



Children in the Marketplace

by Kelly Whitener, JoAnn Volk,
Sean Miskell, and Joan Alker

*First in a series of reports on the
future of children's health
care coverage*



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SUMMARY

This paper addresses changes needed to improve the ability of Marketplace coverage to meet children's needs.¹ As the paper notes, relatively few children (approximately one million) receive their coverage through the Marketplace; most in public coverage are served through Medicaid and the Children's Health Insurance Program. As a new source of coverage, and one that may grow over time, it is important for policymakers to consider ways to improve Marketplace coverage for children.

INTRODUCTION

Addressing Benefits and Costs as More Gain Coverage

Prior to the Affordable Care Act (ACA), children who were insured had coverage either through publicly financed programs such as Medicaid and the Children's Health Insurance Program (CHIP), through private employer-sponsored plans, or through the individual insurance market. As employer-sponsored coverage for children has either declined or flat-lined over many years,² Medicaid and CHIP have filled the gap for low- to moderate-income children. These two programs are largely responsible for the decline in the overall rate of uninsured children from 9.3 percent in 2008 to 6 percent in 2014 and together covered 38 percent of children.³

With the goal of expanding coverage to uninsured working adults and their families, the ACA created health insurance Marketplaces. Individuals who are not eligible for Medicaid or CHIP, or who do not have access to affordable employer-sponsored insurance (ESI) that meets minimum coverage standards, can use the Marketplaces to shop for private insurance plans and apply for subsidies.

Children do not currently make up a significant share of Marketplace enrollees. Overall, children make up 9 percent of enrollees in the federally facilitated Marketplace (FFM) and 6 percent of enrollees in the state-based Marketplaces



(SBM), for a total of slightly more than one million children below the age of 18 covered under insurance from the Marketplace.⁴ The percentage of children enrolled in Marketplace coverage varies considerably at the state level and may change in the future. Not surprisingly, states with lower CHIP income eligibility levels have higher child enrollment in the Marketplace. For example, in North Dakota, CHIP income eligibility is limited to children with incomes below 175 percent of the federal poverty level (FPL) and 23 percent of their Marketplace enrollees are under the age of 18. By contrast, in New York, where the upper limit for CHIP income eligibility is 405 percent of FPL, only 4 percent of Marketplace enrollees are under the age of 18.⁵

This paper summarizes the available literature on children's coverage under Marketplace plans, with a focus on how well those plans are serving children along three primary dimensions: adequacy of coverage, affordability of coverage, and access to providers. It includes recommendations on how to ensure that Marketplace plans meet the unique needs of children.

Until significant policy changes are implemented to improve children's coverage under Marketplace plans, funding for CHIP should continue so that no child loses benefits that are essential to his or her health and development.

As numerous studies, including a congressionally-mandated analysis comparing CHIP and Marketplace coverage, have shown, CHIP coverage is better at meeting children's needs across the country.⁶

Adequacy of Coverage

Prior to the ACA, Medicaid set the standard for pediatric coverage through its comprehensive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, which has also been adopted by CHIP plans in 14 states.⁷ Pediatric benefits in the remaining CHIP programs are based on a benchmark chosen by the state from the following: either the standard Blue Cross/Blue Shield preferred provider option offered to federal employees, the state employees' coverage plan, or the health maintenance organization (HMO) with the largest commercial enrollment within the state (or comparable coverage approved by the Secretary of the Department of Health and Human Services).

The ACA established a different minimum standard for benefits to be covered by private plans sold to individuals and small employers, including those sold in Marketplaces. The ACA's Essential Health Benefits (EHB) package includes 10 categories of services,⁸ one of which is "pediatric services, including oral and vision care." The definition of pediatric services was intended to be broad, but it has been implemented only with respect to oral and vision care.

Ten Categories of Essential Health Benefits

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care



States must select a benchmark plan to serve as the EHB standard. There are 10 EHB benchmark options in each state: three small employer plans, three federal employee plans, three state employee plans, and the non-Medicaid HMO in the state with the greatest enrollment. Nearly all states selected a benchmark from one of the three small employer plans with the greatest enrollment. If the benchmark plan does not adequately meet pediatric standards for oral and vision care, states may use the vision and dental benefits required in their CHIP plan or those available under the federal employee benefit program (known as FEDVIP). In addition, habilitative services must now meet the uniform federal definition. If the selected benchmark plan does not appropriately cover habilitative services, the benefit must be supplemented. While EHB plans cannot have dollar limits, federal rules do permit treatment limits.

