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Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans
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Section 2105(d)(3)(C) of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services (HHS) to review the benefits and cost sharing in qualified health plans (QHP) and certify those plans that offer benefits and cost sharing that are at least comparable to the Children's Health Insurance Program (CHIP). This certification provides the results of that review.

Background

CHIP provides federal funds to assist states in obtaining or providing coverage to uninsured low-income children who do not qualify for Medicaid. Congress established CHIP in 1997 in the Balanced Budget Act and recently extended its funding through federal fiscal year 2017. Since CHIP was established in 1997, children's participation in Medicaid and CHIP has grown steadily. The most recent data indicate that over 87 percent of eligible children are enrolled in CHIP and Medicaid.[1]

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) created an additional coverage option for individuals and families purchasing insurance in the private market. The new Health Insurance Marketplaces (Marketplaces) offer a choice of health plans that meet certain benefit and cost standards, known as QHPs. The Affordable Care Act provides financial assistance to eligible individuals and families purchasing affordable, quality insurance in Marketplaces. Thanks in part to CHIP and the additional options in the Affordable Care Act, the rate of uninsured children has been reduced to a record low.

Section 2105(d) (3) (C) requires that, in 2015, the Secretary of HHS "review the benefits offered for children and the cost sharing imposed with respect to such benefits by qualified health plans and certify those plans that offer benefits for children and impose cost-sharing with respect to such benefits that the Secretary determines are at least comparable to the benefits offered and cost sharing protections provided under the State child health plan."

If a state experiences a federal funding shortfall for CHIP, the Affordable Care Act's maintenance of effort requirement (which is established in section 2105(d)(3)(A) of the Act) would no longer apply to separate CHIPs. In that event, for children who are not Medicaid eligible, states must "establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary" under section 2105(d)(3)(C) of the Act. With the extension of CHIP funding in the Medicare Access and CHIP Reauthorization Act of 2015, we do not anticipate states will experience a federal funding shortfall for at least the next two years.

[1] Genevieve M. Kenney, Nathaniel Anderson, Victoria Lynch. 2013. Medicaid/CHIP Participation Rates Among Children: An Update. Urban Institute. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412901-Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf.

CHIP and Marketplace Coverage

CHIP and the Marketplaces offer different approaches to making coverage affordable for consumers. CHIP was established as a companion program to Medicaid to serve uninsured children whose family incomes exceeded Medicaid eligibility levels. As such, CHIP provides more affordable coverage than is generally available in the private health insurance market and provides benefits specifically targeted for children. QHPs, which must meet certain benefit and affordability standards, were created in 2010 through the Affordable Care Act as an additional coverage option for individuals and families purchasing insurance in the private market.

CHIP Coverage and Cost Sharing

In CHIP, federal cost sharing and benefits standards depend on the state's CHIP design. States have three options for the design of their CHIP programs: (1) expand coverage for children through the Medicaid program;[2] (2) create a separate program for low-income uninsured children (and, at state option, pregnant women) who are not eligible for Medicaid;[3] or (3) extend coverage to low-income children through a combination of a Medicaid expansion CHIP and a separate CHIP.[4] In 2013, over 8 million children were enrolled in CHIP, including approximately 2.5 million children in Medicaid expansion CHIP programs and 5.5 million in separate CHIPs.[5]

States provide separate CHIP benefits that are based on one of three options: (1) benchmark coverage with benefits that are the standard Blue Cross/Blue Shield preferred provider option offered to Federal employees, the state employee's coverage plan, or the HMO plan that has the largest commercial, non-Medicaid enrollment within the state; (2) benchmark equivalent coverage, with benefits actuarially equivalent to one of the benchmarks in (1); or (3) Secretary approved coverage. Some separate CHIPs provide early and periodic screening diagnostic and treatment (EPSDT) benefits, based on the Medicaid EPSDT benefit. The EPSDT benefit includes comprehensive health care services for children ranging from preventive and acute care to potentially long-term care for serious physical, mental, and developmental conditions. EPSDT benefits are considered to be more comprehensive than any commercial benefit package.

