



Comparing Affordability and Benefits Between CHIP and Qualified Health Plans in 35 States: Which Coverage is Best for Kids?

The Children’s Health Insurance Program (CHIP) was enacted in 1997 by a bipartisan group of lawmakers to provide funding to states to improve coverage and reduce the numbers of uninsured children in low-income families with incomes above the Medicaid income eligibility threshold.

Offering child-specific benefits and affordable care that families want and need for their children, CHIP remains a model of health coverage that works. By every measure, CHIP has been successful in lowering the numbers of uninsured children. Since its enactment, the uninsured rate for children has declined from almost 14% to a record low of 7% in 2012. In 2013, eight million children received their health coverage through CHIP.

With CHIP funding due for renewal next year, this is an important time to assess how CHIP stacks up against coverage now being offered through the Affordable Care Act’s (ACA) qualified health plans (QHPs) across the states.

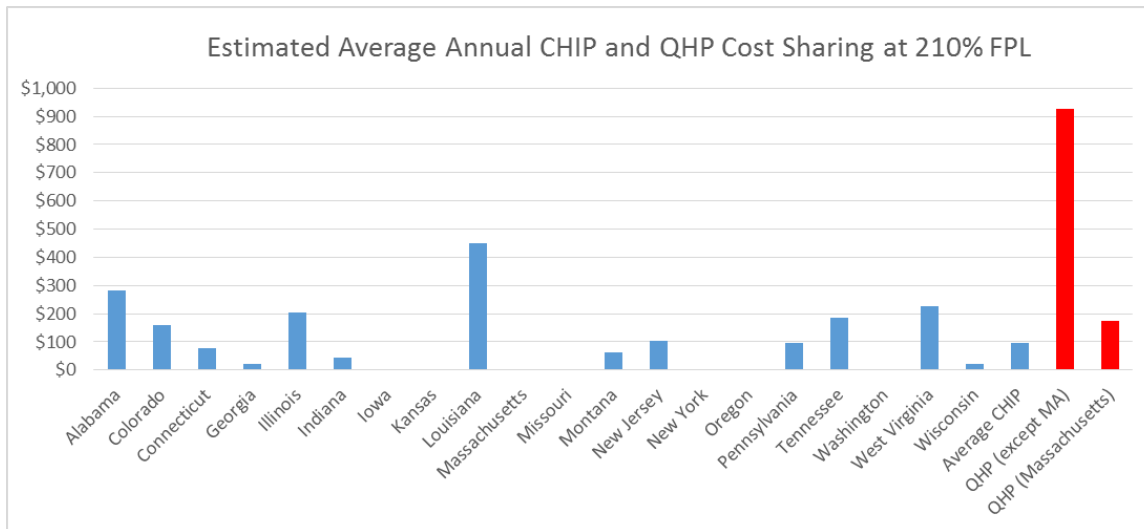
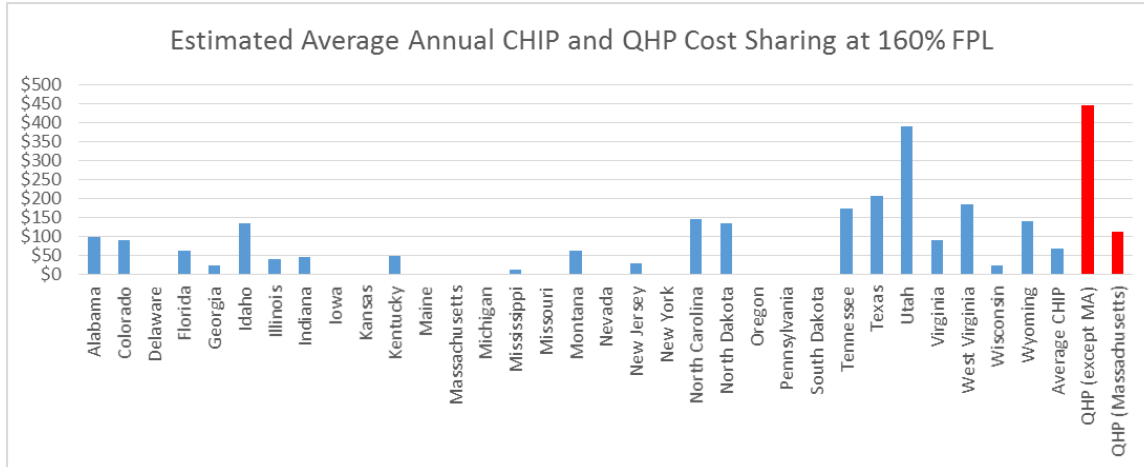
A new analysis, [“Comparison of Benefits and Cost Sharing in Children’s Health Insurance Programs to Qualified Health Plans,”](#) conducted by Wakely Consulting Group, compares actuarial values of CHIP plans and QHPs in 35 states, including 14 states that operate stand-alone CHIP plans and 21 states that operate combination CHIP programs.¹ This analysis provides critical information about CHIP and QHP coverage for children at two income levels – 160% of the federal poverty level (FPL) and 210% FPL – and includes a look at the average user in CHIP or a QHP as well as the maximum out of pocket costs for a child with special health care needs. The analysis shows significant differences between CHIP and QHPs in terms of cost sharing and benefits and provides important insight into how children would fare if CHIP funding is not continued beyond the program’s current September 30, 2015 expiration date.

