Low-Income Children With Chronic Conditions Face Increased Costs If Shifted From CHIP To Marketplace Plans

ABSTRACT More than eight million children risk having their health insurance coverage disrupted if federal funding for the Children’s Health Insurance Program (CHIP) is not extended beyond 2017. In this study we explored two current policy alternatives: extending federal funding for CHIP or enrolling children in the existing health insurance Marketplace plans. We simulated annual out-of-pocket expenses using detailed health plan data from CHIP and federally facilitated Marketplace plans for a nationally representative cohort of children with chronic conditions, conducting comparisons at four different percentage categories of the federal poverty level. If CHIP funding is not renewed and children with chronic conditions shift to coverage under Marketplace plans, their families face increased annual out-of-pocket expenses ranging from $233 at the lowest income levels to $2,472 at the highest income level of 251–400 percent of poverty. Families with children who have epilepsy, diabetes, or mood disorders may face the highest costs. Cost sharing for prescription drugs (25 percent) and hospitalizations (23 percent) account for much of the difference. Absent enhancements to Marketplace cost-sharing protections, and given recent efforts to repeal the Affordable Care Act, renewing funding for CHIP will provide the greatest financial protections to families of income-eligible children with chronic conditions.

Affordable health insurance is critical to ensuring that children are able to obtain high-quality health care services. For children living in families with incomes between 100 percent and 400 percent of the federal poverty level, the predominant source of government-sponsored health insurance is the Children’s Health Insurance Program (CHIP). CHIP was developed in 1997 partly as a response to the growing number of uninsured low-income children. CHIP is a federal-state partnership, whereby states operate their own programs with federal oversight and matching funds either in combination with their Medicaid programs (Medicaid-expansion CHIP) or separate from their Medicaid programs (freestanding CHIP). More than 8.4 million children, including approximately 2.0 million with chronic health conditions, are currently enrolled in CHIP. Children with chronic conditions often require higher amounts of health care services and thus are particularly reliant on insurance.

The key alternative source of government-subsidized coverage for children in families with incomes between 100 percent and 400 percent is the health insurance Marketplace, introduced in 2014 as part of the Affordable Care Act (ACA). The Marketplace is a collection of federal and state-based online exchanges where families...
can purchase private health insurance plans often with support of federal subsidies. The purchase of private health insurance plans on the Marketplace by these families is currently subsidized by the federal government via two mechanisms. First, premium tax credits help reduce the cost of the monthly premium. Second, cost-sharing reductions—special discounts available only to families with incomes below 250 percent of poverty—further lower out-of-pocket spending if the family selects a qualifying plan. Around 1.1 million children are currently covered under the Marketplaces, most with support from government subsidies.

However, the future of government-sponsored or -subsidized insurance for children living in families with incomes between 100 percent and 400 percent of poverty remains uncertain. CHIP is authorized under the ACA until 2019; however, federal funding for the program is due to expire later in 2017, and efforts to repeal the ACA may affect the funding of the program. The Marketplace, perceived by some as a coverage alternative for children if CHIP were dismantled, may become less viable if repeal of the ACA subsidizes moves forward. Although data are limited regarding the impacts of the Marketplace on limiting family cost burdens for children’s services, there is robust evidence linking CHIP enrollment with improvements in affordability of and access to care. Given the benefits of CHIP enrollment, and our nation’s nearly two-decade history of providing coverage for this population of low-income children, it seems likely that there will be efforts to provide supports for these children. However, the path forward is unclear, and few data are available to guide our understanding of how well the existing choices, CHIP versus Marketplace plans, compare in providing coverage for children.

Prior evaluations have suggested that Marketplace plans overall offer less generous protections against high out-of-pocket expenses when compared to CHIP plans. In 2015 the secretary of health and human services, in conducting a statutorily required review of Marketplace plans for children’s coverage, declared that they were not comparable to CHIP plans in providing coverage for children’s services. These limitations of Marketplace plans could also be particularly problematic for families of children with certain chronic health conditions who might need specialized services not routinely covered by Marketplace plans as essential health benefits, or who might experience episodic or continuously elevated need for services. Prior studies, however, have not evaluated the variation in cost sharing under Marketplace and CHIP plans that occurs across common childhood conditions.

