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Background Paper: Financial Protections of CHIP and QHPs

Introduction:

Millions of children and their families have affordable, high-quality health insurance coverage through the Children's Health Insurance Program (CHIP) and the Health Insurance Marketplaces (Marketplaces). The two programs, enacted at different times, provide comprehensive health benefits with each serving different roles in providing individuals, children and families with access to quality and affordable health insurance coverage. Medicaid and CHIP offer critical health insurance coverage to lower income families with children. CHIP was enacted in 1997 to serve lower income children. States operate their own CHIP programs and currently, over half of states provide coverage to children in families with incomes higher than 250% of the federal poverty level (FPL). Lower income families with children can also obtain health insurance coverage through Medicaid. Currently, nearly 32 million children are enrolled in Medicaid, with CHIP covering an additional 8.3 million children for at least one month during the year. Together, Medicaid and CHIP have reduced the uninsured rate for children by half since CHIP's enactment. Because of the important role played by Medicaid and CHIP, children are now the age group most likely to have health insurance coverage after the elderly.[i]

For families with income above Medicaid and CHIP levels, which vary by state, health insurance coverage can be purchased through the Health Insurance Marketplaces (nearly 1 million children have coverage through the Marketplaces). While CHIP was enacted and designed to offer coverage and benefits specifically for children, qualified health plans (QHPs) in the Marketplaces were designed for a broader population of adults as well as children, who may have been uninsured or previously purchased coverage in the individual or small group markets. Under the essential health benefit (EHB) requirements, QHPs include services designed for adult populations such as maternity care, certain screenings for high risk adults, as well as services that people of all ages may need such as hospitalization and physician services. Pediatric dental benefits are an example of a benefit that is treated differently under each program. CHIP integrates pediatric dental services with medical coverage, however, most QHPs offer dental coverage, including pediatric dental coverage, in a stand-alone dental plan (SADP) which must be purchased separately from medical coverage.

CHIP and QHP Certification:

Recognizing that these two programs meet different population needs, the Affordable Care Act requires the Secretary of Health and Human Services to review and certify QHPs that have at least comparable benefits and cost sharing protections to those provided by CHIP.[1] This certification requirement is a one-year requirement for 2015. This paper compares the financial protection provided by the two programs in terms of premiums, out-of-pocket cost sharing, and benefits. The enactment of Medicare Access and CHIP Reauthorization Act of 2015 extends the authorization of CHIP for an additional two years which means that states no longer need to take action in 2015 to transition children from CHIP to QHPs.

This paper compares CHIP and QHP out-of-pocket spending for premiums and cost sharing, taking into account premium subsidies and cost-sharing reductions for Marketplace plans. We also review analyses done by others comparing the benefit packages in separate CHIP plans and QHPs. The paper is organized as follows:

[1] Section 2105(d)(3)(C) of the Social Security Act.

Section I of this issue brief provides background information on QHPs and CHIP.

Section II compares the financial protections of CHIP and Marketplace plans by simulating out-of-pocket expenditures for CHIP eligible children;

Section III reviews the literature on benefit packages in CHIP and the Marketplace; and

Section IV reviews the principal findings and summarizes the key issues.

Additional state specific information and a more in-depth discussion of the methodology and limitations of the analysis can be found in Section V: Appendices.

Key Findings

Financial Protections:

- The actuarial values (AV) of CHIP in each state met or exceeded the AV of QHPs when calculated for child-only spending.
- In general, CHIP eligible children with low to moderate incomes were found to have lower out-of-pocket health care expenditures in CHIP plans than they would have in the second lowest cost silver plans (SLCSP) in the Marketplaces.
- CHIP offers greater financial protection to almost all low and moderate income children compared to SLCSPs in all states examined.

Benefits:

- Coverage of core medical services (e.g. physician, inpatient, and outpatient services) is comparable in CHIP and QHPs.
- CHIP covers a broader scope of "child specific" services without limits (e.g., number of visits, day or annual limits) than QHPs. However, for "child-specific" services covered with limits, CHIP benchmark plans were found to have more limits on these services as compared to QHPs.

I. Background

QHP Background:

Prior to the passage of the Affordable Care Act, families with children who did not qualify for Medicaid or CHIP, and who needed health insurance coverage (many of whom did not have affordable health insurance from an employer), could obtain health coverage in the small group market (if they worked for a small employer) or in the individual market if they could afford the premiums and passed medical underwriting. The affordability of these plans and the benefits offered varied widely, leaving millions of

people unable to afford comprehensive coverage. Since the enactment of the Affordable Care Act, many families with children now have the option of enrolling in qualified health plans (QHP) with premium assistance through the newly created Marketplaces. The Marketplaces, designed to help consumers obtain affordable and comprehensive coverage in a competitive private health insurance market, offer and certify health plans, called QHPs. These health plans are designed to enroll and cover a wide range of the population, including both children and adults. As of the end of February 2015, nearly 1 million (890,017) children under the age of 18, or 8% of total QHP enrollees, selected a QHP plan through the Marketplaces.[ii]

A QHP provides a core comprehensive benefits package known as essential health benefits (EHB), which includes services in 10 benefit categories. Prior to the Affordable Care Act, many individuals and families who purchased their own health insurance did not have coverage for several of the categories of benefits included in the EHBs.[iii] Examples of benefits to which many consumers who purchased coverage through the Marketplace gained access include: maternity and newborn care, pediatric oral and vision services, behavioral health treatment, prescription drugs, and habilitative services.[iv]

QHPs have statutory annual limitations on cost sharing (also known as maximum out-of-pocket limits) to ensure that individuals and families are able to cover the costs of their medical care. In addition, through financial assistance in the form of advanced premium tax credits (available to families with incomes up to 400% of the federal poverty level) and cost-sharing reductions (available to families with incomes up to 250% of the federal poverty level), many families are now able to afford comprehensive coverage. The premium tax credits, cost sharing assistance, annual limitations on cost-sharing, and the EHBs are all part of a package in making health coverage affordable for families.

- For the 2014 plan year, individuals who selected plans in the 37 states using the HealthCare.gov platform pay a premium (after any applicable tax credits) that is 76 percent less than the full premium, on average—reducing their premium on average from $346 to $82 per month.[v]
- For the 2015 plan year, as of the close of the open enrollment period, among individuals with a plan selection in 2015 with financial assistance, the tax credits reduced the premium on average from $364 to $101 per month.[vi]

CHIP Background:

When CHIP was enacted in 1997 with bipartisan support, it provided funding to states to cover children in families with incomes higher than required for Medicaid eligibility. Every state took advantage of the new opportunity to cover children through CHIP, either by expanding their Medicaid program, by establishing a separate child health program, or by operating a combination of both.

