vary by income level and were consistently higher than the CHIP plan in their respective state. These cost differences were particularly pronounced for certain services we reviewed, such as primary care and specialty physician office visits, prescription drugs, and outpatient therapies. For example, depending on income, the copayment for primary care and specialist physician visits ranged from $2 to $10 per visit for Colorado CHIP enrollees, but was $30 and $50 per visit, respectively, for benchmark plan enrollees in the state. In states where the benchmark plan charged coinsurance and the CHIP plan required a copayment, a direct comparison of cost differences could not be made, although data suggest CHIP costs would generally be lower in most cases. For example, while higher-income CHIP enrollees in Illinois paid $100 per admission for an inpatient hospital stay, state benchmark enrollees were responsible for 10 percent coinsurance after the deductible was met, an amount that was likely to be higher than the $100 given that 10 percent of the average price for an inpatient facility stay in 2011 was over $1,500.[31]

[30]As consistent with federal requirements, none of the CHIP or benchmark plans we reviewed imposed cost-sharing requirements on preventive services. In addition, because most of the five states selected CHIP dental or vision as a supplemental plan, the cost-sharing for those services were the same (and often zero) for both plan types.

[31]According to the Health Care Cost Institute, the average price of an inpatient stay, which includes hospital stays, in 2011 was $15,674. See the Health Care Cost Institute, *Health Care Cost and Utilization Report: 2011*. (Washington, D.C., Health Care Cost Institute, 2012), 9.

Table 2 provides examples of differences in copayments and coinsurance for select services between CHIP and benchmark plans.

Table 2: Examples of Copayments and Coinsurance for Prescription Drugs, Office Visits, and Rehabilitative Outpatient Therapies in the State Children's Health Insurance Program (CHIP) and Benchmark Plans of Five States

			CHIP plan		Benchmark plan	
			< 150% FPL	150-200% FPL	> 200% FPL	N/A
Prescription drugs[a]	CO	Generic	$1	$3	$5	$15
		Brand-name	1	10	15	30
	IL	Generic	2	3	3	15[b]
		Brand-name	4	5	7	30[c]
	KS	Generic	0	0	0	15[d]
		Brand-name	0	0	0	30[e]
	NY	Generic	0	0	0	15
		Brand-name	0	0	0	35
	UT	Generic	1-5	15	N/A	50%
		Brand-name	1-5	25%	N/A	50%
Office visit	CO	PCP	2	5	10	30
		Specialist	2	5	10	50
	IL	PCP	4	5	10	20
		Specialist	4	5	10	40
	KS	PCP	0	0	0	25
		Specialist	0	0	0	25
	NY	PCP	0	0	0	25
		Specialist	0	0	0	50
	UT	PCP	3-5	25	N/A	30%
		Specialist	3-5	40	N/A	30%
Rehabilitative outpatient therapy session (physical, occupational, or speech)	CO		2	5	10	30
	IL		0	0	0	10%
	KS		0	0	0	25
	NY		0	0	0	0%
	UT		3-5	40	N/A	30%

Legend: FPL = federal poverty level; N/A = not applicable; PCP = primary care physician

Source: GAO analysis of Colorado, Illinois, Kansas, New York, and Utah CHIP and benchmark plan Evidences of Coverage and information from state and health plan officials.

Notes: CHIP plan data for Colorado and Utah was effective from July 1, 2012 through June 30, 2013 and for Illinois, Kansas, and New York, it was effective calendar year 2013. Benchmark plan data was effective as of December 26, 2012, the deadline for benchmark plan selection.

[a]Brand-name drugs include drugs designated by the plan as "preferred" or included in their formulary.

[b]Benchmark enrollees must pay $30 for generic prescription drugs obtained through a mail order service.

[c]Benchmark enrollees must pay $60 for brand-name prescription drugs obtained through a mail order service.

[d]Benchmark enrollees must pay $37.50 or less for generic prescription drugs obtained through a mail order service.

[e]Benchmark enrollees must pay $75 or less for brand-name prescription drugs obtained through a mail order service.

Our review of CHIP premiums and other sources of premium data suggest that CHIP premiums were also likely lower than benchmark plans. For example, 2013 CHIP annual premiums for an individual varied by income level and ranged from $0 for enrollees under 150, 160, and 100 percent of the FPL in Illinois, New York, and Utah, respectively, to $720 for higher-income enrollees between 351 and 400 percent of the FPL in New York, with most enrollees across the five selected states paying less than $200 a year. Benchmark plan premium data were not readily available at the time of our study; however, national survey data from America's Health Insurance Plans suggest that individuals under 18 years of age enrolled in the private individual market paid annual premiums that averaged $1,350 in 2009.[32]

In addition, both CHIP and benchmark plans in all five states limited the total potential costs to consumers by imposing out-of-pocket maximum costs. For example, all five states applied the limit a family could pay in CHIP plans as established under federal law—including deductibles, copayments, coinsurance, and premiums—at 5 percent of a family's income during the child's (or children's) eligibility for CHIP.[33] This maximum applies to all services, irrespective of the number of children in the family enrolled. For benchmark plans, out-of-pocket maximum costs were established by each plan. For the five benchmark plans we

[32]Per HHS's Assistant Secretary for Planning and Evaluation, individual market premiums have increased 28.6 percent from 2009 to 2012 in a sample of states. In contrast, CHIP officials reported lower premium increases, if any. From 2009 to 2012, there were no increases in CHIP premiums in Colorado and Illinois. The monthly weighted average CHIP premium in New York increased approximately 14 percent and Kansas premiums increased by 23 percent for those who paid premiums. Utah CHIP premiums didn't change for those with incomes up to 150 percent FPL and increased by 25 percent for those with incomes from 151 to 200 percent FPL.

[33]This 5 percent cap results in limits that vary based on a family's income level and in 2013 ranged from $1,766 for a family of four with an income at 150 percent of the FPL to $4,710 for a family of four with an income at 400 percent of the FPL.

reviewed, the annual out-of-pocket maximum costs ranged from $1,000 to $6,050 for an individual and $3,000 to $12,100 for a family. Additionally, the benchmark plans differed from the CHIP plans in that their maximum costs did not include premiums and may not have included deductibles or costs associated with all services. For example, three of the five benchmark plans had deductibles in addition to the out-of-pocket maximum costs. Additionally, copayments for office visits did not apply to the out-of-pocket maximum costs in four of the five states' benchmark plans.

Some evidence suggests that most families in the five selected states and nationally—whether enrolled in CHIP or a benchmark plan—were unlikely to incur costs that reached the out-of-pocket maximum costs. Our interviews with CHIP officials in selected states and information in the states' CHIP annual reports indicated that it was rare for families to exceed their 5 percent maximum costs. Utah was the only state that said they had more than a few families exceeding the maximum costs, with about 140 families reporting doing so in a given year, according to state officials. Similarly, existing national data on average out-of-pocket costs for individuals with employer-sponsored insurance suggested that individuals enrolled in the benchmark plans could also generally incur costs that are lower than the maximum costs established by their plan. For example, the Health Care Cost Institute, an organization that provides information for researchers on health care spending and utilization trends, reported that the average out-of-pocket amount spent per consumer was $735 in 2011 for health care services through employer-sponsored insurance, which was lower than the lowest maximum costs established by our selected benchmark plans.[34]

[34]The Health Care Cost Institute, Health Care Cost and Utilization Report: 2011. (Washington, D.C., 2012), 8.

Five States Expect CHIP Costs to Consumers to Remain the Same; QHP Costs to Consumers Will Be Subject to PPACA Provisions that Limit Consumers' Costs in 2014

According to state CHIP officials in all five states, CHIP costs to consumers, including premiums, copayments, coinsurance, and deductibles, are expected to remain largely unchanged in 2014. All five states said they currently have no plans to raise premiums or change cost-sharing amounts in 2014.