The key findings from the Wakely analysis include:

In every state reviewed, CHIP enrollees could see up to a ten-fold increase in the cost sharing they pay if they are transitioned into QHPs. In every state included in the analysis, CHIP plans have significantly lower average cost sharing than QHPs. **The average annual cost sharing for a child in CHIP is estimated at \$66 for households with incomes of 160% FPL and \$97 for households with incomes of 210% FPL. In contrast, the average cost sharing for a child in a QHP is estimated at \$446 annually for households with incomes of 160% FPL and \$926 for households with incomes of 210% FPL.** There are no states for which CHIP cost sharing is comparable to the level of QHP cost sharing. Children in CHIP in all states reviewed by Wakely would see increases in the cost of receiving medical services if they moved into a QHP. Thirteen of the 35 states do not require any cost sharing in their CHIP plans at one or both of the income levels.

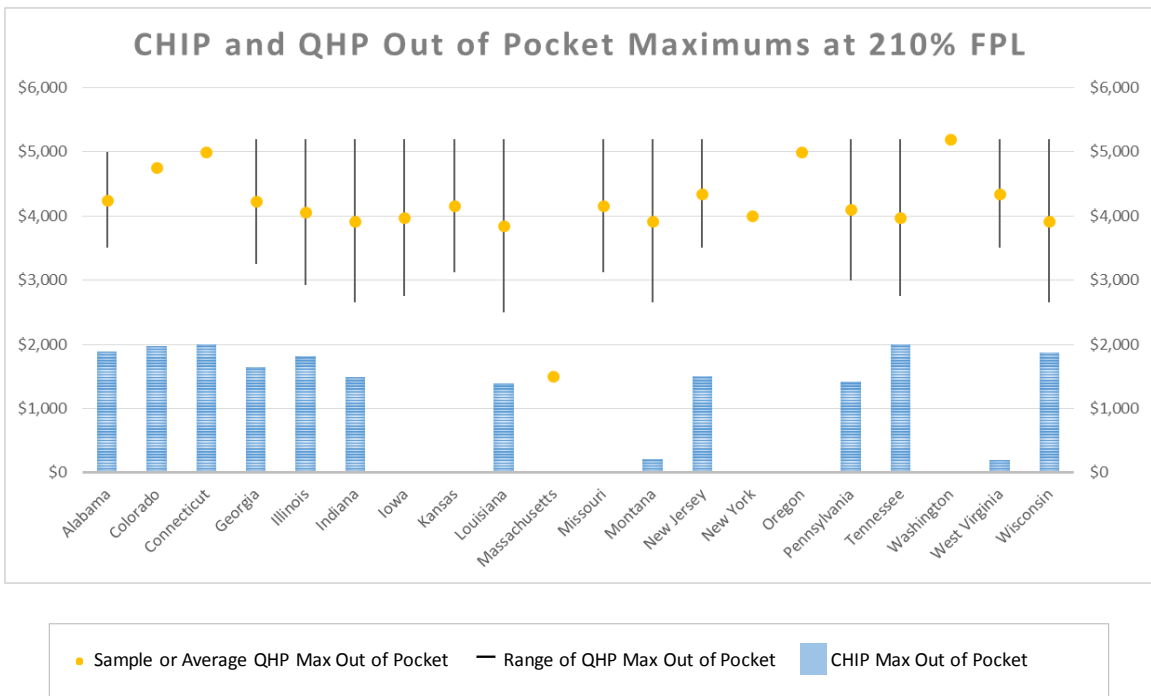
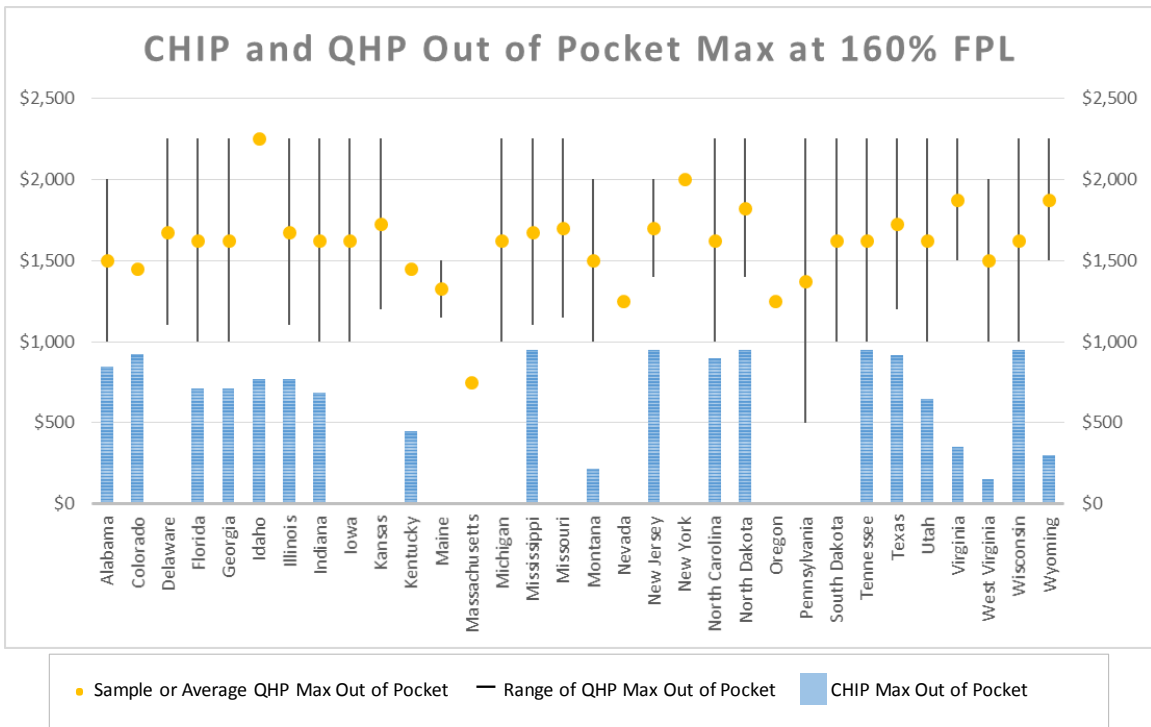
¹ Separate CHIP programs included in the Wakely analysis are: AL, CO, CT, GA, KS, MS, NV, OR, PA, TX, UT, WA, WV, and WY. Combination CHIP programs included in the analysis are: DE, FL, ID, IL, IN, IA, KY, LA, ME, MA, MI, MO, MT, NJ, NY, NC, ND, SD, TN, VA, WI.