The Affordable Care Act extended the requirements related to CHIP through FY 2019, with funding through FY 2015. The law also called for all CHIP enrolled children with household incomes less than 133% of the federal poverty level (FPL) who were covered through separate CHIP programs to be transitioned to coverage through a Medicaid expansion. For states with a CHIP-related Medicaid expansion federal funding is at the CHIP payment rate, which is higher than the regular Medicaid rate, while CHIP allotment funding is available. If CHIP funds are exhausted, federal funding would continue for CHIP children, but at the regular Medicaid matching rate.

Approximately 5 million children might have been impacted if funding for CHIP had not been reauthorized and states chose to phase-out their CHIP program. Among this population, based on point-in-time estimates for non-disabled children ages 0-18 who are not covered by private employer-sponsored insurance (ESI) or Medicaid, approximately 2 million CHIP-eligible children will qualify for subsidized Marketplace coverage. An estimated 2 to 4 million CHIP-eligible children would be ineligible for

subsidized Marketplace coverage due to parent offers of "affordable" ESI range from 2 to 4 million.[2] Recent analysis suggests that while over half of families with children in separate CHIP programs have access to ESI, many of these families would face higher costs of covering their children and most of the plans would be high-deductible plans (deductible greater than $1,000).[vii]

Definitions

There are numerous terms used throughout this analyses to describe how consumers and insurance companies charge and pay for care. For this paper, the following terms are defined as follows:

Terminology	**Definition**
Actuarial Value (AV)	The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, consumers would be responsible for 30% of the costs of all covered benefits. Actuarial Value does not reflect differences in premiums.
Cost Sharing	The share of costs that is paid out-of-pocket (other than premiums) and includes deductibles, coinsurance, and copayments.
Financial Assistance	The term used to refer to the two programs in the Marketplaces that reduce eligible consumers' costs for a QHP. Includes advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR).
Financial Protection	A general term that refers to the benefit package, the associated total out-of-pocket costs for those benefits, as well as any statutory limitations on annual cost sharing amounts.
Out-of-Pocket Expenditures	The amount consumers would pay out-of-pocket, including premiums and other cost sharing.
Premiums	The amount paid by consumers to insurance companies on a regular basis (typically monthly, but can be quarterly or annually) for coverage under a health plan.

II. Comparing Financial Protection for Children in CHIP Plans and Marketplace QHPs

Premium and Cost Sharing Maximums:

The statutory provisions that govern CHIP and Marketplace QHPs differ in regard to premiums and cost sharing requirements. Premiums are the amount that families pay for their health coverage. Premiums are usually paid on a monthly basis, but can be paid quarterly or annually. Cost sharing is the share of costs that is paid out-of-pocket and typically includes deductibles, coinsurance, and copayments. The maximum amounts allowed for enrollee premium expenditures and cost sharing expenditures differ by income, with statutory thresholds that are at times higher in QHPs than in CHIP, depending on family income (Table 1).

[2]3 million children eligible according to: *Simulated insurance eligibility for Separate State CHIP eligible children if CHIP funding expires in 2015* - Interoffice Memo from AHRQ, Data included in: MACPAC June 2014 report.
A range of 2-4 million children eligible according to: *The Family Glitch*, (November 2014) Health Affairs, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129.

Table 1: CHIP and Marketplace QHP Premium Requirements and Cost Sharing Maximums by Income

Family Income as a % of FPL	CHIP Premiums and Cost Sharing Caps	2014 QHP Premium Caps	2014 QHP Cost Sharing Caps[3]
	Maximum % of Income		(Individual/Family)
100% - 133%	N/A	2%	$2,250/$4,500
133% - 150%	No greater than Medicaid[4]	3% to 4%	$2,250/$4,500
150% - 200%	5%	4% to 6.3%	$2,250/$4,500
200% - 250%	5%	6.3% to 8.1%	$5,200/$10,400
250% - 300%	5%	8.1% to 9.5%	$6,350/$12,700
300% - 400%	5%	9.5%	$6,350/$12,700

In CHIP, states are permitted to set enrollee premiums and cost sharing for covered services *up to* a federally required limit of 5% of household income for families with incomes above 150% FPL. States may also vary cost sharing requirements based on family income. Some states do not require any enrollee premiums or cost sharing for covered services, and the vast majority of states limit beneficiary costs to a cap that is well below the 5% maximum threshold.

In Marketplaces, maximum enrollee contributions to premiums are based on income. In addition, annual out-of-pocket maximums (that include cost sharing) are fixed according to family income.

Actuarial Value:

In Marketplaces, QHPs are allowed to set average cost sharing amounts to be within certain ranges based on the percent of claims paid by the plan relative to the total allowed cost of services for essential health benefits (EHB) provided through a health insurance plan's network. This is the actuarial value (AV) of the plan and is based on a standard population without regard to the population the plan may actually provide benefits to. To represent these different cost sharing situations, the Affordable Care Act created categories or "metal levels" of coverage that vary based on the different amounts a health plan would pay of the total costs of an average person's care.

[3] These amounts take into account advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR).

[4] Federal law limits the amounts states can charge Medicaid beneficiaries for premiums and cost sharing. Premiums are not allowed for individuals with incomes less than 150% of the FPL. The total cost of Medicaid premiums and cost-sharing for a family may not exceed 5% of the family's income on a quarterly or monthly basis.

For example, in a silver health plan, the health plan pays 70% on average for the cost of covered services, while the consumer would pay 30%, and in a bronze plan, the health plan would cover on average 60% of medical claims for EHBs, while the consumer would pay for 40%.[5] Generally, lower AV plans (i.e. bronze plans) have lower monthly premiums, but higher out-of-pocket cost sharing for individuals enrolled.

Individuals and families with household incomes between 100% and 250% of the FPL are eligible for cost-sharing reductions (CSRs) *only* if they enroll in a silver level plan.[6] The CSRs further reduce enrollee cost sharing (not including premium payments) and thus increase the silver plan AV (Table 2).

Table 2. Marketplace QHP Silver Plan Actuarial Value and Cost Sharing Levels

Income Band	AV	Enrollee Cost Sharing	Premium Cap % of Income
100-150% FPL	0.94	6%	2% - 4%
150-200% FPL	0.87	13%	4% - 6.3%
200-250% FPL	0.73	27%	6.3% - 8.1%
>= 250% FPL	0.70	30%	8.1% - 9.5%

Analysis:

This analysis compared out-of-pocket spending (including premiums and any additional cost sharing) at the individual level between CHIP and the second lowest cost silver plan (SLCSP) in the Marketplace to assess the extent of the differences in financial protections between the different programs. Instead of comparing all QHPs, the SLCSP was examined since enrollees in these plans may qualify for both premium tax credits and cost-sharing reductions to minimize their overall out-of-pocket spending. . If our analysis confirms that CHIP was more favorable than the SLCSP, it would very likely be true for other QHPs as well since cost-sharing reductions are only available in silver plans.[7] The specific SLCSP in a state chosen for analysis was the "benchmark plan" for tax credits[8] in the largest rating area in the state. For simplicity, the SLCSP will be referred to as the QHP throughout the paper.