A 2014 review of EHB benchmark plans in 35 states found that the coverage available in the Marketplace was similar to CHIP on typical major medical benefits but was more limited on benefits that are critical to children's health and development. The study found that benefits such as physician services, inpatient services, prescription drugs, lab services, and mental health services were relatively comparable between the Marketplace and CHIP, but that dental, vision, and audiology, as well as habilitative, physical, occupational, and speech therapies in the Marketplace fell short of CHIP coverage. In Marketplace plans, those benefits were more likely to be absent or provided with treatment limits. Only 30 percent of Marketplace plans cover the services without limits and nearly half exclude the services completely.⁹ Additionally, Marketplace plans were more likely to impose limits on the coverage of durable medical equipment.¹⁰

The benefit limitations in Marketplace plans have the most profound effects for children with special health care needs. For example, only 37 percent of states require that Marketplace plans cover

audiology exams (based on EHB benchmark selections) and almost half (46 percent) of states' Marketplace plans 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) as compared to CHIP.¹¹

Children's Unique Needs: Audiology

Treating a child with hearing loss is different than treating an adult with the same condition because as children grow, they are developing critical language skills. Regular audiology exams are required to identify whether a child has hearing loss and if so, to determine the appropriate treatment. Children with hearing loss will typically need two hearing aids every three to five years (or sooner if the prescription changes); new ear molds (as often as every month) to ensure proper fit, and speech therapy (often multiple times weekly) to promote language development. All of these services must be provided in a timely way and with frequent monitoring to help the child develop age-appropriate language skills.

While both CHIP and Marketplace plans cover physical therapy, occupational therapy, and speech and language services, 80 percent of states' EHB requirements impose limits on these services.¹² Marketplace coverage was intended to look like the typical employer-sponsored coverage, and though employer-sponsored coverage varies widely, Marketplace and employer-sponsored coverage do have more similarities with respect to dental and audiology services and physical, occupational, and speech therapies than either has with Medicaid or CHIP.¹³ Medicaid covers all of these benefits as part of its EPSDT benefit, as do the CHIP programs that provide EPSDT benefits.



Dental Coverage

In addition, some Marketplace enrollees must purchase dental coverage under a separate policy. Although pediatric dental benefits are required under the EHB standard, federal rules and most Marketplaces allow carriers to omit pediatric dental benefits if stand-alone dental plans (SADP) are available. SADPs are dental plans that are not included as part of a health plan. As a result, it is possible for a family to purchase Marketplace coverage without having coverage for pediatric dental services. Moreover, when families purchase dental coverage separately, the premium cost, as well as any cost-sharing, are not included in the families' expected premium contribution and annual cost-sharing limit. Thus, families are paying extra for these services when they should be included within their overall cost-sharing requirements (see more details below).¹⁴

Finally, one review of EHBs found many plans excluded services for children with special needs and disabilities. For example, the review found exclusions of services for learning disabilities and for speech therapy for developmental delays, stuttering, or both.¹⁵

Policy Options to Improve Adequacy of Coverage

► Define pediatric services.

The ACA statute specifically lists pediatric services as one of the 10 essential health benefits (EHBs) and mentions vision and dental as examples of such services. However, under current regulations, only pediatric vision and dental services are required to be supplemented if the coverage in the selected benchmark plan is absent. Even if a state chose to supplement its benchmark further, for example, to add missing services like hearing aids, the state might be required to pay 100 percent of the cost if this were considered to be a new state mandate.

► Define EHB pediatric benefits using the definition of CHIP “child health assistance services.”

A better way to define pediatric services under EHB would be to require that these services include those spelled out in CHIP regulation as “child health assistance”—a list of those services that

may be paid for under the program.¹⁶ Child health assistance under CHIP includes benefits already covered under EHB, such as inpatient and outpatient hospital services, prescription drugs, and prenatal care. However, child health assistance also includes important services—such as inpatient and residential mental health and substance use disorder services; durable medical equipment such as eyeglasses and hearing aids; and physical therapy—that are not specifically required under EHB; and physical therapy—that are not currently provided under EHB. Defining pediatric services under EHB as those available under CHIP adds specificity to EHB and will help ensure coverage adequacy. Doing so will also provide an incentive for states to cover more services under EHB. States would be required to examine their benchmark selections for all pediatric services and supplement the benchmark to meet the federal definition. This would include instances where the benefit is covered but inadequate and those where the benefit is absent. The federal premium and cost-sharing subsidies would then account for the full range of services, avoiding a cost-shift to states or families, and children would have access to a pediatric benefit package that meets their needs.

► Define medical necessity to include services necessary for healthy development.

When defining pediatric services, it is critical to consider the needs of all children, including children with special health care needs, as well as the unique needs that are associated with healthy development. Children require many of the same types of services as adults, but because they are continuing to develop and grow, they may need certain services more frequently or intensely. For example, children may need durable medical equipment like wheelchairs to be replaced more frequently to accommodate their growth or they may need therapeutic services like speech therapy more intensely as they acquire and develop language skills for the first time.

Acknowledging the challenge of defining medical necessity in a way that adequately captures the needs of all children, the National Health Law Program has articulated criteria that should guide



any attempt to define medical necessity (beyond a doctor prescribing a particular treatment).¹⁷ These criteria specify that any definition of medical necessity should:

1. Incorporate appropriate outcomes within a framework that promotes physical, intellectual, and psychological development, including preventing or ameliorating the effects of a condition, assisting in maintaining or facilitating functional capacity.
2. Address the information that will be needed in the decision-making process, with an emphasis on treatment strategies tailored toward an individual's needs.
3. Identify who will participate in the decision-making process.
4. Start by drawing on specific standards, including scientific evidence, practice guidelines, and consensus statements from experts where available.
5. Support flexibility in the sites of service delivery.

