Georgetown University Health Policy Institute
CENTER FOR CHILDREN AND FAMILIES

CHILDREN'S ACTION ALLIANCE

Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs

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Executive Summary

On January 31, 2014, an estimated 14,000 Arizona children lost their health coverage under KidsCare II, a temporary extension of the state's Children's Health Insurance Program (CHIP). But in fact, Arizona began to dismantle its CHIP program, which provided stable, affordable coverage for uninsured children with family income at or below 200 percent of the federal poverty level (FPL), when it froze enrollment in KidsCare effective January 2010. Arizona is the only state in the country to cut eligibility and phase out CHIP over time.[1]

Arizona froze KidsCare enrollment just weeks before Congress enacted the Affordable Care Act (ACA) along with a "maintenance of effort" (MOE) provision that has protected children's Medicaid and CHIP eligibility and enrollment in all other states.[2] In an effort to bridge the gap for Arizona families until new coverage options became available under the ACA, a creative hospital financing agreement between the state and federal government reopened enrollment under KidsCare II in May 2012. Meanwhile, Arizona slipped from 47th to 49th place in children's health coverage, with only Alaska and Nevada having a higher rate of uninsured children.[3]

Many more Arizona children would have lost coverage if not for the ACA's alignment of Medicaid eligibility for children across age groups at 138 percent FPL.[4] As a result, 60 percent of the 37,000 children enrolled in KidsCare II at the end of 2013 were transitioned to Medicaid. The remainder of the children should qualify for premium subsidies to purchase a qualified health plan (QHP) on the federally-run Arizona health insurance marketplace, but only if they do not have access to "affordable" employer-sponsored insurance (ESI). In this context, ESI is considered "affordable" if the cost to the employee for self-only coverage is less than 9.5 percent of family income, regardless of how much it costs to enroll the whole family. Families caught in this circumstance, often called the "family glitch," will not be able to get financial assistance to purchase a QHP in the marketplace, putting their children at greater risk of becoming uninsured.

If eligible for subsidized premiums in the marketplace, these families would also qualify for reduced cost-sharing when using health care services,[5] but all QHPs require enrollees to pay some combination of deductibles, co-payments and/or co-insurance. In contrast, services covered by KidsCare required no cost-sharing,

Not all KidsCare families will be able to get financial assistance to purchase a plan in the new health insurance marketplace.

although families did pay monthly premiums. This fundamental distinction, plus differences in benefits, raises concerns over the implications of marketplace coverage for these low-income children.

This analysis examines three real-life scenarios of children and their actual use of health care services to determine what their costs would be if enrolled in plans from three different insurance carriers consistently offering the lowest cost QHPs across Arizona's 15 counties:

- Max, a very healthy 15-year-old boy, who broke his wrist playing soccer;
- Jacob, a 7-year-old boy, in generally good health, but who suffers from the common ailments of asthma, allergies and dental caries; and
- Isabel, a 13-year-old girl who was born prematurely and has cerebral palsy, requiring a broad range of acute and habilitative services that enables her to function and learn at school.

Key Findings

In all but one of the scenarios examined, families would face higher out-of-pocket costs for their children's health care when enrolled in a QHP compared to KidsCare.

Some families will incur costs many times higher in QHPs.

Families at the lowest income levels, and those with more than one child, are even more likely to incur QHP costs that are many times higher than their KidsCare premiums. Additionally, children with significant health care needs will face substantially higher costs and exhaust certain benefits that are essential to their health and wellbeing.

Out-of-pocket costs differ considerably based on plan selection.

Cost-sharing for the same services varies markedly among the QHPs studied. An individual's costs depend on the structure of the drug formulary, use of co-insurance versus co-payments, application of deductibles, and limits on out-of-pocket spending. In the examples studied, parents could select plans with lower cost-sharing but higher premiums, which may be unaffordable for low-income families. These differences can make it difficult for families to weigh the tradeoffs between coverage options and fully understand how plan choice impacts their out-of-pocket costs.

The lack of inclusive dental benefits in the marketplace results in higher out-of-pocket costs for families.

Although pediatric dental benefits are required as part of the essential health benefits available through marketplace plans, QHPs are not required to cover dental services when stand-alone dental plans are available. Stand-alone dental plans require a separate premium and dental cost-sharing, which does not count toward the maximum medical out-of-pocket costs that an individual or family may incur.

Conclusion and Policy Implications

Other studies have reached parallel conclusions and raised issues similar to those highlighted in this report. A study conducted by the Government Accountability Office (GAO) comparing CHIP and QHP benchmark plans in five states concluded that CHIP cost-sharing is almost always lower and that while both coverage options may restrict similar services, CHIP programs tend to feature higher benefit limits.[6] There is ample research that cost-sharing, particularly for low-income families, stresses tight household budgets and reduces the use of routine and timely care, which can have adverse health consequences for children.[7]

While the focus of this brief is to study the financial impact of the loss of KidsCare coverage for Arizona families, the state's experience provides important lessons for the upcoming discussion on the future of CHIP, which is currently funded through September 2015. One of the key questions that will be raised as Congress considers extending CHIP financing is whether subsidized coverage in the marketplace is an adequate alternative for low-income children, although cost

is only one of several key issues that must be examined. Additionally, it is important to note that Arizona's experience does not fully illustrate the cost implications for families in states with higher CHIP income eligibility levels, where children may not qualify for cost-sharing reductions, subjecting their families to dramatic increases in out-of-pocket spending.

Together, Medicaid and CHIP have filled a growing gap in benefits, coverage, and affordability in the private insurance market, and underpin our country's success in reducing the rate of uninsured children to historic lows. Health reform builds on their success by preserving and strengthening these programs, while making strides to improve private insurance and expand access to more affordable coverage options. Still, it will take time for the marketplaces to become established before it is feasible to conduct a full evaluation of how well they serve low-income children.

Introduction

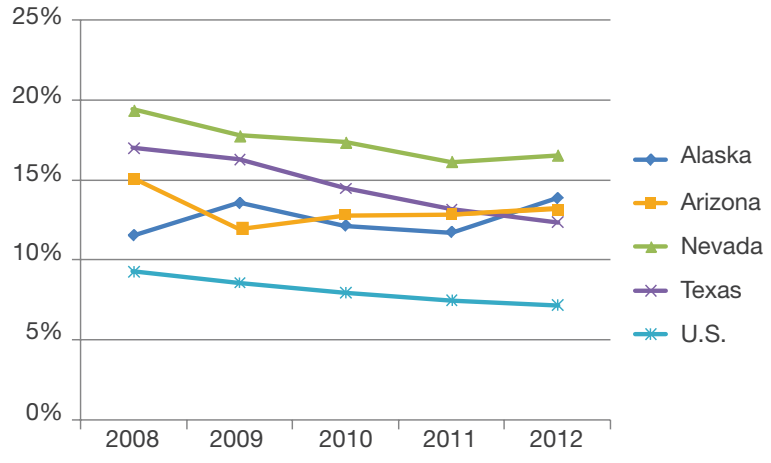
Enacted in 1997, CHIP stands on the shoulders of Medicaid and together these programs have filled the coverage gap for children created by persisting declines in employer-based coverage. Medicaid and CHIP are largely responsible for the gains our country has made in covering children, achieving record high coverage rates of 93 percent, even during an economic downturn that has driven more children into poverty.[8]

In January 2010, Arizona became the first and only state in the country to eliminate coverage under its CHIP program. While currently enrolled children were grandfathered, enrollment of new applicants was frozen. At the time, 12 percent of Arizona children were uninsured,[9] and freezing enrollment in KidsCare worsened the problem as the state slipped from 47th to 49th in its children's coverage rate (see Figure 1). From May 2012 until December 2013, KidsCare II offered a reprieve for low-income families.