For the CHIP and QHP comparison, the analysis:

[5] Note that plans are compliant with metal level requirements if they are within +/- 2% of these defined percentages for standard plans or +/- 1% for plans with cost-sharing reductions.
[6] American Indians and Alaska Natives are eligible for a zero cost-sharing plan if their household incomes are between 100% and 300% of the FPL.
[7] A sensitivity analysis was also conducted on the most popular plan for families in a state based on 2014 enrollment. Findings from this analysis were similar to that of the SLCSP analysis.
[8] Benchmark in this paper refers to two different things. The benchmark plan for tax credits is the second lowest cost silver plan (SLCSP). The benchmark plan for essential health benefits is selected by a state for QHPs. The Final Rule on Standards Related to Essential Health Benefits, Actuarial Value and Accreditation can be accessed here: http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf

1. Estimated average out-of-pocket expenditures (cost sharing and premiums) in each state.
2. Determined the proportion of children who would have greater financial protection by paying less in out-of-pocket expenditures.

Analysis Expectations:

To examine the difference in financial protections between QHPs and CHIP, we expect that CHIP will offer children more financial protections due to the statutory differences in out-of-pocket maximums between the two plans. In general, we expect that families with incomes above 168% of the FPL will be found to have greater financial protections in CHIP as compared to QHPs. At 168% of the FPL, it is possible under the statute for CHIP and QHPs to have equivalent out-of-pocket costs. At this income level, statutory requirements for the maximum enrollee contribution toward premiums for QHPs are 5% of family income. In CHIP, at this income level and higher, the statutory out-of-pocket maximum for premiums *and* cost sharing is 5% of family income. While many states do not have cost sharing requirements under CHIP and several states have $0 premiums, some states do impose premium and cost sharing for families enrolled in CHIP.

When examining the differences in cost sharing protections at an individual family level, we expect that there will be a variety of additional factors that may affect whether children will have greater financial protections in CHIP as compared to QHPs. Combinations of family income, total health spending, type of health spending (e.g., preventive versus inpatient services), CHIP premium and cost sharing requirements, QHP premiums and cost-sharing requirements, as well as aversion to risk may lead some children to be found to have greater financial protections in CHIP and other children to be more financially protected in QHPs.

For example, families with children who have health care spending on services may be found to be more financially protected in CHIP if they live in a state where there are no CHIP premium or cost sharing requirements. But, this same family may be found to be more financially protected in a QHP if they live in a state with CHIP premiums and cost sharing requirements. Likewise, a low-income family who qualifies for a Marketplace subsidy large enough to cover the full cost of their QHP premiums and who has child health spending on just preventive services (which have no co-pays in QHPs or CHIP), may be found to have greater financial protections in the QHP than in CHIP if their state has CHIP premium requirements.

Our expectations were reinforced by a literature review of studies previously conducted by other entities. The Government Accountability Office (GAO), Medicaid and CHIP Payment and Access Commission (MACPAC) and the Wakely Group have all examined financial protections and benefits in CHIP and QHPs and have found that CHIP offers more financial protections and additional benefits most often utilized by children as compared to QHPs.[viii] Different from the prior studies, our analyses is based on actual child health expenditures to determine any differences in financial protections between CHIP and QHPs.

Methodology:

Child health expenditures were examined by simulating claims payment and estimating premiums and cost-sharing expenditures per child based on the child's family income. Each state with a separate CHIP plan and Marketplace QHP were compared over the same national population of children in order to

examine the relative levels of costs and determine the proportion of children with greater financial protection under each program.[9]

- Person-level demographic information, including income, and child health care spending and utilization from the 2011 MEPS-HC (consolidated file) were used to construct the national child population for the analysis. Health care spending was partitioned by service, including splitting office-based physician services into preventive, primary care, and specialty care so that service specific copayments could be evaluated.
- This analysis included only those children between 100% and 400% of the FPL in order to look at the population eligible for Marketplace financial assistance (advance payments of the premium tax credit and cost-sharing reductions (up to 250% of the FPL)). This restriction reduced the universe of 11,451 records for persons under age 21, which represent 87.1 million persons (weighted) in the 2011 MEPS-HS file, to 5,222 records, representing 40.7 million children.
- The universe of records was further restricted to the CHIP eligibility age and poverty levels at a state specific level, based on the minimum and maximum 2014 CHIP eligibility for a particular state, to ensure only files of CHIP-eligible children were used in the evaluation.
- For this analysis, the interest was in child premiums but in order to correctly determine the premium paid, premiums were estimated for all family members (using the child premiums and CMS age-indices). The 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.

The states used for this analysis include those that operate a separate CHIP program. This group includes 36 states. Note that Florida and Georgia have more than one CHIP plan and are listed accordingly in the tables, and Kansas has two SLCSPs in its largest rating area.

CHIP plans that are Medicaid expansion programs were excluded from the analysis for two reasons:

1. Comprehensive Early and Periodic Screening, Diagnostic and Treatment (EPSDT)[10] coverage offered in these CHIP programs exceeds the actuarial value of QHP coverage.

2. The Maintenance of Effort (MOE) provision in the Affordable Care Act, effective through 2019, requires states with a title XXI funded Medicaid expansion program to maintain Medicaid coverage of the CHIP-eligible children, and therefore, children eligible for the title XXI funded Medicaid expansion would not be looking to QHP coverage as an alternative to CHIP coverage in the near future.

For more information regarding methodology as well as a break-out between premiums and cost-sharing for QHPs in states see the Appendices.[11]

[9] Person level data used for the analysis was the 2011 MEPS-HC (consolidated file). In order to more accurately evaluate the plan parameters and subsidy effects, income and medical spending were inflated to 2014 for all plans.
[10] States are required to provide EPSDT benefits, which are comprehensive health care services for children under age 21 in Medicaid, and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on federal guidelines. The EPSDT benefit is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services.
[11] This analysis is based on 2014 QHP and CHIP plans and does not include updated information from 2015.