In contrast, QHP costs to consumers in 2014 may be different than those in the benchmark plans as benchmarks are not models for QHP cost-sharing. Instead, PPACA included provisions applicable to QHPs that will limit premium variation, standardize plan values, and limit out-of-pocket costs. For example,

- PPACA will limit premium variation in the individual market by prohibiting health plans from adjusting QHP premiums based on factors such as health status and gender. Instead, plans will only be allowed to adjust premiums for family size, geographic area, age, and tobacco use.[35]

- PPACA standardizes plan values through QHP coverage level requirements. Specifically, QHPs must offer coverage that meets one of four metal tier levels, which correspond to actuarial value percentages that range from 60 to 90 percent: bronze (an actuarial value of 60 percent), silver (an actuarial value of 70 percent), gold (an actuarial value of 80 percent), or platinum (an actuarial value of 90 percent). Actuarial value indicates the proportion of allowable charges that a health plan will pay, on average—the higher the actuarial value, the lower the cost-sharing expected to be paid by consumers. Deductibles, co-pays, and coinsurance amounts can vary within these plans, as long as the overall cost-sharing structure meets the required actuarial value levels.[36]

[35]States have the authority to determine the geographic rating area in their state, which the Secretary of HHS can review to ensure adequacy. If inadequate, the Secretary can establish the rating area. Additionally, the ratio of rates cannot vary by more than 3 to 1 for adults. This does not apply to children under age 21, who will instead have a single age rating band. The ratio of rates for tobacco vs. non-tobacco users cannot vary by more than 1.5 to 1.

[36]Plans are allowed a de minimis variation of +/- 2 percent (e.g., a silver level plan can have an actuarial value between 68 and 72 percent). SADPs will have different actuarial value requirements and will be offered as "high" and "low" level plans, with 85 and 70 percent actuarial value, respectively, and will have the same allowable de minimis variation.

- PPACA establishes out-of-pocket maximum costs on cost-sharing that apply to all QHPs and vary by income, a change from the non-income-based out-of-pocket maximum costs found in our selected benchmark plans.[37] These maximums for individual plans do not include premiums or costs associated with non-EHB services, but do include deductibles. See table 3.

Table 3: Out-of-pocket Maximum Cost Amounts for Qualified Health Plan Enrollees in 2014 by Federal Poverty Level (FPL)

Income level (as a percentage of FPL)	Individual maximum	Family maximum
250-400%	$6,350	$12,700
200-250	5,200	10,400
100-200	2,250	4,500

Source: GAO analysis of Internal Revenue Service data related to out-of-pocket maximums for high deductible health plans (Internal Revenue Service Revenue Procedure 2013-25) and the Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014.

- SADPs have out-of-pocket maximum costs that are in addition to the QHP maximums described above and therefore may increase potential maximum costs for families who purchase them.[38] For 2014, the out-of-pocket maximum costs for SADPs offered in federally facilitated exchanges and state partnership exchanges are $700 for a plan with one child or $1,400 for a plan with two or more children.[39] For example, a family at 225 percent of the FPL that enrolls their two children in an SADP in addition to their QHP would be subject to an out-of-pocket maximum cost of $11,800.

Additionally, PPACA includes provisions aimed at reducing cost-sharing amounts for certain low-income consumers and eligible Indians who purchase QHPs through an exchange in the individual market. For example, PPACA and federal regulations provide cost-sharing subsidies

[37]In 2014, the maximum annual limitation on cost-sharing is based on the out-of-pocket limits established by the Internal Revenue Service that apply to high deductible health plans. In 2015 and thereafter, the maximum annual limitation on cost-sharing is based on a premium adjustment percentage index to be established by the HHS Secretary.

[38]SADPs must demonstrate they have reasonable annual limitations on cost-sharing as determined by their exchange. The annual limit is calculated without regard to the EHBs provided by the QHP and out-of-network services,

[39]State-based SADP out-of-pocket maximum costs will be determined by individual states.

to individuals with incomes between 100 and 250 percent of the FPL to offset the costs they incur through copayments, coinsurance, and deductibles in a silver-level QHP.[40] The cost-sharing subsidies will not be provided directly to consumers, instead, QHP issuers are required to offer three variations of each silver plan they market through an exchange in the individual market. These plan variations are to reflect the cost-sharing subsidies through lower out-of-pocket maximum costs, and, if necessary, through lower deductibles, copayments, or coinsurance. Once the adjustments are made, the actuarial value of the silver plan available to eligible consumers will effectively increase from 70 percent to 73, 87, or 94 percent, depending on their income levels. However, cost-sharing subsidies are not available for pediatric dental costs incurred by a consumer enrolled in a QHP and an SADP.[41]

PPACA also provides a premium tax credit to eligible individuals with incomes that are at least 100 percent and no more than 400 percent of the FPL when purchasing a plan with a premium no more than the second-lowest cost silver plan in their state.[42] Depending on their income, this provision limits the amount families must contribute to QHP premiums to 2 to 9.5 percent of their annual income; in 2014 these premium contributions will range from $471 to $8,949 for a family of four.[43] Unlike cost-sharing subsidies, which generally do not apply to costs incurred for services by a consumer enrolled in an SADP, the maximum contribution amount on premiums includes premiums for both QHPs and SADPs, if

[40]PPACA directs issuers to reduce cost sharing for EHB for eligible individuals enrolled in certain silver level QHP plans with household incomes between 100-400% of the FPL by first reducing the maximum annual limitation on cost-sharing to achieve certain actuarial value levels. As specified in the 2014 payment notice, the maximum annual limitation on cost-sharing for individuals with incomes between 250-400% of FPL for 2014 was not reduced for the 2014 benefit year.

[41]PPACA provides that, if an individual is enrolled in both a QHP and an SADP, cost-sharing reductions do not apply to the portion of the cost-sharing reductions related to the pediatric dental EHB. This means that if an individual is enrolled in both a QHP and an SADP, cost-sharing reductions are not payable with respect to pediatric dental benefits offered through the SADP.

[42]Advance payments of the premium tax credit are made directly to the issuer of the QHP in which a taxpayer enrolls. The premium tax credit is computed by taking into account only the premiums for QHPs and may not be increased for premiums a taxpayer pays for other minimum essential coverage.

[43]These amounts apply in the 48 contiguous states and the District of Columbia.

relevant.[44] See table 4 for maximum premium contribution amounts by federal poverty level.

Table 4: Maximum Premium Contributions for Qualified Health Plan (QHP) Enrollees by Federal Poverty Level (FPL) in 2014

Income level (% of FPL)	Maximum premium (% of Income)	Individual maximum premium contribution	Family of four maximum premium contribution
400%	9.5%	$4,366	$8,949
250	8.05	2,312	4,739
200	6.30	1,448	2,967
150	4.00	689	1,413
100	2.00	230	471

Source: GAO analysis of the Internal Revenue Service Health Insurance Premium Tax Credit Final Rule and the Department of Health and Human Service 2013 Poverty Guidelines for the 48 Contiguous States and the District of Columbia.

Note: The maximum premium contribution amounts are for the 48 contiguous states and the District of Columbia.