Defining medical necessity through federal rulemaking in a way that is faithful to these criteria would prevent children from being subjected to harmful treatment limitations.

► **Strictly enforce the ACA's antidiscrimination rules.**

The ACA prohibits discrimination based on age and health condition, among other factors, through a number of mechanisms. Rules implementing the EHB requirement prohibit plans that must offer EHB from using discriminatory benefit design. This prohibition includes cost-sharing that would discriminate against individuals based on age or health conditions. For example, plans cannot limit benefits based on age if there is no evidence-based reason to do so, nor can they put all the drugs used to treat a particular condition on the highest cost-sharing tier of a formulary. In addition, Section 1557 of the

ACA prohibits insurers that receive federal funding (e.g., Marketplace plans and Medicaid managed care organizations) from discrimination based on age or disability, among other factors. These provisions are critical to prevent plans from having benefit designs that discriminate against children generally and children with special health care needs in particular. State and federal regulators should carefully review benchmark plans to ensure that they meet these federal standards and should thoroughly investigate complaints where there is evidence that plans are offering discriminatory benefits.

► **Ensure plans are available that embed dental coverage.**

In states using the federal Marketplace platform, only 8 percent of enrollees under the age of 18 purchased a stand-alone dental plan (SADP).¹⁸ There are no data on the take-up rates for plans with dental coverage embedded by age, but only about one-third of plans in the federally facilitated Marketplace (FFM) embedded dental, so it is likely that many children do not even have the option to enroll in a plan with dental included.¹⁹ The low take-up rate of SADPs and the fact that embedded dental coverage is not prevalent suggest that children enrolled in the Marketplace are not able to obtain dental benefits as intended by the ACA. Ensuring that all children have access to a health plan with dental coverage included would help make sure that children get the full range of benefits to which they are entitled. However, in order to make sure the dental benefit is valuable to enrolled children, embedded plans should also standardize the benefit design to either eliminate or greatly reduce the deductible for pediatric dental coverage.²⁰ If the deductible for dental coverage is too high, the benefit will be rendered meaningless given typical dental utilization patterns. The low take-up rate could also be linked to the additional costs of SADP coverage, which would require additional policy changes (see more details below).



Affordability of Coverage for Children and Families

Affordability of coverage includes both the cost of obtaining coverage (premiums) and the cost of using health services once enrolled in a plan (cost-sharing, including copayments and deductibles). The ACA provides tax credits to reduce premiums for Marketplace plan enrollees who meet income guidelines and do not have access to coverage that meets minimum standards. Individuals that are eligible for Medicaid or CHIP, or for affordable and adequate employer coverage, cannot obtain premium tax credits. The ACA also provides cost-sharing subsidies to reduce the amount that families with incomes up to 250 percent of FPL are expected to pay out-of-pocket to obtain services.

While the ACA's Marketplaces and financial assistance have led to significant coverage gains, many families nonetheless face considerable costs. A recent congressionally mandated analysis conducted by the federal Centers for Medicare & Medicaid Services (CMS) provides a useful guide to illustrate the cost that families face for pediatric coverage in Qualified Health Plans (QHPs) through the Marketplace relative to CHIP. For this analysis, CMS compared the second lowest cost silver plan available through the Marketplace in the largest rating area in each state with that state's CHIP coverage. This analysis found that families can expect to pay higher costs for QHPs compared with CHIP in all 36 states that operate a separate CHIP program.²¹ In states that provide health insurance to CHIP-eligible children through Medicaid, this coverage is assumed to be better than Marketplace coverage, given Medicaid's robust EPSDT benefit package and very low cost-sharing.

The analysis looks at two measures. First, the report looks at actuarial value (AV), which measures the percentage of expected medical costs that a health plan will cover and offers a way to compare plans based on overall cost-sharing.²² The remaining charges are not covered by the plan and would be paid by families out-of-pocket. With regard to actuarial value, CHIP pays a higher portion of a child's health care costs in all states except Utah,

where CHIP and the second lowest cost silver plan pay an equivalent portion of a family's cost. Though differences in actuarial value depend on each state's CHIP program and available Marketplace plans, *CHIP provided coverage that was, on average, 25.7 percent greater in actuarial value than the second lowest cost silver plan available through the Marketplace* in states that operate their own CHIP program.²³

The second measure presented in the CMS "comparability study" is out-of-pocket costs from cost-sharing charges, including copayments, coinsurance, and deductibles. CMS found that families spend more on a per-child basis in the second lowest cost silver plan through the Marketplace compared with CHIP. While out-of-pocket charges vary by state in both the Marketplace and in CHIP, families could expect to pay an average of \$969 more per child in the Marketplace compared with state CHIP programs.²⁴

These findings provide an important cautionary note about the nature of the coverage that children and families receive through the Marketplace. Beneath the remarkable gains in the number of children and families with access to coverage as a result of the ACA, this coverage may still entail costs that are out of reach for many families, especially compared with the coverage available to children through Medicaid and CHIP. Policymakers must consider how to reduce these costs for coverage through the Marketplace, which enrolled over a million children in 2016, and may potentially enroll many more as Marketplace enrollment increases.