CHIP enrollees in these states would see very significant increases in their financial exposure should they be transitioned into a QHP.



In all states reviewed by Wakely, the out of pocket maximum costs in QHPs far exceeds that of CHIP.

The financial impact of CHIP enrollees transitioning to QHPs is especially pronounced for children with special health care needs (those with a large number of medical claims) who will likely reach the out of pocket maximum for cost sharing in a year. In some states, children with special health care needs could go from paying \$0 in CHIP to over \$5,000 in annual out of pocket expenditures in QHPs. All states included in the analysis had lower maximum out of pocket costs in CHIP compared to QHPs. The lowest combined medical and prescription drug out of pocket maximum costs for QHPs across the states was \$500 for families with household incomes of 160% FPL, and \$2,250 for families with household incomes of 210% FPL. Families who have children with special health needs could face daunting out of pocket costs in QHPs above and beyond any premiums that must be paid.



CHIP covers more child-specific services with fewer limits than QHPs. While coverage of core health benefits is comparable between CHIP and QHPs, QHPs cover fewer child-specific services than CHIP (e.g. pediatric dental, vision, hearing, autism services, habilitation, etc.) and when the benefits are covered, there tend to be more limits imposed. Some services, such as enabling services and non-emergency transportation are exclusively covered under CHIP plans if covered at all. Whether or not children have access to subsidized coverage through the Marketplace, children transitioning from CHIP into QHPs are generally expected to experience declines in covered child-specific benefits and increased cost sharing for use of medical services.

ACA structure on pediatric dental benefits limits affordable access for children. While pediatric dental services are required essential health benefits (EHBs) under the ACA, QHPs can exclude dental benefits if a stand-alone dental plan is available in that state. As a result, only 40% of QHPs that were reviewed offer pediatric dental as an embedded benefit in the QHP. In more than half of the states studied, children moving from CHIP plans into QHPs would likely need to purchase separate stand-alone dental plans in order to have comparable coverage, which means that families would face additional costs for the separate premium required in a stand-alone dental plan.

CHIP offers richer coverage for pediatric dental services compared to QHPs. Comparing CHIP to QHPs in terms of cost sharing for pediatric dental checkups, 100% of CHIP plans cover these services at both income levels –160% FPL and 210% FPL. In the QHPs, only 37% of the plans that were reviewed cover these services for children at 160% FPL and 40% at 210% FPL. CHIP plans were much more likely than QHPs not to require any cost sharing for pediatric dental checkups (e.g. 94% of CHIP plans have no cost sharing at 160% FPL compared with 19% of QHPs). Wakely found that when cost sharing is required, it tends to be lower in CHIP compared to QHPs. Of the states that impose cost sharing, CHIP plans tend to include only copays while QHPs may have either copays or coinsurance, and often additionally require that a deductible be met.

CHIP offers broader coverage for vision services compared with QHPs. While routine pediatric vision services are required to be covered as an EHB, similar to dental check-ups, CHIP plans provide services with no cost sharing more frequently than QHPs. CHIP plans exclusively use copays when they do require cost sharing while QHPs may include both deductibles and coinsurance. Eyeglasses are included in all CHIP plans and QHPs (with the exception of Massachusetts). All states' CHIP plans include coverage for eyeglasses, although over a third include dollar limits. In general CHIP plans are more generous in providing vision services with no or lower cost sharing than QHPs. Enrollees would likely see increases in the cost sharing required if they move from a CHIP plan into a QHP.