Summary Table: Comparisons of CHIP and QHPs for Families

	B	C	D	E	F	G
	Plan AV		Total Out-of-Pocket Expenditures		% with Greater Financial Protection	
State	QHP	CHIP	QHP	CHIP	QHP	CHIP
Alabama	0.62	0.94	$1,455	$175	0.0%	100.0%
Arkansas	0.78	0.94	$896	$65	0.4%	99.6%
Colorado	0.65	0.95	$1,178	$68	0.0%	100.0%
Connecticut	0.71	0.96	$1,756	$154	0.0%	100.0%
Delaware	0.84	1.00	$805	$129	0.2%	99.8%
Florida	0.92	1.00	$787	$0	0.0%	100.0%
Florida	0.79	1.00	$781	$116	0.0%	100.0%
Florida	0.76	0.98	$871	$140	0.0%	100.0%
Georgia	0.59	1.00	$1,133	$0	0.0%	100.0%
Georgia	0.60	1.00	$1,170	$221	0.0%	100.0%
Idaho	0.85	0.99	$647	$163	0.0%	100.0%
Illinois	0.70	0.97	$1,252	$314	0.0%	100.0%
Indiana	0.72	0.98	$1,102	$225	0.0%	100.0%
Iowa	0.72	1.00	$1,292	$151	0.0%	100.0%
Kansas	0.71	1.00	$1,009	$152	0.1%	99.9%
Kansas	0.76	1.00	$956	$152	0.1%	99.9%
Kentucky	0.66	0.98	$1,037	$23	0.0%	100.0%
Louisiana	0.59	1.00	$1,597	$322	0.3%	99.7%
Maine	0.83	1.00	$824	$115	0.0%	100.0%
Massachusetts	0.77	1.00	$1,422	$225	0.0%	100.0%
Michigan	0.84	1.00	$756	$46	0.0%	100.0%
Mississippi	0.83	1.00	$848	$0	0.0%	100.0%
Missouri	0.62	1.00	$1,492	$829	11.4%	88.6%
Montana	0.70	1.00	$1,111	$5	0.0%	100.0%
Nevada	0.82	1.00	$765	$91	0.0%	100.0%
New Jersey	0.73	0.98	$1,557	$321	0.1%	99.9%
New York	0.74	1.00	$1,396	$326	0.0%	100.0%
North Carolina	0.81	0.99	$802	$43	0.0%	100.0%
North Dakota	0.87	0.99	$638	$8	0.0%	100.0%
Oregon	0.52	1.00	$1,598	$0	0.0%	100.0%
Pennsylvania	0.59	0.99	$1,869	$646	0.2%	99.8%
South Dakota	0.68	1.00	$1,202	$0	0.0%	100.0%
Tennessee	0.67	0.94	$1,103	$64	0.0%	100.0%
Texas	0.76	0.91	$814	$75	0.0%	100.0%
Utah	0.83	0.83	$750	$247	0.8%	99.2%
Virginia	0.88	0.98	$754	$21	0.0%	100.0%
Washington	0.48	1.00	$1,969	$252	0.0%	100.0%
West Virginia	0.67	0.96	$1,441	$245	0.0%	100.0%
Wisconsin	0.67	0.97	$1,409	$146	0.0%	100.0%
Wyoming	0.81	0.97	$830	$32	0.0%	100.0%

The actuarial values (AV) of CHIP in each state met or exceeded the AV of the QHP plans (Summary Table, Columns B and C). The AV of all state CHIP plans examined was between .90 and 1.0 with the exception of Utah where the CHIP plan had an AV of .83.[12] The stated AVs for QHPs are based on adult and child service utilization and expenditures. Column B represents the re-calculated AV based on child service utilization and expenditures and takes into account cost-sharing reductions.[13] In most states, the AV was lower once recalculated based on child service utilization and expenditures. The lower AV once re-calculated for child service utilization and expenditures was lower because children typically use fewer and less expensive services as compared to adults who are more likely to use inpatient services. In some states the re-calculated AV decreased to the point of changing the metal level of the plan. For example, the second lowest cost silver plan was no longer a silver plan for children (i.e. with an AV of .70, where families would be responsible for 30% of the out-of-pocket costs), but instead it became a bronze level plans (and even less than bronze in a few states, with AVs below .60) with the recalculated AV. The lowered AVs may mean that some families with children would spend more out-of-pocket for health care services.[14] QHP coverage was designed for both adult and child service utilization and expenditures, not just child service utilization and expenditures like in CHIP.

On average, children were found to have lower out-of-pocket health care expenditures in CHIP as compared to QHPs (Summary Table, Columns D and E). Average total out-of-pocket costs per child (including premiums and cost sharing) are lower in CHIP than in the QHP in every state. Many states do not have cost sharing requirements under CHIP and several states have $0 premiums which led to lower estimates of total out-of-pocket expenditures in CHIP compared to QHP plans. In contrast, all Marketplace plans have premiums and cost-sharing requirements. However, for families with low to moderate incomes, premium subsidies and cost-sharing reductions can diminish or offset these financial requirements.

In all states examined, nearly all CHIP-eligible children had greater financial protections in the CHIP plan compared to the QHP (Summary Table, Column F and G). Among the states examined, most families with CHIP-eligible children had greater financial protections in terms of their spending for child related services and expenditures as compared to the QHP. Specifically, in 28 of the 36 states examined for the most popular plan, 100% of children would have lower out-of-pocket costs in CHIP as compared to the SLCSP.

In some states, a small proportion of children would have greater financial protections in an SLCSP than in CHIP. In a few states, such as Arkansas, Delaware, Kansas, Louisiana, New Jersey, Pennsylvania and Utah, small numbers of children (i.e., <2% of population used in the analysis) were found to have greater financial protections in a QHP plan.[15] One explanation for these differences is that each of these states has CHIP cost sharing requirements that are more than nominal. For example, CHIP

[12] The most popular plan in Utah was the SLCSP and it had an AV of .83 as well.

[13] Note added June 6, 2016: The AVs re-calculated are based on child services and expenditures only and thus represent a hypothetical projected AV. This analysis was conducted to allow for a comparison of QHP and CHIP coverage. There are a variety of factors that may cause the actual service and spending levels to differ from those projected in the ASPE Background Paper.

[14] The MEPS data covers all health spending, which may be broader than essential health benefits (EHB).

[15] Note that in Arizona, the CHIP program is a demo M-CHIP program with EPSDT waived and benefits similar to a Separate CHIP program. In Arizona, enrollment in the Separate CHIP program is closed and the program is being phased out.

premiums and deductibles are $500 in one state, another state has 10% and 20% coinsurance, and some of the states have service copays such as an inpatient copay of $200.

One notable exception is Missouri where 11% of children in the population would have greater financial protections in a QHP than in CHIP. While Missouri does not have CHIP cost sharing requirements (deductible, coinsurance, or copays) it does have substantial annual premium requirements based on income bands. The portion of the study population found to have greater financial protections in the QHP in Missouri, had family incomes greater than 168% of the FPL, and the estimated total out-of-pocket expenditures (accounting for premium subsidies plus cost sharing reductions) was less than the state's CHIP premium.

III. Comparing Benefit Packages in CHIP Plans and Marketplace QHPs

Background:

States are able to define the benefits required to be covered under both separate CHIP and QHPs, as long as they adhere to general federal guidelines. For CHIP, states had the choice to design their benefit packages based on specific private insurance benchmarks, a package equivalent to those benchmarks, or Secretary approved coverage. Most commonly, states have used Secretary approved coverage as the approach for designing benefit packages.

As previously noted, for QHPs, states had the flexibility to select a benchmark plan to define EHBs. The benchmark options included the most highly enrolled commercial plan available in each of the top three products in the state's small group market, any of the three largest state employee benefit plans, any of the three largest national Federal Employees Health Benefits Program plans, and the largest insured commercial non-Medicaid HMO operating in the state. In some cases, the plan chosen as the benchmark required supplementary services to be added. Most states selected their small group market plan as their benchmark plan. States that did not select a benchmark plan defaulted to the largest commercial plan in the small group market. Regardless of which benchmark plan a state chose, QHPs must include EHBs with the ten required service categories of benefits.