In addition to understanding which children are most likely to be affected, it is also important to determine which health care service categories account for the biggest differences in out-of-pocket expenses between Marketplace and CHIP plans.

Accordingly, in this study we compared the two existing policy choices: extending federal funding for CHIP or enrolling children in the current health insurance Marketplace plans. We used detailed health plan benefit data to simulate total annual, and service-specific, out-of-pocket expenses for a nationally representative cohort of children with selected chronic conditions, comparing their experiences when enrolled in CHIP or Marketplace plans. This information will aid policy makers as they consider extending federal funding for CHIP or making revisions to the ACA that might affect the comparability of Marketplace and CHIP plans for children.

**Study Data And Methods**

**STUDY DESIGN** We modeled two scenarios: Federal funding for CHIP is extended, or federal funding for CHIP is not extended and the Marketplace is maintained as it currently exists. The model was based on detailed health plan benefit data from CHIP and Marketplace plans and utilization data for a nationally representative cohort of children with chronic conditions. We conducted comparisons at four income levels corresponding with Marketplace premium tax credit and cost-sharing reduction eligibility levels, discussed in the following section.

**IDENTIFYING MARKETPLACE BENCHMARK PLANS** We used the Centers for Medicare and Medicaid Services (CMS) federally facilitated Marketplace public use files to identify all qualified health plans sold on the individual group market in the thirty-seven states participating in both the federally facilitated Marketplace and CHIP in 2016. To assist families in selecting among private health plans sold on the Marketplace, each plan is rated according to the plan’s actuarial value, the percentage of the average enrollee’s cost for a standard set of “essential health benefits” paid for by the plan. The plans are currently categorized by actuarial value into four incrementally more generous metal levels: bronze (60 percent actuarial value), silver (70 percent), gold (80 percent), and platinum (90 percent). We identified the second-lowest-price silver plan in each rating area (n = 405), the geographic regions used by all insurers in each state for rate-setting benchmarks. This benchmark plan is used to calculate the premium tax credits for all residents of the rating area.
We also identified the three specific cost-sharing reductions, offered at family income levels 100–150 percent, 151–200 percent, and 201–250 percent of poverty, associated with each benchmark plan (see online Appendix Exhibit A). Cost-sharing reductions contain identical provider networks and covered benefits as the standard version of the plan but are designed to provide more generous protections against out-of-pocket expenses to families at lower income levels.

**Health Plan Benefits** We used the federally facilitated Marketplaces public use files and each state’s current CHIP state plan and Member Handbook (a comprehensive listing of the plan’s coverage and benefits) to abstract copayment, coinsurance, and quantity limit amounts for thirty-four unique benefits corresponding to the utilization benchmark, which we describe in the next section. We excluded dental and orthodontic care because coverage for these services, although integrated into CHIP plans, is often obtained through separate Marketplace products.

**Health Services Utilization Benchmark** We assessed health care utilization for a nationally representative “standard cohort” of noninstitutionalized, nondisabled children (ages 1–18) with one or more chronic conditions and family incomes of 100–400 percent of poverty, pooling data from the Agency for Healthcare Research and Quality’s (AHRQ’s) 2008–13 Medical Expenditure Panel Surveys (MEPS). MEPS includes data on demographics, health status, and health care use for a nationally representative sample of individual households, supplemented by data from their medical providers. We used the MEPS–Household Component Medical Conditions files to identify children reported to have any chronic condition, categorized using AHRQ’s Chronic Condition Indicator linked to three-digit International Classification of Diseases, Ninth Revision, Clinical Modification, codes. We used AHRQ’s Clinical Classifications Software to separately identify children with asthma, attention deficit hyperactivity disorder (ADHD), developmental disorders (including autism), diabetes, epilepsy, and mood disorders (including both anxiety and major depressive disorder), representing the six most common childhood chronic conditions in the sample, collectively accounting for more than two-thirds of children with any chronic condition. We conducted analyses for children with any chronic condition and separately for children with each of the six conditions. In a sensitivity analysis, we also conducted analyses for 4,734 children identified as having special health care needs, using the screener included in MEPS that uses the definition for children with special health care needs established by the Maternal and Child Health Bureau. We used the MEPS–Household Component Full-Year Consolidated file and Event files to identify utilization (encounters/units and expenditure) for each of the thirty-four benefit categories (see Appendix Exhibit B). Expenditure represented the total amount paid collectively by the insurer and out of pocket by the household for each service, inflated to 2016 dollars.