Arizona slipped from 47th to 49th place, with only Nevada and Alaska having lower coverage rates for children.

Examining the impact of the loss of KidsCare offers an opportunity to assess the comparability of certain aspects of CHIP and subsidized coverage in the health insurance marketplace, which will be a key question as we look ahead to efforts to extend CHIP funding beyond September 2015. This brief will compare cost-sharing for children between KidsCare and three qualified health plans (QHPs) offered in the federally-facilitated marketplace (FFM) in Maricopa County, Arizona. However, it also raises related issues such as limits on benefits and the complexity for families as they attempt to choose a plan that best meets their needs.

Figure 1. Uninsured Rate for Children Under 18



14,000 children were disenrolled when KidsCare II, Arizona's temporary program, ended.

Background on KidsCare and KidsCare II

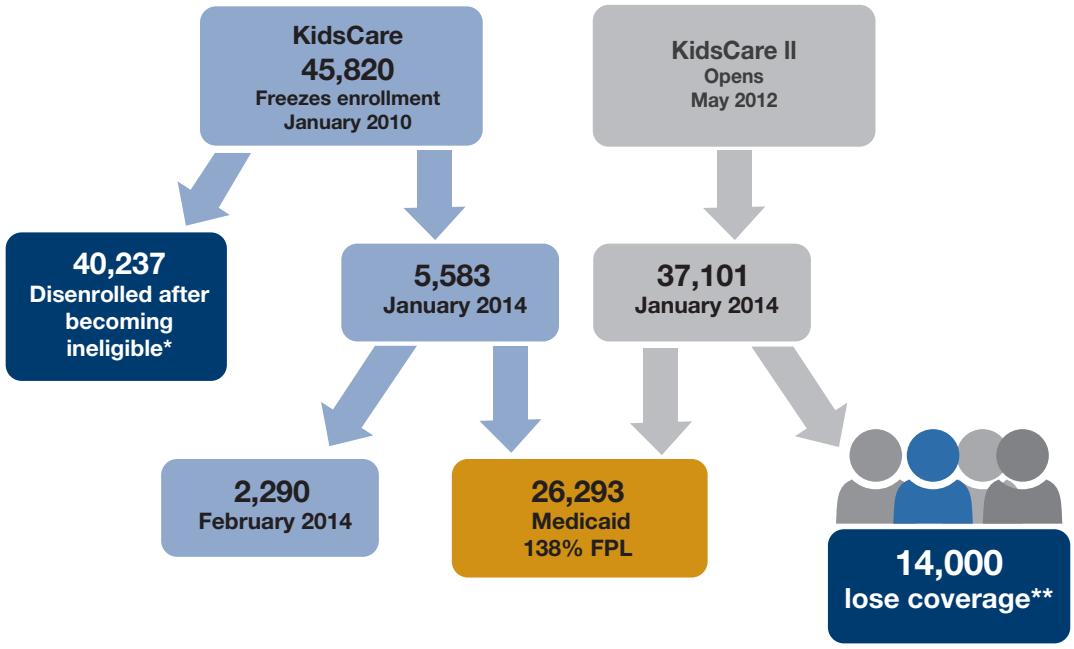
When the Affordable Care Act (ACA) was enacted on March 23, 2010, it recognized the importance of protecting children's coverage by requiring states to hold steady on eligibility and enrollment procedures through a "maintenance of effort" (MOE) provision. But weeks before this critical safeguard went into effect, Arizona began the process of phasing out its CHIP program known as KidsCare. On December 21, 2009, the state stopped enrolling new applicants for coverage effective January 1, 2010, although current enrollees were grandfathered and able to retain their coverage, as long as they remained eligible, renewed their coverage annually, and paid their premiums.[10]

Children were not alone in losing coverage. Arizona, hit especially hard by the recession, also froze enrollment in a Medicaid waiver program that covered adults without dependent children – a change that was estimated to result in the loss of coverage for 100,000 adults.[11]

In an effort to ease the burden on these individuals and address the growing level of uncompensated care costs for the uninsured, three hospitals banded together to help finance temporary coverage for adults. The subsequent agreement between the state and the Centers for Medicaid and Medicare (CMS) required that coverage also be reopened to children.

Arizona's Dismantling of CHIP

History of KidsCare and Kidscare II Enrollment



*Children who aged out, became income ineligible, did not renew, did not pay premiums, or may become eligible for Medicaid.

**These families may apply to the marketplace.

By this time, more than 120,000 children had been put on a waiting list in the event that KidsCare was reinstated. When KidsCare II opened enrollment in May 2012, children with income below 175 percent of the federal poverty level (FPL) who had been on the waiting list the longest were the first to be enrolled. Arizona began accepting new applications in June 2012, and in May 2013, after supplemental funding was made available through a City of Phoenix hospital assessment, the state raised income eligibility back to its original level of 200 percent of the FPL. At the peak of enrollment, KidsCare II served 47,000 children.

Of the 37,000 children enrolled at the end of 2013, 23,000 were transitioned to Medicaid on January 1, 2014 as a result of the ACA's alignment of Medicaid eligibility for children of all ages at 138 percent of the poverty level.[12] The remaining 14,000 children (with family income between 138 and 200 percent of the FPL) were sent two notices:

1) informing them that KidsCare II would end on December 31, 2013, and then
2) extending coverage for one month due to technical issues affecting enrollment through HealthCare.Gov, the federal website through which families could apply for the new coverage options under the ACA.

The federal government also made automated calls encouraging the families to apply.

Given the ongoing challenges accessing coverage through HealthCare.Gov, which were especially pronounced for immigrant and mixed status families, it is not clear how many of these families signed up or how many children remain uninsured due to enrollment barriers, lack of affordability, or other issues. Additionally, some will not be eligible for financial help in the marketplace due to access to what is deemed to be "affordable" family employer-sponsored coverage.

Analysis

While it will be some time before the impact on coverage or utilization of health care services can be fully assessed, it is possible to anticipate the financial implications for low-income families with children who would have been eligible for KidsCare compared to select marketplace plans. This analysis assumes children will receive financial help in purchasing a QHP, but this is not the case for all children. Families do not qualify for premium tax credits (PTCs) or cost-sharing reductions (CSRs) if they have access to "affordable" employer-based coverage in which a self-only plan covering just the employee costs less than 9.5 percent of family income. Known as the "family glitch," this issue is estimated to affect nearly half a million uninsured children with CHIP in place; without CHIP, the number jumps to 2.3 million children.[13] While state level estimates are not available, it is fair to assume that without KidsCare, more Arizona children will lack an affordable source of coverage as compared to states with CHIP programs.

The Qualified Health Plans

Given the level of detail required for this analysis, it was necessary to limit the number of plans compared. It is not intended to be a comparison among QHPs, but instead to provide an illustration of the cost differential between KidsCare and select marketplace plans. QHPs are categorized by metal levels — bronze, silver, gold and platinum. Since families must enroll in a silver-level plan to receive cost-sharing reductions, the analysis only compares silver QHPs. To select the plans, the available silver QHPs across the 15 counties in Arizona were ranked by premiums and issuer to identify the three issuers with the lowest cost silver plans in most of the counties. The analysis was further limited to plans available in Maricopa County, where 60 percent of Arizonans reside. Two of the three plans do not include dental benefits. For comparative purposes, we paired those plans with the lowest cost dental plan available to children in Maricopa County.

It is not clear how many former KidsCare children will remain uninsured due to enrollment barriers, lack of affordability or other issues.

Premiums

A family's expected contribution to purchase a QHP is the same regardless of who in the family is covered.