Plans in CHIP and QHPs are generally required to provide basic services, such as inpatient and outpatient hospital, physician, laboratory and x-rays, and preventive care. Because CHIP benefit packages are designed for children, federal rules also require that all separate CHIP programs cover dental services, well-baby and well-child care, and emergency services. The essential health benefits package requires all QHPs to include coverage for these services as well.

Methodology:

At roughly the same time that the cost-sharing analysis was commissioned and conducted by ASPE, an evaluation of benefit packages was published by the Wakely Group.[16] Their analysis included a comprehensive study of differences in benefit and financial protections in health coverage provided through CHIP and QHPs offered through the Marketplace. Their study focused on 35 states,[17] including

[16] This study was funded by the Robert Wood Johnson Foundation and conducted by the Wakely Group. Bly, A., Lerche J., Rustagi, K. 2014. Comparison of benefits and cost sharing in Children's Health Insurance Programs to qualified health plans. Englewood, CO: Wakely Consulting Group. http://www.wakely.com/wpcontent/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and-Benefits-Comparison-First-Focus- July-2014-.pdf.

[17] To the extent possible, the ASPE analysis tried to capture information from a similar subset of states as Wakely.

states that operate CHIP programs separate from Medicaid and states with CHIP programs that are combined with Medicaid.

The Wakely Group evaluation used the essential health benefits summaries that are posted by CCIIO for QHP information. QHPs are required to cover the basic EHB package as well as any state-specific mandated benefits. The CHIP benefit information used in the Wakely Group analysis was collected by the National Academy for State Health Policy (NASHP) and Georgetown University Health Policy Institute, Center for Children and Families for the May 2014 report "Benefits and Cost Sharing in Separate CHIP Programs." This information was supplemented by web searches to identify whether the state CHIP plans covered additional state-specific EHB requirements. For any states with more than one CHIP plan in a state, the analysis was based on the most highly enrolled CHIP plan.[ix]

There are limitations to the Wakely study because the publicly available data are not comprehensive. Not all benefits, limits, and exclusions were explicitly addressed in either the EHB summaries or the CHIP benefit summaries.[x] Also, it is important to note that QHP issuers have the option of substituting required EHBs within an EHB category, if actuarially equivalent; providing additional benefits; or having broader limitations that were not included in the EHB summaries. In spite of these limitations, the Wakely Group study provides a compilation of benefit specific information at the state plan level and offers the broadest publicly available examination of benefit comparability between CHIP and QHPs in terms of service categories and states examined.[18]

In the Wakely group evaluation, benefits were categorized as either "core" or "child-specific" based on how commonly they were covered and the relative importance to children.

> *Core benefits* are services that are almost always covered in CHIP and QHPs and the differences in benefits is typically in the form of limits or cost sharing. Examples include physician services, laboratory and radiological services, inpatient, and outpatient services (See Table D).
>
> *"Child-specific" benefits* are services that are particularly important for children though they are less likely to be consistently covered in CHIP or QHPs and have larger variation in limits and exclusions. Examples include dental services, vision and corrective lenses, audiology, habilitation and physical, occupational and speech therapy.

The Government Accountability Office (GAO) also conducted two evaluations that compared CHIP and EHB benchmark plan benefit packages in 14 states. The findings are included in this analysis although the underlying data from the GAO analysis are not publicly available.

Findings:

The services covered in the core benefit packages are generally similar between CHIP and QHPs (Table B). Wakely defined 10 core benefits, many of which overlap with the essential health benefit categories, examples of which include: physician services, inpatient and outpatient services, prescription drugs, surgical services and medical emergency transport. From their in-depth analysis, the Wakely Group found that generally, the benefits packages between CHIP and QHPs for core services are similar.[xi]

However, there is some variation in the extent to which limits are imposed on core benefits, and CHIP plans have slightly more limits on covered core benefits as compared to QHPs (Table B). In

[18]The benefits analysis conducted by Wakely only includes plan information for 2014 and has not been updated to reflect any 2015 plan benefit changes.

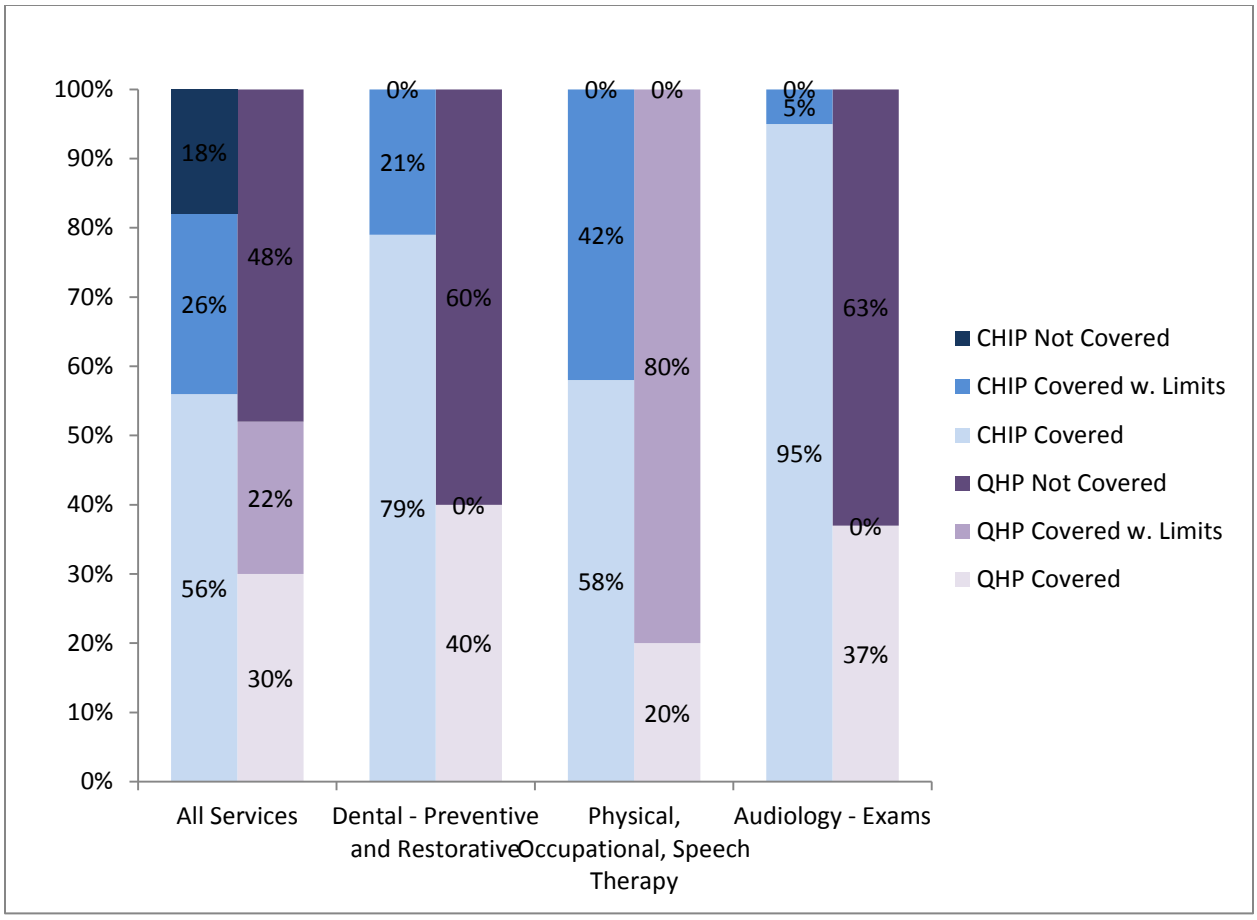
their analysis, the Wakely Group examined benefit limits and found that CHIP programs are more likely to have limits for certain core benefits relative to QHPs. Benefit restrictions/limits may relate to day, visit or dollar limits for a specified benefit or category of benefits. Examples of benefits where CHIP has more limits as compared to QHPs include: physician, clinic and outpatient services, surgical services and prescription drugs and inpatient services.[xii] Wakely noted that this difference is negated and QHPs have slightly more limits on core benefits overall if the Pennsylvania CHIP program is excluded from the analysis.[19] [xiii]

