CHAPTER 3

Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance



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Key Points

- States are expected to exhaust existing funding for their CHIP programs during fiscal year 2016 under current law. Under that scenario, most children now served by the program would likely transition to Medicaid, exchange plans, and employer-sponsored insurance. A key question in considering the future of CHIP is whether other sources of coverage will provide sufficient benefits for the health care needs of these children.
- Children at CHIP-eligible income levels tend to have a higher prevalence of chronic conditions and use more health services than those with private insurance, so the adequacy of benefits is a key consideration for this population.
- MACPAC's analysis of benefits offered by separate CHIP, Medicaid, exchange plans, and employer-sponsored insurance found the following:
 - Covered benefits vary within each source—between states for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans.
 - Most CHIP, Medicaid, exchange plans, and employer-sponsored insurance plans cover major medical benefits, such as inpatient and outpatient care, physician services, and prescription drugs.
 - Although Medicaid and CHIP cover pediatric dental services, dental benefits are offered as a separate, stand-alone insurance product in most exchanges.
 - CHIP and Medicaid cover many services that are not always available in exchange plans. For example, all state CHIP and Medicaid programs cover audiology exams, and 95 percent of state CHIP programs cover hearing aids. However, only 37 percent of exchange plan essential health benefit benchmarks cover audiology exams, and only 54 percent cover hearing aids.
 - For other benefits, such as applied behavioral analysis therapy and autism services, coverage varies.
- Benefit comparisons are inherently complex and must be considered in the context of payer and plan policies on the amount, duration, and scope of covered benefits as well as the definition of services within benefit categories and definitions of medical necessity.
- The Commission is examining the feasibility, complexity, and costs of a range of policy options that address concerns about the comparability of CHIP coverage to other sources, and the implications that such options might have for children and families, and federal and state governments.



CHAPTER 3: Comparing CHIP Benefits to Medicaid, Exchange Plans, and Employer-Sponsored Insurance

A key question in considering the future of children's coverage is whether other sources of coverage, to which children now enrolled in CHIP may transition, will provide children with coverage that meets their health care needs. Survey data indicate that children likely to have CHIP coverage are more likely to have special health needs than those who are privately insured (24 percent vs. 19 percent). They have a prevalence of chronic conditions that is similar to children likely to be enrolled in Medicaid, but higher than that of children with private coverage (MACPAC 2015). And they use more services, including dental care, than children likely to be enrolled in Medicaid, but use fewer services than privately insured children. Moreover, children likely to be enrolled in CHIP reported unmet need for medical care (5 percent) and dental care (3 percent) at levels comparable to those likely to be enrolled in Medicaid, but higher than privately insured children (2 percent for both medical and dental care). Whether other sources of coverage will provide children with benefits that meet their health care needs remains a key consideration for the Commission.

The Commission's June 2014 report highlighted concerns about whether other sources of coverage can serve as an appropriate alternative to CHIP. It is expected that states will exhaust existing funding for their CHIP programs during fiscal year 2016 under current law. Most children now served by the program would likely transition to other sources of coverage, including Medicaid (for children enrolled in Medicaid-expansion CHIP), exchange plans, and employer-sponsored insurance as dependents. Covered benefits vary within each source—between states for Medicaid and CHIP, and among plans for employer-sponsored insurance and exchange plans. Most major medical benefits, such as inpatient care, physician services, and prescription drugs, are offered by all of these sources. For other benefits, coverage varies. For example, dental services are a covered benefit in Medicaid and CHIP, but they are often offered as a separate stand-alone insurance product in exchange plans and employer-sponsored insurance.

Benefit comparisons are inherently complex because the extent to which different types of services are offered must be considered in the context of payer and plan policies on the scope of coverage, description of benefit categories, and definitions of medical necessity. It is also worth noting that coverage of a benefit does not guarantee access to services. Utilization management practices and cost-sharing requirements (the latter of which is discussed in greater detail in Chapter 2) can limit access to services for some families. As a result, it can be quite difficult to assess the effect of differences in benefits on individuals.