Children enrolled in KidsCare were subject to premiums of $10, $40 or $50 per child per month (capped at $15, $60 and $70 per month for two or more children) based on income. QHP premiums are also based on income; with families in the range of KidsCare eligibility (income between $26,951 and $39,060 per year for a family of three)[14] expected to pay between 3 and 6.2 percent of household income in premiums, plus required cost-sharing for services. Notably, a family's expected premium contribution to purchase a QHP in the marketplace is the same regardless of how many members of the family are enrolled. The premium tax credit (PTC) is calculated by subtracting the expected premium contribution from the cost of the benchmark plan (the second-lowest cost silver plan). In essence, the premium tax credit is the discount that families can use to lower the cost of the plan they select.[15] If they choose a plan that costs more than the benchmark, they would have to pay the additional amount (See box below, which illustrates the premium cost of the three plans used in this analysis).

Premium Contribution and Tax Credits

Peter and Mary have one son, Max, and earn $37,107 per year (190% FPL). They are expected to pay 5.84% of their income or $2,167 per year toward the premium of the second-lowest cost silver (or benchmark) plan. Their expected premium contribution is the same regardless of how many people enroll in the plan. The family is eligible for a premium tax credit equal to the difference between the cost of the second-lowest cost silver plan and their expected premium contribution. The premium tax credit is applied to the cost of the plan they select—meaning if they select a more expensive plan, they will pay the additional cost; if they select a lower cost plan, their final premium cost will be lower.

The benchmark plan for family coverage in Maricopa County costs $477 per month or $5,724 per year. The cost of coverage for the parents only in the same plan is $379 per month or $4,548.

Calculating their premium tax credit	Family	Parents Only
Cost of benchmark plan	$5,724	$4,548
Less premium contribution	- $2,167	- $2,167
Premium tax credit	$3,557	$2,381

Family Coverage

	Plan A (Benchmark)	Plan B	Plan C
Annual Cost	$5,724	$7,320	$7,560
Premium Tax Credit	$3,557	$3,557	$3,557
Premium Cost to Family	$2,167	$3,763	$4,003
Additional Cost above the Benchmark	n/a	$1,596	$1,836
Percent of Family Income Paid in Premiums	5.8%	10.1%	10.8%

Dental coverage may also come at an additional premium cost. Although pediatric dental care is a required component of the essential health benefit package, QHPs are not required to provide dental benefits if coverage is available through stand-alone dental plans. If families select a QHP that does not cover dental services, they will pay more for this key aspect of children's coverage. Additionally, dental cost-sharing in separate dental plans does not count toward the medical deductible or maximum out-of-pocket costs that families may incur.

Cost-Sharing

KidsCare covered 100 percent of the cost of covered services– meaning there were no deductibles, copayments or coinsurance. On the other hand, the different QHP coverage levels — bronze, silver, gold, platinum — on average, cover between 60 and 94 percent of aggregate costs, depending on income and plan selected. Plans have flexibility in determining how they structure cost-sharing in order to meet the applicable coverage values.

Children who were eligible for KidsCare should qualify for cost-sharing reductions in silver QHPs that cover either 94 percent or 87 percent of aggregate costs. Families with income less than 150 percent of the FPL level will have a higher portion of costs paid and therefore incur lower cost sharing than those with income between 151 and 200 percent of the FPL. To reflect these differences, the cost-sharing was calculated based on two income scenarios – 140 and 190 percent of the FPL.

Comparison of KidsCare and QHPs

In comparing the sources of coverage, the ***additional costs that families incur to secure health care for their children above whatever costs they incur for their own health care*** are examined. Given the different premium and cost-sharing structures in KidsCare compared to QHP coverage, this analysis compares KidsCare premiums to the cost-sharing these children would sustain if enrolled in each of the three QHPs studied, along with any additional premium and cost-sharing for separate dental coverage (see Table below). It is also noted where families would pay an additional monthly premium if enrolled in a plan that costs more than the benchmark.

If families select a QHP that does not cover dental services, they will pay more for this coverage.

Cost-Sharing Comparison: KidsCare and Select QHPs

	KidsCare		QHP Financial Assistance for Eligible Families	
Income	Premiums	Plan Coverage of Cost of Services	Premiums	Plan Coverage of Cost of Services
140% FPL ($27,342 for a family of 3)	$10 per month per child	100%	No additional cost for children if dental coverage is included	94% of average costs
190% FPL ($37,107 for a family of 3)	$50 per month per child	100%	No additional cost for children if dental coverage is included	87% of average costs

Covered Benefits

KidsCare provided children with the full range of medical, dental, vision and hearing services covered under Medicaid known as Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT is considered to the be gold standard for children's health coverage by the American Academy of Pediatrics.[16]

QHPs are required to cover the essential health benefits (EHB) package encompassing ten major categories of services based on a benchmark plan selected by the state, which in Arizona is the State Employee Exclusive Provider Organization (EPO) Plan.[17] Pediatric services, specifically hearing, vision and oral health care, as well as habilitative services, are explicitly included in the EHB and must be supplemented if the state QHP benchmark does not include them. The state may define those services or leave it to the discretion of each QHP. For pediatric dental and vision services, Arizona requires QHPs to offer benefits available through the federal employee vision and dental plan. The state allows plans to define habilitative services.

States may leave it to health plans to define habilitative and pediatric hearing, vision and oral health services.

Children's Health Care Utilization

To examine the financial implications for families with children who have varying health needs, this brief analyzes the specific care of three children. Each child received both routine medical and dental checkups during the year in addition to the care described below.

- Max is a healthy 15-year-old who broke his wrist playing soccer. This required initial emergency treatment and casting, but was not severe enough to require ongoing physical therapy. Also, his acne is being treated with prescription medications. To put Max's health care in perspective, about one-third of children suffer a broken bone before the age of 17.[18] By mid-teens, more than 40 percent of adolescents have acne or acne scarring, which requires treatment by a dermatologist.[19]
- Jacob, a generally healthy 7-year old, is one of those unlucky children experiencing the common childhood ailments of allergies and asthma. Upwards of 40 percent of children live with some form of allergic reaction,[20] such as seasonal or food allergies, and 9.5 percent of American children have been diagnosed with asthma.[21] Despite regular oral health care, Jacob is also prone to dental cavities, the most common childhood chronic disease, which impacts 42 percent of children by age 11.[22]
- Isabel was born prematurely and has cerebral palsy. Her health care needs are extensive and include a broad range of acute and ongoing habilitative services that enable her to function and learn at school. Cerebral palsy is the most common cause of severe physical disability among children, occurring in approximately 2 in 1,000 births.[23] Notably, approximately 15 percent of children have a developmental disability, including attention deficit hyperactivity disorder, or a debilitating chronic health condition, such as cystic fibrosis, cerebral palsy and epilepsy.[24]

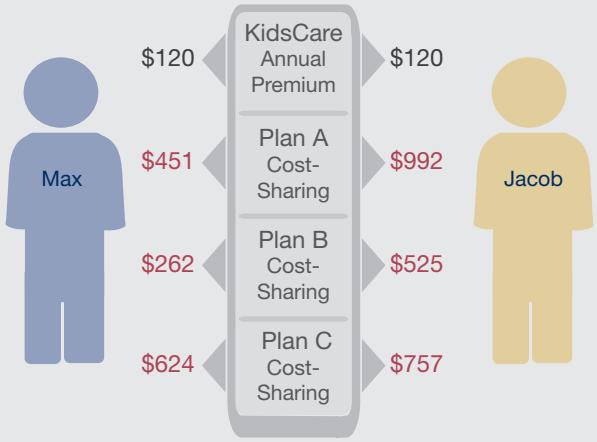
Profiles of the health care utilization of these children in a one-year span were developed through interviews with their parents and reviewed for medical reasonableness by a pediatrician.[25] The children's actual utilization was then compared to the benefit coverage and cost-sharing requirements of the three selected QHPs to determine which of their services would be covered and what their families would pay for their needed care, both in cost-sharing for covered services and out-of-pocket for non-covered services. Details on each child's health care needs and the methodology used are described in Appendix A and B.