A March 2016 report from the Medicaid and CHIP Payment and Access Commission (MACPAC) concluded that, due to their higher out-of-pocket costs, Marketplace plans are not ready to serve as an adequate alternative for children enrolled in CHIP.²⁵ The report 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.



Premiums

A key concern for families regarding the implementation of the ACA is that the test for affordable employer coverage prevents half a million children from obtaining premium tax credits.²⁶ Under the ACA, employer coverage is considered “affordable,” and thus ineligible for premium tax credits, if the cost to the employee for self-only coverage is less than 9.66 percent of family income. Dependent coverage is generally far more expensive than coverage for the employee only. The result—known as the “family glitch”—is that children and parents who have “access” to employer-sponsored dependent coverage can be excluded from premium tax credit eligibility even if the dependent coverage is unaffordable. The Government Accountability Office (GAO) estimated that 6.6 percent of uninsured children (approximately 460,000 children) would be ineligible for Medicaid and CHIP based on household income that was too high and also would be ineligible for the premium tax credit because one parent had access to employer-sponsored insurance (ESI) that had an estimated premium deemed “affordable.”²⁷

Even for families who qualify for premium tax credits, the expected family contribution can be so high that coverage remains out of reach. A recent report from the Kaiser Family Foundation found that 33 percent of those with Marketplace coverage had reported difficulty paying their premiums, compared with 17 percent of those with ESI. Of those reporting difficulty paying their premiums, 49 percent had dependent children in the home.²⁸

Sliding scale tax credits cap the amount a family is expected to contribute based on household income. For the 2016 plan year, families are expected to pay from 2.03 percent of household income for those at the poverty line to 9.66 percent of household income for those at four times the poverty level (See Table 1). Thus, families at the higher end of the sliding scale for premium tax

credits face costs in excess of what the ACA itself defines as affordable. While families between 250 and 400 percent of FPL receive financial assistance under the ACA, their expected contribution ranges from 8.18 to 9.66 percent of income for silver level plans—even though the ACA exempts those with health costs above 8 percent of income from the individual mandate.²⁹

Table 1: Expected Family Contribution Under the ACA’s Premium Tax Credit Caps, 2016³⁰

Percent of Federal Poverty Level	For Family of 3		
	Total earnings	Expected premium contribution percentage, 2016	Expected premium contribution in dollars, 2016
100%	\$20,160	2.03%	\$409
133%	\$27,813	3.05%	\$848
150%	\$30,240	4.07%	\$1,231
200%	\$40,320	6.41%	\$2,585
250%	\$50,400	8.18%	\$4,123
300%	\$60,480	9.66%	\$5,842
350%	\$70,560	9.66%	\$6,816
400%	\$80,640	9.66%	\$7,790

Subsidized Marketplace premiums are generally lower than those typically faced by families enrolled in employer coverage, particularly at lower income levels. However, premiums for Marketplace coverage are higher than in CHIP, where premiums are nominal in most states. At 151 percent of FPL, more than half of states’ CHIP programs do not charge a premium to enroll, and at 201 percent of FPL, half of states with a separate CHIP program charge premiums of less than \$10 per child.³¹ Additionally, some states charge per-family premiums rather than per-child premiums, or limit the per-child premiums to two or three children per family.³² By comparison, the required contribution for Marketplace premiums for those in the CHIP income range is between 3.05 and 9.66 percent of family income.



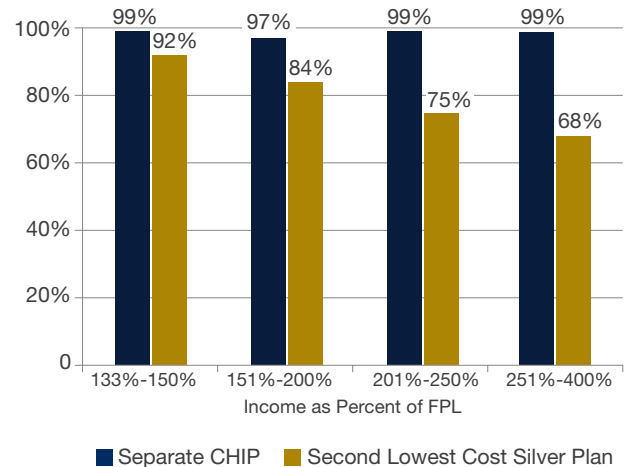
Cost-Sharing

Using health services in a Marketplace plan is another area where children may face high costs. Families with incomes up to 250 percent of FPL qualify for additional cost-sharing reduction (CSR) subsidies. Families enrolled in Marketplace plans with the lowest incomes (those with income between 100 and 150 percent of FPL) qualify for plans with an actuarial value of 94 percent, meaning enrollees pay, on average, 6 percent of health care costs out-of-pocket. This level of enrollee cost-sharing is more than that required of families with CHIP coverage and, by definition, higher than for families with children in Medicaid—where copayments are prohibited for children. Further, the difference for families with slightly higher incomes is more pronounced.

