FIRST FOCUS
MAKING CHILDREN & FAMILIES THE PRIORITY

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December 19, 2014

Diane Rowland, Chair
Medicaid and CHIP Payment and Access Coalition
1800 M Street, NW
Suite 650 South
Washington, DC 20036

Dear Chairperson Rowland:

As a bipartisan children's advocacy organization, First Focus is dedicated to making children and families the priority in federal budget and policy decisions. We work on all issues related to children's health and well-being and appreciate this chance to comment on the issues related to Marketplace/Exchange coverage for children through the Affordable Care Act (ACA), Medicaid, and the Children's Health Insurance Program (CHIP). We realize that the Commission has studied the issues in depth and continues to search for the best answers for children.

As was indicated in our letter to you dated April 24, 2014, we are deeply concerned about several areas when it comes to children's coverage through the qualified health plans (QHPs). First Focus has long supported all federal policy efforts to protect and improve health coverage for low-income children, with a focus on Medicaid and CHIP, and we are certainly heartened by the coverage trends for children.

Today the numbers of uninsured children stand at a record low with 93 percent of children in America enrolled in coverage. CHIP is a major part of this positive coverage trend for children. In its 17-year history, CHIP has successfully evolved to serve as a catalyst for cutting the uninsured rate for children in half. While we understand and fully support MACPAC'S efforts to ensure that coverage provided through the ACA is appropriate to meet the needs of children, we believe it is critical to adopt a policy that we "do no harm" and not gamble with health coverage for children. We are committed to securing CHIP funding for the next four years and are working hard to make that a reality. We believe that no one should consider moving children to the QHPs unless child health coverage is fully comparable and equivalent to what is offered to children through CHIP.

A study released this summer by the Wakely Consulting Group entitled "Comparison of Benefits and Cost Sharing in Children's Health Insurance Programs to Qualified

Health Plans"[1] which MACPAC has reviewed, shows that CHIP is substantially more affordable and offers more child-specific benefits than what is offered in QHPs. The study reveals that in state after state children receive more medical services in a much more cost-effective way through CHIP than they would in their state's QHP. In fact, the cost difference can be as much as ten times higher in a QHP for children with special health care needs.

CHIP health benefits are designed with children's needs in mind, and over the years states have honed their CHIP programs to better meet children's needs. In Medicaid-expansion CHIP programs, children receive Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is particularly important for children with special health care needs who often require an array of services on an ongoing basis. Some states with separate CHIP programs have also developed comprehensive benefit packages with children in mind so they have access to a range of necessary health services to meet their needs. In sharp contrast, the Essential Health Benefits (EHB) under the ACA have not been implemented in a way that takes into account the needs of children. The federal EHB standards fall short in ensuring that children have access to a comprehensive package of services, particularly coverage for habilitative therapies and other ancillary services that are critical for children with chronic or complex conditions.

Children need comprehensive benefits that address their continuous growth and development. Gaps in benefits can result in life-long health consequences that generate extensive and avoidable costs and suffering. Children should not have to wait for QHPs to be designed to meet their needs and moving from CHIP to the QHPs as they stand now would be detrimental to children, particularly children with special health care needs.

The ACA requires that QHPs must cover EHBs that have been largely set through state and federal choices for 2014 and 2015. To prepare for the entrance of millions of children into those plans, if CHIP goes away, states should establish a definition of habilitation that ensures children access to all necessary services and devices to attain and maintain function. States should adopt a definition of habilitative services no more restrictive than the one put forth by the National Association of Insurance Commissioners.

Next, to ensure children have access to all necessary benefits in the EHB, states should create a definition of medical necessity that applies across health plans in the state, modeled on Medicaid's EPSDT standard, which is based on children's unique health care needs. At a minimum, the QHPs should be identical to the state CHIP plan as far as child specific benefits, so that children are not left worse off.

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[1] 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/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and- Benefits-Comparison-First-Focus-July-2014-.pdf.

As the Wakely analysis shows, time and again, CHIP benefits meet children's needs where QHPs fall short. For example: where CHIP provides speech therapy at an "unlimited/medically necessary" level, many QHPs limit such services to twenty visits a year. A young child who is deaf or hard of hearing will likely need more than twenty visits in a year's time (just two visits weekly over ten weeks) when they are acquiring critical language and communication skills.

It is also critical that states develop methods for measuring children's access to needed care under the state's chosen EHB benchmark plan. States must monitor the QHPs for any gaps, with particular attention to children who may go without needed services because they are uncovered and to families who must pay out-of-pocket for uncovered but medically-necessary care. When the cost of services is out of reach due to out-of-pocket costs, children will suffer due to lack of needed care. States should monitor when that happens and respond appropriately. CHIP's cost-sharing protections are critical to ensuring families seek needed care for their children rather than forgoing care because of cost constraints. Families do not find these same protections in the private coverage options under the ACA. Again, we know that MACPAC is interested in studying the problem of children not receiving needed medical care due to higher out-of-pocket costs or premiums and we encourage that effort.

For many families, CHIP is the only affordable insurance option for their children even though the ACA was intended to expand access to affordable coverage. During consideration of the ACA, First Focus commissioned an actuarial value (AV) study that showed CHIP has a 98% AV compared with 65-95% AV in the exchanges (depending on the level of exchange plan, bronze, silver, gold, or platinum.).

More recently, in July 2014, the Wakely Consulting Group conducted a follow-up in-depth analysis that 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. The 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 both cost sharing and benefits. It also 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.

The ACA mandates that the Secretary of HHS will certify, by April 1, 2015, that the benefits and cost-sharing in the QHPs are comparable to CHIP before moving children into the QHPs. At this point, and for the foreseeable future, we believe the QHPs will not be able to be certified in either regard and that children should stay in CHIP unless both provisions are met after a careful and suitable review. We should not gamble with the health care of low-income children and should ensure that coverage is comprehensive and comparable before thinking about moving them to any alternative system of care.

CHIP contains important cost-sharing protections that limit aggregate cost sharing to five percent of a family's income, in addition, 18 states do not impose CHIP premiums on families. Though Wakely did not study the cost of QHP premiums on families, MACPAC is conducting that review and we expect the costs will be significant as compared to CHIP. The initial review of the premium cost, explained at the December 10th MACPAC meeting, offered the idea that premium costs could be "lowered" and cost-sharing in QHPs could be "reduced." Though those ideas are reasonable, there is no clear political path on how to accomplish either of them. Instead, families will be faced with higher premiums and much higher out-of-pocket costs if CHIP ends.

If CHIP ends, 1.9 million kids will lose coverage due to the "kid glitch" because families won't be able to afford ESI-offered family coverage but will be ineligible for subsidized exchange coverage. First Focus has asked the Administration, Congress, and the Treasury Department to address this serious issue several times to no avail. Without a fix, either administratively or legislatively, and without CHIP, children will be left uninsured. It will take us back to the pre-CHIP days, even though we have the ACA in place. Though many groups, including MACPAC, talk about "altering or fixing" the glitch, there is no real direction or consensus policy solution right now to get that done. No one who can fix it is telling us they will do it.

Because CHIP is a program dedicated to children, CHIP has pediatric provider networks designed to meet their needs. For example, under CHIP, children have access to a full range of primary, specialty and ancillary pediatric providers to

ensure that they receive comprehensive and medically and developmentally appropriate care. In addition, CHIP requires states to ensure that children with special health care needs have access to specialists and out-of-network providers when the CHIP provider network does not meet a child's health needs. This is a critical component of an accessible health care system for the children covered by CHIP. Pediatric provider networks in the QHPs should include a full range of primary, specialty, and ancillary pediatric providers. The networks should also include contracts with all essential community providers as defined in the statute.

Pediatric-specific network adequacy standards (related to timeliness, quantity and types of providers, and monitoring) and developed with input from pediatric health researchers, providers, and families will ensure children have access to needed services without unreasonable delay. Required contracts with all essential community providers will ensure access to especially qualified providers with expertise in the care of low-income and critically or chronically ill and disabled children. In addition, network standards that require or encourage shared or overlapped networks with Medicaid/CHIP will allow for continuity of care for children who move between public and private coverage. Again, over the last seventeen years, state CHIP plans have responded to the needs of the children and families in their states, to the providers, and payers and have designed networks that provide the right services at the right time in the right place. By definition, these networks are also pediatric-focused and intensive, which stands in sharp contrast to the networks found in the QHPs or most private health plans.

Finally, the lack of aggregated federal subsidies for medical and dental benefits also makes exchange coverage less affordable for families than CHIP. All CHIP programs cover dental benefits and cost-sharing for them is included under CHIP's overall five percent cap on family costs. QHPs sometimes include pediatric dental benefits, but they are not required to do so when stand-alone dental plans are available in an exchange. When families purchase dental benefits separately, no federal cost-sharing reductions are available and premium tax credits are only available if the family chooses a particularly low-cost health plan that leaves some of their tax credit "left-over" to apply to the dental plan. Thus, most families with exchange coverage face separate premiums and cost sharing for their children's dental benefits, including a separate and additional out-of-pocket maximum, with no affordability assistance. These affordability challenges likely contribute to the very low rates of take-up for pediatric dental coverage in exchanges and reduce the effectiveness of the ACA's requirement that the EHBs include pediatric dental services. In short, the pediatric dental benefit is far worse in the exchange than that provided and guaranteed in CHIP.

All of the concerns discussed in these comments are well known to members of the Commission as the Commission and other groups, including First Focus, have raised them for some time. Although MACPAC has clearly and powerfully articulated the issues children will face if CHIP ends, there remains a lack of clarity as to how to fix the problems within the political landscape we live in today. In addition to needing

time to make changes, allow the states to adjust, etc., it is clear that some of the issues will require legislative action to correct. We believe it is unrealistic to expect that a Congress preparing to vote to repeal the Affordable Care (ACA) in early 2015 will, in the same legislative session, consider numerous improvements to the ACA that fix the various complicated problems facing kids in the QHPs. Not only is it politically unfeasible for the fixes to happen anytime soon, Congress may need to see and perhaps study how coverage changes over time before they act.

Among other things, Congress would need to carefully think and forge bipartisan legislative solutions to best address the kid glitch/affordability test, pediatric benefit differences, the pediatric dental benefit, significant actuarial value differences, pediatric network adequacy in the QHPs, and the fact that CHIP is more comprehensive and less expensive than QHP coverage to the federal government. Additionally the lack of both quality measurements and a pediatric focus in the exchanges, that make children's health outcomes central in CHIP but an afterthought in the QHPs, should be fixed before considering ending CHIP and moving millions of children to a new program that is currently inferior and remains politically precarious.

At First Focus we concentrate our efforts on solutions and how to make them happen. We would like nothing more than for the solutions to these issues to be worked out reasonably and in ways that benefit children. However, we remain deeply concerned that the changes that need to happen will not occur without a political will that does not currently exist in Washington. Until real changes transpire that drastically alter how the QHPs deal with children, we cannot support ending CHIP or moving children into the QHPs. Again, we should not gamble with the health care of low-income children and should ensure that coverage is comprehensive and comparable before thinking about moving them to any alternative system of care.

Thank you for your time and for considering my comments. I welcome any questions or follow-up.

Sincerely,

Bruce Lesley

Bruce Lesley
President