**Simulation Model** We constructed a model to simulate mean annual out-of-pocket spending incurred by the standard cohort comparing enrollment in CHIP and Marketplace plans at each income level. The unit of analysis was the child/income/plan level, whereby each child was alternatively “enrolled” in each of the 1,157 income-level/plan combinations (1,056 Marketplace and 101 CHIP). Analysis was conducted at the national level and stratified by Medicaid-expansion and freestanding CHIP states. Next, we calculated the percentage of plans at each income level that generated out-of-pocket spending exceeding 5 percent of the median family income at each income category. This value approximates the maximum cost-sharing threshold currently allowable under CHIP. We also separately calculated out-of-pocket spending incurred through the use of each service category. Next we modeled two alternative scenarios, comparing the standard model (full deductible) to a scenario whereby the child’s expenditures are not subject to any deductible (no deductible), or whereby the child would be enrolled in a family plan along with their parent(s) (shared deductible). Under the “shared deductible” scenario, the health care spending for each child’s parent(s) contributes first to the deductible; the child’s spending contributes only at the margin. Finally, we calculated total expenditures for each study cohort. Additional detail on the simulation approach is described in Appendix Exhibit H.

**Statistical Analysis** All analyses were conducted using Stata statistical software, version 14. Sample means were weighted by the MEPS child sample weight, with further weighting by the population of the state (CHIP) or rating area.
(Marketplace) relative to the total population at each income level. We used the adjusted Wald test to assess differences in the main outcome measures comparing CHIP and Marketplace plans at each income level. Statistical comparisons adjusted for the complex survey design of MEPS.

**Limitations** Our study had a number of limitations. We assumed that when children were enrolled in a Marketplace plan, it was the benchmark plan in their rating area; however, the benchmark plan might not be the most frequently selected plan in the rating area. Prior evaluations have also used the benchmark plan given its unique role in setting the premium tax credit subsidy for the rating area. We limited our analysis to the federally facilitated Marketplace, and our results might not reflect differences between CHIP and Marketplace plans in states operating state-based Marketplaces. We defined our standard cohort on the basis of income, not insurance, because MEPS data do not identify which children were enrolled in CHIP versus Medicaid or which children might become eligible for Marketplace subsidies. Furthermore, we kept health care utilization constant across plans; however, in reality, utilization is responsive to differences in cost sharing and would likely vary across plan types. We did this to avoid conflating the effect of insurance enrollment with behavioral responses to different levels of cost sharing. Lastly, we simulated out-of-pocket expenses for a single chronically ill child. While we did assess cost sharing in a parent-child household, we did not account for spending by the other children in the household.

**Study Results**

The standard cohort included 7,266 children with one or more chronic conditions, representing an average of 10.9 million children annually. Among children with a chronic condition, asthma was the most common, representing 29 percent of the sample, followed by ADHD (20 percent) and mood disorders (13 percent). A detailed description of the demographic characteristics of the standard cohort is available in Appendix Exhibit C.

**Total Annual Health Care Expenditures**

Children with any chronic condition incurred, on average, $3,361 (95 percent confidence interval: $2,811, $3,918) in annual health care expenditures. Prescription drugs (29 percent), inpatient hospitalization (20 percent), and professional services (20 percent) were the largest expenditure categories. A detailed description of health expenditures by benefit category and chronic condition is available in Appendix Exhibit D.

**Health Plans**

Marketplace plans’ cost-sharing elements differed from those of CHIP plans along a number of dimensions. For example, Marketplace plans often included deductibles, which were rare in CHIP plans. Between 60 percent (100–150 percent of poverty) and 93 percent (201–250 percent of poverty) of Marketplace plans used deductibles (Exhibit 1). The deductible levels in Marketplace plans increased with increasing family income, starting at an average deductible of $178 (100–150 percent of poverty) and rising to $3,126 (251–400 percent of poverty). Annual maximum out-of-pocket caps were higher for Marketplace plans at family incomes above 200 percent but lower for CHIP plans be-

### Exhibit 1

Cost-sharing elements of Marketplace benchmark plans and Children’s Health Insurance Program (CHIP) plans, 2016

<table>
<thead>
<tr>
<th></th>
<th>Family income as percent of federal poverty level</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>100–150%</td>
</tr>
<tr>
<td><strong>Marketplace Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Number of plans</td>
<td>404</td>
</tr>
<tr>
<td>Number of plans with deductible (%)</td>
<td>242 (60%)</td>
</tr>
<tr>
<td>Deductible amount, mean</td>
<td>$178</td>
</tr>
<tr>
<td>Maximum out-of-pocket cap, mean</td>
<td>$840</td>
</tr>
<tr>
<td><strong>CHIP Plans</strong></td>
<td></td>
</tr>
<tr>
<td>Number of plans</td>
<td>36</td>
</tr>
<tr>
<td>Number of plans with deductible (%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Deductible amount mean</td>
<td>$1</td>
</tr>
<tr>
<td>Maximum out-of-pocket cap mean</td>
<td>$1,305</td>
</tr>
</tbody>
</table>

**Source** Authors’ analysis data from the 2016 Centers for Medicare and Medicaid Services’ health insurance Marketplace public use files and each participating state’s current CHIP plan and Member Handbook. **Notes** Includes states participating in both the federally facilitated health insurance Marketplace and CHIP in each income category. For Marketplace plans, the authors selected the second-lowest-price silver qualified health plan (the benchmark plan) in each geographic rating area. For CHIP plans, the maximum out-of-pocket cap was set to 5 percent of the family income unless specified otherwise by the plan. *All CHIP plans at this family income level do not include deductibles.*
low that level.

**Average Annual Out-of-Pocket Spending**

Simulated annual out-of-pocket spending for children with a chronic condition was higher under Marketplace plans compared with CHIP plans at every income level. The mean difference in annual out-of-pocket spending between Marketplace and CHIP plans ranged between $233 (Marketplace: $259 versus CHIP: $26; \( p < 0.001 \)) at family income level 100–150 percent of poverty to $1,078 (Marketplace: $1,152 versus CHIP: $74; \( p < 0.001 \)) at family income level 251–400 percent of poverty (Exhibit 2; Appendix Exhibit E). The Marketplace-CHIP difference ranged between $98 and $259 higher in Medicaid-expansion CHIP programs as compared with freestanding CHIP programs (see Appendix Exhibit F).

Annual out-of-pocket spending was significantly higher under Marketplace plans compared with CHIP plans for children with each of the six chronic conditions, across all four income categories (Exhibit 2) \( (p < 0.001 \) for all). Similar results were observed when comparing mean annual out-of-pocket spending under Marketplace and CHIP plans for children with special health care needs (see Appendix Exhibit E). Among children with specific chronic conditions, those with epilepsy experienced the largest increase in annual out-of-pocket spending when enrolled in Marketplace plans, compared to CHIP, with the difference ranging from $416 (100–150 percent of poverty) to $2,472 (251–400 percent of poverty) (Exhibit 2). A full listing of out-of-pocket expenditures by condition is in Appendix Exhibit E.