This chapter begins with a description of the benefits generally available in CHIP, Medicaid, exchange plans, and employer-sponsored insurance plans, including a discussion of health benefit mandates. We then compare CHIP coverage-what is typically available to current CHIP enrolleesto the coverage generally available in Medicaid, exchange plans, and employer-sponsored insurance. These comparisons are intended to be instructive of the experience of CHIP-enrolled children if they were to transition to other sources of coverage. The chapter concludes by discussing some possible policy options for addressing concerns about the comparability of coverage between CHIP and other sources. Policy options identified to address these concerns include changing the essential health benefit definition of pediatric services, allowing states the option of establishing a separate



pediatric coverage benchmark, and requiring that all exchange plans embed pediatric dental coverage. However, all of these options have not only cost implications, but also implications for individuals, families, states, and the federal government. The Commission will continue to consider these and other potential options for smoothing the transition to other sources of coverage.

Health Benefit Coverage

CHIP benefits. Benefits offered by state CHIP programs vary because states have flexibility in designing their programs. States can operate CHIP as an expansion of Medicaid, as a program entirely separate from Medicaid, or as a combination of both approaches (MACPAC 2013). States can model their separate CHIP benefits on specific private insurance benchmarks, create a package that is equivalent to one of those benchmarks, or provide coverage approved by the Secretary of the U.S. Department of Health and Human Services (Secretary-approved coverage). The most flexible of these options is Secretary-approved coverage, which is used by 25 of the 42 separate CHIP programs (Cardwell et al. 2014). Fourteen of these 25 programs use a benefit package similar to Medicaid.1

Some services are universally covered by separate CHIP programs. Federal rules require that all separate CHIP programs cover dental services, well-baby and well-child care (including ageappropriate immunizations), and emergency services (42 CFR 457.10(b)). All separate CHIP programs also covered inpatient and outpatient services, physician and surgical services, clinic services, durable medical equipment, and prescription drug coverage in 2013, although some states limited the scope or coverage, applied a monetary cap on benefits, or both (Cardwell et al. 2014). Although they rarely do, states can reduce benefits in separate CHIP as there are few mandatory benefits. Some benefits are available in many, but not all, states. For example, all separate CHIP programs except Arkansas cover inpatient substance abuse services (Cardwell et al. 2014). Other such benefits include autism services (available in 35 of 42 states with separate CHIP programs), nursing care services (38), disposable medical supplies (39), hearing aids (39), podiatry services (39), outpatient substance abuse services (41) and hospice services (41).²

Some benefits are covered by a smaller number of states. For example, non-emergency medical transportation services are covered in 23 of 42 separate CHIP programs. Over-the-counter medications (covered in 28 of 42 programs) and enabling services (14) are two other examples.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit is available in separate CHIP in 13 states. EPSDT is a Medicaid benefit under which states must cover medically necessary services for children, even if a particular service is not available as a covered benefit in the Medicaid state plan. EPSDT benefit coverage is not required in separate CHIP, but several states have opted to include EPSDT coverage in their Secretaryapproved coverage.³

Medicaid benefits. Medicaid benefits are categorized as either mandatory or optional. The coverage available to an individual will depend on the state in which the individual is enrolled. Mandatory benefits include inpatient and outpatient services, physician and surgical services, federally qualified health center and rural health clinic services, laboratory and X-ray services, home health services, family planning services, and non-emergency medical transportation.

Medicaid is required to cover the EPSDT benefit for children under age 21 who are enrolled in Medicaid. Medicaid coverage for children is generally viewed as comprehensive because the EPSDT benefit can expand coverage to include optional Medicaid services not listed in the Medicaid state plan. For example, under EPSDT requirements, states must



cover autism screenings and services if medically necessary (CMS 2014).

Some optional services are covered widely, and others less so.⁴ All states provide prescription drug coverage through their Medicaid programs, 42 states cover eyeglasses, and 41 cover hospice care (KCMU 2014). Physical and speech therapies are covered in 36 states, and occupational therapy is covered in 34. While states have the option of providing dental services to adults, they must provide dental services to children as a required Medicaid EPSDT benefit.

Children enrolled in Medicaid-expansion CHIP receive the Medicaid benefit package available in their state, including coverage of the EPSDT benefit.

