Childhood Asthma Leadership Coalition

December 19, 2014

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Medicaid and CHIP Payment and Access Commission
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Comments submitted electronically to joanne.jee@macpac.gov

Re: Request for comments regarding children's coverage and the future of the Children's Health Insurance Program

Dear Dr. Rowland and Dr. Sundwall:

On behalf of the *Childhood Asthma Leadership Coalition* (CALC), a multi-sector coalition of asthma stakeholders dedicated to raising awareness and improving public policy to reduce the burdens of childhood asthma, we are pleased to submit comments in response to your request for input about access to and affordability of children's coverage. We are grateful for the Commission's extensive work on key issues related to the Children's Health Insurance Program (CHIP) and the Affordable Care Act's (ACA) Marketplace coverage. We welcome the opportunity to share our views and concerns about the future of CHIP and the adequacy of Marketplace coverage, with a particular focus on children with asthma.

As you are aware, asthma is the single most common chronic condition among children in the U.S. Approximately 7 million children under age 18 (1 in 11 children) have asthma, with poor and minority children suffering a greater burden of the disease, and disparately adverse outcomes such as hospitalizations and emergency room visits.[1] [2]Working in tandem with Medicaid, CHIP is an essential source of coverage for 8 million children[3]; in one study it was estimated that approximately 5 percent of children with asthma are covered by CHIP.[4]

As MACPAC considers CHIP's future and is tracking the development and operation of Marketplace coverage it is important to recognize the significant role that CHIP has played for children with asthma. A recent study published in the journal *Pediatrics* examined the impact of CHIP on children with asthma and confirmed that enrollment in CHIP is associated with improvements in access to asthma care and quality of asthma care. Children in the study had fewer asthma-related attacks and medical visits after

[1] Bloom B, Jones LI, Freeman G. Summary health statistics for U.S. children: National Health Interview Survey, 2012. National Center for Health Statistics. Vital Health Stat 10(258). 2013. http://www.cdc.gov/nchs/data/series/sr_10/sr10_258.pdf
[2] http://www.epa.gov/childrenstaskforce/federal_asthma_disparities_action_plan.pdf (page 2)
[3] Kaiser Family Foundation State Health Facts (2012) http://kff.org/other/state-indicator/annual-chip-enrollment/
[4] Piper CN et al. Disparities Between Asthma Management and Insurance Type Among Children. *Journal of the National Medical Association.* 2010 Jul:102(7):558.

enrolling in CHIP.[5] Several other studies have shown that children with chronic care needs who enroll in CHIP receive improved access to specialty care, are less likely to have unmet care needs, receive better overall quality of care, and are less likely to be hospitalized for their condition.[6,7,8] Without a doubt, CHIP has played a role in reducing asthma disparities and ensuring children have access to high quality, affordable care that has led to improved health outcomes for children with chronic illness, including those with asthma.

Because a significant number of children with asthma rely on CHIP for their health coverage, we have serious concerns about how they would fare if CHIP were no longer available. The Government Accountability Office (GAO) estimates that if CHIP funding expires as scheduled at the end of FY 2015, up to 2 million currently-insured children could become uninsured.[9] While alternative coverage could be available for some portion of the children who would be displaced, Marketplace coverage affordability and benefits fall short when compared with CHIP, especially for children with chronic and special health care. A recent study conducted by the Wakely Consulting Group shows that Marketplace plans provide fewer child-specific benefits at a significantly higher cost to families.[10] Without a comparable alternative coverage option, the data suggests that the end of CHIP would result in a significant uptick in the numbers of uninsured and underinsured children.

The CALC is aware of MACPAC's June 2014 recommendation that promoted only a two-year extension of CHIP funding through FY 2017. We have serious concerns about the premature termination of CHIP and the potential for children to be moved into more costly, less comprehensive coverage. Given the Commission's public testimony and comments recognizing the current status of pediatric coverage in the Marketplace, we urge MACPAC to play a leadership role in defining the criteria that would need to be met before children covered through CHIP could be transitioned to Marketplace plans. We believe the Commission could be instrumental in developing specific policy recommendations delineating child-specific benefits, cost-sharing protections, and network adequacy criteria necessary to ensure that Marketplace plans are able to meet the unique health and developmental needs of children, including children who require chronic care management for conditions like asthma.