**Out-of-Pocket Spending by Plan Service Category** For children with any chronic condition, out-of-pocket spending associated with prescription drugs (25 percent) and inpatient hospitalizations (23 percent) accounted for the majority of the Marketplace-CHIP difference. There was variation across conditions in service-specific out-of-pocket spending (Exhibit 3). For example, among children with asthma or ADHD, the predominant source of higher out-of-pocket spending under Marketplace plans was cost sharing for prescription drugs, whereas for children with diabetes, epilepsy, or mood disorders, the predominant source of that spending was

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**Exhibit 2**

Annual out-of-pocket spending for children with chronic conditions when enrolled under Marketplace plans compared to Children’s Health Insurance Program (CHIP) plans, by family income level.

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**Source** Authors’ simulation of annual out-of-pocket spending based on health plan benefit data culled from 2016 federally facilitated Marketplace benchmark plans and each participating state’s current CHIP plan and Member Handbook, and based on health care utilization data from the Agency for Healthcare Research and Quality’s Medical Expenditure Panel Surveys (2008–13).

**Notes** The exhibit displays the spending difference a family would pay when enrolling a child in a Marketplace plan compared to what the family would spend for CHIP coverage for that child. All comparisons of out-of-pocket spending under Marketplace versus CHIP plans are statistically significant at \( p < 0.001 \). ADHD is attention deficit hyperactivity disorder. FPL is federal poverty level.
cost sharing for inpatient hospitalization. For children with developmental disorders, the majority of their out-of-pocket spending under Marketplace plans came from their use of therapeutic services.

**Marketplace Plans With Out-of-Pocket Spending Exceeding 5 Percent of Income**

We then calculated the proportion of children expected to incur out-of-pocket expenses under Marketplace plans exceeding 5 percent of their family gross income (the maximum currently allowed under CHIP). At family income level 201–250 percent of poverty, nearly one in five (18 percent) Marketplace plans generated expected out-of-pocket spending exceeding 5 percent of family income for children with any chronic conditions. At this family income level, nearly half of Marketplace plans covering children with epilepsy (48 percent) or diabetes (44 percent) and one-third of Marketplace plans covering children with developmental disorders (33 percent) were simulated to generate out-of-pocket spending in excess of 5 percent of the family income. Considerably fewer Marketplace plans yielded simulated out-of-pocket spending in excess of 5 percent of family income at incomes above 250 percent of poverty or below 201 percent of poverty (Exhibit 4).

**Role of Deductibles in Determining Cost Sharing in Marketplace Plans**

We then compared the Marketplace-CHIP difference in out-of-pocket spending for children with any chronic conditions in the baseline scenario: ($233 [100–150 percent of poverty], $491 [151–200 percent of poverty], $1,032 [201–250 percent poverty], and $1,078 [251–400 percent of poverty]), which were calculated using the cost-sharing levels presented in Exhibit 1, with the shared-deductible and no-deductible scenarios. When we assumed that each index child was enrolled in a Marketplace plan along with their parents (shared-deductible scenario) the Marketplace-CHIP difference remained similar to the baseline scenario at the lower income levels: $191 (100–150 percent of poverty) and $397 (151–200 percent of poverty) but decreased considerably at the higher income levels: $621 (201–250 percent poverty) and $660 (251–400 percent of poverty). When we exempted the index child entirely from the plan deductible (for example, to model a scenario in which the child’s family members use up the entire plan deductible and the costs for the child were no longer subject to the deductible) the Marketplace-CHIP difference decreased even further and across all income levels: $150 (100–150 percent of poverty), $227 (151–200 percent of poverty), $370 (201–250 percent of poverty), and $454 (251–400 percent of poverty) (see Appendix Exhibit G).

**Discussion**

More than eight million children risk having their health insurance coverage disrupted if fed-

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**EXHIBIT 3**

Differences between out-of-pocket spending in Marketplace plans and that in Children’s Health Insurance Program (CHIP) plans, by service category

**Source** Authors’ simulation of annual out-of-pocket spending based on health plan benefit data culled from 2016 federally facilitated Marketplace benchmark plans and each participating state’s current CHIP plan and Member Handbook, and based on health care utilization data from the Agency for Healthcare Research and Quality’s Medical Expenditure Panel Surveys (2008–13). **Notes** The exhibit depicts the difference in simulated annual out-of-pocket spending between Marketplace and CHIP plans for each health plan benefit category. Deductibles and maximum out-of-pocket caps were ignored for this calculation. ADHD is attention deficit hyperactivity disorder.
Marketplace plans with annual out-of-pocket spending greater than 5 percent of family income, by family income level and child's chronic condition

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Any chronic condition</th>
<th>Asthma</th>
<th>ADHD</th>
<th>Developmental disorders</th>
<th>Diabetes</th>
<th>Epilepsy</th>
<th>Mood disorders</th>
</tr>
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<tbody>
<tr>
<td>100–150% FPL</td>
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<td><img src="image2" alt="Diagram" /></td>
<td><img src="image3" alt="Diagram" /></td>
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<tr>
<td>151–200% FPL</td>
<td><img src="image8" alt="Diagram" /></td>
<td><img src="image9" alt="Diagram" /></td>
<td><img src="image10" alt="Diagram" /></td>
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<tr>
<td>201–250% FPL</td>
<td><img src="image15" alt="Diagram" /></td>
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<tr>
<td>251–400% FPL</td>
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<td><img src="image27" alt="Diagram" /></td>
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**Source:** Authors’ simulation of annual out-of-pocket spending based on health plan benefit data culled from 2016 federally facilitated Marketplace benchmark plans and current Children’s Health Insurance Program state plans and Member Handbooks, and based on health care utilization data from the Agency for Healthcare Research and Quality’s Medical Expenditure Panel Surveys (2008–13).

**Notes:** The exhibit depicts the percentage of Marketplace plans in each income group that yielded simulated annual out-of-pocket expenses in excess of 5 percent of the median income amount for income category, as calculated based on the 2016 Department of Health and Human Services federal poverty level (FPL) guidelines for a family of three. ADHD is attention deficit hyperactivity disorder.

General funding for CHIP is not extended beyond 2017. As Congress considers alternatives for providing affordable health insurance coverage for these children, special attention to the out-of-pocket spending burdens faced by their families is needed. Our results suggest that CHIP plans offer much greater cost-sharing protections than Marketplace plans for children with chronic conditions. Moreover, at family income levels above 200 percent of poverty, despite the Marketplace cost-sharing reductions, children with chronic conditions will still experience dramatically higher out-of-pocket expenses under Marketplace plans, compared to CHIP plans. Among children with common childhood conditions, those with developmental disorders, diabetes, or epilepsy might be the most vulnerable to high out-of-pocket expenses under Marketplace plans. Higher cost sharing under Marketplace plans for prescription drugs and inpatient hospitalizations accounts for much of the difference between the two programs.

Recent analyses published by the Medicaid and CHIP Access and Payment Commission and the Department of Health and Human Services have also raised concerns about higher out-of-pocket spending burdens under Marketplace plans as compared to CHIP plans, for both all children and children with special needs.14,15 Our results extend these findings by uniquely describing variation in cost sharing across common childhood conditions. In addition, by modeling out-of-pocket expenses using detailed health plan benefit data, we can better account for plan-level variation in coverage of health benefits that are used disproportionately by children.19 Finally, by identifying the cost-sharing elements that contribute the most to the Marketplace-CHIP difference, we can provide important insights to policy makers as they design alternatives to CHIP in the event that federal funding for the program is not extended.

**Three Potential Modifications** We present three potential modifications to existing Marketplace plans that might increase the comparability with CHIP:

▸ **Adjust Cost-Sharing Protections:** First, cost-sharing reductions currently included in Marketplace plans for families with incomes below 250 percent of poverty still leave families at risk for high out-of-pocket spending. This is most notable at incomes between 200 percent and 250 percent of poverty, in which the cost-sharing supports are only modestly better than unsubsidized Marketplace plans. Enhancements to cost-sharing protections at these income levels might help close the gap between Marketplace and CHIP plans, particularly for families with slightly higher income levels.