Preliminary information released by some states suggests that this tax credit could defray the premium cost for certain lower-income individuals. For example, QHP premium data available in California indicates that, on average, it may cost a family of four with an income above 400 percent of the FPL over $9,700 a year to enroll in the most affordable silver-level QHP.[45] Additionally, if the parents chose to purchase pediatric dental coverage for their children, annual SADP premiums could range from about $120 to $360 per child depending upon the region and type of plan chosen. If a state exchange does not offer the pediatric dental benefit through an integrated QHP and only offers it through an SADP, as is expected to be the case in California, all exchange enrollees in that state will pay a separate premium for pediatric dental coverage. Together, the lowest annual premium cost for the family of four with an income above 400 percent of the FPL would be close to $10,000. However, if the family had an income at 150 percent of the FPL, and was therefore eligible for

[44]If an individual who is eligible for premium tax credits enrolls in a QHP and an SADP, the portion of the SADP that is allocable to the pediatric dental EHB must be considered part of the QHP premium to which the individual's premium tax credit applies. However, unless the consumer purchases a QHP with a premium that is less than the second lowest cost silver plan, e.g., a bronze plan, the consumer would likely pay the premium for the SADP.

[45]The family of four includes two parents age 40 and two children under the age of 21.

the premium tax credit, their annual premium contribution for the QHP and SADPs combined would be much lower, no more than the PPACA-established annual maximum of $1,413 plus the cost of the SADP. Therefore, this family with an income at 150 percent of the FPL could have a premium payment over $8,000 less annually than if their income was over 400 percent FPL, and they were not eligible for the premium tax credit.[46]

National Survey Data Suggest that CHIP Access to Care is Comparable to Medicaid and Lower than Private Insurance for Some Services

When asked a series of questions about access to care, MEPS respondents with children covered by CHIP reported positive responses to nearly all questions regarding their ability to obtain care and at levels that were generally comparable to those with other types of insurance. MEPS includes questions about respondents' ability to obtain care, and responses to these questions can provide insight to an individual's access to services. In examining questions related to having a usual source of care, getting appointments and care when needed, and accessing care, tests, or treatment or seeing specialists when needed, most respondents with children enrolled in CHIP had positive responses to questions for calendar years 2007 through 2010.[47] Specifically, five of the six MEPS questions we analyzed related to respondents' ability to obtain care. At least 88 percent of CHIP enrollees responding to these questions reported they had a usual source of care and usually or always got the care they needed. When compared to respondents with other sources of insurance, the proportion of CHIP enrollees' with positive responses to

[46]Premium data included in a September 2013 Kaiser Family Foundation report also suggest that QHP enrollees in other states who were eligible for the premium tax credit could also experience a significant reduction in their annual premium contribution. For example, without the tax credit, the annual QHP premium for the second lowest cost silver-level QHP—not including any SADP premium—for a family in Denver, Colorado, would be about $9,000, and it would be about $13,000 for a family in New York City. However, if these families had incomes at 255 percent of the FPL, and were therefore eligible for the premium tax credit, their annual maximum premiums would be much lower at about $4,900. The Henry J. Kaiser Family Foundation, *An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014*. (Menlo Park, CA. Henry J. Kaiser Family Foundation, 2013), 10, 19.

[47]For purposes of our analysis, we considered certain responses to be positive. For the question about a usual source of care, we considered all "yes" responses to be positive. For the question about how difficult it is to reach the usual source of care by telephone, we considered the "it was not at all difficult" or "was not too difficult" responses as positive. For the remaining four questions, which measured perceptions on accessing health care, we considered answers of "usually" or "always" to be positive.

these questions were, for most questions, comparable to respondents with Medicaid or with private insurance—that is, within 5 percentage points. For example, about 89, 91, and 93 percent of CHIP, Medicaid, and privately insured respondents, respectively, reported that they had a usual source of care. The proportions of CHIP enrollees and those who were uninsured reporting positive responses were also within 5 percentage points on four of the six questions, but the differences were larger for the remaining two questions. Specifically, about 56 percent of those who were uninsured reported having a usual source of care compared to about 89 percent of CHIP enrollees, and about 75 percent of those who were uninsured reported that it was usually or always easy to see a specialist compared to about 81 percent of CHIP enrollees. The area of greatest dissatisfaction appeared to be related to ease in seeing a specialist. Approximately 18 percent of CHIP enrollees reported that it was sometimes or never easy to see a specialist. (See table 5.)

Table 5: Percentage of Respondents Who Reported Positive Responses to Six Medical Expenditure Panel Survey (MEPS) Questions Related to Obtaining Needed Care, by Health Insurance Status, 2007 through 2010

	Insurance status			
MEPS question	**CHIP**	**Private insurance**	**Medicaid**	**Uninsured**
Do you have a usual source of care?	88.6%	92.6%	90.5%	55.9%
How difficult was it to reach the usual source of care by telephone during office hours?	88.2	89.9	86.2	88.3
Did you usually or always get care as soon as was needed?	91.6	96.6	92.3	90.6
Did you usually or always get an appointment for health care as soon as was needed?	92.2	95.0	92.4	91.6
Was it usually or always easy to get a person the care, tests or treatment that the parent or a doctor believed necessary?	91.5	96.7	91.9	89.9
Was it usually or always easy to see a specialist?	81.4	86.9	79.0	74.5

Source: GAO analysis of MEPS data from surveys conducted in 2007 through 2010.

Notes: For our analysis, we pooled MEPS data from surveys conducted in 2007 through 2010. For purposes of our analysis, we considered the following responses to be positive: for the question about a usual source of care, we considered all “yes” responses to be positive; for the question about how difficult it is to reach the usual source of care by telephone, we considered the “it was not at all difficult” or “was not too difficult” responses as positive; for the remaining four questions, which measured perceptions on accessing health care, we considered answers of “usually” or “always” to be positive. Questions “was it usually or always easy to get a person the care, tests or treatment that the parent or a doctor believed necessary” and “was it usually or always easy to see a specialist” were added in 2008, therefore, we pooled MEPS data from surveys conducted in 2008 through 2010 for these two questions.

Additional MEPS questions related to respondents’ use of certain medical and dental visits also provide insight on respondents’ access to services and suggest that, for most services, access to care for individuals

covered by CHIP is comparable to that of those with Medicaid and lower than that of the privately insured, particularly for dental care.[48] MEPS questions ask about respondents' health care visits, including office-based health provider, emergency room, and dental visits, in the year prior to the survey. Respondents with children in CHIP reported using services at rates generally comparable to those with Medicaid and lower—except for emergency room visits, which were higher—than those with private health insurance, particularly for oral health care. A higher proportion of CHIP respondents reported using health care services compared to those who were uninsured. For example, about 51 percent of those with private insurance reported visiting a dentist in the past 12 months compared to about 42 percent of CHIP respondents. Additionally, 69 percent of CHIP respondents reported having an office-based provider visit compared to about 50 percent of respondents who were uninsured. (See table 6.)

Table 6: Percentage of Respondents Who Used Specific Services as Reported in Medical Expenditure Panel Survey (MEPS) Data Related to Health Care Service Visits within the Past 12 Months, by Health Insurance Status, 2007 through 2010

	Insurance status			
MEPS data related to health care service visits	**CHIP**	**Private insurance**	**Medicaid**	**Uninsured**
Had an office–based provider visit	69.1%	76.9%	70.2%	49.9%
Had an outpatient department provider visit	6.8	7.0	6.4	2.8
Had an emergency room visit	14.1	10.4	16.6	9.0
Had any dental care visit	45.9	55.8	36.8	21.2
Had a general dentist visit	42.4	50.9	34.1	18.3
Had an orthodontist visit	4.9	11.2	2.6	3.9

Source: GAO analysis of MEPS data from surveys conducted in 2007 through 2010.

Notes: For our analysis, we pooled MEPS data from surveys conducted in 2007 through 2010. The "had any dental care visit" variable includes visits to a broad group of dental providers, including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists. The "had a general dentist visit" and "had an orthodontist visit" variables are more narrowly defined and refer specifically to visits to general dentists and orthodontists, respectively.

[48]The MEPS questions we reviewed included three related to respondents' use of various dental services. The MEPS question, which asked whether the respondent "had any dental care visit," includes visits to a broad group of dental providers, including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists. The "had a general dentist visit" and "had an orthodontist visit" questions are more narrowly defined and refer specifically to visits to general dentists and orthodontists, respectively.