In separate CHIPs, total out-of-pocket expenditures (premiums, deductibles, copayments, and coinsurance) are limited to 5 percent of total family income, but states have discretion to determine premiums and cost sharing levels within that parameter. As a result, premiums vary significantly by state in CHIP. Some states do not charge premiums at any income level. Others charge premiums on a sliding scale, and some charge premiums or enrollment fees to all CHIP beneficiaries. Cost sharing also varies significantly by state. States may charge nominal cost sharing for children in families earning below 150 percent of the federal poverty level (FPL) and have more flexibility to design cost sharing for families above 150 percent FPL. Medicaid expansion CHIPs follow Medicaid cost-sharing rules, which allow only limited cost sharing for children.

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[2] Currently, eight states (AK, HI, MD, NM, OH, SC, NH, and VT) and the District of Columbia enroll all CHIP-eligible children from birth to age 19 in a Medicaid expansion program.

[3] Two states (CT and WA) enroll all CHIP-eligible children in a separate CHIP.

[4] The remaining 40 states use a combination of a Medicaid expansion program and a separate CHIP, such that a portion of the CHIP child population in the state is enrolled in a Medicaid expansion program (e.g., children of a certain age or up to a certain income) and the remainder is in a separate CHIP.

[5] Unduplicated, ever enrolled for the year as reported in the CMS Statistical Enrollment Data System.

Marketplace Coverage and Cost Sharing

Marketplace coverage provides financial assistance to eligible individuals and families purchasing private insurance products to reduce out-of-pocket spending, such as premiums, co-pays, and deductibles. In addition, total out-of-pocket expenditures in QHPs are limited to $6,600 for an individual plan and $13,200 for a family plan in 2015. QHPs use actuarial value (AV) to reflect plan generosity as related to the amount the consumer could be expected to pay in deductibles, coinsurance, and copayments. AV is commonly used as a measure of the percentage of expected health care costs for covered services that a health plan will pay.

QHPs must provide ten essential health benefits (EHBs), and states could choose a benchmark plan to define EHBs for QHPs. The benchmark options include: (1) the largest health plan by enrollment in any of the three largest small group insurance products in the state's small group market; (2) any of the three largest state employee benefit plans; (3) any of the three largest national Federal Employees Health Benefits Program plans; and (4) the largest insured commercial non-Medicaid HMO operating in the state. If a state did not choose a benchmark plan, it was assigned the default benchmark of the largest plan by enrollment in the largest product by enrollment in the State's small group market.

QHP issuers have the option of substituting benefits within EHB categories as long as the AV of the plan remains the same. Therefore, in each category a QHP may offer more or fewer benefits than the benchmark, although benefits cannot be unduly weighted toward any one category.

Comparison of Cost Sharing and Benefits

HHS reviewed the second lowest cost silver plan (SLCSP) in the largest rating area in each state to compare it to CHIP in that state and determined that CHIP and Marketplace coverage offer beneficiaries different levels of financial protection and benefits, reflecting the programs' different purposes and structure as established in statute. The review found that the average out-of-pocket spending in the SLCSP was higher than out-of-pocket spending in CHIP for CHIP eligible children in all states reviewed, on a per child basis under CHIP and under SLCSP with financial assistance. In addition, the AV of CHIP exceeds the AV of the SLCSP in every state reviewed except Utah, where the CHIP and SLCSP AVs are equivalent. This finding indicates that families are expected to pay for a larger percentage of expected covered health care costs in QHPs than CHIP in all but that state. When premiums are taken into account, Utah's average out-of-pocket spending in the SLCSP was higher than out-of-pocket spending in CHIP.

HHS also reviewed benefit comparisons and determined that benefit packages in CHIP are generally more comprehensive for "child-specific" services (such as dental, vision, and habilitation services) and for children with special health care needs as compared to those offered by QHPs. CHIP coverage of "core" benefits (such as physician services, laboratory, and radiological services) is similar between CHIP and QHPs.