Despite those protections, a 2016 MACPAC study illustrates how out-of-pocket costs for Marketplace coverage are higher than those in separate state CHIP programs. For example, CHIP and the second lowest cost silver plan offer actuarial value levels for families between 133 and 150 percent of FPL at 99 percent and 92 percent, respectively. The difference between an actuarial value of 99 percent and 92 percent is not negligible, especially for families at this income level. These values progressively diverge as family income goes up, such that for families between 251 and 400 percent of FPL, CHIP still provides coverage with a 99 percent actuarial value while the effective actuarial value for coverage through the second lowest cost silver plan is 68 percent (figure 1). In comparison, the majority of employer-sponsored plans have an actuarial value of 88 percent.³³

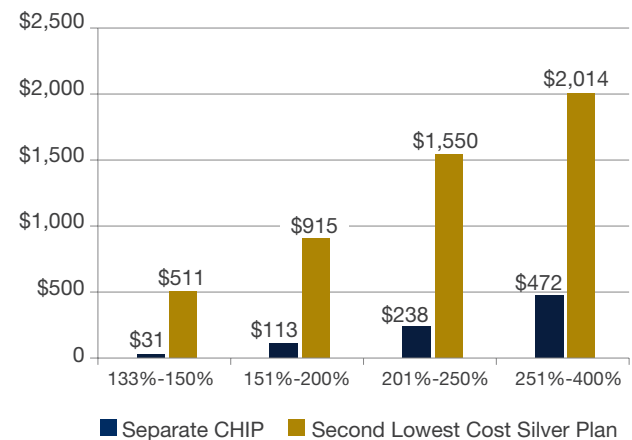
Figures 1 and 2 illustrate how out-of-pocket costs increase with enrollee income in CHIP and Marketplace coverage. Costs for coverage available in the Marketplace become greater as premium tax credits and cost-sharing reductions phase out as income rises.

Figure 1. Actuarial Value, CHIP vs. Second Lowest Cost Silver Plan



Source: MACPAC

Figure 2. Total Out-of-Pocket Costs, CHIP vs. Second Lowest Cost Silver Plan



Note: Total costs include cost-sharing and premiums.

Source: MACPAC



CHIP regulations limit total cost-sharing for families to 5 percent, but most states are not near this cap. According to MACPAC, only 1 percent of children in separate CHIP programs have out-of-pocket costs in excess of 2 percent of their income.³⁴ By contrast, 48 percent of children enrolled in the second lowest cost silver plan face out-of-pocket costs in excess of 2 percent of income.

While 2 percent of income may seem small, families in this range face a variety of cost-of-living expenses that constitute a significant share of their incomes. A Kaiser Family Foundation recently found that those who had difficulty paying their health costs were more likely to face financial challenges in other aspects of their lives.³⁵

Families of children with health problems also face higher out-of-pocket costs. MACPAC found that children being treated for chronic conditions (including mental health treatment, asthma, or trauma) as well as those that needed unexpected hospital care faced the highest out-of-pocket spending in Marketplace coverage.³⁶

As a result, total out-of-pocket costs in Marketplace plans—from both higher cost-sharing and coverage gaps created by service limits—are higher than the costs found in CHIP coverage. These differences pose the greatest challenges for children with the most health care needs. Using three real-life scenarios of children and their actual use of health care services, a Georgetown study of Arizona Marketplace coverage found typical children would face cost-sharing that is between 2.2 and 8.3 times higher, and children with special health care needs would face cost-sharing that is between 35 and 38 times higher, than would be required under CHIP.³⁷

Marketplace plan coverage of pediatric dental services raises additional cost concerns for families. Families that purchase dental coverage separately from their Marketplace plan must pay an additional premium, and they are subject to separate deductibles. Average SADP premiums in 2014 were \$238 per child per year.³⁸ The cost-sharing limit for SADPs is \$350 for one child, \$700 for two or more children.

Premium tax credits (PTCs) do not apply to premiums for stand-alone dental plans unless enrollees have unspent tax credits after applying them toward a QHP.³⁹ In addition, cost-sharing for SADPs does not count toward the maximum out-of-pocket limit that applies to QHPs (\$5,200 for an individual, \$10,400 for a family at 250 percent of FPL in 2015).⁴⁰ Therefore, the costs of SADP premiums, dental deductibles and other cost-sharing are not included in the family's overall expected contribution, effectively requiring families to pay more than the stated out-of-pocket maximum in order to obtain dental coverage.

Policy Options Related to Affordability of Coverage

► Improve federal financial assistance.

The financial assistance available through PTCs and CSR subsidies has had a significant impact on insurance affordability in the individual and small group markets. However, in some cases, coverage is still out of reach for children and families. Increasing the value of the PTCs would help more families afford the premium payments. An analysis by the Urban Institute highlighted several ways to make coverage more affordable, including the following: decreasing the expected premium contribution amounts and eliminating the indexing, extending CSR assistance to those with higher incomes, and changing the reference premium to gold rather than silver.⁴¹ Alternatively, the value of the CSR for families with incomes between 200 and 250 percent of FPL could be increased to reflect actuarial values in the employer market, as was done for those with incomes between 100 and 200 percent of FPL.

► Incentivize state-based supplemental financial assistance.

In the absence of federal action to improve financial assistance, two states, Massachusetts and Vermont, provide additional cost-sharing assistance for families with incomes too high to qualify for federal cost-sharing reduction payments (i.e., 250 percent of FPL), but below 300 percent of FPL. Two other states, Minnesota and New York, adopted the Basic Health



Program and are providing additional financial protection to enrollees up to 200 percent of FPL. These and other approaches may also serve low- to moderate-income families well by helping make Marketplace coverage more affordable.

► **Fix the family glitch.**

Incorporating the cost of dependent coverage into the affordability test when determining PTC eligibility would help some children who are currently uninsured gain coverage. Further, many legal and policy experts believe legislation is not required to address this problem. The Internal Revenue Service already uses the required contribution for coverage of family members when considering exemptions from the individual mandate.⁴²

Even so, as modeled by MACPAC and the Urban Institute, fixing the family glitch would not solve the affordability problem completely. According to their analyses, approximately one million children previously in a separate CHIP program would remain uninsured even if the affordability test accounted for family premiums.⁴³

► **Eliminate premium stacking.**

Families relying on multiple sources of coverage, like QHPs for the parents and CHIP for the children, or families enrolling in multiple plans, such as medical and dental, face multiple premiums. However, only the premium for the Marketplace medical plan is considered when determining the expected premium contribution amounts. Expected premium contributions for QHPs should be reduced to reflect other premium obligations that families face. Families seeking an exemption from the individual responsibility payment are able to include multiple premiums to show the available coverage is unaffordable, and the same principle should apply to expected premium contributions for those seeking coverage.

► **Offer standardized benefit designs that promote pediatric benefits.**

States may standardize the benefit and cost-sharing structures across all participating Marketplace plans so that the deductibles, copayments and coinsurance promote utilization of pediatric benefits. Many pediatric services are low cost relative to adult services, making high-deductible plans of little value to children because all of the child's services may still not reach the deductible. High-deductible plans could be prohibited for children, or states could require that some pediatric benefits, such as dental, have zero or low deductibles.

States such as California offer standardized plan designs that allow consumers to easily compare plans, as consumers know that each plan has the same cost-sharing levels and benefits.⁴⁴ While a plan option with standardized in-network deductibles, cost-sharing limits, and copayments and coinsurance amounts will be available through the federal platform for the 2017 plan year,⁴⁵ children would benefit if these standardized options specifically promote pediatric services.

► **Apply affordability rules to dental coverage.**

Dental is one of the pediatric benefits that is expressly identified in the ACA, and yet, many children enrolling in the Marketplace are not getting dental coverage. The affordability provisions of the ACA have limited or no application to dental benefits, making them unaffordable for many families. Requiring application of the PTC to dental coverage would increase take-up of SADPs, and counting dental expenditures toward maximum out-of-pocket limits would promote access to dental services, as guaranteed by the ACA.



Access to Providers

The ACA requires Marketplace plans to “maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.”⁴⁶ Insurers selling plans in the FFM in for the 2017 plan year must also include 30 percent of available “essential community providers” (ECPs), such as community health centers, that serve predominantly low-income, medically underserved individuals. Insurers must also offer contracts “in good faith” to all Indian health providers, and to at least one ECP in each of six categories of ECPs (family planning providers, federally qualified health centers, hospitals, Indian health care providers, Ryan White providers, and “other” ECPs) in their service area.⁴⁷ States can impose more stringent standards on networks, including quantitative standards that require providers to be accessible within defined timeframes and/or distances. In 2015, 30 states required at least some Marketplace plans to meet one or more quantitative standards for network adequacy.⁴⁸

To date, there has been relatively little data on how Marketplace plans are meeting network adequacy standards and what it means for children’s access to needed providers.⁴⁹ However, there is some evidence that plans are excluding some providers that charge higher prices from their network or are using tiered networks that require enrollees to pay higher out-of-pocket costs to obtain care from a less-preferred provider.⁵⁰ And in one highly publicized case, the Washington state insurance commissioner’s interpretation of “reasonable access” was in conflict with that of the state’s Marketplace. The commissioner rejected some plans for participation in the Marketplace because their networks lacked access to a children’s hospital that provides critical tertiary care, but the state’s Marketplace and an administrative law judge overruled his recommendation.⁵¹

In the absence of comprehensive data on Marketplace plans, it is difficult to know if consumers are able to obtain care through in-

network providers. However, even networks that work relatively well for most enrollees do not necessarily work well for those with special health care needs, especially children. Families that must get care out-of-network are subject to higher cost-sharing and their out-of-pocket costs do not count toward the ACA out-of-pocket cap. Plans will consider requests to obtain care from an out-of-network provider at in-network rates if an enrollee can demonstrate that the network does not provide access to needed services, but the burden falls on the enrollee to seek and obtain plan approval, and the enrollee may still receive a bill from the provider for costs not covered by the plan (known as balance billing). For example, families may face surprise medical bills for out-of-network services when they seek care during emergencies (and thus are not able to choose where they receive care) or receive care at an in-network facility that incorporates out-of-network providers for some services (such as anesthesia).⁵² Medicaid managed care plans, in contrast, 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.⁵³ The final rule on Medicaid and CHIP managed care subjects CHIP managed care plans to this same requirement.⁵⁴

Policy Options Regarding Access to Care

► Develop and enforce pediatric network adequacy requirements.

The combination of narrow networks and the inapplicability of affordability provisions such as maximum out-of-pocket limits for out-of-network care create an environment in which children may be unable to get the care they need. To ensure that families across all states have sufficient access to providers, there should be a federal default standard for network adequacy that contains quantitative measures of distance standards, minimum ratios of patients to providers, and wait-time limits. These default standards should apply to plans sold through the Marketplace in states that have not adopted their own federally approved set of network adequacy standards. Further, these standards should specifically apply to services relevant to children,



such as pediatric mental health care, pediatric urgent care, and pediatric dental care. If pediatric network adequacy standards were developed and enforced, children would be more likely to find in-network care that is affordable.

► **Limit out-of-network charges.**

In order to limit the costs that families face when they need to receive out-of-network care and reduce surprise medical bills when families inadvertently do so, insurers selling in the Marketplace should be required to cover any out-of-network services unavailable through in-network providers at network rates, especially for children with special health care needs. Further, the costs that families incur through services received from out-of-network providers should count towards their maximum out-of-pocket costs.

► **Strengthen requirements for including Essential Community Providers in plan networks.**

Currently, plans are only required to offer a contract in good faith to one essential community provider in each class in order to fulfill the contracting thresholds for these providers.⁵⁵ Federal rule-makers should strengthen this requirement so that QHPs must actually cover an essential community provider, rather than just attempt to do so. Further, pediatric providers should be added to the classes of essential community providers that insurers must include in their networks.

► **Collect and report coverage and utilization data for use by consumers and regulators.**

Adopting standardized reporting requirements for insurers would assist policymakers and regulators in monitoring how children and families are faring in the various network arrangements available in Marketplace plans. For example, standardized reporting requirements would better document the frequency with which families receive out-of-network services, as well as the cost of these services, and could help identify areas where families need additional protections. Plans should also collect and report complaints from consumers

regarding problems obtaining care or regarding inaccurate provider directories. In addition to providing this data to consumers via public forums such as Marketplace and state Department of Insurance websites, health plans themselves should also make this information available to families.

More generally, section 1311(e) of the ACA requires QHPs to submit and make public data regarding claims payment policies and practices, financial disclosures, enrollment, disenrollment, denied claims, rating practices, cost-sharing and payment for out-of-network coverage, enrollee rights, and other information as determined appropriate by the Secretary of Health and Human Services. Collecting and making public these data would help regulators target enforcement and oversight and inform evidence-based policymaking on non-discrimination, network adequacy, overall adequacy of the benefit package, and many other critical issues. Additionally, stakeholders could use the data to identify trends and offer solutions for ongoing coverage improvement efforts. To date, federal regulators have required only limited data from QHPs to begin in 2017.

Summary of Recommendations

The ACA has achieved some major milestones, including helping to bring the rate of uninsured children to the lowest point in history at just 6 percent.⁵⁶ However, Marketplace coverage should be modified to improve access for children enrolled in QHPs today and in the future. Budgetary and political constraints may make it difficult to make many of the suggested policy changes, but they must be considered in combination to ensure that children's coverage in the Marketplace meets their needs. For example, fixing the family glitch would make more children eligible for a premium tax credit, but such a change would have limited benefit if Marketplace coverage were not strengthened for children. Moreover, as policymakers consider CHIP's future, the inadequacies of Marketplace coverage for children raise serious concerns about proposals that would move children into the Marketplace.



Policy Options to Strengthen Marketplace Coverage for Children

Adequacy of Coverage

- Define pediatric services to include the full range of services children need—not just vision and dental services, but particularly services that are essential to development and frequently absent from EHB benchmark plans, such as audiology exams and hearing aids. One way to accomplish this would be to require that pediatric services include the services spelled out in CHIP regulation as being “child health assistance” services that may be paid for under the program.
- Ensure that medical necessity definitions include services necessary for healthy development.
- Strictly enforce the antidiscrimination rules to prevent discrimination based on age and diagnosis.
- Ensure that every child has access to a plan with dental coverage embedded.