Because factors other than insurance coverage may affect these observed differences in responses about obtaining care or utilization of health care services, we ran a logistic regression to determine whether differences between CHIP respondents and those with other sources of insurance coverage were significant after controlling for other factors, such as age, race, and income levels. (See app. I for more detailed information on our model and results.) After controlling for these factors, we found that differences between CHIP and Medicaid responses were not statistically significant for any of the 12 questions we reviewed, and that the differences between CHIP and privately insured respondents were statistically significant for 4 questions, which related to respondents' reported use of emergency rooms, dentist visits, orthodontist visits, and their reported ease in getting needed care, tests, or treatment. CHIP-covered individuals were more likely to report emergency room visits and visits to a general dentist, and less likely to report orthodontist visits and ease in getting needed care than the privately insured. More pronounced differences in reported access existed between CHIP enrollees and those who were uninsured. When comparing CHIP to the uninsured, differences in responses were statistically significant for 8 of the 12 questions we reviewed.[49]

Concluding Observations

Congress, HHS, and the states have important decisions to make regarding the future of CHIP. Congress will face decisions concerning CHIP funding as current funding has been appropriated only through federal fiscal year 2015. The Secretary of HHS will face decisions around parameters by which QHPs offered by exchanges can be considered to be comparable to CHIP plans. Beginning in October 2015, if CHIP funding is insufficient, states will need to have procedures in place to enroll CHIP-eligible children in Medicaid, if eligible, and, if not, in QHPs as long as the Secretary of HHS has certified the QHPs are comparable to CHIP in covered services and cost-sharing protections.

[49]We found there was a statistically significant difference between CHIP and the uninsured with respect to differences in having a usual source of care; the ease of getting a person the care, tests or treatment that the parent or a doctor believed necessary; the ease of seeing a specialist; or having had an office-based provider visit, outpatient department provider visit, emergency room visit, any dental care visit, and a visit to a dentist within the past 12 months.

Although state officials in the five states we reviewed expect the CHIP landscape to remain relatively stable over the next year, uncertainty remains regarding issuer decisions and the implementation of other PPACA provisions. This uncertainty complicates making a definitive determination of what CHIP enrollees would face if they were to obtain QHP coverage rather than be enrolled in CHIP. To some extent, coverage and costs in QHPs will be determined by individual states, issuers, and families' choices. For example, individual issuers of QHPs in many states will define the habilitative services they cover and the limits on services they cover, including ones that are required under PPACA but that they may not have previously covered. In many states, families seeking coverage through exchanges will be allowed to choose whether to obtain pediatric dental coverage by enrolling in a stand-alone dental plan, which will affect upfront and other costs they face. Yet, some—or many—families may choose not to purchase dental coverage that all CHIP plans must cover. PPACA provisions, which seek to standardize QHP costs and reduce cost-sharing for certain individuals, could narrow the cost gap we identified, but will vary by consumers' income level and plan selection. Assessing the comparability of CHIP and QHP plans will require ongoing monitoring of a complex array of factors.

Agency Comments

We provided a draft of this report for comment to HHS. HHS officials provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from its date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact Katherine Iritani at (202)512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Sincerely yours,

Katherine M. Iritani
Director, Health Care

Appendix I: Scope and Methodology of the Medical Expenditure Panel Survey (MEPS) Analysis

To describe how access to care for CHIP children compares to other children, we analyzed data from the Medical Expenditure Panel Survey (MEPS), a nationally representative survey that collects data from a sample of non-institutionalized Americans on their health insurance status and service utilization, among other factors. MEPS is administered by the Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ) and collects information from respondents on many topics, including demographic characteristics, insurance status, health conditions, and their use of specific health services. We analyzed results from the MEPS household component, which collects data from a sample of families and individuals in selected communities across the United States and is drawn from a nationally representative subsample of households that participated in the prior year's National Health Interview Survey.[1] The MEPS household component features five rounds of interviews, which occur over two full calendar years. MEPS collects information for each person in the household, and information is generally provided by an adult member of the household.

To identify MEPS questions related to health care access, we reviewed the MEPS codebook, which lists all of the MEPS variables available for data analysis, and reviewed prior analyses that used MEPS data to compare access to care in public and private insurance by AHRQ and the Urban Institute. Through these efforts, we identified for further review 29 MEPS questions related to health care access.[2] Once we identified the relevant questions, we compared responses of MEPS respondents in households with children from ages 0 to 19 years who were eligible for the State Children's Health Insurance Program (CHIP) to those who were covered under private insurance, Medicaid, and who were uninsured.[3] Although MEPS combines responses from Medicaid and CHIP-eligible individuals, we consulted with AHRQ to disaggregate these responses. Specifically, we applied the Medicaid and CHIP income eligibility and earnings disregard rules for all 50 states and the District of Columbia to

[1]The National Health Interview Survey is one of the major data collection programs of the Centers for Disease Control and Prevention's National Center for Health Statistics. It provides a cross-sectional household interview survey with participants in each state and the District of Columbia and is used to monitor the health of the United States population through data collection and analysis on a broad range of health topics.

[2]We did not include questions that focused on the quality of care received.

[3]The six access to care questions reflect an age range of 0 to 18 years of age.

identify which respondents were eligible for CHIP versus Medicaid.[4] To ensure we had a large enough sample size for our analysis of CHIP-eligible respondents, we included respondents who were continuously enrolled in CHIP for at least 8 months, and we analyzed responses from respondents enrolled in CHIP, Medicaid, or private insurance for at least eight months or who were uninsured at least 8 months out of the year.[5] In addition, we pooled MEPS survey results from 2007 through 2010, the most recent, complete MEPS data available at the time of our analysis, and combined response choices for some of the MEPS questions. For example, some questions had several response choices, such as "always," "usually," "sometimes," or "never." We combined the four response choices into two response choices (e.g., "usually or always" and "sometimes or never"). Despite these efforts, 8 questions that we originally selected for analysis were excluded because of an insufficient number of responses. Nine additional questions were excluded due to our determination that they were redundant of other questions. As a result, our analyses focused on 12 MEPS questions: 6 questions asked about respondents experiences obtaining care and 6 questions asked about their utilization of specific services. (See table 7.)

[4]An earnings disregard is a portion of earnings from a working family's income that states can exempt in determining income eligibility for certain children's health coverage programs. We obtained information on each state's Medicaid and CHIP income disregards and income eligibility rules for years 2007 through 2010 from Kaiser Family Foundation and state Medicaid and CHIP officials. See http://kff.org/Medicaid/ and http://kff.org/health-reform/ for the Kaiser Family Foundation websites where the annual reports on Medicaid and CHIP are posted. We did not apply earnings disregards related to child care expenses, child support paid, or child support received.

[5]Our analysis did not include responses from individuals who reported more than one source of insurance during a given year.

Table 7: Description of the 12 Medical Expenditure Panel Survey (MEPS) Questions and Survey Items and Related Responses Included in Our Analysis of Survey Data from 2007 through 2010

MEPS questions related to experiences obtaining care	Do you have a usual source of care?
	How difficult was it to reach the usual source of care by telephone during office hours?[a]
	Did you usually or always get care as soon as was needed?[b]
	Did you usually or always get an appointment for health care as soon as was needed?[b]
	Was it usually or always easy to get a person the care, tests or treatment that the parent or a doctor believed necessary?[b]
	Was it usually or always easy to see a specialist?[b]
MEPS survey items related to service utilization	Had an office–based provider visit[c]
	Had an outpatient department provider visit[d]
	Had an emergency room visit[e]
	Had any dental care visit[f]
	Had a general dentist visit[f]
	Had an orthodontist visit[f]

Source: GAO analysis of MEPS data from 2007 through 2010.

