Georgetown University
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Marketplace Coverage Is Not an Adequate Substitute for CHIP

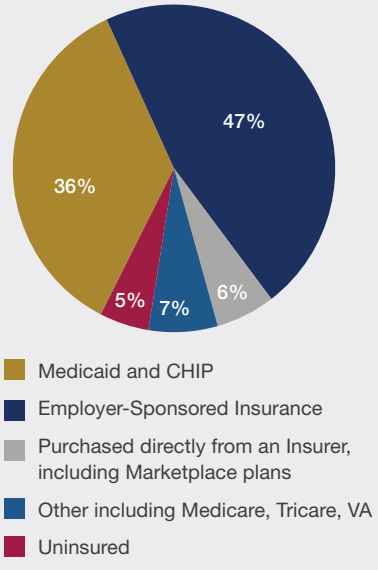
by Kelly Whitener and Tricia Brooks

In 2015, the United States reached a historic milestone in health insurance for children with more than 95 percent of kids covered. This success is largely attributable to Medicaid and the Children's Health Insurance Programs (CHIP), which have filled the coverage gap for low-income children who are more likely to be uninsured. However, with funding for CHIP set to expire on September 30, 2017, our progress in covering the nation's children is at risk.

The primary coverage sources for children are employer-sponsored insurance (47 percent) and public coverage through Medicaid and CHIP (36 percent).[1] While a smaller share of children (13 percent) are covered through other sources including insurance purchased privately, only 1.1 million children are enrolled in Marketplace plans, which have been suggested as an alternative to CHIP. *But if federal funding for CHIP is allowed to expire, would Marketplace coverage be an adequate substitute for the nearly 9 million children covered by CHIP?*

To answer this question, it is important to consider affordability, scope of benefits, and access to health care providers. Each dimension is discussed in more detail below, but the conclusion is clear: *CHIP is a better source of coverage for meeting children's health care needs across the country.*[2] CHIP funding should continue for the foreseeable future so that no children lose benefits that are essential to their health and development.

Sources of Children's Coverage in United States



Affordability

Affordability includes the cost of premiums to purchase insurance, as well as the cost-sharing incurred when using health services once enrolled in a plan. A key element of Marketplace coverage is financial assistance in the form of premium tax credits (PTC) and cost-sharing reductions (CSR), but these subsidies are only available to families who lack access to "affordable" employer-based coverage. The problem is how "affordability" is defined. Employer coverage is considered "affordable" if the cost to the employee for *self-only coverage* is less than 9.56 percent of family income without regard to the additional cost employees pay to enroll their families, which is often many times higher.[3] This major barrier, known as the family glitch,[4] would prevent nearly 1 million children from qualifying for lower costs in the Marketplace.[5] At the same time, employers—even those subject to the employer responsibility provisions – are not required to subsidize dependent coverage. The result is that children who have "access" to a parent's employer-based dependent coverage, regardless of cost, will be excluded from premium tax credit eligibility.

Premiums

Even for families who qualify for premium tax credits, the expected family contribution can be so high that coverage remains out of reach. Sliding scale tax credits cap a family's share of the cost of Marketplace plans, with families in the CHIP income range paying premiums between 3 and 9.5 percent of family income.[6] By comparison, many states do not charge premiums in CHIP, and for those that do, the premium amounts are lower and are more often limited to children in families with incomes above 200 percent of the federal poverty level (FPL).[7] Additionally, some states charge per-family premiums rather than per-child premiums in CHIP, or limit the per-child premiums to two or three children per family. In its comparability report on pediatric coverage, CMS found that families would pay higher costs for Marketplace plans compared with CHIP across all states.[8]

Premium Payments in Marketplace Plans Compared to CHIP

Federal Poverty Level (FPL)	Number of States with CHIP Eligibility at that FPL Level	Income for Family of 3	Expected Contribution for Marketplace Plan		CHIP	
			Percentage of Income	Monthly Contribution Amount	Number of States Charging Premiums	Median Monthly Premium
151% FPL	51	$30,834	4.03%	$104	11	$15
201% FPL	49	$41,044	6.34%	$217	23	$20
251% FPL	27	$51,254	8.10%	$346	18	$32

Cost Sharing

The higher level of cost-sharing in the form of deductibles, copayments and coinsurance in Marketplace plans is also striking compared to CHIP. A March 2016 report from the Medicaid and CHIP Payment and Access Commission (MACPAC) found that the average actuarial value of CHIP coverage in the 36 states with separate CHIP is 98 percent per child compared with 82 percent for benchmark plans available in the Marketplace. MACPAC also reports that families faced an average of $158 in out-of-pocket spending across separate CHIP programs compared with $1,073 for Marketplace coverage.