Exchange plan benefits. Exchange plans must cover specific benefits in order to be certified. One of the federal minimum requirements is that health insurers, if they offer any coverage in an exchange, must also offer child-only plans. Child-only plans, which are restricted to individuals under the age of 21, are similar to other exchange plans in that they must be offered at the same actuarial value categories, and they must cover the essential health benefits.

All exchange plans must provide coverage of the 10 essential health benefits, as required by Section 1302(b) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).⁵ Each state defines its essential health benefit package by choosing a benchmark plan from among four options; the benchmark plan then serves as a model and minimum standard of coverage (including scope of coverage) that must be met for exchange plans to be certified.⁶ If a benchmark plan is missing any of the 10 essential health benefits, federal regulations require states to supplement the benefit category using an alternative benchmark option.

Habilitative benefits and pediatric services are exceptions to the benefit supplement framework, and regulations establish specific rules for these two benefit categories. In the preamble to the final rule on exchange plan benefits, the Centers for Medicare & Medicaid Services (CMS) explained that employer-sponsored plans do not often include habilitative services, and that small group plans do not typically cover pediatric oral and vision services (CMS 2013).⁷ CMS adopted a more uniform definition of what is considered a habilitative benefit in 2015, and states continue to have some flexibility to determine what services are included under the habilitative services benefit category (CMS 2015).⁸

State flexibility in defining their essential health benefit benchmarks leads to some differences in the benefits offered by exchange plans across states. For example, in 2014, general autism services were not covered in exchange plans in 23 percent of states (Bly et al. 2014). Audiology exams were not covered in essential health benefit benchmarks in 63 percent of states, and hearing aids were not covered in 46 percent of states (Bly et al. 2014).

Pediatric dental services are required as part of the pediatric services essential health benefit, but not all exchange plans cover this benefit because federal law does not require exchange plans to provide pediatric dental coverage if a stand-alone dental plan is also available in an exchange.9 Moreover, families are not required to purchase a stand-alone dental plan for their children, except in four states.¹⁰ The cost of stand-alone dental plan premiums is rarely included in the calculation of a family's premium tax credit, and there is no additional premium subsidy specifically for purchasing stand-alone dental coverage. This raises concerns about the affordability of pediatric dental coverage, which we address in more detail in Chapter 2 of this report.¹¹

Employer-sponsored insurance benefits. Employersponsored insurance (ESI) plans vary in terms of benefits covered because such plans are designed by employers and insurers with employee health needs and costs in mind, and there are few federally mandated benefits.¹² Plans must cover preventive



services, including contraceptives and breast pumps for women. Plans are not required to cover mental health and substance use disorder services, but if they do, they must cover these services at parity with their other medical and surgical benefits. Plans are not required to cover inpatient hospital care or physician services, although a 2008 survey found that nearly all plans did (Mercer 2008). Most benefit mandates are issued at the state level. For example, even without federal mandates, 37 states and the District of Columbia required plans to cover certain autism services (NCSL 2012). Some states require employer-sponsored insurance to provide other benefits, including certain screenings, immunizations (including pediatric), and infertility treatments.

Most employer-sponsored insurance plans cover inpatient and outpatient services, physician services, and prescription drugs (Table 3-1). Autism services are covered by about 69 percent of plans in small firms and 80 percent of plans in large firms. Half of all plans cover applied behavioral analysis therapy. More than half of all plans (54 percent) do not include coverage for dental services. Of the employers that offer separate dental coverage, many require an additional premium.

Although the ACA does not mandate many specific benefits, it does require that employer-sponsored insurance plans provide actuarial value of at least 60 percent in order to meet the minimum value threshold to be considered creditable coverage.¹³ Most employer-sponsored insurance enrollees— 98 percent—were enrolled in plans with 80 percent actuarial value or higher in 2011 (ASPE 2011a).

Comparison of CHIP Coverage to Other Sources of Coverage

How a child will fare in his or her transition from CHIP to another source of coverage will depend on individual circumstances—income, health status, state of residence, plan choice, even a parent's employer (if employer-sponsored insurance is available). Nonetheless, broad comparisons can be drawn between the different sources of coverage (Table 3-1). Most major medical services are covered by all sources of coverage. The story is less clear for other benefits, such as autism services, audiology exams, and hearing aids, which are more frequently covered in CHIP than by ESI or exchange plans. These benefit comparisons should be considered cautiously, as they are complicated by a number of factors (described in the next section).