There is no ACA coverage requirement for hearing exams in a state's EHB but all CHIP plans studied by Wakely covered these services. While 100% of CHIP plans in the Wakely analysis cover routine hearing exams, 63% of states did not include these services among their EHBs. Coverage of hearing aids is also very different between CHIP and QHPs. Almost half of states do not include hearing aid coverage as an EHB. For QHPs that cover hearing aids, there are a wide variety of limits: on age, dollar limits, limits on type of hearing aid, and utilization limits. For CHIP, all of the plans (except Wyoming and the Wisconsin Benchmark plans) cover hearing aids, though more than half of the states that cover hearing aids in CHIP include either dollar or age limits.

Other Child-Specific Services

Autism services: More than three-fourths of states reviewed included coverage for autism services among their EHBs, however, almost half of the states do not explicitly include Applied Behavior Analysis (ABA) coverage. Benchmark plans for EHBs frequently include dollar and age limits for these services as well. Relative to QHPs, CHIP plans tend to utilize fewer limits on both general autism services and ABA.

Habilitation: Habilitation benefits – those that are provided to develop skills that were not learned due to developmental or medical conditions – are covered in both CHIP and QHP plans in all states (although the ACA does not specify the types of services to be included in a state's EHB and it is left to the discretion of the state or insurer). More than two-thirds of the states reviewed by Wakely include utilization limits in QHPs compared to just over one-third in CHIP plans. Enrollees in CHIP would be able to receive more habilitation services than those in QHPs.

Physical therapy, occupational therapy, and speech therapy services: In all states, CHIP plans and QHPs cover physical therapy, occupational therapy, and speech therapy services. The difference is in the use of limits, with 80% of QHPs reflecting utilization limits for these services compared to only 42% of CHIP plans.

Non-emergency transportation services: Non-emergency transportation services allow children to attend medical office visits as well as transfers between facilities and home. Over half of the CHIP plans in the states reviewed cover non-emergency transportation, with about half of those imposing some limits. The limits used reflect age and income restrictions, specific medical conditions, and types of transportation. Non-emergency transportation is not covered in any state's EHB.

Enabling services: Enabling services, such as translation and outreach, make it easier for enrollees to utilize the medical services covered in their health plans. None of the states reviewed by Wakely include enabling services in their EHB. For CHIP plans, 32% of states include some type of enabling services for enrollees.

Routine podiatry services: Routine podiatry services are covered in more than one-third of states' EHB. Of the states that cover routine podiatry, only Mississippi, North Carolina, and Tennessee include limits to restrict services to individuals with diabetes. In CHIP plans, 76% of states cover routine podiatry, although half of these states also have a limitation indicating coverage is only for enrollees with diabetes or a similar condition.

First Focus Urges Congress to Take Action this Year to Extend Funding for CHIP

Across every category, almost without exception, the Wakely analysis shows that CHIP is more affordable and provides more comprehensive benefits for children, especially children with special health care needs. In every state studied, if children were transitioned into QHPs, they would face significantly higher out of pocket costs with fewer covered child-specific benefits than what children currently get in CHIP.

While the ACA holds great promise for the millions of Americans who have lacked an affordable coverage option, especially uninsured adults, more work is needed to be sure that new coverage options, eligibility rules, enrollment systems, policies and procedures, benefits, plans and provider networks are able to meet the unique health and developmental needs of children. This analysis shows that CHIP must remain intact as Marketplace coverage matures to be sure we don't lose ground on our nation's unprecedented success in covering children.

CHIP is a cost-effective, common-sense approach to coverage that has reduced the numbers of uninsured children to record lows, even during the economic crisis that began in 2008. Children must continue to have access to stable coverage through proven programs like CHIP until it is clear that there is a comparable alternative. **First Focus urges Congress to extend CHIP funding for four years to ensure that children's coverage remains strong.** If Congress does not extend CHIP funding beyond the current September 30, 2015 expiration, important gains for children will be lost. Now is not the time to disrupt the coverage that is working for children.

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