The cost to obtain coverage and access health care services must be considered together to have a full understanding of the affordability of Marketplace coverage. These costs vary by geography, income, family size, health plan selection, utilization, and other factors. As an illustrative example, a Georgetown University study of the Arizona Marketplace found that the cost of covering two children in the Marketplace benchmark plan would be eight times higher than CHIP at 140 percent of poverty and 2.4 times higher than CHIP at 190 percent FPL when considering premiums and cost sharing in both programs.[9]

Family of 4 with two children in Arizona		
Poverty level	CHIP costs	Marketplace benchmark costs
140%	$180	$1443
190%	$840	$1978

Benefit Adequacy

While 15 states provide Medicaid benefits to CHIP enrollees, most states modeled their separate CHIP programs on commercial insurance. On the surface, Marketplace coverage of major medical benefit categories like physician services, inpatient services, and prescription drugs appears similar to CHIP. However, Marketplace plans often limit or exclude benefits in areas that are critical to children's health and development such as dental, vision, audiology, and physical, occupational, and speech therapies. For example, more than a third of Marketplace plans do not cover audiology exams (based on essential health benefits benchmark selections) and almost half do not cover hearing aids. When hearing aids are covered, there is greater cost-sharing and/or limits on utilization (for example, aids are covered just once every two to five years) compared to CHIP. Additionally, Marketplace plans do not typically include pediatric dental coverage, which must be purchased under a separate policy. When purchased separately, the premium cost as well as any cost-sharing limits, are not included in the calculations for the family's overall expected financial contributions.

Access to Providers

Until recently, there was relatively little data on how Marketplace plans are meeting network adequacy standards and what it means for children's access to needed providers.[10] However, there has been ample evidence that plans exclude some higher-cost providers from their networks or use tiered benefit structures that require enrollees to pay higher out-of-pocket costs to obtain care from a non-preferred provider.[11]

One recent study found that narrow networks in Marketplace plans were more prevalent among pediatric than adult specialists, because of their exclusion from networks in addition to sparseness of pediatric specialists.[12] Among the nearly 2,000 unique silver plan networks reviewed, the share of narrow networks was greater for pediatric (65.9 percent) than adult specialty (34.9 percent) networks. Specialties with the highest proportion of narrow networks for children were infectious disease (77.4 percent) and kidney specialists (74.0 percent).

Even networks that work relatively well for most enrollees do not necessarily work well for children, especially those with special health care needs. Families who must access care out-of-network are subject to higher cost sharing that does not count toward the Marketplace out-of-pocket caps. CHIP networks, on the other hand, are required to cover contracted services out-of-network if they are unable to cover them in-network and must coordinate with the provider to ensure the cost to the enrollee is no greater than it would have been in-network.[13]

Biggest Impact on Children with Special Health Care Needs

Higher cost-sharing, benefit limitations, and a lack of access to pediatric specialists in Marketplace plans would have the most profound effects for children with special health care needs, who made up 25 percent of the 8 million CHIP enrollees in 2015.[14] Families with children who have epilepsy, diabetes, or mood disorders may face the highest costs.[15] These families would pay higher cost-sharing or the full cost of services not covered in Marketplace plans. For example, a Georgetown study modeling the health care needs of a child with cerebral palsy in a family with income at 190 percent FPL showed that out-of-pocket costs in three different Marketplace plans would be $5,000 or more compared to $600 in Arizona's CHIP program.[16]

Conclusion

CHIP was modeled on private market coverage but designed with low-income children in mind. As a result, CHIP is more likely to offer affordable, comprehensive, and accessible pediatric benefits than Marketplace plans. Higher out-of-pocket costs, limited or excluded benefits, and a lack of network adequacy, particularly in regard to pediatric specialists, in Marketplace plans would have a pronounced adverse impact on all children currently covered by CHIP. The impact would be even more severe for children with higher than average health care utilization, like children with chronic health conditions. Without significant changes to Marketplace coverage that include removing the family glitch, making cost-sharing more affordable, ensuring the pediatric benefits meet the needs of all children, and elevating and enforcing standards for network adequacy, there is no doubt that CHIP remains a critical source of health coverage for children.