Note: Questions are paraphrased from the MEPS survey.

[a]The answer choices for this question were: “very difficult, somewhat difficult, not too difficult, not at all difficult, refused and don’t know.” Certain answer choices were combined as follows: very or somewhat difficult were coded as “difficult”; and not too or not at all difficult were coded as “not difficult.”

[b]The answer choices for this question were: “never, sometimes, usually, always, refused, and don’t know.” Certain answer choices were combined as follows: never or sometimes; usually or always. Also, the age range for this question was from age 0 to age 17 years.

[c]This category of services includes encounters that took place primarily in office-based settings and clinics for all survey years included in our analysis. This category includes the number of office-based visits to physicians and non-physician providers, such as chiropractors, midwives, nurses and nurse practitioners, optometrists, podiatrists, physician’s assistants, physical therapists, occupational therapists, psychologists, social workers, technicians, receptionists/clerks/secretaries, or other medical providers.

[d]This category of services includes the reported visits to hospital outpatient departments for all survey years included in our analysis. It includes the number of outpatient department visits to physicians and non-physician providers.

[e]This variable represents a count of all emergency room visits reported for all survey years included in our analysis.

[f]The “had any dental care” variable includes visits to any person or persons for dental care including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists for all survey years included in our analysis. The “had a general dentist visit” and “had an orthodontist visit” variables are more narrowly defined and refer specifically to visits to general dentists and orthodontists, respectively.

Because factors other than insurance coverage—such as income, parent education, and family composition, may affect access to care, we also ran a multivariate logistic regression analysis of responses to these 12 questions. Based on the literature and in consultation with experts at AHRQ and the Urban Institute, an organization that has conducted past

research on access to care using MEPS data, we identified a number of factors in addition to insurance that could influence access to care and constructed logistic regression models to control for the effects of these factors on our results. The factors we included were age, race, income, total number of parents in the household, parent education, family size, health status, mental health status, children with special needs, total number of workers in the household, metropolitan statistical area, sex, whether the respondent was born in the United States, and English versus non-English speakers.[6] We then tested whether there was a statistically significant difference in the effect of enrollment in CHIP versus other types of insurance coverage on responses to questions about access to care after controlling for these factors.[7] For 9 of the 12 questions in our analysis, there were statistically significant differences between CHIP and certain comparison groups after controlling for other factors.

To determine the reliability of the MEPS data, we reviewed related documentation, identified other studies, including our prior reports, that used MEPS data to address similar research questions, and consulted researchers at AHRQ and the Urban Institute about our analysis. We determined that the MEPS data were sufficiently reliable for the purposes of our report. However, there were several limitations to our analysis. First, to separate CHIP and Medicaid respondents, we relied on state CHIP and Medicaid income eligibility and income disregard rules reported by Kaiser between 2007 through 2010, and did not independently verify

[6]The MEPS Survey factor we used to control for children with special health care needs applies to children age 0 to 17 years.

[7]Statistical significance indicates that the difference between observations is unlikely due to chance alone.

these data.[8] In addition, the information available from Kaiser on each state's income disregard rules was limited and had not been uniformly updated since 2008. Therefore, to account for potential gaps in information, we applied the income disregard rules from the 2008 Kaiser report to MEPS results from 2007 and 2008, and applied unverified 2010 income disregard rules from Kaiser to MEPS results from 2009 and 2010. When discrepancies between the 2008 and 2010 Kaiser data existed, we contacted states for clarification. In the event we could not verify the change in income disregard rules, which was the case with two states, we applied the 2008 income disregard rules for MEPS survey results to all 4 years of our analysis, 2007 through 2010. In addition, our analysis did not account for earnings disregards related to child care expenses, child support paid, or child support received; therefore, the groups we identified as Medicaid- or CHIP-eligible may be understated. Further, our analysis also did not account for income-ineligible respondents. Therefore, there may be some overlap between Medicaid and CHIP respondents or under-reporting of CHIP respondents.[9] Finally, because our analyses reflect an eight-month period of enrollment or uninsurance, the responses may not precisely align with the respondents' current health insurance status, particularly because several MEPS questions refer to respondents' experiences and utilization over the prior 12 months.

[8]Kaiser Commission on Medicaid and the Uninsured, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008* (Washington, D.C.: Kaiser Family Foundation, 2008); *Challenges of Providing Health Coverage for Children and Parents in a Recession: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2009* (Washington, D.C.: Kaiser Family Foundation, 2009); *A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009* (Washington, D.C.: Kaiser Family Foundation, 2009); *Holding Steady, Looking Ahead: Annual Findings of a 50-State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP, 2010-2011* (Washington, D.C.: Kaiser Family Foundation, 2011); and *Determining Income Eligibility in Children's Health Coverage Programs: How States Use Disregards in Children's Medicaid and SCHIP* (Washington, D.C.: Kaiser Family Foundation, 2008).

[9]For example, an income-ineligible respondent could be an individual who reported being enrolled in Medicaid, but whose income exceeded the state's Medicaid income eligibility and earnings disregard rules we applied. These individuals would not be included in the Medicaid group. Similarly, survey respondents who reported being enrolled in CHIP, but whose incomes exceeded the state's CHIP income eligibility and the earnings disregard rules we applied, were not included in our CHIP group.

Appendix II: Coverage for Selected Services in CHIP and Benchmark Plans in Five States

Service			CHIP plan					Benchmark plan				
			CO	IL	KS	NY	UT	CO	IL	KS	NY	UT
Ambulatory patient services	Provider office visits		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Outpatient surgery		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emergency care			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient hospital	Facility		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Professional		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ancillary		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maternity care			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental health	Inpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Outpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Substance abuse treatment	Inpatient		✓	✓	✓	✓	✓	✓	✓	✓	☒	✓
	Outpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescription drugs			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outpatient therapies	Physical	Rehabilitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Habilitative	✓	✓	☒	✓	☒	☒	✓	☒	☒	✓
	Speech	Rehabilitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Habilitative	✓	✓	☒	✓	☒	☒	✓	☒	☒	✓
	Occupational	Rehabilitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Habilitative	✓	✓	☒	✓	☒	☒	✓	☒	☒	✓
Laboratory services	Inpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Outpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Preventive care	Well-child		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Immunizations		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Chronic disease management		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pediatric dental	Routine		✓	✓	✓	✓	✓	✓[a]	✓[a]	✓[a]	✓[a]	✓
	Emergency		✓	✓	✓	✓	✓	✓[a]	✓[a]	✓[a]	✓[a]	☒
	Other		✓	✓	✓	✓	✓	✓[a]	✓[a]	✓[a]	✓[a]	☒
Pediatric vision	Exams		✓	✓	✓	✓	✓	✓	✓[b]	✓[c]	✓[c]	✓
	Corrective lenses		✓	✓	✓	✓	☒	☒	✓[b]	✓[c]	✓[c]	☒
Pediatric hearing	Testing		✓	✓	✓	✓	✓	✓	☒	☒	✓	✓
	Hearing aids		✓	✓	✓	✓	☒	✓	✓	☒	✓	☒
Durable medical equipment			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

	CHIP plan					Benchmark plan				
Service	**CO**	**IL**	**KS**	**NY**	**UT**	**CO**	**IL**	**KS**	**NY**	**UT**
Home- and community-based health care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospice	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Legend: ✓= yes; ☒ = no.

Source: GAO analysis of data from CHIP and benchmark plan Evidences of Coverage and contact with state and health plan officials in Colorado, Illinois, Kansas, New York, and Utah.

Notes: CHIP plan data for Colorado and Utah was effective from July 1, 2012, through June 30, 2013, and for Illinois, Kansas, and New York, it was effective calendar year 2013. Benchmark plan data was effective as of December 26, 2012, the deadline for benchmark plan selection.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and its implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]State selected CHIP plan as its supplemental dental benchmark plan.