Affordability of Coverage

- Improve the federal financial assistance to reduce premiums and make services more affordable. Ways to accomplish this include decreasing the expected premium contribution amounts, extending CSR assistance to those with higher incomes, and changing the reference premium to gold rather than silver.
- Fix the family glitch by accounting for the cost of family rather than individual coverage.
- Address premium stacking by including premiums for other coverage family members have in calculations of the expected premium contributions for QHPs.
- Incentivize state-based supplemental financial assistance.
- Standardize benefit designs to promote utilization of pediatric services.
- Apply affordability rules to SADP.

Access to Providers

- Develop and enforce pediatric network adequacy requirements. Establish a federal default standard for network adequacy that contains quantitative measures of distance standards, minimum ratios of patients to providers, and wait-time limits.
- Limit out-of-network charges by requiring insurers selling in the Marketplace to provide any out-of-network services unavailable through in-network providers at network rates and by counting these costs towards families’ Maximum Out-of-Pocket costs.
- Strengthen requirements for including Essential Community Providers in plan networks.
- Collect and report coverage data to support oversight and inform future policymaking and family choices.

Adopting these recommendations would set a standard for pediatric coverage; the recommendations could be applied flexibly to allow states and issuers to take different approaches. The ACA made a commitment to protecting patients by providing them with meaningful access to affordable coverage. In order to live up to that promise, some modifications need to be made, particularly for children. As children grow and develop, they must meet critical milestones to put them on the path to realize their full potential.



Endnotes

¹ Other planned papers in the series will examine topics such as ensuring that all children receive health coverage and rethinking pediatric dental coverage.

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⁴ Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), “Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report,” March 11, 2016, available at <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>.

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¹⁰ Ibid.

¹¹ Ibid.

¹² Ibid.

¹³ Medicaid and CHIP Payment and Access Commission (MACPAC), “Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance,” Report to Congress on Medicaid and CHIP, March 2015, available at <https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicaid-and-chip/>.

¹⁴ A forthcoming paper in this series will focus on pediatric dental coverage.

¹⁵ A. Grace et al., “The ACA’s Pediatric Essential Health Benefit Has Resulted in a State-by-State Patchwork of Coverage with Exclusions,” *Health Affairs* 33, no. 12, 2014, available at <http://content.healthaffairs.org/content/33/12/2136.abstract>.

¹⁶ 42 C.F.R. § 457.402.

¹⁷ J. Perkins and M. Youdelman, “Q & A: Defining Medical Necessity,” National Health Law Program, June 24, 2004, available at http://www.healthlaw.org/about/staff/mara-youdelman/all-publications/qa-defining-medical-necessity#.VwQPGRMrL_9.

¹⁸ Department of Health and Human Services, 2016.

¹⁹ C. Reusch, “Greater transparency needed on dental coverage provided by health plans,” Children’s Dental Health Project, May 10, 2014, available at <https://www.cdhp.org/blog/261-greater-transparency-needed-on-dental-coverage-provided-by-health-plans>.

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²¹ CMS, 2015.

²² For example, someone enrolled in a plan with an 80 percent AV can expect to pay 20 percent of the cost of their medical expenses in the form of copayments, coinsurance, and deductibles. For more information on actuarial value and how it is calculated, see L. Quincy, “Actuarial Value: Why It Matters and How It Will Work,” *Health Affairs Blog*, February 28, 2012, available at <http://healthaffairs.org/blog/2012/02/28/actuarial-value-why-it-matters-and-how-it-will-work/>.

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²⁴ Ibid.

²⁵ Medicaid and CHIP Payment and Access Commission, “Design Considerations for the Future of Children’s Coverage: Focus on Affordability,” *Report to Congress on Medicaid and CHIP*, March 2016, available at <https://www.macpac.gov/publication/march-2016-report-to-congress-on-medicaid-and-chip/>.

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³² *Ibid.*

³³ Medicaid and CHIP Payment and Access Commission, “Affordability of Exchange Coverage for Children Now Covered by CHIP,” *Report to Congress on Medicaid and CHIP*, March 2015, available at <https://www.macpac.gov/publication/march-2015-report-to-congress-on-medicaid-and-chip/>.

³⁴ MACPAC, March 2016.

³⁵ Tolbert and Young, 2016.

³⁶ MACPAC, *op cit.*

³⁷ T. Brooks, M. Heberlein, and J. Fu, “Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child’s Health Care Costs,” Georgetown University Center for Children and Families and Children’s Action Alliance, May 2014, available at <http://ccf.georgetown.edu/wp-content/uploads/2014/05/Dismantling-CHIP-in-Arizona.pdf>.

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³⁹ See 26 U.S. Code § 36B(3)(E).

⁴⁰ This amount is indexed to grow annually. In 2017, the maximum out-of-pocket limits will be \$7,150 for an individual and \$14,300 for a family plan.

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⁴² For more on this issue, see T. Brooks, “The Family Glitch,” *Health Affairs Health Policy Brief*, November 10, 2014, available at http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129.

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Center for Children and Families
Health Policy Institute
Georgetown University
Box 571444
3300 Whitehaven Street, NW, Suite 5000
Washington, DC 20057-1485
Phone (202) 687-0880
Email childhealth@georgetown.edu



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