The Findings and Implications for Arizona Families

To analyze the financial implications for families, only what they would pay for their children's health care are examined.

For all three children, in all but one of the scenarios examined, families will face higher costs for their children's health care when enrolled in a QHP compared to KidsCare.

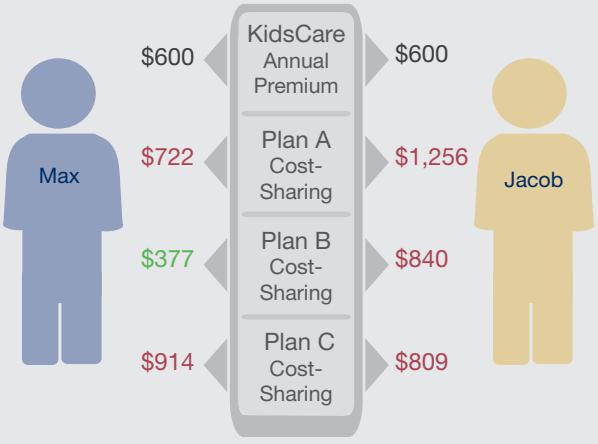
At 140% FPL - 94% Cost Sharing Level



At the lower income level (140 percent of the FPL), families paid $120 annually in premiums for one child. In all QHPs, both Max and Jacob incur higher costs than in KidsCare.

Cost-sharing for services may be lower in a non-benchmark QHP but premiums will be higher.

At 190% FPL - 87% Cost Sharing Level



At the higher income level (190 percent of the FPL), families paid $600 annually in premiums for one child. Jacob's cost-sharing would be higher in all three QHPs. Max's cost-sharing was higher in two QHPs and lower in one. *Importantly, his family would pay an additional $1,596 annual premium to enroll in the plan that offers lower cost-sharing.*

The cost difference between the QHPs and KidsCare is many times larger for lower income families.

For the lower income level family, the cost-sharing that would be incurred by Max and Jacob is between 2.2 and 8.3 times higher than KidsCare. At the higher income level (excluding Plan B for Max), the family's cost-sharing increase is more modest – ranging from 1.2 and 2.1 times more than their KidsCare premiums.

Families with more than one child pay considerably more in QHP costs than in KidsCare.

Premiums were capped in KidsCare, effectively lowering the cost for a family with multiple children. At the 140 percent of FPL income level, families with two or more children would pay $15 per month or $180 per year; premiums at the 190 percent of the FPL would be $70 per month for two or more children. If Max and Jacob were brothers, their family's costs would be 1.4 to 8 times higher than KidsCare. In families with three or more children, the difference between their capped KidsCare premiums and cost-sharing in the QHPs would be even greater.

If Max and Jacob were brothers	KidsCare Annual Premium	Plan A Cost-Sharing	Plan B Cost-Sharing	Plan C Cost-Sharing
At 140% FPL	$180	$1,443	$787	$1,381
At 190% FPL	$840	$1,978	$1,217	$1,723

Children with significant health care needs will face substantially higher out-of-pocket costs in the marketplace, as well as limits on benefits, which will be especially difficult for lower income families who cannot afford to pay for non-covered services.

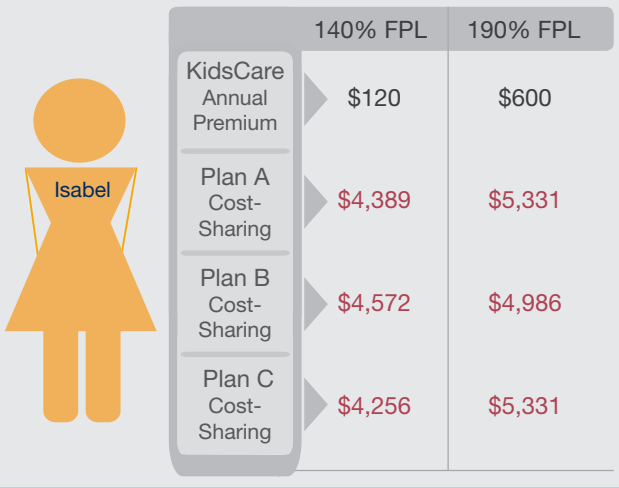
While protected by a limit on out-of-pocket spending, children with special health care needs may max out certain benefits.

Isabel has extensive health care needs. In KidsCare, she would have qualified for the full array of medically-necessary services under EPSDT and her cost in KidsCare is dwarfed in comparison to the cost-sharing she would incur under all QHPs studied. She hits the maximum out-of-pocket limit within the first three to four months in many of the plans, after which covered services are fully paid for by the plan (see table on page 11). However, these plans do not cover all of the services she needs. Although QHPs cannot impose annual or lifetime dollar caps on benefits, they may limit the number of services covered. These limits are often imposed on habilitative services such as physical or occupational therapies. Such services are critical to Isabel's ability to function, and her family would incur substantial out-of-pocket costs for uncovered services beyond the maximum cost-sharing limit that is set in law.

At the lower income level to receive all of her necessary care, Isabel's family would pay cost-sharing in the modeled QHPs that is between 35 and 38 times higher than the cost of KidsCare. These costs for Isabel alone would exceed 15 percent of the family's total income.

At the higher income level, Isabel's cost-sharing in the QHPs would be between 8 and 9 times higher than the cost KidsCare, and the cost for all of the services she needs would exceed 13 percent of her family's total income.

Isabel's Out-of-Pocket Costs



Isabel's family faces cost-sharing that is between 8 and 38 times more than her KidsCare annual premium.

Isabel		Plan A	Plan B	Plan C
140% FPL	Out-of-Pocket Maximum (Medical only)	$2,250	$2,250	$1,175
	Cost-Sharing for Covered Benefits (including Dental)	$1,653	$1,837	$1,520
	Cost for Uncovered Services	$2,736	$2,736	$2,736
190% FPL	Out-of-Pocket Maximum (Medical only)	$2,250	$2,250	$2,250
	Cost-Sharing for Covered Benefits (including Dental)	$2,595	$2,250	$2,595
	Cost for Uncovered Services	$2,736	$2,736	$2,736

In summary, these three families would pay more in cost-sharing in 17 of the 18 scenarios studied. In only one scenario, Max's costs at the higher income level in QHP plan B would be lower than KidsCare. While a non-benchmark plan may offer lower out-of-pocket spending, it is important to emphasize that families would pay any additional premium costs. For example, families at the higher income level would pay $1,596 more to enroll in plan B. In purchasing the benchmark plan, the families would pay 5.8 percent of income but their premium costs jump to more than 10 percent of income if they select an alternative plan. As such, to fully understand the financial implications, this additional cost must be taken into consideration (see box on page 6).

Plan selection can make a significant difference to costs incurred by families depending on a child's health care usage.

Families are never able to predict all of the specific services their child will need in a given year, so plan selection based on cost-sharing is an imprecise science at best. But it is important to note that the decision impacts the amount of out-of-pocket spending for all of the children we considered (see Appendix B for details). For example, Jacob's drug costs are much lower in one plan because all of his prescriptions are categorized as generics, whereas certain drugs are considered specialty drugs in a different plan. There was wide ranging variability in cost-sharing for Max's emergency room treatment across the plans. Isabel's cost for covered habilitative services are subject to coinsurance in one plan and cost less (once the deductible is met) than the same visits under the other plans. Additionally, she hits her out-of-pocket maximum in some plans and not others, which can also make a difference in overall cost exposure for her family.