[b]State selected FEDVIP as its supplemental vision benchmark plan.

[c]State selected CHIP as its supplemental vision benchmark plan.

Appendix III: Copayments, Coinsurance, and Annual Coverage Limits for Selected Services in CHIP and Benchmark Plans in Five States

Tables 8 through 12 provide information on copayments, coinsurance, and annual coverage limits for selected services in the State Children's Health Insurance Program (CHIP) and benchmark plans in each of the five states we reviewed: Colorado, Illinois, Kansas, New York, and Utah.[1] States' CHIP and benchmark plans may also include a deductible, which was the case for all five states' benchmark plans and one state's CHIP plan. For all five states, cost-sharing for individuals and families was also subject to an out-of-pocket maximum cost. For CHIP enrollees, the out-of-pocket maximum cost amount was applied by the plans as established by federal statute, limited to 5 percent of a family's income, and included all consumer costs, including premiums.[2] For the benchmark plans, the out-of-pocket maximum cost for benchmark plans was established by each issuer, did not include premium costs, and was sometimes in addition to the deductible.

[1]Mental health and substance abuse services had the same cost-sharing amounts and annual coverage limits in three of the five states, and were therefore combined into a single category for all states except New York and Utah.

[2]All CHIP costs (deductibles, cost-sharing amounts, and premiums) count toward a 5 percent out-of-pocket maximum cost, which varies by income level, and in 2013 ranged from $1,766 for a family of four at 150 percent of the FPL to $4,710 for a family of four at 400 percent of the FPL.

Table 8: Cost-Sharing Amounts and Annual Coverage Limits for Selected Services in the State Children's Health Insurance Program (CHIP) and Benchmark Plans in Colorado

Service		CHIP plan: Copay ($)/coinsurance (%) by federal poverty level (FPL)			CHIP plan	Benchmark plans	
		101-150%	151-200%	201-250%	Annual coverage limits	Copay ($)/ coinsurance (%)	Annual coverage limits
Ambulatory patient services: office visits	Primary care physician	$2	$5	$10	None	$30	None
	Specialty physician	$2	$5	$10	None	$50	None
Emergency care		$3	$30	$50	None	20%	None
Inpatient hospital		$2	$20	$50	30 days for rehabilitation therapies[a]	20%	100 days for skilled nursing hospital bed
Maternity care		$0	$0	$0	1 metabolic screening, 1 postpartum visit, and 1 prescreening visit	$0	None
Mental health and substance abuse	Inpatient	$0	$0	$0	None	20%	None
	Outpatient therapy	$2	$5	$10	None	$15 per group therapy session $30 per individual therapy session	None
Prescription drugs	Generic	$1	$3	$5	None	$15[b]	None
	Brand-name	$1	$10	$15	None	$30[b,c]	None
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$2	$5	$10	40 visits[d]	$30	20 visits per therapy type[e]
	Habilitative	$2	$5	$10	40 visits[d]	Not covered	Not covered
Preventive care		$0	$0	$0	None	$0	None
Pediatric dental	Routine	$0	$0	$0	$600[f]	Same as CHIP	Same as CHIP
	Other[g]	$0	$5	$10	$600[f]	Same as CHIP	Same as CHIP
Pediatric vision	Optometrist exam	$0	$0	$0	1 exam	$30	None
	Corrective lenses	$0	$0	$0	$150	Not covered	Not covered
Pediatric hearing	Testing	$0	$0	$0	None	$30	None
	Hearing aids	$0	$0	$0	1 aid every 5 years	20%	1 aid every 5 years

Service	CHIP plan: Copay ($)/coinsurance (%) by federal poverty level (FPL)			CHIP plan	Benchmark plans	
	101-150%	151-200%	201-250%	Annual coverage limits	Copay ($)/ coinsurance (%)	Annual coverage limits
Durable medical equipment	$0	$0	$0	$2,000	20%	$2,000
Home- and community-based health care	$0	$0	$0	None	20%	28 hours per week[h]
Hospice	$0	$0	$0	9 months[i]	20%	None

Source: GAO analysis of the Colorado Access HMO+ plan CHIP plan and the Kaiser Foundation Health Plan of Colorado HMO 1200D benchmark plan Evidences of Coverage and information from state and plan officials.

Notes:

The CHIP plan was in effect July 1, 2012, through June 30, 2013. The benchmark plan was in effect as of December 26, 2012, the deadline for benchmark plan selection, with the Colorado Access HMO+ CHIP plan supplementing the pediatric dental benefit. For the benchmark plans, the coinsurance amounts (numbers given as percentages) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers given as dollars) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost. The Colorado CHIP plan did not include a deductible while the benchmark plan included a deductible, which was $1,200 for an individual and $3,600 for a family. The benchmark plan out-of-pocket maximum costs were in addition to the deductible and were $2,500 for an individual and $5,000 for a family.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]Rehabilitation therapies are occupational, physical, and speech therapies.

[b]The Colorado benchmark plan subjects enrollees to a separate $100 pharmacy deductible. Payments for prescription drugs are applied to this deductible and accumulate separately from the plan deductible for covered medical services. Each covered family member must meet their individual annual pharmacy deductible before any prescription drug benefit is paid by the health plan.

[c]Brand-name drugs include drugs designated by the plan as “preferred” or included in their formulary.

[d]Outpatient therapy visit limits are per diagnosis, per calendar year. Service is unlimited to children under 3 years of age and speech therapy is unlimited for those with a cleft palate or lip.

[e]Outpatient rehabilitative therapies are covered for children 3 to 6 years of age, and under 3 years of age if not participating in early intervention services. Service is unlimited for children with autism spectrum disorder who are under age 19.

[f]The CHIP plan imposes a $600 maximum benefit for all dental services. Additional limits on routine dental services include: two fluoride varnish treatments per calendar year for children ages 0 to 4 years of age. Full mouth x-ray every 5 years; one panoramic film every 5 years; one prophylaxis per year; two oral evaluations per year; two topical fluoride treatments per year; and one bitewing x-ray per year. Additional limits on other dental services include one amalgam or resin restoration every 2 years; one prefabricated crown per tooth every 2 years.

[g]Other dental services include such services as root canals and fillings.

[h]Home- and community-based health care must not exceed 8 hours per day. An additional 35 hours a week may be approved by the health plan on a case-by-case basis. Those in the Special Services Program (individuals with a terminal illness with a life-expectancy of 1 year or less that are not yet receiving hospice care or benefits) are limited to 15 home health visits per lifetime.

[i]Hospice is available in 3 month increments, which do not have to be consecutive.