▸ **Examine Spending for Drugs and Hospitalizations:** Second, copayments for prescription drugs and inpatient hospitalizations are the predominant drivers of the difference in cost sharing between Marketplace and CHIP plans. Cost sharing for these two services, collectively, accounts for approximately half of the Marketplace-CHIP difference. Continued growth in prescription drug and hospitalization prices, without limitations placed on cost sharing for these services, will likely translate into progressively higher out-of-pocket cost burdens in the coming years in private health plans. As policy makers consider new coverage models for low-income children, they should devote special attention to out-of-pocket spending burdens for prescription drugs and hospitalizations.

▸ **Monitor Use of Deductibles:** Third, Marketplace and CHIP plans differ vastly in their use of deductibles for determining overall beneficiary cost sharing. CHIP plans rarely include deductibles, and when they are included, the amounts are nominal. Marketplace plans often include deductibles, and the amounts for the deductibles often constitute substantial expense for families. There are concerns that high deductibles may cause parents of children with chronic conditions to delay, or even forgo, necessary care.27 As deductibles continue to rise, close monitoring for any adverse impacts on afford-

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**Source:** Authors’ simulation of annual out-of-pocket spending based on health plan benefit data culled from 2016 federally facilitated Marketplace benchmark plans and current Children’s Health Insurance Program state plans and Member Handbooks, and based on health care utilization data from the Agency for Healthcare Research and Quality’s Medical Expenditure Panel Surveys (2008–13).

**Notes:** The exhibit depicts the percentage of Marketplace plans in each income group that yielded simulated annual out-of-pocket expenses in excess of 5 percent of the median income amount for income category, as calculated based on the 2016 Department of Health and Human Services federal poverty level (FPL) guidelines for a family of three. ADHD is attention deficit hyperactivity disorder.
Reauthorizing funding for CHIP is most likely the least disruptive strategy moving forward.

Specific Family Contexts Our main results assess the spending for children with chronic health conditions relative to each plan’s individual deductible and out-of-pocket maximum, assuming enrollment in an individual plan. We used this approach to illustrate the potential out-of-pocket spending for children with specific conditions in CHIP compared to Marketplace plans. However, family Marketplace plans commonly have family-level deductibles and out-of-pocket maximums equivalent to twice the individual levels. As a result of these family caps, the marginal out-of-pocket spending associated with services for any individual child will be affected by the context—whether they are enrolled in a single child plan or added to a family plan with parents, siblings, or both, and what those other family members will contribute to spending. While it is difficult to explicitly model out-of-pocket spending for a specific child in this family context (after all, who is the marginal enrollee?) we presented two extreme scenarios—one in which the child contributes fully to an individual deductible and out-of-pocket maximum (the main results) and one in which the child contributes nothing to the family deductible. We also presented a shared-deductible scenario, assuming that the child is enrolled with his or her parents. As expected, this scenario resulted in intermediate spending estimates, particularly at higher income levels. Because the family context varies by child, we chose to focus on the single child scenario but acknowledge that it represents an upper-bound estimate of the difference in family out-of-pocket spending burden for each child. Future studies are needed to assess the impact of familial insurance concordance and the role of individual and family deductibles on determining spending burdens in Marketplace plans.

Premium Costs Similarly, we focused specifically on out-of-pocket expenses and did not assess the cost of plan premiums. In our sample, unsubsidized Marketplace plan monthly premiums were much higher than CHIP premiums ($154 versus $19). However, as noted previously, context matters. The marginal premium for a child in a Marketplace plan similarly depends on the family context. Many families insured on the Marketplaces currently qualify for premium tax credits that are proportionate to the family’s income; thus, the actual premium contribution is lower for most families. Furthermore, the incremental cost of adding a child to a family plan might fit under the family’s premium tax credit. As a result, assuming the premium tax credits remain intact, families might find themselves paying as much as $135, or as a little as $0, more in monthly premiums if they transition to a Marketplace plan.

Other Factors Several factors that we did not analyze might also contribute to differences in cost sharing between CHIP and Marketplace plans. We did not account for payer- and provider-based care management activities (that is, patient-centered medical homes), which could improve care and translate into lower health care use in selected plans. We also did not account for utilization management techniques such as setting more aggressive visit limits or prior authorization for selected services. We assumed that children would receive all needed services from in-network providers; however, in reality, families could encounter networks that are inadequate to meet their children’s specialty care needs and lead to even higher out-of-pocket expenses. Thus, our results call for additional research into the adequacy of physician networks in Marketplace plans and the role of network inadequacy on out-of-pocket spending burdens.

The generalizability of our study might be affected by our assumption that rollbacks would immediately occur in states operating freestanding and Medicaid-expansion CHIP programs alike. Maintenance-of-effort requirements, put in place by the ACA, prohibit states operating Medicaid-expansion CHIP programs from rolling back existing coverage levels until 2019. However, these could be lifted as part of efforts to repeal the ACA. The Marketplace-CHIP difference in out-of-pocket spending was greater among Medicaid-expansion CHIP programs than it was for freestanding CHIP programs, largely as a result of the lower cost sharing imposed by states that operate Medicaid-expansion CHIP programs, which by statute must abide by more stringent cost-sharing rules. It is important to note, however, that our limited sample is not representative of all states operating Medicaid-expansion CHIP programs since not all participate in the federal Marketplace.

Furthermore, we assumed enrollment in Mar-
Marketplace cost-sharing reductions at all family incomes below 250 percent of poverty; however, in the event of CHIP disenrollment, many children could be ineligible to qualify for subsidies because of the "family glitch." Families are eligible for subsidies in the Marketplace if they do not have access to an affordable plan from an employer. However, the determination of whether a plan offered by an employer is affordable is based on the premium for an individual plan, not that for a family plan. It is estimated that nearly two million children currently insured under CHIP will not be able to access Marketplace subsidies as a result of this family glitch. Families affected by the glitch could still purchase unsubsidized Marketplace plans for their children; however, in the absence of the subsidies, it is not clear that they could do so affordably. The results in the unsubsidized Marketplace plans (251–400 percent of poverty) might be our best approximation of cost sharing in private health plans under this scenario.

Finally, it is important to note that efforts to repeal the ACA could affect both Marketplace and state CHIP plans. If the Marketplace tax credits for premiums or the cost-sharing reductions, or both, are discontinued or replaced with less generous alternatives, the cost of health insurance coverage in Marketplace plans might become prohibitive to many families of children with chronic conditions. Under the ACA, the federal government increased its already enhanced rate at which it reimbursed the states for CHIP services. Reductions to this enhanced federal matching rate for CHIP services (23 percentage points) or elimination of the maintenance-of-effort restrictions, or both, both currently in place through 2019, could prompt states to employ higher cost sharing on covered services, impose quantity limits on selected services, or reduce eligibility in their CHIP plans. Finally, efforts to transition federal funding for CHIP or Medicaid, or both, into a per capita-based cap on payments might affect states' strategies for program delivery.

Conclusion

More than eight million children could have their health insurance disrupted if federal funding for CHIP is not extended. In this study we explored policy alternatives of extending federal funding for CHIP or enrolling children in the existing health insurance Marketplace. As currently configured, both CHIP and Marketplace plans offer generous protections against high out-of-pocket expenses compared to being uninsured. When comparing CHIP and Marketplace plans, at all income levels, CHIP provides better protections against high out-of-pocket spending for families of children with chronic conditions.

The results of our study point to several strategies that policy makers might consider to enhance the financial protections offered by Marketplace plans for children—in particular, children in families with incomes above 200 percent of poverty. However, these strategies presume a robust health insurance Marketplace and small modifications to the ACA. Given concerns about the viability of the Marketplace, the legal battles regarding the cost-sharing reduction payments, and the efforts to repeal the ACA, re-authorizing funding for CHIP is most likely the least disruptive strategy moving forward.

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NOTES

enrollment-period-january-enrollment-report


23 To access the Appendix, click on the Appendix link in the box to the right of the article online.