Out-of-pocket costs differ considerably based on plan selection.

QHPs do not automatically include pediatric oral health benefits; securing dental coverage may be at an additional cost to families.

Routine and restorative dental services are essential to a child's health and were covered in KidsCare. If marketplace plans do not provide oral health benefits, buying optional dental coverage is subject to an additional premium. Any dental deductibles and cost-sharing in stand-alone plans do not count toward the individual's medical deductibles and out-of-pocket maximum.

Two of the three plans studied did not cover dental services, although 67 percent of QHPs in Arizona's marketplace include embedded dental benefits.[26] These plans were paired with the lowest cost stand-alone dental plan available to families in Maricopa County through the marketplace. Minimally, families will pay $300 per child for this coverage, as well as any deductibles and co-insurance for services.

			Plan A	Plan B	Plan C
140% FPL	Jacob	Dental Cost-Sharing	$365	$345	$365
		Dental Premium	$300	$0	$300
	Max	Dental Cost-Sharing	$45	$0	$45
		Dental Premium	$300	$0	$300
190% FPL	Jacob	Dental Cost-Sharing	$365	$640	$365
		Dental Premium	$300	$0	$300
	Max	Dental Cost-Sharing	$45	$0	$45
		Dental Premium	$300	$0	$300

Policy Implications for CHIP Reauthorization

The ACA protects children's eligibility in Medicaid and CHIP through 2019.

CHIP and Medicaid have successfully reduced the number of uninsured children to historic lows. The ACA anticipated the continuation of CHIP by requiring that states maintain eligibility and enrollment procedures for children through September 2019; however, it only extended CHIP funding through fiscal year 2015. While its statutory authority remains in effect indefinitely, without additional funding states are likely to exhaust federal CHIP funds in early 2016. If federal financing were to end, children across the country will likely encounter the same kind of disruptions in coverage experienced by Arizona families.

The "family glitch" means that more than half of CHIP children could be locked out of financial assistance in the marketplace, and either remain uninsured or face unaffordable premiums if CHIP is not available.

This brief assumes that children would be eligible for financial assistance to enroll in a QHP but that is not necessarily the case. As noted earlier, families do not qualify for premium tax credits or cost-sharing reductions if they have access to "affordable" employer-based coverage in which a self-only plan covering just the employee costs less than 9.5 percent of family income. A recent analysis for the Medicaid and CHIP Payment and Access Commission (MACPAC) suggests that an estimated 56 percent of CHIP eligible children nationwide would not qualify for financial assistance in the marketplace because a parent is either enrolled or eligible to enroll in what is deemed to be affordable employer coverage.[27]

Families are almost certain to face higher cost-sharing in QHPs as compared to CHIP.

As this analysis demonstrates, many families will face higher cost-sharing in marketplace plans than CHIP, although the added out-of-pocket expenses will vary based on the child's health care needs and the structure of the plan. This conclusion was also noted in a recent study comparing CHIP programs and benchmark plans selected as models for QHP coverage in five states. Cost-sharing in CHIP was almost always less than in the state's respective marketplace benchmark plans.[28]

Increases in cost-sharing for children moving from CHIP to the marketplace could be even more dramatic in states that have higher CHIP income eligibility.

The families studied in this analysis would have access to significant cost-sharing reductions based upon their income. Families with slightly higher income (between 200 and 250 percent of the FPL) would receive only modest cost-sharing reductions with the plan covering 73 percent of average costs, and those with income at or above 251 percent of the FPL will not qualify for cost-sharing reductions at all. This is significant given that the median income eligibility level for CHIP

is 255 percent of the FPL, with more than half (28 states including DC) covering children above 250 percent of the FPL.[29] For example, the maximum out-of-pocket costs for an individual in the plans examined jumps from $2,250 to $6,350 with no cost-sharing reductions and emergency room and primary care visit co-pays are 10 times higher.

Some children with chronic health conditions will need care that exceeds a plan's limitations on services.

Children have a broad and unique range of health care needs. Beyond acute care, children need regular preventive care, including dental, hearing and vision care, for their healthy development. Further, children with special health care needs require additional services, including durable medical equipment and habilitative services such as physical, speech, or occupational therapies. These children may not receive all of the care they need if families have to pay out of pocket for the full cost of these services after exhausting their benefits. The GAO comparison of CHIP and state QHP benchmark plans found that most EHB benefit categories were covered with two exceptions: outpatient habilitative services and pediatric hearing services. While CHIP programs and QHP benchmarks generally restrict services within these categories, CHIP programs tend to feature higher benefit limits, which are especially critical to a child with special health care needs.[30]

Low-income families may decline stand-alone dental coverage in the marketplace due to the high cost.

This would be a significant missed opportunity to improve children's oral health. Studies show that without dental coverage, individuals are less than half as likely to receive routine preventive care. Among people with dental benefits, 81 percent report seeing a dentist at least twice a year, compared to only 34 percent of people without dental benefits.[31]

Families will want and need assistance in choosing a health plan that is a good fit for them.

Finding the best plan for any given individual or family is a complicated process. Premiums are often the driver in selecting a plan, but a top priority for most consumers is ensuring that their doctors and other health care providers are included in the network of the specific plan. Additionally, for a consumer needing ongoing medications, considerations include whether there is a separate prescription drug deductible, which drugs are included in the plan's formulary, and the different co-pay levels for generic, brand and specialty drugs. As this report has shown, plan choice has a significant impact on cost-sharing but discerning the differences in coverage and costs create challenges for families. Such an analysis involves deciphering often confusing and incomplete plan information, and obtaining price data that is not readily available. Thus, many families may not have all of the information they need to make a fully-informed plan selection.

Choosing a health plan that fits a family's needs is complicated.

Additional research is needed.

The differences in cost-sharing between Arizona's CHIP program and QHP coverage, along with the other concerns raised in this analysis – the complexity of choosing the best plan based on a child's unique needs, the added cost of stand-alone dental plans, ineligibility for financial assistance due to the family glitch, and the extent to which plan limitations fail to meet the healthcare needs of children with chronic health conditions – must be carefully examined to assess the impact on children if CHIP was no longer an option for families. Furthermore, other issues, including the adequacy of pediatric services and access to pediatric specialists in marketplace plan networks should be thoroughly researched when considering the future of CHIP.

Conclusion

More time is needed before the adequacy of marketplace coverage for low-income children can be assessed.

KidsCare was a robust, inexpensive, child-focused coverage program that provided comprehensive benefits to low-income children. Its lack of deductibles, co-payments and co-insurance encouraged families to seek the preventive and routine care their children needed to stay healthy. The full impact of the loss of KidsCare requires further study, including examining how many children become uninsured and any change in how, when, and where they access of health care services. From a cost-sharing perspective, however, it is clear that families will pay more, and in some cases, substantially more for the care their children need.

Examining the impact of the loss of CHIP in Arizona highlights the broader implications for children's coverage and, particularly, the future of CHIP and whether marketplace coverage is an adequate alternative. For children who do qualify for premium tax credits, it is not clear that all QHPs will provide them with a benefit package that covers the full range of their health care needs at an affordable cost to families. Given the large body of research showing that low- and moderate-income families are very sensitive to cost-sharing and may delay or forego needed care due to costs, assessing the affordability of coverage is critical.[32] Furthermore, it is important that the new marketplaces become more established so that the experience of low-income children in QHPs can be thoroughly evaluated.