Table 9: Cost-Sharing Amounts and Annual Coverage Limits for Selected Services in the State Children's Health Insurance Program (CHIP) and Benchmark Plans in Illinois

Service		CHIP plan: Copay ($)/coinsurance (%) by federal poverty level (FPL)			CHIP plan	Benchmark plans	
		134-150%	151-200%	201-300%	Annual coverage limits	Copay ($)/ coinsurance (%)	Annual coverage limits
Ambulatory patient services: office visits	Primary care physician	$4	$5	$10	None	$20	None
	Specialty physician	$4	$5	$10	None	$40	None
Emergency care		$0	$5	$30	None	Hospital: $0; Emergency room: $150[a]	None
Inpatient hospital		$4[b]	$5[b]	$100	None	10%	None
Maternity care		$0	$0	$0	None	$20	1 routine inpatient newborn exam and 1 hearing screening
Mental health and substance abuse	Inpatient	$4[b]	$5[b]	$100	None	10%	None
	Outpatient therapy	$0	$0	$0	None	$20	None
Prescription drugs	Generic	$2	$3	$3	None	$15[c]	None
	Brand-name	$4	$5	$7	None	$30[d]	None
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$0	$0	$0	None	10%	None
	Habilitative	$0	$0	$0	None	10%	None
Preventive care		$0	$0	$0	None	$0	None
Pediatric dental	Routine	$4	$5	$10	None	$0	Same as CHIP
	Other[e]	$4	$5	$10	None	$0	Same as CHIP
Pediatric vision	Optometrist exam	$0	$0	$0	None	$0	1 exam
	Corrective lenses	$0	$0	$0	None	$0	FEDVIP[f]
Pediatric hearing	Testing	$0	$0	$0	None	Not covered	Not covered[g]
	Hearing aids	$0	$0	$0	None	Not covered	Not covered
Durable medical equipment		$0	$0	$0	None	10%	None
Home- and community-based health care		$0	$0	$0	None	10%	None

	CHIP plan				Benchmark plans	
	Copay ($)/coinsurance (%) by federal poverty level (FPL)					
Service	134-150%	151-200%	201-300%	Annual coverage limits	Copay ($)/ coinsurance (%)	Annual coverage limits
Hospice	$0	$0	$0	None	10%	None

Source: GAO analysis of the Illinois CHIP State plan, Illinois Medicaid State plan, and the Blue Cross Blue Shield of Illinois BlueAdvantage Entrepreneur PPO benchmark plan Evidence of Coverage and information from state and plan officials.

Notes:

The CHIP and Medicaid plans were in effect in calendar year 2013. The benchmark plan was in effect as of December 26, 2012, the deadline for benchmark plan selection, with the Illinois CHIP and Medicaid plans supplementing the pediatric dental benefit, and the Blue Cross and Blue Shield Association Federal Employee Program Blue Vision-High plan supplementing the pediatric vision benefit. For the benchmark plans, coinsurance amounts (numbers given as percentages) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers given as dollars) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost. The Illinois CHIP plan did not include a deductible while the benchmark plan included a deductible, which was $500 for an individual and $1,500 for a family. The benchmark plan out-of-pocket maximum costs were in addition to the deductible and were $1,000 for an individual and $3,000 for a family.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]The emergency room copayment is waived if consumer is admitted to hospital as an inpatient immediately following.

[b]The copayment amount is charged per day.

[c]If generic prescription drugs are ordered through the mail, the cost per prescription is $30.

[d]If brand-name prescription drugs are ordered through the mail, the cost per prescription is $60. Brand-name drugs include drugs designated by the plan as “preferred” or included in their formulary.

[e]Other dental services include such services as root canals and fillings.

[f]The 2012 Federal Employee Dental and Vision Insurance Program annual coverage limits for corrective lenses includes: one pair of standard eyeglass lenses or contact lenses; and one frame (or contacts in lieu of glasses). The plan pays for non-collection frames up to $150 and up to $600 for medically necessary contact lenses.

[g]Pediatric hearing testing was not covered with the exception of one hearing screening for newborns.

Table 10: Cost-Sharing Amounts and Annual Coverage Limits for Selected Services in the State Children's Health Insurance Program (CHIP) and Benchmark Plans in Kansas

		CHIP plan		Benchmark plans	
Service		Copay ($)/ coinsurance (%)	Annual coverage limits	Copay(S)/ coinsurance ($)	Annual coverage limits
Ambulatory patient services: office visits	Primary care physician	$0	None	$25	None
	Specialty physician	$0	None	$25	None
Emergency care		$0	None	$100[a]	None
Inpatient hospital		$0	None	20%	None
Maternity care		$0	None	20%	None
Mental health and substance abuse	Inpatient	$0	None	20%	None
	Outpatient therapy	$0	None	$25	None
Prescription drugs	Generic	$0	None	$15[b]	None
	Brand-name	$0	None	$30[c]	None
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$0	None	$25	Physical and occupational: None Speech: 90 days[d]
	Habilitative	Not covered	Not covered	Not covered	Not covered
Preventive care		$0	None	$0	None
Pediatric dental	Routine	$0	Various[e]	$0	Same as CHIP
	Other[f]	$0	Various[g]	$0	Same as CHIP
Pediatric vision	Optometrist exam	$0	None	$0	Same as CHIP
	Corrective lenses	$0	4 pair	$0	Same as CHIP
Pediatric hearing	Testing	$0	None	Not covered	Not covered
	Hearing aids	$0	Various[h]	Not covered	Not covered
Durable medical equipment		$0	None	20%	None
Home- and community-based health care		$0	None	$0	3 visits for home care education
Hospice		$0	None	$0	$5,000 per insured per lifetime

Source: GAO analysis of the Kansas Sunflower State Health CHIP plan and the Blue Cross and Blue Shield of Kansas Comprehensive Major Medical Blue Choice PPO GF 500 deductible with Blue Rx card benchmark plan Evidence of Coverage and information from state officials.

Notes:

The CHIP plan was in effect in calendar year 2013. The benchmark plan was in effect as of December 26, 2012, the deadline for benchmark plan selection, with the Kansas Sunflower State Health CHIP plan supplementing the pediatric dental and vision benefits. For the benchmark plans, coinsurance amounts (numbers given as percentages) apply after the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers given as dollars) are paid each time

a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost. The Kansas CHIP plan did not include a deductible while the benchmark plan included a deductible, which was $500 for an individual and $1,000 for a family. The benchmark plan out-of-pocket maximum costs were in addition to the deductible and were $1,000 for an individual and $2,000 for a family.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]The emergency care copayment is paid after the Enhanced Accidental Injury Benefit is reached. Under this provision, the consumer pays $0 for covered services associated with any and all accidental injuries incurred up to a maximum of $1,000 per insured per benefit period.

[b]If generic prescription drugs are ordered through the mail, the cost per prescription is $37.50 or less.

[c]If brand-name prescription drugs are ordered through the mail, the cost per prescription is $75 or less. Brand- name drugs include drugs designated by the plan as “preferred” or included in their formulary.

[d]Speech therapy is limited to one service per day up to a maximum benefit of 90 daily services per insured per year.

[e]Routine pediatric dental services include: two exams per year; one comprehensive exam per lifetime; one re-evaluation per year; one set of full mouth (or panoramic x-rays and bitewings) every 3 years: three topical fluoride treatments per year; one sealant per tooth per year; one space maintainer-fixed-unilateral per quadrant per year; one space maintainer-fixed-bilateral per arch per year; one space maintainer-removable-bilateral per arch per year.

[f]Other dental services include such services as root canals and fillings.

[g]Other dental services include one porcelain, resin, or full cast base metal crown every 5 years; one prefabricated steel crown every 2 years; one endodontic therapy and pulpectomy per tooth per lifetime; and dentures every 5 years.

[h]Hearing aid batteries are limited to 6 batteries per month for monaural aids and 12 per month for binaural aids. Batteries for use with cochlear devices are limited to lithium ion (3 per 30 days) or zinc air (6 per 30 days). Batteries for cochlear devices are covered for CHIP-eligible beneficiaries only. Only one type of battery is allowed every 30 days.