Certification

Accordingly, and based on this review, the Secretary is not certifying any QHPs as comparable to CHIP coverage at this time. Because the allotments provided under section 2104 of the Act are sufficient to provide coverage to all children who are eligible to be targeted low-income children at this time and in the foreseeable future, the requirement at 2105(d)(3)(B) of the Act that requires states to establish processes to enroll children in certified QHPs does not apply.

Table 1: Comparing CHIP and SLSCP in 36 states

		Plan AV[6]		Average Premium + Cost Sharing OOP $[7]	
State	**CHIP offers EPSDT benefits**	**SLCSP**	**CHIP**	**SLCSP**	**CHIP**
Alabama		0.62	0.94	$1,455	$175
Arkansas		0.78	0.94	$896	$ 65
Colorado		0.65	0.95	$1,178	$68
Connecticut		0.71	0.96	$1,756	$154
Delaware		0.84	1.00	$805	$129
Florida (ages 0-1)	X-[8]	0.92	1.00	$787	$-
Florida(ages 1-5)		0.79	1.00	$781	$116
Florida (ages 6-18)		0.76	0.98	$871	$140
Georgia (ages 0-5)	X-[9]	0.59	1.00	$1,133	$-
Georgia (ages 6-18)	X-[9]	0.60	1.00	$1,170	$221
Idaho	X	0.85	0.99	$647	$163
Illinois	X	0.70	0.97	$1,252	$314
Indiana		0.72	0.98	$1,102	$225
Iowa		0.72	1.00	$1,292	$151
Kansas	X	0.71	1.00	$1,009	$152
Kansas		0.76	1.00	$956	$152
Kentucky		0.66	0.98	$1,037	$23
Louisiana	X	0.59	1.00	$1,597	$322
Maine	X	0.83	1.00	$824	$115
Massachusetts		0.77	1.00	$1,422	$225

[6] This analysis calculated QHP AVs based on child expenditures in order to appropriately compare to CHIP AVs.
[7] Premium+Cost Sharing OOP dollars represent total amounts, per child, paid for by the family. In order to correctly determine the premium paid, premiums were estimated for all family members. An adjustment factor derived from this comparison was then applied to the child only premiums within the family. That is, if a subsidy calculation resulted in only 75% of the theoretical premium for the family being paid by the family (with a 25% subsidy), and then this 75%/25% split was applied to the child-only premium.
[8] EPSDT provided only for children in Florida's Medi-Kids program (kids ages 1-4) or CMSN (children ages 0-19 with special healthcare needs).
[9] State provides all EPSDT benefits except non-emergency transportation.

		Plan AV		Average Premium + Cost Sharing OOP $[7]	
State	**CHIP offers EPSDT benefits**	**SLCSP**	**CHIP**	**SLCSP**	**CHIP**
Michigan		0.84	1.00	$756	$46
Mississippi		0.83	1.00	$848	$-
Missouri	X-[9]	0.62	1.00	$1,492	$829
Montana		0.70	1.00	$1,111	$5
Nevada	X-[9]	0.82	1.00	$765	$91
New Jersey	X/_[10]	0.73	0.98	$1,557	$321
New York		0.74	1.00	$1,396	$326
North Carolina		0.81	0.99	$802	$43
North Dakota		0.87	0.99	$638	$8
Oregon	X/_[11]	0.52	1.00	$1,598	$-
Pennsylvania		0.59	0.99	$1,869	$646
South Dakota	X	0.68	1.00	$1,202	$-
Tennessee		0.67	0.94	$1,103	$64
Texas		0.76	0.91	$814	$75
Utah		0.83	0.83	$750	$247
Virginia		0.88	0.98	$754	$21
Washington	X	0.48	1.00	$1,969	$252
West Virginia	X-[9]	0.67	0.96	$1,441	$245
Wisconsin	X/_[12]	0.67	0.97	$1,409	$146
Wyoming		0.81	0.97	$830	$32

[10] NJ offers EPSDT only in the plan offered to lower income children (under 200% FPL).
[11] OR offers EPSDT only in the plan offered to lower income children (under 200% FPL).
[12] WI offers EPSDT only in the plan offered to lower income children (under 200% FPL).