We urge MACPAC to develop a comprehensive analysis of coverage differences between CHIP and Marketplace plans, to identify the specific areas where Marketplace coverage is not currently comparable to CHIP, and develop clear guidance on the range of policy issues that need to be addressed before children could be appropriately transitioned from CHIP to Marketplace plans. It would also be helpful for MACPAC to monitor efforts by the Administration or Congress to address these concerns. Given the range of coverage differences between these CHIP and Marketplace coverage, it is clear that ending CHIP too soon could result in a serious setback in coverage for children, especially those with special or chronic health care needs.

The policy issues that are ripe for MACPAC's engagement include those where there is a significant disparity between CHIP and Marketplace coverage, including, but not limited to, the following:

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[5] Szilagyi PG et al. Improved asthma care after enrollment in the State Children's Health Insurance Program in New York. *Pediatrics*. 2006 Feb;117(2):486-96.

[6] Kenney G. The impacts of the State Children's Health Insurance Program on children who enroll: findings from ten states. *Health Serv Res*. 2007 Aug;42(4):1520-43.

[7] Davidoff A1, Kenney G, Dubay L. Effects of the State Children's Health Insurance Program Expansions on children with chronic health conditions. *Pediatrics*. 2005 Jul;116(1):e34-42. Epub 2005 Jun 15.

[8] Bermudez D1, Baker L. The relationship between SCHIP enrollment and hospitalizations for ambulatory care sensitive conditions in California. J *Health Care Poor Underserved*. 2005 Feb;16(1):96-110.

[9] GAO Report: "Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance," November 2013

[10] Bly, A., Lerche J., Rustagi, K. 2014. Comparison of benefits and cost sharing in Children's Health Insurance Programs to qualified health plans. Englewood, CO: Wakely Consulting Group. http://www.wakely.com/wp-content/uploads/2014/07/FINAL-CHIP-vs-QHP-Cost-Sharing-and- Benefits-Comparison-First-Focus-July-2014-.pdf.

Pediatric benefits: CHIP benefits are designed with children's needs in mind. In Medicaid-expansion CHIP programs, children receive Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is particularly important for children with asthma and other chronic illnesses who require an array of services on an ongoing basis. Some states with separate CHIP programs have also developed comprehensive benefit packages with children in mind so they have access to a range of necessary health services to meet their needs.

To date, Marketplace plans have not been implemented in a way that takes into account the specific needs of children. The federal Essential Health Benefits (EHB) standards fall short in ensuring that children have access to a comprehensive package of services, particularly coverage for ancillary services that are critical for children with chronic or complex conditions. Children need comprehensive benefits that address their continuous growth and development. Gaps in benefits can result in life-long health consequences that generate extensive and avoidable costs and suffering. Children should not be moved to Marketplace plans until it is clear that their particular medical needs can be met.

As currently implemented, Marketplace plans must cover EHBs that have been largely set through state and federal choices for 2014 and 2015. To prepare for the possible influx of millions of CHIP children into those plans, states should be required to create a definition of medical necessity that applies across health plans in the state, modeled on Medicaid's EPSDT standard, which is based on children's unique health care needs. It is also critical that states develop methods for measuring children's access to needed care under the state's chosen EHB benchmark plan. States should be required to monitor EHBs for any gaps, with particular attention to children who may go without needed services because they are uninsured and families who must pay out-of-pocket for uncovered but medically-necessary care.

Cost-sharing: While the ACA expanded coverage for millions of previously uninsured low-income adults, its reach has been limited in terms of children's coverage because Medicaid and CHIP were already available for low-income children. For many families, CHIP is the only affordable insurance option for their children. According to the Wakely Consulting Group study, which compared CHIP to Marketplace plans in 35 states, CHIP plans have significantly lower average cost-sharing than Marketplace plans. The average annual cost-sharing for a child in CHIP is estimated at $66 for households with incomes of 160% FPL and $97 for those at 210% FPL. In contrast, the average cost-sharing for a child in a Marketplace plan is estimated at $446 annually for households with incomes of 160% FPL and $926 for those at 210% FPL. In every state, it was estimated that children in CHIP could see up to a ten-fold increase in the cost-sharing they pay if they were transitioned to Marketplace coverage. By every measure, a family's out-of-pocket costs in CHIP are significantly lower than in the Marketplace.[11] For children with special or chronic health care needs who have high medical claims, this disparity in cost-sharing is even more pronounced and would result in thousands of dollars in increased out-of-pocket costs if these children were moved from CHIP to Marketplace coverage.