Coverage for most major medical benefits is consistent across sources of coverage. In most cases, children transitioning from separate CHIP to Medicaid, exchange plans, or employer-sponsored insurance will have access to inpatient and outpatient hospital services, physician services, durable medical equipment, and prescription drug services.

For other benefits, coverage varies. Dental benefits are available in separate CHIP coverage and Medicaid (as an EPSDT benefit), but some families might incur additional premiums and cost sharing to access services in exchange plans and employer-sponsored insurance. Audiology exams are covered by all separate CHIP programs and Medicaid, but were covered by fewer than 40 percent of exchange and ESI plans.

At least half of the plans in each of the different sources of coverage cover certain benefits. Coverage for autism services, applied behavioral analysis therapy, and hearing aids varies across different sources of coverage. For example, applied behavioral analysis therapy is offered by 58 percent of state CHIP programs, 57 percent of exchange plans, and 50 percent of ESI plans.

Although most separate CHIP programs may cover the 10 essential health benefits, there are few mandates and states can reduce the number and scope of covered benefits. In particular, as federal CHIP funds diminish, states may opt to limit covered benefits rather than discontinue their separate CHIP programs.



TABLE 3-1. Coverage of Selected Benefit Categories, by Source of Coverage

	Separate CHIP	Medicaid	Exchange plans	Employer- sponsored insurance plans
Benefit category	Percent of states with some coverage in this benefit category	Percent of states with some coverage in this benefit category	Percent of essential health benefit benchmarks with some coverage in this benefit category	Percent of plans with some coverage in this benefit category
Physician services	100%	100%	100%	100%*†
Durable medical equipment and other medically related or remedial devices	100	100	100	67 ¹ * 97 [‡]
Inpatient services	100	100	100	98 (small firms); 99 (large firms)†
Inpatient mental health services	100	100	100	99*
Outpatient services	100	100	100	97 (small firms); 98 (large firms)⁺
Outpatient mental health services	100	100	100	85*
Prescription drugs	100	100	100	99§
Emergency medical transportation	100	100	100	642*
Autism-general	82	NA ³	77	69 (small firms); 80 (large firms)∥
Autism—applied behavioral analysis therapy	58	NA ³	57	50 [‡]
Audiology services-exams	100	NA ⁴	37	345#
Audiology services—hearing aids	95	NA ⁴	54	43 [‡]
Physical therapy	100	716	100	99 [‡]
Occupational therapy	100	67 ⁶	100	92 [‡]
Speech therapy	100	71 ⁶	100	85 [‡]
Dental	100	94 ⁶	40	46 [‡]
Pediatric vision-exams	100	100	100	44 [‡]

Notes: EHB is essential health benefit. NA is not applicable.

The table presents the percent of states, EHB benchmarks, or ESI plans with some coverage in the benefit category listed. Covered benefits are available to all enrollees and not limited to children, unless otherwise noted. There are several additional limitations (described in further detail below) to the data presented in this table. Although the benefit category may be covered, the amount or scope of coverage available can vary by state and plan. Benefit categories are broad and may not include coverage of specific benefits. Some benefits are only available when determined medically necessary. Although a benefit may be listed as covered, this does not guarantee that an individual will be able to access that coverage, depending on health status or condition.

¹ Of the workers' plans reviewed by the U.S. Department of Labor (DOL), 67 percent explicitly listed durable medical equipment as a covered benefit category, 33 percent did not mention durable medical equipment in plan documentation, and none excluded durable medical equipment coverage. Because specific benefits can often fall under different benefit categories, it is possible, for example, that some plans will cover diabetes supplies (e.g., test strips, glucose meter, syringes) under the prescription drug or a diabetes care management benefit category, or breast pumps under a prenatal or maternity care benefit category, while other plans categorize these items as durable medical equipment. On the other hand, it is possible that some plans exclude certain items from coverage.