Table 11: Cost-Sharing Amounts and Annual Coverage Limits for Selected Services in the State Children's Health Insurance Program (CHIP) and Benchmark Plans in New York

Service		CHIP plan		Benchmark plans	
		Copay ($)/ coinsurance (%)	Annual coverage limits	Copay ($)/ coinsurance (%)	Annual coverage limits
Ambulatory patient services: office visits	Primary care physician	$0	None	$25	None
	Specialty physician	0	None	$50	None
Emergency care		0	None	0%	None
Inpatient hospital		0	None	0%	None
Maternity care		0	1 home care visit for early discharge	0%[a]	1 home care visit for early discharge
Mental health	Inpatient	0	None	0%	30 days
	Outpatient therapy	0	None	0%	30 days
Substance abuse	Inpatient	0	None	$0	30 days
	Outpatient therapy	0	None	0%	60 days
Prescription drugs	Generic	0	None	$15[b]	None
	Brand-name	0	None	$35[b,c]	None
Outpatient therapies (occupational, physical, speech)	Rehabilitative	0	Physical and occupational: 6 weeks Speech: None	0%	60 visits per condition per lifetime
	Habilitative	0	Physical and occupational: 6 weeks Speech: None	Not covered	Not covered
Preventive care		0	None	$0	None
Pediatric dental	Routine	0	Various[d]	Same as CHIP	Same as CHIP
	Other[e]	0	None	Same as CHIP	Same as CHIP
Pediatric vision	Optometrist exam	0	1 exam[f]	Same as CHIP	Same as CHIP
	Corrective lenses	0	1 pair[g]	Same as CHIP	Same as CHIP
Pediatric hearing	Testing	0	1 test	$0	None
	Hearing aids	0	None	0%	$1,500 1 aid every 3 years
Durable medical equipment		0	None	0%	$1,500[h]
Home- and community-based health care		0	40 visits	0%	40 visits
Hospice		0	None	0%	210 days

Source: GAO analysis of the Fidelis Care New York CHIP plan and the New York Oxford Health Insurance, Inc. Oxford EPO benchmark plan Evidence of Coverage and information from state and plan officials.

Notes:

The CHIP plan was in effect in calendar year 2013. The benchmark plan was in effect as of December 26, 2012, the deadline for benchmark plan selection, with the Fidelis Care New York CHIP plan supplementing the pediatric dental and vision benefits. For the benchmark plans, coinsurance amounts (numbers given as percentages) apply after the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers given as dollars) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost, unless otherwise indicated. The New York CHIP plan did not include a deductible while the benchmark plan included a deductible, which was $2,850 for an individual and $5,700 for a family. The benchmark plan out-of-pocket maximum costs included the deductible and were $2,850 for an individual and $5,700 for a family.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]Maternity care is only subject to the deductible for the initial visit.

[b]Enrollees pay 100 percent of costs for prescription drugs until they've reached their deductible, after which they pay the copayment amount listed here.

[c]Brand-name drugs include drugs designated by the plan as "preferred" or included in their formulary.

[d]Routine pediatric dental services include prophylasis every 6 months; topical fluoride at 6 month intervals where the local water supply is not fluoridated; one exam every 6 months; full mouth x-rays at 36 month intervals if necessary; bitewing x-rays at 6-to12-month intervals or panoramic x-rays at 36 month intervals.

[e]Other dental services include such services as root canals and fillings.

[f]Optometrist exams are limited to one per year, unless they are required more frequently, and the enrollee has the appropriate documentation.

[g]Enrollees are limited to one frame and one set of lenses per year, unless they are required more frequently, and the enrollee has the appropriate documentation.

[h]This limit is on non-essential durable medical equipment.

Table 12: Cost-Sharing Amounts and Annual Coverage Limits for Selected Services in the State Children's Health Insurance Program (CHIP) and Benchmark Plans in Utah

		CHIP plan				Benchmark plan	
		Copay ($)/coinsurance (%) by federal poverty level (FPL)					
Service		<100%	100-150%	151-200%	Annual coverage limits	Coinsurance (%)	Annual coverage limits
Ambulatory patient services: office visits	Primary care physician	$3	$5	$25	None	30%	None
	Specialty physician	$3	$5	$40	None	30%	None
Emergency care		$3	$5	$300[a]	None	30%	None
Inpatient hospital		$50	$150[a]	20%	None	30%	None
Maternity care		20%	20%	20%	None	30%	None
Mental health	Inpatient	$50	$150[a]	20%	None	30%	30 days
	Outpatient therapy	$3[b]	$5[b]	$40[b]	None	30%	8 visits
Substance abuse	Inpatient	20%	20%	20%	None	30%	Combined with mental health
	Outpatient therapy	20%	20%	20%	None	30%	Combined with mental health
Prescription drugs	Generic	$1	$5	$15	None	50%	None
	Brand-name	$1	5%[c]	25%[c]	None	50%[d]	None
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$3	$5	$40[a]	20 visits (all therapies combined)	30%	20 visits (all therapies combined)
	Habilitative	Not covered	Not covered	Not covered	N/A	30%	20 visits (all therapies combined)
Preventive care		$0	$0	$0	None	$0	None
Pediatric dental	Routine	$0	$0	$0	2 cleanings	30%	Various[e]
	Other[f]	$0	5%[c]	20%	None	Not covered	Not covered
Pediatric vision	Optometrist exam	$3	$5	$40	1 exam	30%	1 exam[g]
	Corrective lenses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Pediatric hearing	Testing	$3	$5	$40	1 test	$0	Not covered
	Hearing aids	Not covered[h]	Not covered[h]	Not covered[h]	Not covered	Not covered	Not covered
Durable medical equipment		$3	5%	20%	None	30%	Various[i]
Home- and community-based health care		$3	5%	20%	None	30%	30 visits

Service	CHIP plan: Copay ($)/coinsurance (%) by federal poverty level (FPL)				Benchmark plan	
	<100%	100-150%	151-200%	Annual coverage limits	Coinsurance (%)	Annual coverage limits
Hospice	$3	5%	20%	None	30%	Up to 6 months within 3 years

Source: GAO analysis of the Utah CHIP Select Health plan and the Utah Public Employee's Health Program Utah Basic Plus benchmark plan Evidences of Coverage and information from state and plan officials.

Notes:

The CHIP plan was in effect in July 2012, through June 30, 2013. The benchmark plan was in effect as of December 26, 2012, the deadline for benchmark plan selection. Coinsurance amounts (numbers given as percentages) apply once the deductible is met unless otherwise indicated. Copayments (numbers given as dollars) are paid each time a consumer receives a service and are not subject to the deductible, unless otherwise indicated. The Utah CHIP plan did not include any deductibles for enrollees at or below100 percent of the FPL; had a $40 deductible for individuals and families for enrollees from 101 to150 percent of the FPL, with no dental deductible; and a $500 individual deductible and $1,500 family deductible for enrollees between 151 and 200 percent of the FPL, with a $50 and $150 dental deductible for a child and family, respectively. The Utah benchmark plan deductible were $3,000 for an individual and $6,000 for a family. The benchmark plan out-of-pocket maximum costs included the deductible and were $6,050 for an individual and $12,100 for a family.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]This copayment is paid after the deductible is met.

[b]This is the copayment for outpatient therapy office visits.

[c]This coinsurance is not subject to the deductible.

[d]Brand-name drugs include drugs designated by the plan as “preferred” or included in their formulary.

[e]Routine pediatric dental services include oral exams 2 times a year, ages 3 to18; complete mouth x-rays, once a year for members ages 13 to18 (or panorex once during any 3 year period in lieu); full series bitewing x-rays, twice a year; vertical bitewings up to eight films; cleaning two times a year; sealants on permanent molars once during any 5 year period for eligible dependents through 17 years.

[f]Other dental services include such services as root canals and fillings.

[g]This annual limit is for children 5 to18 years; one routine vision exam per plan year for children between 3 and 5 is covered as a preventive service.

[h]Hearing aids are not covered by CHIP unless following cochlear implants.

[i]Pre-authorization is required for durable medical equipment over $750 and rentals that exceed 60 days; one lens after corneal transplant surgery; one pair of ear plugs within 60 days following surgery; continuous passive motion machines up to 21 days; one artificial eye prosthetic every 5 years; one breast prosthetic per affected breast every 2 years; one wheelchair every 5 years; one knee brace per knee every 3 years.

Appendix IV: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

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