Endnotes

[1] Georgetown University Center for Children and Families and American Academy of Pediatrics, United States Snapshot of Children's Coverage, 2017, available at https://ccf.georgetown.edu/wp-content/uploads/2017/02/United-States-Medicaid-CHIP-new-v1.pdf.

[2] Centers for Medicare & Medicaid Services, "Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans," November 25, 2015, available at https://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf.

[3] This number is re-indexed each year. In 2018, the threshold for affordable employer coverage will be 9.56 percent of household income, down from 9.69 percent in 2017 and the first year that the affordability test has declined since the ACA's initial test of 9.5 percent was implemented in 2014. See https://www.irs.gov/pub/irs-drop/rp-17-36.pdf.

[4] T. Brooks, "Fixing The 'Family Glitch' Will Boost Economic Security For Low-Income Families And Increase Marketplace Stability, July 2016, *Health Affairs Health Policy Blog*, available at http://healthaffairs.org/blog/2016/07/27/fixing-the-family-glitch-will-boost-economic-security-for-low-income-families-and-increase-marketplace-stability/.

[5] L. Dubay, M. Buettgens, G.M. Kenney, "Estimates of Coverage Changes for Children Enrolled in separate Children's Health Insurance Programs in the Absence of Additional Federal CHIP Funding – Key Findings and Methodology," *Urban Institute Report to the Medicaid and CHIP Payment and Access Commission*, March 2015, available at http://www.urban.org/sites/default/files/publication/43736/2000145-Estimates-of-Coverage-Changes-for-Children.pdf.

[6] Medicaid and CHIP Payment and Access Commission, Design Considerations for the Future of Children's Coverage: Focus on Affordability, March 2016, available at https://www.macpac.gov/publication/design-considerations-for-the-future-of-childrens-coverage-focus-on-affordability-2/.

[7] T. Brooks and K. Wagnerman, Georgetown University Center for Children and Families, and S. Artiga, E. Cornachione, and P. Ubri, Kaiser Family Foundation, "Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey," January 2017, available at https://ccf.georgetown.edu/wp-content/uploads/2017/01/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2017-1.pdf.

[8] Centers for Medicare and Medicaid Services, "Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans," November 25, 2015, available at https://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf.

[9] T. Brooks, M. Heberlein, and J. Fu, Georgetown University Center for Children and Families and Children's Action Alliance, "Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs," May 2014, available at http://ccf.georgetown.edu/wp-content/uploads/2014/05/Dismantling-CHIP-in-Arizona.pdf.

[10] Sabrina Corlette, JoAnn Volk, Robert Berenson, Judy Feder, "Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality Care," Robert Wood Johnson Foundation, May 2014.

[11] Corlette, et al.

[12] C. Wong, et al., "Pediatric and Adult Physician Networks in Affordable Care Act Marketplace Plans," *Pediatrics*, April 2017, available at http://pediatrics.aappublications.org.

[13] 42 CFR § 457.1230

[14] A. Peltz, A. Davidoff, C. Gross, and M. Rosenthal, "Low-Income Children with Chronic Conditions Face Increased Costs if Shifted from CHIP to Marketplace Plans," *Health Affairs* 36, no.4 (2017):616-625.

[15] C. Wong, et al., "Pediatric and Adult Physician Networks in Affordable Care Act Marketplace Plans," *Pediatrics*, April 2017, available at http://pediatrics.aappublications.org.

[16] T. Brooks, M. Heberlein, and J. Fu, op.cit.

For more information, see K. Whitener, J. Volk, S. Miskell, and J. Alker, Children in the Marketplace, Georgetown University Center for Children and Families, June 2016.