Endnotes

[1] Four states have converted their separate CHIP programs, choosing to cover children at the same income levels in Medicaid instead. They include Maryland (2007), South Carolina (2010), New Hampshire (2012), and California (2013); data based on an annual survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities (2008) and the Georgetown University Center for Children and Families (2011-2013).

[2] The Affordable Care Act includes a "maintenance of effort" provision, requiring states to maintain current Medicaid eligibility and enrollment policies as of March 23, 2010 for adults until January 2014 and for children through September 2019.

[3] Georgetown Center for Children and Families analysis of uninsured data for children from the Census Bureau's American Community Survey, 2008 – 2012, as reported in annual briefs on uninsured children.

[4] Children, ages 6 – 18, with income between 100 and 138 percent FPL enrolled in CHIP became eligible for Medicaid on January 1, 2014 in all states. 23,000 of KidsCare II enrollees were transitioned to Medicaid as a result. Source: Arizona Health Care Cost Containment System, http://www.azahcccs.gov/applicants/KidsCareII.aspx.

[5] Marketplace plans are categorized by metal level – bronze, silver, gold and platinum – based on actuarial value of covered benefits ranging from 60 to 90 percent. Individuals who qualify for cost-sharing reductions in silver plans receive benefits at a 73, 87 or 94 percent coverage level, based on income.

[6] Government Accountability Office "Children's Health Insurance: Information on Coverage of Services, Cost to Consumers and Access to Care in CHIP and Other Sources of Insurance," (November 2013).

[7] S. Goodell and K. Swartz, "Cost-sharing: Effects on Spending and Outcomes," The Robert Wood Johnson Foundation (December 2010).

[8] T. Mancini and J. Alker, "Children's Health Coverage on the Eve of the Affordable Care Act," Georgetown University Center for Children and Families (November 2013).

[9] J. Alker, T. Mancini, and M. Heberlein, "Uninsured Children 2009-2011: Charting the Nation's Progress," Georgetown University Center for Children and Families (October 2012).

[10] Technically, Arizona's enrollment freeze was effective January 1, 2010, but as eligibility is prospective, the state stopped processing new applications for coverage once the Governor issued the order on December 21, 2009.

[11] M. Heberlein, J. Guyer, and C. Hope, "The Arizona KidsCare CHIP Enrollment Freeze: House Has it Impacted Enrollment and Families?," Kaiser Commission on Medicaid and the Uninsured (September 2011).

[12] Prior to the ACA, states were required to cover children ages 0 – 5 in Medicaid up to 133 percent of the FPL, while the mandatory income limit for children ages 6 – 18 was 100 percent of the FPL.

[13] Government Accountability Office "Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance," (June 2012).

[14] Income levels are based on the 2013 federal poverty guidelines since these are used for determining eligibility for financial assistance for enrollment in QHPs until open enrollment begins again in November 2014.

[15] T. Brooks, "Handle with Care: How Premiums are Administered in Medicaid, CHIP and the Marketplace Matters," Georgetown University Center for Children and Families (November 2013).

[16] In comparing CHIP to QHP coverage, it's important to note that not all CHIP programs offer full EPSDT coverage.

[17] Arizona's benchmark plan is the State Employee EPO Plan, http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/arizona-ehb-benchmark-plan.pdf.

[18] C. Cooper, et al, "Epidemiology of Childhood Fractures in Britain: A Study Using the General Practice Research Database,"Journal of Bone and Mineral Research, 19(12): 1976-1981 (December 2004).

[19] American Academy of Dermatology, "Acne Facts," http://www.aad.org/media-resources/stats-and-facts/conditions/acne.

[20] American College of Allergy, Asthma and Immunology, "Facts and Statistics," http://www.acaai.org/allergist/news/Pages/Allergy_Facts.aspx.

[21] Centers for Disease Control and Prevention, "Asthma: Data and Surveillance," http://www.cdc.gov/asthma/asthmadata.htm.

[22] National Institute of Dental and Craniofacial Research, "Dental Caries (Tooth Decay) in Children (Age 2 to 11)," http://www.nidcr.nih.gov/DataStatistics/FindDataByTopic/DentalCaries/DentalCariesChildren2to11.

[23] R. McAdams and S. Juul, "Cerebral Palsy: Prevalence, Predictability and Parental Counseling," Neo Reviews, American Academy of Pediatrics (October 2011).

[24] C. Boyle, et al, "Trends in the Prevalence of Developmental Disabilities in US Children, 1997 – 2008," American Academy of Pediatrics (May 2011).

[25] Jacob and Isabel were featured in a prior study conducted by researchers at the Georgetown Center for Children and Families. See J. Alker, et al., "Children and Health Care Reform: Assuring Coverage that Meets Their Health Care Needs," Kaiser Family Foundation (September 2009).

[26] Based on an analysis of plan information from HealthCare.Gov by the Children's Dental Health Project, https://www.cdhp.org/blog/261-greater-transparency-needed-on-dental-coverage-provided-by-health-plans.

[27] Presentation by Staff, "The Future of CHIP and Federally Subsidized Children's Coverage," Medicaid and CHIP Payment and Access Commission (MACPAC) (February 2014).

[28] Op.cit. 6.

[29] M. Heberlein, T. Brooks, S. Artiga, and J. Stephens, "Getting into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies into Drive," Kaiser Commission on Medicaid and the Uninsured (November 2013).

[30] Op.cit. 6.

[31] L. Harrison, "Oral Health and the Affordable Care Act: Only Part Way to the Finish Line," Alliance for Health Reform (October 2012).

[32] Op.cit. 7.

Appendix A: Methodology

Plan Selection

Using a family of three (two parents, with one child), insurance plans available through the federally-facilitated marketplace (FFM), HealthCare.Gov, were selected. To find options available to families whose children would have been eligible for KidsCare based on income, plans were searched based on family income of $27,342 (140 percent of the 2013 FPL) and $37,107 (190 percent of the 2013 FPL). Families in this income range should qualify for silver-level plans that respectively cover 94 percent and 87 percent of aggregate costs (referred to as cost-sharing reduction levels or CSRs).

The available plans across the 15 counties in Arizona were ranked by the different health insurance issuers based on plan costs. HealthNet of Arizona, Blue Cross Blue Shield of Arizona, and Aetna were the three issuers with the lowest cost plans in most of the counties. The analysis was then limited to plans available in Maricopa County, where 60 percent of Arizona's population resides. The benchmark plan is the HealthNet CommunityCare HMO $45/$65/$1500 and Aetna's lowest cost Silver offering is the Classic 5000 plan. While Blue Cross Blue Shield of Arizona (BCBSAZ) offered two silver plans with the same cost (Everyday Health Select 4000 and Everyday Health Alliance 4000), the Health Select plan was chosen because Phoenix Children's Hospital is in its network.

Plan Details

Coverage details, limitations, and cost sharing requirements were pulled from the Summary of Benefits and Coverage (SBC) documents supplied to HealthCare.Gov by the carriers. Aetna's SBCs were available by CSR; however, SBCs for the HealthNet and BCBSAZ were available for the standard plan only and therefore did not take into account the cost-sharing assistance the families would receive. BCBSAZ provided SBCs based on the two cost-sharing levels reviewed upon request. Data on the HealthNet plan was gathered from the plan finder on HealthCare.Gov and supplemented with an 87 percent CSR SBC provided by a consumer in AZ. Where not provided, cost-sharing requirements in the 94 percent plan were assumed to follow the same structure as those in the standard and 87 percent CSR plans. For example, primary care and mental health visits have the same $15 copayment in the 87 percent plan; as such a mental health visit copayment was assumed to be $3, the same as a primary care visit in the 94 percent plan.