² Of the workers' plans reviewed by the DOL, 64 percent explicitly listed ambulance services as a covered benefit category, 35 percent did not mention ambulance services in plan documentation, and none excluded ambulance service coverage. As noted above, specific benefits can be categorized different ways, for example, plans might cover ambulance services or emergency medical transportation under the broader emergency benefits category. On the other hand, it is possible that some plans exclude ambulance services.



TABLE 3-1 (continued)

³ Although autism services are not listed as a covered benefit category in the Medicaid statute, states may provide coverage under the following categories: services of other licensed practitioners, preventive services, therapy services, and home- and community-based services, a benefit listed under Section 1915(i) of the Social Security Act.

⁴ Although audiology services are not listed as a covered benefit category in the Medicaid statute, states may provide coverage under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit or under the category of other diagnostic, screening, preventive, and rehabilitative services.

⁵ Thirty-four percent of private health insurance plans covered audiology exams for children. Plans reviewed by McManus (2001) listed audiology exams as a covered benefit or covered exams under the preventive services benefit. Forty-nine percent of private insurance plans did not specify whether audiology exams were covered, and 17 percent of plans specifically excluded exams.

⁶ Medicaid is required to cover medically necessary services for children under the EPSDT benefit even if a particular service is not listed in the Medicaid state plan. Therefore, coverage might be available to children even though dental, physical therapy, occupational therapy, and speech therapy are optional benefits in traditional Medicaid.

Sources: For CHIP: Cardwell et al. 2014; for Medicaid: KCMU 2014; for exchange plans: Bly et al. 2014; for employer-sponsored insurance: *DOL 2011, †BLS 2009, ‡Mercer 2011, §Claxton et al. 2014, Mercer 2009, #McManus 2001.

More limited coverage of some benefits in the exchanges concerns the Commission to the extent that children currently enrolled in CHIP will not have access to benefits they need. For example, children likely to have CHIP coverage report higher unmet need for dental care than those who are privately insured, and might lose dental coverage if they transition from CHIP to exchange coverage.

Limitations of the Comparison

Benefit comparisons across sources of coverage can be complicated by different factors and therefore should be interpreted with caution. Determining whether an individual has access to certain services is more complicated than knowing whether a benefit is covered. For example, costsharing requirements and utilization management practices (including prior authorization requirements) may be designed to encourage or discourage use of certain services.¹⁴ Comparisons raised in this chapter should be considered along with the limitations described below.

Scope of coverage. Even though our analyses reflect when a benefit is offered, data are not

available on other policies that affect the extent to which a service is actually available. Each source can define the scope of coverage or can limit how much of a service an individual is entitled to receive. Benefits can be limited to an aggregate value, number of visits, or duration of time. For example, the CHIP program in New York makes physical therapy services available within a certain time limit, while the benchmark plan allows up to a certain number of visits per condition. Notwithstanding this limitation, CHIP programs tend to apply fewer benefit limits for certain benefits than exchange plans (Bly et al. 2014). Medicaid programs may apply benefit limits within federal parameters, but could be required to provide services beyond these limits as part of the EPSDT benefit if the services were considered medically necessary.

Medical necessity. Determinations of medical necessity can affect use of services even when a benefit is considered covered. Medicaid, CHIP, employer-sponsored plans, and exchange plans all have the ability to limit coverage so that it is only available when medically necessary. For example, a plan might require that a physician prescribe physical therapy before an individual can access that benefit. On the other hand, medical necessity can also be used to expand benefits (IOM 2012).



Individuals may be eligible for non-listed services deemed medically necessary (typically by a doctor or health care provider) if coverage documentation does not specifically exclude these services. In other cases, individuals can appeal for additional benefits beyond established limits by claiming that services are medically necessary, for example, when an individual's need exceeds plan limits. Although there is no national standard for medical necessity (IOM 2012), many determinations of medical necessity are assisted by nationally recognized software programs that rely on clinical standards to guide their determinations.