CHIP coverage of "child-specific" benefits is generally more comprehensive than QHP coverage (Table E). Compared to adults, children often need services that include dental preventive and restorative care services, vision exams and corrective lens, audiology exams, habilitation, physical therapy, enabling services and medical transportation.[xiv]

The Wakely Group found that CHIP plans typically cover more of these "child-specific" services than QHPs. Specifically, in the states examined, CHIP covered 56% of "child-specific" services with no limits compared to only 30% of these same services covered with no limits in QHPs. Among the states studied, 48% of "child-specific" benefits were not covered at all in QHPs as compared to only 18% of these same services that were not covered in CHIP (Figure 2). Among the 35 states examined, only five states had QHPs that were more generous that CHIP in covering "child-specific" benefits with no limits.[xv]

Figure 2: Percentage of States Covering Certain "Child-Specific" Benefits[xvi]

[19] Pennsylvania CHIP plans have limits on many services because their child population consists of healthier children and their Medicaid population covers children with special health care needs. Most children will not reach the limits imposed in the PA CHIP program.



The Wakely group noted specific examples of "child-specific" services that are more likely to be covered by CHIP than QHPs:

- Preventive and Restorative Dental services – As required, all separate CHIP plans provide preventive and restorative dental services, and the Wakely analysis found that 79% of states include this benefit in their CHIP plan with no limitations. In contrast, only 40% of states embed pediatric dental check-ups in their EHB package (instead of offering these services in a separate stand-alone plan).[20]
- Physical Therapy, Occupational Therapy, and Speech Therapy – 58% of states cover all three types of therapy with no limits in their CHIP program compared to 20% of states that include this benefit in their EHB package
- Audiology – Exams – CHIP covers audiology exams in all states (in 5% with limits on the coverage) compared to only 37% of states covering this benefit in their EHB package.

CHIP plans have slightly more limits on covered "child-specific" benefits as compared to QHPs (Table C). Despite broader coverage of "child-specific" benefits, a greater percentage of state CHIP

[20] Many states offer stand-alone dental plans (SADP). Pediatric dental services are allowed to be excluded from coverage in a QHP in states that offer SADPs. The Wakely Group did not include SADP information in their analysis, so these benefits may be available to children if they also chose to enroll in an SADP in addition to their QHP.

programs impose limits on covered benefits as compared to QHPs (26% vs 22%). CHIP programs may have more limitations on "child-specific" benefits because they cover more benefits overall, or the results could be due to the previously noted limitation in the Wakely group analysis, that available plan information did not provide details on limits and exclusions so the results may be biased due to a lack of complete information.

Children also have better access to affordable dental benefits in CHIP compared to QHPs. Many low-income children experience high rates of tooth decay, and in the 2009 CHIPRA reauthorization bill, all CHIP programs were newly required to provide dental coverage.

In QHPs, one of the EHB benefit categories includes pediatric dental services, but these services can be provided via a stand-alone dental plan, if offered in a state, instead of being included in a QHP. A MACPAC evaluation found that only 40% of plans in the Marketplace embed pediatric dental services, as compared to 100% of states that offer these services to children covered by CHIP.[xvii] Further complicating the dental benefits issue, stand-alone dental plans may be unaffordable for families because they have separate premiums, cost sharing and out-of-pocket maximums which are generally not included in the calculation of a family's premium tax credit. However, dental services from an SADP can be accessed and used prior to meeting the QHP deductible.

GAO Findings:

GAO also conducted evaluations and published findings from 2013-2015 that reviewed federal statutes and regulations governing CHIP-eligible services and the required EHBs in 5 states. GAO did not release detailed data from their analyses but in the description of their findings came to similar conclusions as the Wakely Group.

GAO found that CHIP and QHPs are similar in their coverage and limits on coverage for services, but that CHIP provides more comprehensive services for dental and enabling services.[xviii] In their first analysis released in 2013, GAO reviewed federal statutes and regulations governing CHIP-eligible services and the required EHBs in five selected states. The GAO found that separate CHIP programs and QHP benchmark plans in states were generally similar in terms of the services covered as well as those benefits for which they imposed limits. Neither CHIP plans nor the EHBs typically imposed any limits on ambulatory patient services, emergency care, preventive care, or prescription drugs, but they commonly imposed limits on outpatient therapies and pediatric dental, vision, and hearing services.

In a report released in 2015, GAO found generally comparable services between CHIP and QHPs in the five states that they examined, but that CHIP plans more frequently covered embedded pediatric dental services and additional enabling benefits such as translation and transportation services.

IV. Summary of Cost Sharing and Benefit Analysis

This analysis compared two programs that are designed for different populations. Our expectations were that CHIP may provide greater financial protections to this sub-population due to the different statutory requirements for the programs and the analysis confirmed this finding.

The ASPE cost sharing analysis indicates that eligible children have greater financial protections in CHIP compared to QHPs. This was true on average in all states we examined, although the analysis found there are a limited number of children who have greater protection in QHPs than in CHIP in certain states. Our review of the publicly reported Wakely Group findings and the GAO evaluations, suggest that core benefit coverage is similar between CHIP and QHPs, but the benefit packages in CHIP are more

comprehensive for "child-specific" services and for children with special needs as compared to EHB packages included in QHPs.