Drug formularies were checked for each child's prescription drugs to assess the correct drug tier and generics were assumed, when available. Additionally, all care received was assumed to be in-network. Unlike the BCBSAZ plans studied, the HealthNet and Aetna plans do not include dental coverage. For comparative purposes, they were paired with the lowest cost dental plan available to children in Maricopa County – the Dentegra Children's Plan 70.

Children's Health Care Utilization Data

Jacob and Isabel were featured in a previous report conducted by Georgetown University researchers.[a] To obtain the children's utilization history, interviews were conducted with each child's mother in May and June of 2009. Dr. Chen Kenyon, a member of the American Academy of Pediatrics (AAP), reviewed the children's profiles to validate them for clinical reasonableness. Max was added to this analysis to provide another example of the varying health needs of children. In January 2014, his father provided his medical history over the last

year, including details on the number and dates of visits and prescriptions. Dr. Eddie Ochoa, also a member of AAP, reviewed Max's history for clinical appropriateness.

For this analysis, additional necessary details for Jacob and Isabel, such as the number of prescription drugs, were assumed and verified with the same pediatrician who reviewed Max's case. Also, while the number of visits was known, the timing of such visits was not available. As such, the children's usage was mapped out so that determinations could be made regarding when the deductible and out-of-pocket and visit maximums would be reached.

Cost Data

In some cases, deductibles or coinsurance apply to services; as such, the price of these services needed to be factored into the analysis of the family's out-of-pocket spending. However, insurance payments for services are generally considered proprietary information and not available to the general public. In contrast, Medicare payment data are publicly available and were used to approximate the cost of services. As research shows that Medicare's payments for physician and other health services are about 82 percent of commercial rates, prices were adjusted to account for the differential payment between Medicare and private payers.[b]

Drug prices are based on Costco Pharmacy prices as of March 2014 and dental costs are based on data posted at fairhealthconsumers.org. When possible, price information is based on the local Phoenix, AZ area.

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[a] J. Alker, et al., "Children and Health Care Reform: Assuring Coverage that Meets Their Health Care Needs," Kaiser Family Foundation (September 2009).

[b] Medicare Payment Advisory Commission, "Report to the Congress: Medicare Payment Policy" (March 2013).

Appendix B: Detailed Health Care Analysis

Max

Max is a healthy 15-year-old receiving ongoing treatment for acne, which includes several oral medications and topical creams. He also visited a travel doctor prior to a school trip who prescribed two preventive medications for altitude and motion sickness.

In September, he was injured while playing soccer and was taken to the emergency room. The emergency room physician was not certain whether or not his wrist was broken and referred Max to an orthopedist. Max saw the orthopedist the following day. Another x-ray at the orthopedist office proved inconclusive, but as a precaution he casted Max's arm and scheduled a follow-up visit in two weeks. When Max returned the break was confirmed, and his cast was removed three weeks later.

Services	Plan A (Benchmark): HealthNet CommunityCare HMO and Dentegra Dental PPO			Plan B: BCBSAZ Everyday Health Select			Plan C: Aetna Classic and Dentegra Dental PPO		
Deductible(s)[1]	Usage	94%	87%	Usage	94%	87%	Usage	94%	87%
Medical	n/a	$0	$500	n/a	$50	$1,250	n/a	$150[2]	$600[2]
Prescription	n/a	$0	$50	n/a	$0	$0	n/a	$0	$0
Dental	n/a	$45	$45	n/a	$0	$0	n/a	$45	$45
Physician Visits									
Well-Child Visit	1	$0	$0	1	$0	$0	1	$0	$0
PCP Visit	3	$9	$45	3	$15	$30	3	$15	$30
Specialist	1	$20	$80	4	$40	$80	4	$60	$120
Emergency Care									
E.R. Visit	1	$25	$75	1	$35	$75	1	$100	$300
X-Ray	1	$5	$47[3]	1	$47[4]	$47[4]	1	$15	$30
Prescription Drugs									
Generic	14	$42	$115[5]	6	$30	$30	14	$56	$56
Preferred Brand	1	$5	$15	8	$80	$80	0	$0	$0
Non-Preferred Brand	0	$0	$0	1	$15	$35	1	$33	$33
Dental Visits									
Premium	n/a	$300	$300	n/a	n/a	n/a	n/a	$300	$300
Cleanings	2	$45[6]	$45[6]	2	$0	$0	2	$45[6]	$45[6]
Total Out-of-Pocket Spending[7]	**n/a**	**$451**	**$722**	**n/a**	**$262**	**$377**	**n/a**	**$624**	**$914**

Table notes next page

Max: Table Notes

1. The applicability of the deductible varies across plans. The amounts listed here are the full amount of the deductible, not what Max paid towards meeting it. These amounts are instead included in what he pays towards receiving services subject to the deductible.
2. While there is a deductible in both the 94% and the 87% Aetna plans, it is waived for all of Max's services.
3. Max does not meet the medical deductible in the 87% HealthNet plan; as such, he pays the full cost of the x-ray done in the emergency room.
4. The deductibles are not met in either the 94% or the 87% BCBS plans, so Max pays the full cost of the x-ray done in the emergency room.
5. Max meets the prescription drug deductible in the 87% HealthNet plan with his first drug purchase.
6. The $45 deductible in the stand-alone Dentegra plan applies to diagnostic and preventive services and is met with Max's first cleaning.
7. Includes spending on stand-alone dental premium in the HealthNet and Aetna analyses.

Jacob

Jacob is a 7-year-old boy who is generally in good health but suffers from common allergies and mild, persistent asthma. His environmental allergies are improved by over-the-counter antihistamines, which he takes daily. In addition, Jacob takes several prescription medications. During hay fever season, he takes Flonase, a prescription nasal spray that controls the reaction to pollen and other allergens. Throughout the year, he uses Flovent, a low-dose inhaled corticosteroid, on a daily basis to help prevent asthma attacks. He also uses Albuterol, an inhaler that helps relax his airways, if he has an asthma attack. Jacob has also been prescribed a peakflow meter – a portable hand-held device to help him monitor his asthma.

Jacob also has food allergies to dairy products, tree nuts, and peanuts. When he eats a food he is allergic to, he can experience an episode of anaphylaxis – a severe, whole-body allergic reaction that can cause difficulty breathing. To stop the reaction, Jacob has to be injected with epinephrine and keeps an Epi-pen at home, at school, at his after-school program, and with him at all times in case this treatment is needed.

As Jacob has grown older and his allergies and asthma are well managed, fewer visits to the doctor are necessary. Last year, he saw his allergist and his pediatrician each just once. However, because he is prone to cavities, regular check-ups and dental cleanings are essential for his oral health.

Services	Plan A (Benchmark): HealthNet CommunityCare HMO and Dentegra Dental PPO			Plan B: BCBSAZ Everyday Health Select			Plan C: Aetna Classic and Dentegra Dental PPO		
Deductible(s)[1]	Usage	94%	87%	Usage	94%	87%	Usage	94%	87%
Medical	n/a	$0	$500	n/a	$50	$1,250	n/a	$150[2]	$600
Prescription	n/a	$0	$50	n/a	$0	$0	n/a	$0	$0
Dental	n/a	$45	$45	n/a	$0	$0	n/a	$45	$45
Physician Visits									
Well-Child Visit	1	$0	$0	1	$0	$0	1	$0	$0
PCP Visit	1	$3	$15	1	$5	$10	1	$5	$10
Specialist	1	$5	$20	1	$10	$20	1	$15	$30
Prescription Drugs									
Generic	10	$30	$95[3]	4	$20	$20	18	$72	$72
Preferred Brand	0	$0	$0	14	$140	$140	0	$0	$0
Specialty	8	$286	$429	0	$0	$0	0	$0	$0
Durable Medical Equipment									
Peak Flow Meter	1	$3	$32[4]	1	$5	$10	1	$0	$32[5]
Dental Visits									
Premium	n/a	$300	$300	n/a	n/a	n/a	n/a	$300	$300
Cleanings	2	$45[6]	$45[6]	2	$0	$0	2	$45[6]	$45[6]
Fillings	4	$320	$320	4	$345[7]	$640[7]	4	$320	$320
Total Out-of-Pocket Spending[8]	**n/a**	**$992**	**$1,256**	**n/a**	**$525**	**$840**	**n/a**	**$757**	**$809**

Jacob: Table Notes

1. The applicability of the deductible varies across plans. The amounts listed here are the full amount of the deductible, not what Jacob paid towards meeting it. These amounts are instead included in what he pays towards receiving services subject to the deductible.
2. While there is a deductible in 94% Aetna plan, it is waived for all of Jacob's services.
3. Jacob meets the prescription drug deductible in the 87% HealthNet plan with his first drug purchase.
4. Jacob does not meet the medical deductible in the 87% HealthNet plan; as such, he pays the full cost of his peak flow meter.
5. In the 87% Aetna plan, only his DME is subject to the deductible, so Jacob pays the full cost of the peak flow meter.
6. The $45 deductible in the stand-alone Dentegra plan applies to diagnostic and preventive services and is met with Jacob's first cleaning.
7. The $50 deductible in the 94% BCBS plan is met with Jacob's first dental filling. He does not meet the deductible in the 87% plan and therefore pays the full cost of his fillings.
8. Includes spending on stand-alone dental premium in the HealthNet and Aetna analyses.

Isabel

Isabel is a 13-year-old girl who suffered a brain hemorrhage shortly after birth. She was born prematurely at 31 weeks and was subsequently diagnosed with spastic diplegia cerebral palsy, a central nervous system disorder that impairs the movement of her legs. Isabel receives weekly physical therapy, which includes intensive stretching and massage to keep her leg muscles in tone. She receives Botox therapy every few months to aid with stretching and range of motion. She has problems walking and alternatively uses a cane and a walker. In addition, she sometimes uses a manual wheelchair.

A complication of Isabel's condition is scoliosis. During the year studied, Isabel had spinal fusion surgery, including the insertion of rods to help correct her scoliosis. She also has a brace for her back and one for each arm. Isabel sees two specialists – an orthopedist and a physiatrist – to manage care of her spine and limbs. She also sees a urologist because of recurring infections.

The cerebral palsy caused some cognitive damage. Isabel has vision problems and went to the emergency room once for a problem with her eyes. Following that visit, she had eye surgery to correct the condition. Isabel also has difficulty using her hands to write. To help overcome this limitation in school, she has a computer equipped with voice recognition that types words as she speaks them. Isabel sees an occupational therapist approximately once to twice per week (80 sessions over the year) to develop and improve her computer skills.

Isabel has some anxiety related to her condition, so she sees a psychologist on a weekly basis to help her manage it. She also takes Prozac and a low dose of Risperdal for anxiety and must see a psychiatrist every three or four months to monitor her medications.

Note that for Isabel, the quantity (usage) of services within coverage limits is included, however, only the cost-sharing incurred prior to reaching the out-of-pocket maximum is displayed below. For example, under BCBSAZ, Isabel's psychologist visits reflect payments of $500 for the 94% share plan but only $340 for the 87% share plan, because some of those visits occurred subsequent to hitting her out-of-pocket maximum, after which there is no charge for covered benefits. Additionally, Isabel's physical and occupational therapy visits exceeded the plan maximums and are reflected as full out-of-pocket costs, displayed in the table below.

Services	Plan A (Benchmark): HealthNet CommunityCare HMO and Dentegra Dental PPO			Plan B: BCBSAZ Everyday Health Select			Plan C: Aetna Classic and Dentegra Dental PPO		
Deductible(s)[1]	Usage	94%	87%	Usage	94%	87%	Usage	94%	87%
Medical	n/a	$0	$560	n/a	$50	$1,250	n/a	$150	$600
Prescription	n/a	$0	$50	n/a	$0	$0	n/a	$0	$0
Dental	n/a	$45	$45	n/a	$0	$0	n/a	$45	$45
Physician Visits									
Well-Child Visit	1	$0	$0	1	$0	$0	1	$0	$0
PCP Visit	3	$9	$30	3	$15	$20	3	$10	$20
Specialist	13	$65	$80	13	$130	$100	13	$45	$60
Vision	1	$0	$0	1	$5	$0	1	$0	$0
Mental Health Care									
Psychiatrist	3	$9	$15	3	$30	$20	3	$15	$30
Psychologist	50	$150	$225	50	$500	$340	50	$215	$326
Emergency Care									
E.R. Visit	1	$25	$75	1	$35	$75	1	$100	$300
Rehabilitative/ Habilitative Therapies									
Physical Therapy	21	$105	$280	21	$82	$379	21	$210	$300
Occupational Therapy	39	$195	$560	39	$198[2]	$754[2]	39	$390	$570
Surgeries									
Eye Surgery	1	$76	$540[3]	1	$76	$252[2]	1	$150[4]	$616[4]
Spinal Surgery	1	$207	$0	1	$207	$0	1	$0	$0
Prescription Drugs									
Generic	36	$108	$90[5]	36	$180	$60	36	$40	$28
Durable Medical Equipment									
Wheelchair	1	$237	$355	1	$237	$237	1	$0	$0
Back Brace	1	$25	$0	1	$25	$13	1	$0	$0
Walker	1	$6	$0	1	$10	$0	1	$0	$0
Canes	2	$4	$0	2	$20	$0	2	$0	$0
Arm Braces	2	$87	$0	2	$87	$0	2	$0	$0
Dental Visits									
Premium	n/a	$300	$300	n/a	n/a	n/a	n/a	$300	$300
Cleanings	2	$45[6]	$45[6]	2	$0	$0	2	$45[6]	$45[6]
Total Out-of-Pocket Spending[7]	**n/a**	**$1,653**	**$2,595**	**n/a**	**$1,837**	**$2,250**	**n/a**	**$1,520**	**$2,595**
Out-of-Pocket Maximum	n/a	$2,250	$2,250	n/a	$2,250	$2,250	n/a	$1,175	$2,250
Date Reached	n/a	--	4/18	n/a	--	4/30	n/a	4/12	3/15
Additional Cost for Ongoing OT	41	$1,602	$1,602	41	$1,602	$1,602	41	$1,602	$1,602
Additional Cost for Ongoing PT	29	$1,133	$1,133	29	$1,133	$1,133	29	$1,133	$1,133
Total Out-of-Pocket Spending with OT/PT	**n/a**	**$4,389**	**$5,331**	**n/a**	**$4,572**	**$4,986**	**n/a**	**$4,256**	**$5,331**

Table notes next page

Isabel: Table Notes

1. The applicability of the deductible varies across plans. The amounts listed here are the full amount of the deductible, not what Isabel paid towards meeting it. These amounts are instead included in what he pays towards receiving services subject to the deductible.
2. Isabel meets the deductible in the 94% BCBS plan with her second OT visit and with a combination of OT/PT visits and her eye surgery in the 87% plan.
3. Isabel meets the medical deductible in the 87% HealthNet plan with her eye surgery.
4. Isabel meets the deductible in both the 94% and the 87% Aetna plans with her eye surgery.
5. Isabel meets the prescription drug deductible in the 87% HealthNet plan after 4 drug purchases.
6. The $45 deductible in the stand-alone Dentegra plan applies to diagnostic and preventive services and is met with Isabel's first cleaning.
7. Includes spending on stand-alone dental premium in the HealthNet and Aetna analysis.

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