Benefit categories. The analyses presented in this chapter consider benefit categories rather than individual benefits. Benefit category descriptions often lack specificity that would be useful in making comparisons across sources of coverage. For example, we have compared coverage of autism services, and in doing so, we relied on states' essential health benefit benchmark summaries that specifically note that this coverage is included.¹⁵ However, the range of services used to treat autism is broad, and can range from social skills building to treatment planning; it includes physical, occupational, and speech therapies as well as other services.¹⁶ Our data sources do not say specifically what services are included within the category of general autism services, and benefits in this category could vary widely by state, coverage program, and health plan.

Possible Approaches for Addressing Comparability of Benefits

There are several ways to structure policy options for closing the benefit gaps described above so that children transitioning from separate CHIP to other sources of coverage would not face less generous coverage in the future. Some options would increase costs for federal government alone, while others would also increase costs for state governments and enrollees, including those who receive premium tax credits and those who pay full premiums in exchange plans. Policymakers will have to weigh these costs with the comprehensiveness of coverage available in publicly subsidized programs and employersponsored insurance. In the months ahead, the Commission will examine a range of policy options, such as those described below, in greater depth for their feasibility, complexity, and implications (including additional costs) for children and families and for federal and state governments.

Change the essential health benefit definition of pediatric services. Essential health benefit regulations require that pediatric services include at least dental and vision services. But the statute and regulations do not limit pediatric services to these two benefits. The Secretary of the U.S. Department of Health and Human Services (the Secretary) could choose to reevaluate the definition of pediatric services, and in doing so, consider including in the definition some specific benefits that are more frequently covered by CHIP than exchange plans (e.g., audiology services).

Establishing additional benefit requirements for the pediatric services essential health benefit could provide more comprehensive coverage for children in individual and small group plans, including exchange plans. In particular, it could improve the comparability of coverage for children transitioning from CHIP to exchange plans, especially those children with frequent and ongoing health care needs that are beyond routine care in terms of scope and quantity. We note that providing additional coverage through the pediatric services essential health benefit would mean additional coverage for all children in the exchange because there is no way to target this policy option exclusively to children who were previously enrolled in CHIP. On the other hand, this policy option could be targeted to children with special health needs if the definition of pediatric services were to include medically necessary services for children with



such needs. This policy does not address concerns about the separate offering and additional cost of pediatric dental coverage because these services are already an essential health benefits requirement (see below).

This policy approach has implications for state and federal governments as well. States have the authority to regulate commercial insurance, although the ACA established a new paradigm of federal health insurance regulations for the individual and small group markets. New federal requirements would limit a state's authority and flexibility to define coverage available in that state. Additional benefits would also be likely to increase premiums for exchange plans, which would affect individuals purchasing exchange plans without federal subsidies. This option could also increase federal costs, because it would require the federal government to increase premium subsidies for individuals receiving them.

Provide states the option of establishing a pediatric-specific essential health benefits

benchmark. All exchange plan benefits, whether offered in a general exchange plan or a child-only plan, are based on the same essential health benefit benchmark established by the state. This benchmark is modeled on a previously existing commercial plan. Policymakers could consider providing states the option of establishing a separate pediatric-specific essential health benefit benchmark in addition to their general essential health benefit benchmark, and allow states to select CHIP coverage (including Secretaryapproved coverage) to serve as a pediatric-specific essential health benefit benchmark.¹⁷

A pediatric-specific benchmark could improve coverage available to children, although the impact would vary by state. States that define the benchmark to include additional benefits, such as audiology services or non-emergency medical transportation, could make their coverage more comprehensive relative to general essential health benefit benchmarks. On the other hand, this policy would likely have no effect on access to dental coverage, which is already a required essential health benefit. This policy approach would also preserve state flexibility in defining the coverage available in each state, although it might not have an effect on pediatric coverage if a state chose not to implement a separate pediatric-specific benchmark.

Finally, a pediatric-specific benchmark could increase exchange plan premiums and therefore require increased federal subsidies. As previously noted, additional benefits would likely increase the premiums and subsequently increase federal spending on premium subsidies while reducing out-of-pocket spending for families in need of the newly covered benefits. This policy approach could also increase the administrative burden for states and the federal government.