V. Appendices

Table A. CHIP and Marketplace: Comparing QHP and CHIP in 36 States, 2014

	Plan AV		Cost Sharing		Avg Prem Pd		Total Out-Of-Pocket Spending		% with Greater Financial Protection	
State	QHP	CHIP	QHP	CHIP	QHP	CHIP	QHP	CHIP	QHP	CHIP
Alabama	0.62	0.94	$457	$77	$998	$98	$1,455	$175	0.0%	100.0%
Arkansas	0.78	0.94	$226	$65	$670	$0	$896	$65	0.4%	99.6%
Colorado	0.65	0.95	$305	$40	$873	$27	$1,178	$68	0.0%	100.0%
Connecticut	0.71	0.96	$321	$40	$1,434	$114	$1,756	$154	0.0%	100.0%
Delaware	0.84	1.00	$191	$2	$614	$127	$805	$129	0.2%	99.8%
Florida	0.92	1.00	$136	$0	$651	$0	$787	$0	0.0%	100.0%
Florida	0.79	1.00	$142	$0	$639	$116	$781	$116	0.0%	100.0%
Florida	0.76	0.98	$245	$22	$626	$119	$871	$140	0.0%	100.0%
Georgia	0.59	1.00	$288	$0	$846	$0	$1,133	$0	0.0%	100.0%
Georgia	0.60	1.00	$362	$0	$808	$221	$1,170	$221	0.0%	100.0%
Idaho	0.85	0.99	$115	$4	$532	$159	$647	$163	0.0%	100.0%
Illinois	0.70	0.97	$322	$28	$931	$286	$1,252	$314	0.0%	100.0%
Indiana	0.72	0.98	$281	$21	$821	$204	$1,102	$225	0.0%	100.0%
Iowa	0.72	1.00	$292	$3	$1,000	$148	$1,292	$151	0.0%	100.0%
Kansas	0.71	1.00	$284	$0	$725	$152	$1,009	$152	0.1%	99.9%
Kansas	0.76	1.00	$230	$0	$725	$152	$956	$152	0.1%	99.9%
Kentucky	0.66	0.98	$360	$23	$677	$0	$1,037	$23	0.0%	100.0%
Louisiana	0.59	1.00	$469	$0	$1,128	$322	$1,597	$322	0.3%	99.7%
Maine	0.83	1.00	$179	$0	$644	$115	$824	$115	0.0%	100.0%
Massachusetts	0.77	1.00	$283	$0	$1,139	$225	$1,422	$225	0.0%	100.0%
Michigan	0.84	1.00	$139	$0	$617	$46	$756	$46	0.0%	100.0%
Mississippi	0.83	1.00	$193	$0	$655	$0	$848	$0	0.0%	100.0%
Missouri	0.62	1.00	$427	$0	$1,064	$829	$1,492	$829	11.4%	88.6%
Montana	0.70	1.00	$313	$5	$797	$0	$1,111	$5	0.0%	100.0%
Nevada	0.82	1.00	$151	$0	$614	$91	$765	$91	0.0%	100.0%
New Jersey	0.73	0.98	$303	$20	$1,254	$301	$1,557	$321	0.1%	99.9%
New York	0.74	1.00	$349	$0	$1,047	$326	$1,396	$326	0.0%	100.0%
North Carolina	0.81	0.99	$172	$10	$630	$33	$802	$43	0.0%	100.0%
North Dakota	0.87	0.99	$179	$8	$459	$0	$638	$8	0.0%	100.0%
Oregon	0.52	1.00	$505	$0	$1,093	$0	$1,598	$0	0.0%	100.0%
Pennsylvania	0.59	0.99	$516	$13	$1,353	$633	$1,869	$646	0.2%	99.8%
South Dakota	0.68	1.00	$322	$0	$879	$0	$1,202	$0	0.0%	100.0%
Tennessee	0.67	0.94	$342	$64	$761	$0	$1,103	$64	0.0%	100.0%
Texas	0.76	0.91	$197	$75	$617	$0	$814	$75	0.0%	100.0%
Utah	0.83	0.83	$124	$122	$626	$125	$750	$247	0.8%	99.2%
Virginia	0.88	0.98	$115	$21	$640	$0	$754	$21	0.0%	100.0%
Washington	0.48	1.00	$582	$0	$1,387	$252	$1,969	$252	0.0%	100.0%
West Virginia	0.67	0.96	$463	$53	$978	$192	$1,441	$245	0.0%	100.0%
Wisconsin	0.67	0.97	$364	$29	$1,045	$118	$1,409	$146	0.0%	100.0%
Wyoming	0.81	0.97	$206	$32	$624	$0	$830	$32	0.0%	100.0%

Table B: Percentage of States Covering Core Benefits[xix]

	CHIP			QHP		
	Covered No Limits	Covered With Limits	Not Covered	Covered No Limits	Covered With Limits	Not Covered
Average for All Core Benefits	95	5	0	96	4	0
Physician Services	97	3	0	100	0	0
Clinic Services and Other Ambulatory Health Care	97	3	0	100	0	0
Laboratory and Radiological Services	100	0	0	97	3	0
DME	82	18	0	71	29	0
Inpatient Services	95	5	0	100	0	0
Inpatient Mental Health	95	5	0	97	3	0
Surgical Services	92	8	0	100	0	0
Outpatient Services	97	3	0	100	0	0
Outpatient Mental Health	95	5	0	97	3	0
Prescription Drugs	92	8	0	100	0	0
Emergency Medical Transport	100	0	0	97	3	0

Table C: Percentage of States Covering "Child-Specific" Benefits[xx]

	CHIP			QHP		
	Covered No Limits	Covered With Limits	Not Covered	Covered No Limits	Covered With Limits	Not Covered
Total All States	56	26	18	30	22	48
Dental – Preventive and Restorative	79	21	0	40	0	60
Dental – Orthodontics	71	24	5	31	0	69
Vision – Exams	97	3	0	97	3	0
Vision – Corrective Lenses	63	37	0	91	6	3
Audiology – Exams	95	5	0	37	0	63
Audiology –Hearing Aids	39	55	5	9	46	46
Autism –General	66	16	18	29	49	23
ABA Therapy	26	32	42	9	49	43
Habilitation	63	37	0	31	69	0
Physical, Occupational and Speech Therapy	58	42	0	20	80	0
Enabling Services	32	0	68	0	0	100
Medical Transportation- Non-Emergency Transport	29	26	45	0	0	100
Over the Counter Medications	29	32	39	3	0	97

Data and Methods:

The 2011 MEPS-HC (consolidated file) provided the underlying data for the analysis. Person level demographic information, including income as well as health care spending and utilization, was used to make an extract for the analysis. Health care spending was partitioned by service, including splitting office-based physician services into preventive, primary care and specialty care so that service specific copayments could be evaluated. In order to more accurately evaluate the plan parameters and subsidy effects, income and medical spending were inflated to 2014 terms for all plans.