CHIP also contains important cost-sharing protections that limit a family's aggregate cost-sharing to five percent of family income. These cost-sharing protections have been critical, ensuring that families seek needed care for their children rather than forgoing care because of cost constraints. These cost-sharing protections are not currently available to families enrolled in Marketplace coverage. The disparity in cost-sharing between CHIP and Marketplace coverage must be addressed before children can be moved out of CHIP.

Network adequacy: Because CHIP is a program dedicated to children, CHIP has pediatric provider networks designed to meet their needs. For example, under CHIP, children have access to a full range of primary, specialty and ancillary pediatric providers to ensure that they receive comprehensive, medically and developmentally appropriate care. In addition, CHIP requires states to ensure that children with special health care needs have access to specialists and out-of-network providers when the CHIP provider network does not meet a child's health needs. This is a critical component of an accessible

[11] Ibid

health care system for the children covered by CHIP.

Pediatric provider networks in Marketplace plans should include a full range of primary, specialty, and ancillary pediatric providers. The networks should also include contracts with all essential community providers as defined in the ACA statute. Pediatric-specific network adequacy standards (related to timeliness, quantity and types of providers, and monitoring) developed with input from pediatric health researchers, providers, and families will ensure children have access to needed services without unreasonable delay. Required contracts with all essential community providers will ensure access to especially qualified providers with expertise in the care of low-income and critically or chronically ill and disabled children. In addition, network standards that require or encourage shared or overlapped networks with Medicaid and CHIP will allow for continuity of care for children who churn between public and private coverage.

Family Glitch: As noted above, the GAO estimates that approximately 1.9 million children could lose coverage altogether if CHIP is no longer available due to the so-called "family glitch." The family glitch stems from the ACA's coverage affordability test, which bases affordability of coverage for a family on the cost of employee-only coverage and not on how much it actually costs for a family to buy coverage. Specifically, if an employee's offer of self-only coverage is less than 9.5 percent of family income that offer is deemed "affordable" for the entire family even if the cost of family coverage, which is typically three times as expensive as individual coverage, takes up much more than 9.5 percent of family income. Families that do not meet the "affordability test" are not eligible for ACA subsidies. The most likely scenario for employees who have an "affordable" offer of self-only coverage is that the employee will take up coverage for themselves but would not be able to afford the more expensive coverage for their family. This would leave children in these families without affordable employer-sponsored coverage and locked out of subsidized Marketplace coverage.

As long as CHIP continues to be available, a large portion of the children that fall into the "family glitch" remain eligible for CHIP and have CHIP as a backstop. However, if CHIP funding runs out, almost two million currently-insured children stand to lose coverage altogether. A policy solution must be developed and implemented to address the family glitch before CHIP is terminated.

As our nation's health care systems continue to adjust to the changing health coverage landscape, it is essential that the coverage sources designed for and working well for children are not disrupted unless and until comparable coverage is widely available. This is important for all children, but critical for those who have special or ongoing health care needs. While there is no cure for asthma, decades of research have established evidence-based disease management strategies that prevent the onset of serious symptoms and mitigate the impact of asthma. The research is clear that having a comprehensive, high quality, affordable source of health coverage like CHIP is essential if children with asthma are to be able to manage their disease effectively. As MACPAC develops future policy recommendations related to children's coverage, we urge the Commission in the strongest possible terms to memorialize its policy concerns regarding what children would need if CHIP is terminated and establish specific conditions that need to be met before children can be moved into Marketplace coverage.

In closing, we underscore that our organizations have long supported a broad range of federal policy efforts to protect and improve health coverage for low-income children. We have certainly been heartened by the improving coverage trends for children. Today the numbers of uninsured children stand at a record low with 93 percent of children in America enrolled in some form of coverage they can count on.[12] CHIP has been a critical element in achieving this positive trend and its role in children's coverage must continue until comparable coverage – in terms of affordability and benefits – is available.

[12] T. Mancini and J. Alker, "Children's Health Coverage on the Eve of the Affordable Care Act," Georgetown University Center for Children and Families (November 2013)

We appreciate your consideration of these issues and would be happy to provide any additional information that might be helpful.

Sincerely,

Allergy and Asthma Network
American College of Allergy, Asthma & Immunology
Association for Clinicians for the Underserved
Association of Asthma Educators
Asthma and Allergy Foundation of America
First Focus
Green & Healthy Homes Initiative
Merck Childhood Asthma Network, Inc.
School-Based Health Alliance
Trust for America's Health