Require all exchange plans to embed pediatric

dental coverage. Although pediatric dental services is a required essential health benefit, plans are not required to offer the benefit if stand-alone dental plans are available in an exchange. Coverage for dental benefits was often separate from medical coverage in the individual market and employersponsored insurance prior to the ACA, and the decision to include stand-alone dental plans in exchanges preserves this market. Current policy could be changed to require all exchange plans to include dental coverage for children in their exchange offerings. California and Connecticut already require this in their state-based exchanges, although this is a new requirement for California, having just been implemented for the 2015 plan year. Some plans embed coverage by offering the benefit themselves, while other plans subcontract with a dental insurer to provide the benefit.

This policy would ensure that children enrolled in exchange plans have access to dental coverage. Embedded plans are eligible for premium subsidies, unlike stand-alone dental plans purchased in conjunction with a medical plan. Embedding dental coverage within a medical plan might increase the affordability of the coverage and increase the likelihood that a family would secure dental coverage. The policy would affect all families purchasing coverage through exchanges, although it might be possible to target children who were previously enrolled in CHIP.

This policy approach would increase premium subsidies (for the same reasons as noted above), thereby increasing costs to the federal government. As with all federal mandates, this policy would limit states' ability to regulate insurance coverage. And it is unclear what effect, if any, this policy would have on the dental insurance market. Standalone dental plans offered through exchanges become irrelevant for children to some extent if all exchange plans include embedded pediatric dental coverage, although the market for adult dental coverage would remain.

Providing wrap-around coverage for benefits.

Medicaid wrap-around benefit coverage could be developed to provide benefits in areas where there are gaps. This policy option would allow Medicaid to provide wrap-around benefits to a primary source of coverage if a certain benefit were not covered. For example, Medicaid could pay for autism services if a child were enrolled in an exchange plan that did not cover these services. Models for wrap-around coverage exist within Medicaid and CHIP already, as discussed in Chapter 5 of this report. For example, young adults enrolled in the Arkansas private-option Section 1115 Medicaid waiver are covered by exchange plans, but they receive EPSDT benefit coverage through the state's fee-for-service Medicaid program.¹⁸

One of the challenges of this policy option is that it would impose additional administrative burden for Medicaid programs and exchange plans. Medicaid agencies and exchange plans would have to share eligibility information and coordinate which services would be covered by the exchange plan and which would be covered by Medicaid. This would also mean that children and families would have to go through two eligibility determinations in order to be eligible for both exchange plan and Medicaid coverage. This option could also have implications for continuity of care, for example, if a provider were to participate in an exchange plan network but not in Medicaid.

This policy option would address the issue of gaps in covered benefits for children transitioning from CHIP to other coverage sources. While the option would make coverage more comprehensive for children, it would likely increase costs for states and the federal government. The magnitude of any cost increase is likely to be a factor of how comprehensive the benefit design of wrap-around coverage would be. For example, wrap-around coverage could be designed to provide specific benefits (e.g., audiology exams only), CHIP benefits, or Medicaid benefits, including EPSDT coverage. The policy could be designed to target families at certain income levels, but it might be more difficult to target this policy based on health needs.

This option would require changing the provision of current law that prohibits the receipt of exchange subsidies for those with Medicaid coverage.¹⁹ Some states have used Section 1115 waivers to provide wrap-around Medicaid benefits to exchange enrollees. Aside from these waivers, legislative action would be required to implement this policy option.

Augment existing exchange subsidies to include the cost of stand-alone dental plans. Increasing the amount of exchange subsidies available to individuals and families to include the cost of stand-alone dental plans could help families purchase dental coverage. This option is discussed in detail in Chapter 2.





Endnotes

¹ MACPAC has previously discussed the states' role in benefit design in CHIP programs and defining benefit standards for exchange plans (MACPAC 2014). For example, states can implement a Medicaid-expansion CHIP program in which federal Medicaid rules apply, including Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Essential health benefits do not apply to CHIP. For more information on benefit design, see Chapter 1 of the June 2014 *Report to the Congress on Medicaid and CHIP*.

² As with all benefits, there is variation in how states and plans describe coverage available within a benefit category. For example, some plans describe certain medical supplies such as glucose test strips or insulin syringes as disposable medical supplies, while others cover these supplies under prescription drug or durable medical equipment benefits.

³ The Cardwell et al. (2014) analysis did not examine the full scope of EPSDT benefits in separate CHIP programs. Less is known about how EPSDT is implemented within separate CHIP than in Medicaid.

⁴ States can define the breadth of Medicaid coverage (i.e., amount, duration, and scope) as long as it is adequate to reasonably achieve its purpose, although the state may limit coverage of a service based on criteria such as medical necessity or through utilization control measures. So while a benefit may be covered in a state, there is some variation in the amount of that benefit an enrollee can receive.

- ⁵ The ten essential health benefits are:
 - (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; and

(10) pediatric services, including oral and vision care.

⁶ The four benchmark options, outlined in statute, are: any of the three largest small group plans offered in a state, any of the three largest health plans offered to state employees, any of the three largest health plans offered to federal employees, or the largest non-Medicaid HMO operating in a state.

⁷ Some research indicates that habilitative services are sometimes available under rehabilitative benefits (ASPE 2011b).

⁸ The regulation defines habilitative services as those which generally refer to health care services that help a person learn new skills and functioning for daily living (CMS 2015). These services could include speech, physical therapy, or occupational therapy designed to help an individual acquire new skills (CMS 2015). The regulation also prohibits plans from imposing habilitative benefit limits that are less favorable than any such limits imposed on rehabilitative benefits. For plan years beginning on or after January 1, 2017, exchange plans cannot impose a combined benefit limit on rehabilitative and habilitative benefits (CMS 2015).

⁹ California and Connecticut require that insurers embed pediatric dental coverage in their exchange offerings.

¹⁰ Four states (Colorado, Kentucky, Nevada, and Washington) have laws that require families and individuals to purchase dental coverage for children when it is not embedded within an exchange plan (Yarbrough et. al. 2015, Snyder et al. 2014).

¹¹ Families purchasing a second-lowest-cost silver exchange plan without pediatric dental coverage would need to pay an additional premium for stand-alone dental coverage, meaning their total premium costs would exceed the ACA's expected premium contribution amount for their income level. If families purchase an exchange plan with premiums less than the second-lowest-cost silver plan and there is any tax credit remaining after it is first applied to the cost of the exchange plan, then the tax credit can be applied to the cost of the stand-alone dental plan (45 CFR 155.340(e)).

¹² Some mandates may not apply to self-funded or selfinsured plans, in which the employer assumes direct financial responsibility for employee claims. Covered workers in large firms (those with 200 or more employees) are more likely to be in a self-funded plan than covered workers in small firms (81 percent vs. 15 percent) (Claxton et al. 2014).



¹³ When the minimum value regulations took effect, it became apparent that employer-sponsored plans could meet requirements without covering inpatient care. More recent HHS regulations now require that such plans cover both hospitalizations and physician services (CMS 2015).

¹⁴ Cost sharing and affordability concerns are discussed in more detail in Chapter 2.

¹⁵ Essential health benefit benchmarks establish a minimum standard that all exchange plans must meet in order to be certified. Issuers can provide additional services or establish higher benefit limits than those established in essential health benefit definitions. As a result, actual coverage may vary from the essential health benefit benchmark used for comparison.

¹⁶ Some of the services used to treat autism spectrum disorders may also be used to treat other developmental disorders. Thus, the coverage of autism services may affect more families than those with children that have a diagnosis of autism spectrum disorder.

¹⁷ Under current law, states can choose the same plan to serve as the benchmark for their separate CHIP program and as the essential health benefit benchmark for exchange plans. However, there is not a separate benchmark specific to children, and current law does not allow states to choose Secretary-approved CHIP coverage, the most common benefit design in separate CHIP programs, to serve as the essential health benefit benchmark.

¹⁸ Arkansas and Iowa have waivers that provide premium assistance for adults to purchase exchange plans, and provide EPSDT benefits to 19- and 20-year-olds through fee-for-service Medicaid. For more information, see Chapter 5 of this report.

¹⁹ Individuals who are eligible for other insurance that qualifies as minimum essential coverage, such as Medicaid, are ineligible for subsidized exchange coverage (26 CFR 1.36B(c)(2)(B)).

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