The 2014 Medicare Trustees' Report for the change in CPI (for unearned income) and change in HI taxable payroll (for wages) was used to inflate income to 2014. Poverty was calculated against the 2014 HHS poverty income guidelines (by family size).[21] To adjust medical spending to be consistent with 2014 levels, the average per capita change in health expenditures from 2011 to 2014, from the most recent National Health Expenditure series was used. A single medical inflation factor was applied to all services evaluated.

Premium and plan specification information for QHP plans in states using the HealthCare.gov platform came from the HIOS database available on HealthCare.gov for 2014 plans. Plan information for State-based Marketplaces using their own marketplace platforms came from the Health Insurance Exchange (HIX) Compare dataset from the RWJ Foundation.[xxi]

Universe:
There are 11,451 records for persons under age 21 which represent 87.1 million persons (weighted) in the 2011 MEPS-HS file. This evaluation included only those children between 100% and 400% of poverty in order to look at the population eligible for Marketplace subsidies (APTC and CSR). This restriction reduced the universe to 5,222 records, and represented 40.7 million children. The universe of records was further restricted to the poverty levels at a state specific level, based on the minimum and maximum 2014 CHIP eligibility for a particular state, to ensure only files of CHIP-eligible children were used in the evaluation.

The initial set of plans examined used the state specific poverty bands, along with state specific CHIP age bands, for each pair of CHIP and QHP plans. State CHIP plans that are Medicaid expansion programs were excluded from the analysis leaving 36 states and 40 pairs of plans[22] based on 2014 income and poverty levels. Each pair was evaluated in 2014 terms, as described above, as well as using state specific adjustments for both income and medical expenses. To adjust income to state-specific levels, we used a three-year average ratio of state median household income to US median household income (from 2011-2013 CPS files).

Adjusting spending to be state specific was also done as part of the plan and premium evaluation routine. Expenditures on each person record were adjusted with a factor that represented the ratio of average per capita state spending to average US per capita spending. These factors were calculated from state specific National Health Account estimates for 2009. The calculation was for the personal health care "core" services of hospital, physician, other professionals and prescription drugs.

QHP Plans:

[21] http://aspe.hhs.gov/poverty/14poverty.cfm
[22] FL had three CHIP plans, GA had two CHIP plans (both states using different specifications by age of child), and Kansas had two SLCSP plans evaluated.

Premium and plan specification information for QHP plans in states using the HealthCare.gov platform came from the HIOS database. Plan information for state based marketplaces using their own marketplace platforms came from the Health Insurance Exchange (HIX) Compare dataset from the RWJ Foundation.[xxii] All premiums were converted to an annual basis. Plan specifications were recoded for simplicity. The main plan parameters used to evaluate QHP plans were as follows: deductible, coinsurance rate, out-of-pocket maximum, copay for primary care, copay for specialty care, inpatient hospital copay (either per day or per admission), emergency room copay, and prescription drug copay (low brand tier selected for use). In addition, each state's second lowest cost silver plan had four sets of specifications that corresponded to the adjustment to the basic silver actuarial value (AV) at incomes below 250% FPL due to cost sharing subsidies (CSRs).

In general, each state SLCSP plan included cost-sharing parameters adjusted for the highest silver AV (for lowest income levels, 100-150% FPL). For a few states, the lower income (higher actuarial value) specifications were missing and the CCIIO actuarial value calculator was used to adjust plan specifications in order to hit the higher actuarial values. These states were: Colorado, Kentucky, Massachusetts, and New York

In addition to plan parameters that vary by income, the maximum premium faced by a family was also determined by their income as a percent of poverty. This maximum is a sliding scale represented by the following intervals:

2014 QHP Tax Credit Thresholds

% of Poverty	Maximum % of Income
100% - 133%	2%
133% - 150%	3% to 4%
150% - 200%	4% to 6.3%
200% - 250%	6.3% to 8.1%
250% - 300%	8.1% to 9.5%
300% - 400%	9.5%

The maximum income percent, for those between 133 and 300 percent of poverty was estimated, for modeling purposes, by the equation:

$$\text{max income (\%)} = (0.07988 * \ln(\text{poverty})) + 0.00743$$

The unit of observation for the evaluation (for poverty levels and therefore plan specifics and premium calculations) was the insurance family, which is a subset of household comprised of parents and eligible children. The plans themselves were evaluated at the person (child) level.

For this evaluation, the interest was for child premiums but in order to correctly determine the premium paid, premiums were estimated for all family members (using the child premiums and CCIIO age-indices) and compared to income. The 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.

Once a child's family income was determined and the premium calculation was performed, the corresponding plan specifications were then used in conjunction with the child's medial spending and utilization in order to determine the amount of spending paid for by the QHP plan with the remainder considered out-of-pocket costs.

Summary actuarial values were calculated by examining the average amount paid by the plan as compared to total medical spending for the population of children as a whole. In addition, out-of-pocket costs due to both plan cost-sharing as well as premiums paid for coverage (minus subsidy) were tabulated. Actuarial values for QHP only covers EHB, which may be narrower than MEPS health spending which could lead to a smaller AV overall.

CHIP Plans:
Updated 2014 CHIP premium and plan specification from the Center for Medicaid and CHIP Services (CMCS) were used. When information was not available from CMCS, premiums and plan basic plan specifications were taken from "Benefits and Cost Sharing in Separate CHIP Programs", NASHP, Georgetown University, May 2014[xxiii], as well as from the Kaiser Family Foundation[xxiv] for prescription drug cost-sharing.

Maximum premiums were used for the highest income levels modeled. All premiums (and/or enrollment fees) were converted to an annual basis. In general, premiums were per child. Some states had a maximum per family premium, while a few states had only a family premium for CHIP coverage. Premiums were assigned based on poverty of the child's family. Preferred brand cost-sharing for prescription drugs was used, to be consistent with the copay used for the silver plan analysis. In general, specifications used were the same as those for the SLCSP plan analysis with the exception that all CHIP inpatient copays were per admission. In addition, out-of-pocket costs under CHIP include both cost sharing and premiums and are limited to 5% of family income. Any reductions calculated due to this limit were applied pro-rata to both the cost-sharing and premium contributions of the family.

As with the QHP plans, summary actuarial values were calculated by comparing the average amount paid by the plan to average total medical spending for the population of children as a whole. In addition, out-of-pocket costs due to both plan cost-sharing as well as premiums paid for coverage were tabulated.

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[xxi]Robert Wood Johnson, Health Insurance Exchange Compare, February 2015. http://www.rwjf.org/en/research-publications/find-rwjf-research/2014/03/breakaway-policy-dataset.html
[xxii] ibid
[xxiii] Premiums were from Table J: "Premiums and Enrollment Fees for Children at Selected Income Levels." Cost sharing parameters were taken from Table K: "Cost Sharing Amounts for Selected Services for Children at Selected Income Levels."
[xxiv]Artiga Samantha and Jessica Stephens, "Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013," Kaiser Family Foundation, January 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf.