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Report to Congressional Requesters

February 2015

CHILDREN'S HEALTH INSURANCE

Coverage of Services and Costs to Consumers in Selected CHIP and Private Health Plans in Five States

GAO-15-323

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GAO Highlights

Highlights of GAO-15-323, a report to congressional requesters

Why GAO Did This Study

Federal funds appropriated to states for CHIP—the jointly financed health insurance program for certain low-income children—are expected to be exhausted soon after the end of fiscal year 2015 unless Congress acts to appropriate new funds. Beginning in October 2015, any state with insufficient CHIP funding must establish procedures to ensure that children who are not covered by CHIP are screened for Medicaid eligibility. If ineligible, children may be enrolled into a private qualified health plan—or QHP—that has been certified by the Secretary of Health and Human Services (HHS) as comparable to CHIP, if such a QHP is available.

GAO was asked to examine coverage and costs to consumers in selected CHIP plans and private QHPs in selected states. GAO reviewed (1) coverage and (2) costs to consumers for one CHIP plan, one QHP, and, where applicable, one SADP in each of five states—Colorado, Illinois, Kansas, New York, and Utah. State selection was based on variation in location, program size, and design; CHIP plan selection was based on high enrollment; and QHP selection was based on low plan premiums. GAO obtained CHIP and QHP premium data from state officials and federal and state websites. GAO also obtained documents from and spoke to federal officials, including from HHS's Assistant Secretary for Planning and Evaluation, state officials, including from CHIP and insurance departments, and issuers of QHPs.

HHS provided technical comments on a draft of this report, which GAO incorporated as appropriate.

View GAO-15-323. For more information, contact Katherine Iritani at (202) 512-7114 or iritanik@gao.gov.

What GAO Found

In five selected states, GAO determined that coverage of services in the selected State Children's Health Insurance Program (CHIP) plans was generally comparable to that of the selected private qualified health plans (QHP), with some differences. In particular, the plans were generally comparable in that most covered the services GAO reviewed with the notable exceptions of pediatric dental and certain enabling services such as translation and transportation services, which were covered more frequently by the CHIP plans. For example, only the selected QHP in New York covered pediatric dental services; the QHPs in the other four states did not include pediatric dental services, although some officials indicated this would change for 2015 offerings. In those four states, stand-alone dental plans (SADP) could be purchased separately. Selected CHIP plans and QHPs were also similar in terms of the services on which they imposed day, visit, or dollar limits, although the five selected CHIP plans generally imposed fewer limits than the selected QHPs. For services where coverage limits were sometimes imposed on QHPs and CHIP plans, GAO's review found that the limits on CHIP plans were at times less restrictive. For example, the selected QHP in Utah limited home- and community-based health care services to 60 visits per year while the selected CHIP plan did not impose any limits. In addition, for pediatric dental services, coverage limits in the selected SADPs were generally similar to those in the selected CHIP plan; however, when there were differences, CHIP was generally more generous.

Consumers' costs for these services—defined as deductibles, copayments, coinsurance, and premiums—were almost always less in the five states' selected CHIP plans when compared to their respective QHPs, despite the application of subsidies authorized under the Patient Protection and Affordable Care Act (PPACA) that reduce these costs in the QHPs. Specifically, when cost-sharing applied, the amount was typically less for CHIP plans, even considering PPACA provisions aimed at reducing cost-sharing amounts for certain low income consumers who purchased QHPs. For example, an office visit to a specialist in Colorado would cost a CHIP enrollee a $2 to $10 copayment per visit, depending on their income, compared to the lowest available copayment of $25 per visit in the selected Colorado QHP. GAO's review of premium data further suggests that selected CHIP premiums were always lower than selected QHP premiums, even when considering the application of PPACA subsidies that help to defray the cost to certain consumers. For example, the 2014 annual premium for the selected Illinois CHIP plan for an individual at 150 percent of the federal poverty level (FPL) was $0. By comparison, the 2014 annual premium for the selected Illinois QHP was $1,254, which was reduced to $944 for an individual at 150 percent of the FPL, after considering federal subsidies to offset the cost of coverage. Finally, all selected CHIP plans and QHPs GAO reviewed limited out-of-pocket maximum costs, and these maximum costs were typically less in the CHIP plans.

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Abbreviations

ASPE	Assistant Secretary for Planning and Evaluation
AV	actuarial value
CHIP	State Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
EHB	essential health benefits
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FPL	federal poverty level
HHS	Department of Health and Human Services
MAGI	Modified Adjusted Gross Income
PPACA	Patient Protection and Affordable Care Act
QHP	qualified health plan
SADP	stand-alone dental plan

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February 25, 2015

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
House of Representatives

Federal funding appropriated to states to support the State Children's Health Insurance Program (CHIP), a joint federal-state program that was established in 1997 to provide health coverage to certain low-income children, will end after September 2015 unless Congress acts to appropriate new funds. CHIP finances health insurance for over 8 million children whose household incomes are too high for Medicaid eligibility but may be too low to afford private insurance, and federal funds are expected to run out shortly after the end of fiscal year 2015.[1] Since January 2014, federal subsidies have been available to qualifying individuals to offset the cost of private health insurance purchased through health insurance exchanges—marketplaces where eligible individuals can compare and select among qualified health plans (QHP) and stand-alone dental plans (SADP) offered by participating private issuers—established under the Patient Protection and Affordable Care

[1]Medicaid is a joint federal-state program that finances health insurance coverage for certain categories of lower-income individuals, including children. Most states' upper income CHIP eligibility levels are between 200 and 300 percent of the federal poverty level (FPL), with the highest eligibility level being 400 percent of the FPL.

Act (PPACA).[2] PPACA also requires that, beginning in October 2015, if a state's CHIP funding is insufficient to cover all CHIP-eligible children, the state must establish procedures to ensure that the children who are not covered by CHIP are screened for Medicaid eligibility. If found ineligible for Medicaid, the children may be enrolled into a QHP that has been certified as comparable to CHIP by the Secretary of Health and Human Services (HHS), if such a QHP is available.[3]

States administer their CHIP programs under broad federal requirements, and programs vary in the services covered and the costs to individuals and families. For example, states can operate CHIP as a separate program, include CHIP-eligible children in their Medicaid program, or do both.[4] HHS' Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing CHIP.

[2]Pub. L. No. 111-148, 124 Stat. 119 (2010). In this report, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), unless otherwise indicated. PPACA required the establishment of health insurance exchanges in each state by January 1, 2014, to allow consumers to compare participating individual health insurance plans, known as QHPs and SADPs, available in that state and enroll in coverage. In states electing not to operate their own exchange, PPACA requires the federal government to establish and operate an exchange in the state, referred to as a federally facilitated exchange. QHPs and SADPs offered in the exchanges must meet certain minimum requirements, including those relating to coverage and cost. The Department of Health and Human Services' Centers for Medicare & Medicaid Services (CMS), which is tasked with overseeing the establishment of exchanges, refers to exchanges as marketplaces.

[3]The Secretary is required to report by April 2015 on comparability of benefits and cost sharing between CHIP and QHPs. As of January 2015, CMS had not issued guidance on how comparability between QHPs and CHIP will be defined. Given the uncertainty regarding the affordability and adequacy of children's coverage outside of CHIP, the Medicaid and CHIP Payment and Access Commission recommended that Congress extend federal CHIP funding for a transition period of 2 years. CHIP regulations also generally require that, for children found ineligible for CHIP, either at the time of initial application or during a follow-up eligibility determination, the state must screen the child for Medicaid eligibility and, if ineligible for Medicaid, the state must then screen for potential eligibility for other insurance affordability programs, including subsidized coverage in a QHP.

[4]As of January 2015, 42 states operated separate CHIP programs (1 state had a separate CHIP program only and 41 states covered CHIP children through both a separate CHIP program and Medicaid.) The number of states that cover CHIP children through both a separate CHIP program and Medicaid increased in 2014 due to federal requirements in PPACA that children ages 6 to18 in families earning under 133 percent FPL must be covered under Medicaid.

In November 2013, we issued a report that compared coverage of services and costs to consumers in separate CHIP plans and plans intended as models for the benefits that would be offered through QHPs, known as benchmark plans, in five states—Colorado Kansas, Illinois, New York, and Utah—and described how coverage and costs might change in 2014.[5] We found that coverage in selected separate CHIP plans was generally comparable to benchmark plans and consumers' costs for these services were almost always less in CHIP than in benchmark plans. We also concluded that uncertainty remained regarding issuer decisions regarding how to define certain covered services and the implementation of other PPACA provisions, such as pediatric dental services, and that further study would be beneficial. At the time, QHPs were not available for study.

Now that QHPs have been made available on the exchanges, you asked us to examine the comparability of benefits and costs to consumers between CHIP plans and QHPs. In this report, we describe (1) how coverage of services in separate CHIP plans compares to QHPs in selected states, and (2) how costs to consumers in separate CHIP plans compare to QHPs in selected states.

To address both objectives, we selected the same health care services we reviewed in our 2013 report, which were identified by reviewing federal statutes and regulations governing CHIP-eligible services and the essential health benefit (EHB) categories, which are those 10 categories

[5]To prepare for the offering of QHPs in 2014, HHS asked states to select benchmark health plans—plans intended as models for the benefits that would be offered through QHPs. Benchmark plans were not models for QHP cost-sharing. Instead, PPACA includes provisions that standardize QHP costs and reduce cost-sharing for certain individuals. GAO, *Children's Health Insurance: Information on Coverage of Services, Costs to Consumers, and Access to Care in CHIP and Other Sources of Insurance*, GAO-14-40 (Washington, D.C.: November 21, 2013).

of service that QHPs are required to cover.[6] In addition to these services, we also identified selected enabling services, which can help individuals access the medical care they need and are recognized by the Health Resources and Services Administration's Maternal and Child Health Bureau as especially important for low income children and those with special health care needs, a significant number of whom rely on Medicaid or CHIP for some or all of their health care coverage.[7] We focused our review on the five states selected for our November 2013 report: Colorado, Kansas, Illinois, New York, and Utah, selected on the basis of variations in CMS region, CHIP program design, and size of enrollment in the separate CHIP program.[8] For these five states, we contacted state officials to identify the separate CHIP plan with the largest enrollment in 2014 and obtained plan coverage and cost sharing information from them for that CHIP plan in each state.

To compare the CHIP plan coverage and costs to that in QHPs, we identified the lowest cost silver level QHP in the most populous county in each of the five states in 2014 by reviewing 2010 Census data and information available on data.healthcare.gov for states with a federally facilitated exchange and from state officials in states operating their own

[6]Based on our review of federal regulation and health plan documents, we identified sub-categories of services for further review. We reviewed the following services: ambulatory patient services (primary care physician and specialist office visits and outpatient surgery); emergency care; inpatient hospital services (facility, professional, and ancillary); maternity care; mental health services (inpatient and outpatient); substance abuse services (inpatient and outpatient); prescription drugs; preventive care (well-child care, immunizations, and chronic disease management); outpatient therapies (physical, speech, and occupational therapies for rehabilitation and habilitation); pediatric dental services (routine, emergency, and other); pediatric vision services (exams and corrective lenses); laboratory services (inpatient and outpatient); pediatric hearing services (testing and hearing aids); durable medical equipment; hospice; and home- and community-based health care.

[7]We limited our review to the following enabling services: office translation services; non-hospice respite care; routine transportation; and care coordination/case management.

[8]These five states cover children through separate CHIP programs and Medicaid; however, for our review, we only examined their separate CHIP programs.

exchanges.[9] We also relied on these data sources to identify the lowest cost SADP in 2014 in each state where the pediatric dental benefit was not included in our selected QHP. We then reviewed Evidences of Coverage from each of the QHPs and SADPs identified to determine whether the services we identified were covered; whether there were any annual limits on those services in terms of days, visits, age, or expenditures; and to identify cost-sharing amounts, including deductibles, copayments, and coinsurance, for each of the services and any stated out-of-pocket maximum costs.[10] We obtained 2014 CHIP premiums from state officials and 2014 QHP premiums from data.healthcare.gov, state websites, and state officials. We also obtained enrollment data for federally facilitated exchange states from HHS's Assistant Secretary for Planning and Evaluation (ASPE).[11] Finally, we interviewed state officials, including from CHIP programs and insurance departments in our five states, officials from an SADP issuer in one of our five states, and representatives from two large issuer associations whose members participate in both CHIP and the marketplaces to obtain their input on the implementation of certain PPACA provisions.

Our coverage and cost comparisons were limited to the selected services, limits, and plans in these five states, and our results cannot be

[9]QHPs must offer coverage that meets one of four metal tier levels—bronze, silver, gold, and platinum—that correspond to plans' actuarial value. We focused our review on silver level plans because reduced cost-sharing is available for eligible individuals enrolled in these plans. Sixty-five percent of QHP enrollees in the 36 federally facilitated exchange states chose a silver-level plan in 2014, according to an Assistant Secretary for Planning and Evaluation (ASPE) enrollment report. See the Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period*, Assistant Secretary for Planning and Evaluation Issue Brief (Washington, D.C.: May 1, 2014).

[10]An Evidence of Coverage document is a comprehensive guide to an enrollee's health care coverage. It explains the benefits and cost-sharing; conditions and limitations of coverage; and plan rules. Our analysis did not include other coverage limits, such as unspecified limits based on medical necessity, expected improvement deadlines (e.g., improvement must be expected within 2 months), and drug day limits (e.g., prescriptions filled for 30 days at a time).

[11]ASPE provided data for the following states: Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, West Virginia Wisconsin, and Wyoming. We did not obtain similar enrollment data from states using their own state-based exchanges.

generalized to other plans or states. To determine the reliability of the information from data.heathcare.gov, we spoke with researchers who have used these data to learn about any potential limitations. To determine the reliability of information from state officials regarding QHP identification and premiums, we interviewed officials regarding the steps they took to assess its reliability. To determine the reliability of enrollment data from ASPE, we interviewed officials regarding the steps they took to assess its reliability, and performed minimal data checks for obvious errors. We did not independently verify the accuracy or completeness of the data beyond these steps. Based on these efforts, we determined that these data sources were sufficiently reliable for the purposes of this report.

We conducted this performance audit from November 2014 to February 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Coverage and Cost Requirements for CHIP

Unlike states that opt to cover CHIP-eligible children in their Medicaid programs and therefore must extend Medicaid covered services to CHIP-eligible individuals, states with separate CHIP programs have flexibility in program design and are at liberty to modify certain aspects of their programs, such as coverage and cost-sharing requirements. However, federal laws and regulations require states' separate CHIP programs to include coverage for routine check-ups, immunizations, emergency services, and dental services defined as "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions." States typically cover a broad array of additional services in their separate CHIP programs and, in some states, adopt the Medicaid requirement to cover Early and Periodic Screening,

Diagnostic and Treatment (EPSDT) services.[12] State CHIP programs must also comply with mental health parity requirements—meaning they must apply any financial requirements or limits on mental health or substance abuse benefits in the same manner as applied to medical and surgical benefits.

With respect to costs to consumers, CHIP premiums and cost-sharing—irrespective of program design—may not exceed amounts as defined by law. States may vary separate CHIP premiums and cost-sharing based on income and family size, as long as cost-sharing for higher-income children is not lower than for lower-income children. Federal laws and regulations also impose additional limits on premiums and cost-sharing for children in families with incomes at or below 150 percent of the federal poverty level (FPL). In all cases, no cost-sharing can be required for preventive services—defined as well-baby and well-child care, including age-appropriate immunizations and pregnancy-related services. In addition, states may not impose premiums and cost-sharing that, in the aggregate, exceed 5 percent of a family's total income for the length of the child's eligibility period in CHIP.[13]

Coverage and Cost Requirements for QHPs

PPACA includes provisions that seek to standardize coverage and costs of private health plans in the individual and small group markets. QHPs offered both on and off the exchanges are required to comply with applicable private insurance market reforms, including relevant premium rating requirements, the elimination of lifetime and annual dollar limits on EHBs, prohibition of cost-sharing for preventive services, mental health parity requirements, and the offering of comprehensive coverage. PPACA allows exchanges in each state to offer coverage of pediatric dental services as an integrated benefit in a QHP or through an SADP, which consumers can purchase separately. In exchanges with at least one participating SADP, QHPs are not required to include the pediatric dental benefit. Some states require children obtaining coverage in their state-based exchanges to enroll in an SADP if their QHP does not include the

[12]EPSDT services include comprehensive screenings, preventive health care services, and other services necessary to correct illnesses or conditions identified by the screenings.

[13]This annual cumulative maximum applies to premiums, deductibles and any applicable cost-sharing requirements, including copayments and coinsurance, irrespective of the number of children in the family who are enrolled in CHIP.

pediatric dental benefit; consumers purchasing coverage in the federally facilitated exchange are not required to do so.[14]

With respect to costs to consumers, QHPs must offer coverage that meets one of four metal tier levels, which correspond to actuarial value (AV) percentages that range from 60 to 90 percent: bronze (AV of 60 percent), silver (AV of 70 percent), gold (AV of 80 percent), or platinum (AV of 90 percent).[15] AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers. Cost-sharing subsidies are available to individuals with incomes between 100 and 250 percent of the FPL to offset the costs they incur through copayments, coinsurance, and deductibles in a silver-level QHP. The cost-sharing subsidies are not provided directly to consumers; instead, QHP issuers are required to offer three variations of each silver plan they market through an exchange in the individual market. These plans are to reflect the cost-sharing subsidies through lower out-of-pocket maximum costs and, if necessary, through lower deductibles, copayments, or coinsurance. Once the adjustments from the subsidies are made, the AV of the silver plan available to eligible consumers will effectively increase from 70 percent to 73, 87, or 94 percent, depending on income. SADPs have different AV requirements than QHPs. SADPs are categorized as “high” and “low” level plans, with 85 and 70 percent AV, respectively.[16] Cost-sharing subsidies are not available for pediatric dental costs incurred by a consumer enrolled in an SADP.

PPACA also provides a premium tax credit to eligible individuals who purchase QHPs through the exchanges and who have incomes that are between 100 and 400 percent of the FPL. Depending on their income, this provision limits the amount families must contribute to QHP premiums to between 2 and 9.5 percent, inclusive, of their annual income; in 2014

[14]In 2014, Kentucky, Nevada, and Washington required children obtaining coverage in their state-based exchanges to enroll in an SADP if their QHP did not include the pediatric dental benefit.

[15]Deductibles, co-pays, coinsurance amounts, and out-of-pocket maximum costs can vary within these plans, as long as the overall cost-sharing structure meets the required AV levels. Plans are allowed a de minimis variation of +/- 2 percent. Premium costs are not included in the AV computation.

[16]Plans are allowed a de minimis variation of +/- 1 percent.

these premium contributions ranged from $471 to $8,949 for a family of four. The premium tax credit is available to eligible consumers regardless of which metal tier they choose; however, the credit is calculated based on the second-lowest cost silver plan in the rating area in which the consumer resides.[17] Unlike cost-sharing subsidies, which generally do not apply to costs incurred for services by a consumer enrolled in an SADP, the maximum contribution amount on premiums includes premiums for both QHPs and SADPs, if relevant.[18]

Finally, PPACA established out-of-pocket maximum costs that apply to EHBs included in QHPs and SADPs. In 2014, these maximum costs for QHPs ranged from $2,250 to $6,350 for individuals and $4,500 to $12,700 for families for households with incomes between 100 and 400 percent of the FPL. Out-of-pocket maximum costs for SADPs are in addition to the out-of-pocket maximum costs for QHPs and were established by each exchange in 2014.

CHIP-Eligible Children and Enrollment in QHPs

CHIP-eligible children may enroll in QHPs instead of enrolling in CHIP—either through a child-only plan or through a plan with other family members—but they are ineligible for premium tax credits and cost-sharing subsidies because of their eligibility for CHIP. However, if a state experiences a CHIP funding shortfall in the future and is therefore unable to enroll all CHIP-eligible children into a CHIP plan, such children may qualify for premium tax credits and cost-sharing subsidies to offset the cost of QHP coverage.[19] In states not experiencing a funding shortfall, enrolling CHIP-eligible children in QHPs would generally increase costs for families. Under CMS regulations, if an individual who is ineligible for

[17]Each state can divide up areas of residence in the state into locations called rating areas, and issuers of QHPs may vary premiums based on rating area.

[18]If an individual who is eligible for premium tax credits enrolls in a QHP and an SADP, the portion of the SADP that is allocable to the pediatric dental EHB must be considered part of the QHP premium to which the individual's premium tax credit applies. However, unless the consumer purchases a QHP with a premium that is less than the second lowest cost silver plan, e.g., a bronze plan, the consumer would likely pay the full premium for the SADP.

[19]This applies only to children enrolled in a separate CHIP plan. In the event of a CHIP funding shortfall, children enrolled in a CHIP-funded Medicaid expansion would remain eligible for Medicaid, at least until fiscal year 2019, during which time states may not reduce Medicaid eligibility levels for children. Children remaining Medicaid eligible would not qualify for premium tax credits or cost-sharing subsidies.

cost-sharing subsidies enrolls in the same policy as another family member who is eligible for cost-sharing subsidies, nobody covered under the policy will qualify for cost-sharing subsidies.[20] As a result, enrolling CHIP-eligible children in QHPs could result in a loss of cost-sharing subsidies for family members that are eligible for these subsidies. To maintain cost-sharing subsidies for eligible family members, the CHIP-eligible child would need to be enrolled in a child-only health plan, for which premium tax credits would be unavailable because of the child's eligibility for CHIP.

[20]77 Fed. Reg. 73118, 73165 (Dec. 7, 2012) (codified at 45 C.F.R. § 155.305(g)(3)). According to CMS, the agency adopted this rule because it would be operationally difficult for an issuer to establish separate cost-sharing amounts for different enrollees covered under the same policy.

In Five States, Coverage in Selected CHIP Plans and QHPs Was Generally Comparable, Although the CHIP Plans More Commonly Covered Dental and Certain Enabling Services and Had Fewer Coverage Limits

We determined that coverage in the selected CHIP plans and QHPs in our five states was generally comparable in that it included some level of coverage for nearly all the services we reviewed.[21] Notable exceptions were certain enabling services and pediatric dental services, which were more frequently covered by the selected CHIP plans.[22] (See app. I for a detailed list of selected services covered by the plans we reviewed.) With respect to certain enabling services, which may be particularly important for low income children, care coordination or case management was offered by all selected CHIP plans, but by only one selected QHP. Similarly, routine transportation to and from medical appointments was covered by two CHIP plans but by none of the selected QHPs.[23] With respect to pediatric dental services, the QHP in New York was the only selected QHP that covered them; the selected QHPs in the other four states did not integrate pediatric dental services within the medical coverage they offered.[24] To obtain coverage for pediatric dental services, consumers who purchased the selected QHP in these states would also need to purchase an SADP. For consumers who purchased the selected QHP in New York or the selected SADP in the other four states, we determined that pediatric dental coverage available was generally comparable to what was available in their state's selected CHIP plan, with

[21]Officials from each of the selected states reported that they had not undertaken efforts to compare CHIP and QHP coverage and costs.

[22]Additionally, habilitative services were not covered by the selected CHIP plan in Kansas.

[23]Selected CHIP plans and QHPs were similar in that most did not cover non-hospice respite care.

[24]We refer to pediatric dental services as those other than non-emergency dental only. Officials from two large national issuer associations noted several factors that may have contributed to their QHP issuers' decisions not to include coverage for pediatric dental services in 2014, including lack of experience offering these services, concerns about how the additional cost of providing these services could affect their competitiveness, and the option to not provide them if an SADP was available in the state. QHP offerings may be different in 2015, however. According to Colorado officials, more QHPs in their state have included pediatric dental services in 2015 than did in 2014 primarily because of administrative simplification. Additionally, plan officials for the Utah SADP told us the selected SADP would be discontinued at the end of 2014, as the dental benefits offered would be embedded in the issuer's medical plans in 2015.

the exception of Utah, where the selected CHIP plan was more generous than the selected SADP.[25]

However, the extent to which consumers obtained coverage that included pediatric dental services is not clear. Available federal data with information on QHP enrollment suggest that many children in the United States with exchange coverage in 2014 may have been without comprehensive dental coverage. According to our analysis of enrollment data for 2014 provided by ASPE, 16 percent of children younger than 18 years of age in the 36 states with federally facilitated exchanges were enrolled in a QHP that included comprehensive dental services that covered check-ups, basic, and major dental services.[26] The remaining children were enrolled in QHPs that either had less than comprehensive or no dental coverage. Some of these families are likely to have purchased an SADP for their children, however. According to an ASPE report issued in May 2014, 18 percent of children younger than 18 years of age in the 36 states with federally facilitated exchanges who enrolled in a QHP also enrolled in an SADP, and these were likely among the families that had no comprehensive dental coverage included in their QHP.[27] According to our analysis of enrollment data for 2014 provided by ASPE, virtually no children younger than 18 years of age in the 36 states with federally facilitated exchanges were enrolled in a QHP that included comprehensive dental services and an SADP.

Selected CHIP plans and QHPs were also similar in terms of the services on which they imposed day, visit, or dollar limits; however, in the aggregate, CHIP plans imposed fewer limits than QHPs. (See fig.1.) The selected CHIP plans and QHPs we reviewed were generally similar in that they typically did not impose day, visit, or dollar limits on office visits, emergency care, prescription drugs, and preventive care, but commonly

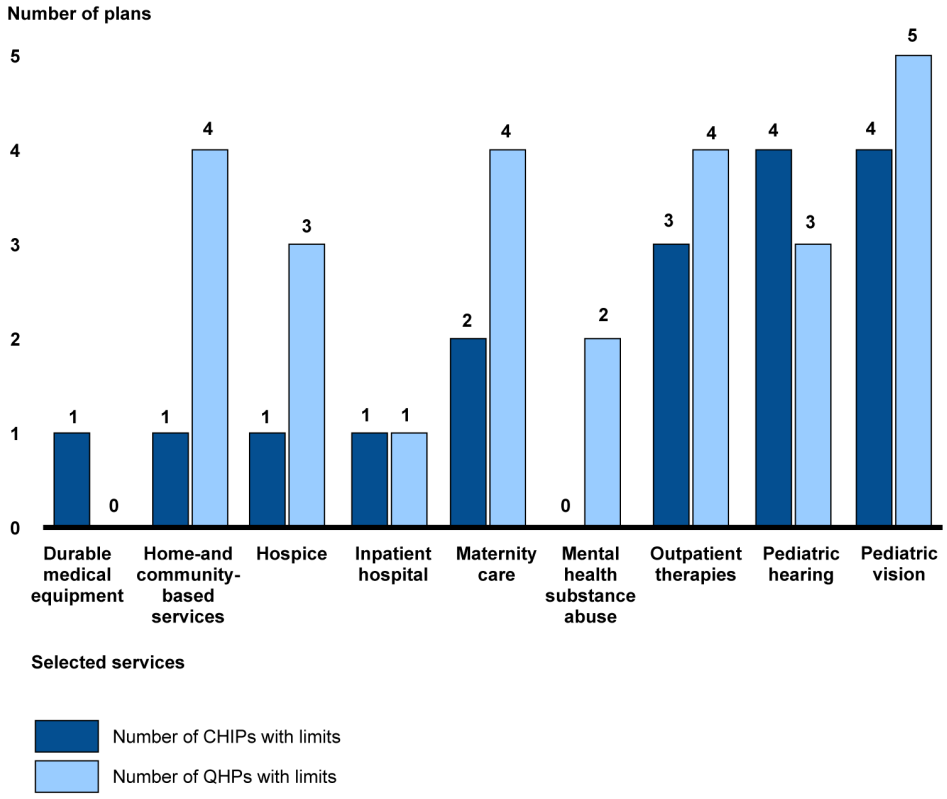
[25]Each state's CHIP was the model for dental benefits in Colorado, Illinois, Kansas, and New York QHPs and SADPs in 2014. Utah's benchmark plan was the model for dental benefits in Utah's QHPs and SADPs.

[26]According to CMS, a QHP must offer check-ups, basic, and major dental services to be considered a QHP with embedded dental coverage. According to our analysis of enrollment data for 2014 provided by ASPE, less than half of the QHPs in a given state offered any type of dental coverage—checkups, basic, or major dental services—in two thirds of states with federally facilitated exchanges.

[27]See Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report.*

did impose limits on outpatient therapies, pediatric vision, and pediatric hearing. One notable difference between these selected CHIP plans and QHPs was the frequency by which they limited home-and community-based health care. While the selected QHP in four states imposed day or visit limits on these services, only one state's selected CHIP plan did so. In contrast, no QHPs imposed limits on durable medical equipment, while one CHIP plan imposed a $2,000 annual limit.

Figure 1: Selected Services with Coverage Limits in State Children's Health Insurance Program (CHIP) Plans and Qualified Health Plans (QHP) GAO Reviewed in Five States, Calendar Year 2014



Source: GAO analysis of information from states and QHPs. | GAO-15-323

Note: We did not identify any limits on the following services in the selected CHIP plans and QHPs: office visits, emergency care, prescription drugs, preventive services, and when covered, enabling services. Coverage limits on pediatric dental services are excluded from this table because the selected QHP in four of the five states did not cover pediatric dental services.

For services where coverage limits were sometimes imposed on QHPs and CHIP plans, our review found that the limits on CHIP plans were at times less restrictive. For example, the selected QHP in Utah limited home- and community-based health care services to 60 visits per year while the selected CHIP plan in the state did not impose any limits on these services. Comparability between service limits in states' selected CHIP plans and QHPs was less clear for outpatient therapy services. For example, the selected CHIP plan in New York limited outpatient physical and occupational therapies to 6 weeks per year, with no limits on outpatient speech therapy, while the selected QHP in the state limited outpatient therapies to a combined 60 visits per condition per lifetime. (See app. II for a detailed list of coverage limits for services we reviewed in the selected plans.)

In addition, for pediatric dental services, coverage limits in the selected QHP and SADPs were generally similar to those in the selected CHIP plan; however, when there were differences, CHIP was generally more generous. For example, the selected CHIP plan in Kansas allowed one sealant per tooth per year; in contrast, the selected high and low SADP in the state allowed one sealant per tooth every three years. Similarly, the selected CHIP plan in Utah did not have any coverage limits on x-rays while the selected high and low SADPs in the state did. (See app. III for a detailed list of selected dental limits we reviewed in selected plans.)

Costs to Consumers Were Almost Always Less in Selected CHIP Plans Than in Selected QHPs Despite PPACA Provisions That Limit QHP Costs

We determined that costs to consumers were almost always less in the selected CHIP plans than in the selected QHPs. Even considering PPACA provisions aimed at reducing cost-sharing amounts for certain low-income consumers who purchased QHPs, the differences remained, though were smaller. For example, the selected CHIP plans in four of the five states did not include any deductible, which means that enrollees in those states did not need to pay a specified amount before the plan began paying for services.[28] In contrast, QHPs we reviewed typically imposed annual deductibles, which were as high as $500 for an individual and $1,500 for a family in the plan variation that offered the lowest available deductibles for QHP enrollees.[29] In addition, consumers who purchase selected SADPs may face separate deductible costs. For example, whereas dental services were subject to the plan deductible in the New York QHP, SADPs in Colorado, Illinois, and Kansas had separate dental deductibles that ranged from $25 to $50 for individuals enrolled in selected high plans to $45 to $50 for individuals enrolled in selected low plans. (See app. III for a detailed list of selected dental cost-sharing we reviewed in the selected plans.)

For services we reviewed where the plans imposed copayments or coinsurance, the amount was typically less in a state's selected CHIP plan compared to its selected QHP, even considering PPACA provisions aimed at reducing cost-sharing amounts for certain low income consumers who purchased QHPs.[30] For example, the selected CHIP plan in two of our five states – Kansas and New York – did not impose copayments or coinsurance on any of the services we reviewed. In two of the remaining three states, the selected CHIP plan imposed copayments or coinsurance on less than half of the services we reviewed, and the

[28]Utah is the only selected state that imposed a deductible on its CHIP population. In 2014, CHIP enrollees in Utah with family incomes between 134 and 150 percent FPL were subject to a deductible of $40 a year for the family. Those with family incomes between 151 and 200 percent FPL were subject to an annual deductible of $500 and $1,500 for a child and family, respectively.

[29]These annual deductible amounts were for the 94 percent AV plan. To qualify for the 94 percent AV plan, enrollees must have family incomes at or below 150 percent FPL. The deductibles for the lower AV plans (70, 73, and 87 percent) were often considerably higher. See appendix IV.

[30]A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay.

amounts were usually minimal and on a sliding income scale.[31] For example, for each brand-name prescription drug, the Illinois CHIP plan imposed a $3.90 copayment on enrollees with incomes greater than 142 and up to 157 percent of the FPL, which was increased to $7 for enrollees with incomes greater than 209 and up to 313 percent of the FPL. In contrast, selected QHPs in all five states imposed copayments or coinsurance on most covered services we reviewed, and the amounts were consistently higher than the CHIP plan in the same state. For example, depending on income, the copayment for primary care and specialist physician visits in Colorado ranged from $2 to $10 per visit for enrollees in the selected CHIP plan, but was $25 and $35 per visit, respectively, for all enrollees in the selected QHP. Cost-sharing for dental services was also higher in a state's selected SADP than in its selected CHIP plan a majority of the time. In addition, in states where the selected QHP charged coinsurance and the selected CHIP plan required a copayment, a direct comparison of cost differences could not be made, although data suggest CHIP costs would generally be lower. For example, for an inpatient hospital admission, higher-income enrollees in the selected CHIP plan in Colorado paid $50, while all enrollees in the selected QHP in the state were responsible for 20 percent coinsurance after the deductible was met, an amount that was likely to be higher given that 20 percent of the average price for an inpatient facility stay in 2011 was over $3,000.[32] (See app. IV for a detailed list of cost-sharing for services we reviewed in selected plans.)

Our review of premiums for selected CHIP plans and QHPs also suggests that premiums were always less in the CHIP plans than in the QHPs we reviewed, even with the application of the premium tax credit to defray the cost of QHP premiums. For example, according to CHIP officials, annual CHIP premiums in 2014 for an individual varied by income level and ranged from $0 for the lowest income CHIP enrollees in Colorado, Illinois, Kansas, and New York, to $720 for enrollees between 351 and 400 percent of the FPL in New York, with most enrollees across the five

[31]The selected CHIP plan in Utah differed from the selected CHIP plans in the other four states in that that it imposed either a copayment or coinsurance on nearly all services we reviewed, which varied by income level.

[32]According to the Health Care Cost Institute, the average price of an inpatient stay, which includes hospital stays, in 2011 was $15,674. See the Health Care Cost Institute, *Health Care Cost and Utilization Report: 2011* (Washington, D.C., Health Care Cost Institute, 2012).

selected states paying less than $200 per year.[33] By comparison, 2014 annual premiums for a single child only enrolled in selected QHPs ranged from $1,111 to $1,776 in our five states before the application of the premium tax credit. With the premium tax credit, the annual premium amount for selected QHPs was often significantly lower, but was still higher than the selected CHIP plan in all five states. For example, in Illinois, the premium for the selected CHIP plan for an individual with an income at 150 percent of the FPL was $0 and was $1,254 for the selected QHP, which was reduced to $944 after the premium tax credit was applied.

However, the additional premium cost to families enrolling previously eligible CHIP children into their QHPs—a possibility if CHIP funding is not reauthorized—may be minimal or nothing.[34] Because PPACA limits the amount lower income families pay in premiums, families with incomes at 250 percent or less of the FPL—at least 75 percent of the separate CHIP enrollees in the states we reviewed—would generally pay no additional premium to add a child to their QHP. For example, in Kansas, the 2014 annual premium for the lowest cost silver level QHP was $4,875 for a couple age 40 and an additional $1,211 to add a child. However, if the couple's income was 200 percent of the FPL, their maximum annual

[33]The lowest income enrollees fall in the lowest FPL range that CHIP covers in each respective state. This range was between 143 and 156 percent for Colorado, greater than 142 and up to 157 percent for Illinois, between 134 and 166 percent for Kansas, greater than 154 and less than 160 percent for New York, and between 134 and 150 percent FPL for Utah.

[34]In some cases, enrolling previously eligible CHIP children into QHPs could reduce premium costs for families. This is because CHIP plans and QHPs each have statutory limits on premiums based on family income, and the limits applied to each program do not account for families that pay premiums to both programs, known as premium stacking. More than 3 million children are subject to CHIP premiums, so many families enrolling in exchanges may be subject to premium stacking if they also purchase CHIP plans. In contrast, some families with CHIP-eligible children may not qualify for premium tax credits and, therefore, enrolling previously eligible CHIP children into QHPs could increase their premium costs. Specifically, families do not qualify for QHP subsidies if a parent is offered "affordable" employer coverage. The law considers employer coverage affordable if the cost of the employee-only plan—without the cost of additional family members—does not exceed 9.5 percent of household income. This is often referred to as the "family glitch," as the actual premium that a family pays for insurance may be much higher than 9.5 percent. See GAO, *Children's Health Insurance: Opportunities Exist for Improved Access to Affordable Insurance,* GAO-12-648 (Washington, D.C.: June 22, 2012).

premium would be $2,494, and they would incur no additional costs by adding a child to their plan.[35]

Finally, all selected CHIP plans and QHPs limited the total potential costs to consumers by imposing out-of-pocket maximum costs, and these maximum costs were typically less in the CHIP plans we reviewed. For example, all five states applied the limit a family could pay in CHIP plans as established under federal law—including deductibles, copayments, coinsurance, and premiums—at 5 percent of a family's income during the child's (or children's) eligibility for CHIP. This 5 percent cap resulted in limits that varied based on a family's income level. This amount ranged from $584 to $2,334 for individuals, and $1,193 to $4,770 for a family of four, between 100 and 400 percent of the FPL in 2014. PPACA also established out-of-pocket maximum costs that apply to QHPs and may vary by income.[36] Unlike CHIP, however, QHP maximums do not include premiums, which may be separately reduced through the application of premium tax credits. QHPs may set out-of-pocket maximum costs that are lower than those established by PPACA, which was the case for three of the five selected QHPs.[37] For example, the selected QHP in Colorado had individual out-of-pocket maximum costs ranging from $750 to $6,300 for individuals between 100 and 400 percent FPL. This amount was less than out-of-pocket maximum costs established under federal law, which ranged from $2,250 to $6,350 for individuals between 100 and 400 percent FPL in 2014.

[35]If an individual who is eligible for premium tax credits enrolls in a QHP and an SADP, the portion of the SADP that is allocable to the pediatric dental EHB must be considered part of the QHP premium to which the individual's premium tax credit applies. However, unless the consumer purchases a QHP with a premium that is less than the second lowest cost silver plan, e.g., a bronze plan, the consumer would likely pay the full premium for the SADP.

[36]PPACA out-of-pocket maximum costs on EHB for households with incomes between 100 and 400 percent of the FPL in 2014 ranged from $2,250 to $6,350 for individuals and $4,500 to $12,700 for families. In 2015, out-of-pocket maximum costs on EHB for households with incomes between 100 and 400 percent of the FPL ranged from $2,250 to $6,600 for individuals and from $4,500 to $13,200 for families.

[37]Similarly, a recent report by Avalere Health found that 74 percent of silver level QHPs in 2015 have out-of-pocket maximum costs that are below PPACA-established limits. Avalere Health LLC, *Consumers Should Look at Maximum Out-of-Pocket Limits & Deductibles in the Exchanges* (Washington, D.C., Avalere Health LLC, 2014).

Out-of-pocket maximum costs for SADPs are in addition to the out-of-pocket maximum costs for QHPs and may increase potential costs for families who purchase them. In 2014, each exchange established maximum out-of-pocket costs for SADPs, which do not include premiums. Annual out-of-pocket maximum costs for selected SADPs for three of the four selected SADPs were $700 for one child and $1400 for two or more children.[38]

Agency Comments

We provided a draft of this report for comment to HHS. HHS officials provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from its date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact Katherine Iritani at (202)512-7114 or iritanik@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix V.

Katherine M. Iritani
Director, Health Care

[38]The selected SADP in Utah differed from the selected SADPs in the other three states in that it imposed an out-of-pocket maximum cost of $40 for the low plan and $20 for the high plan. CMS regulations impose uniform out-of-pocket maximum costs on SADPs beginning in 2015. Under these regulations, cost-sharing may not exceed $350 for one covered child and $700 for two or more covered children.

Appendix I: Coverage for Selected Services in CHIP Plans and Qualified Health Plans (QHP) GAO Reviewed in Five States

			CHIP plan					QHP				
Service			**CO**	**IL**	**KS**	**NY**	**UT**	**CO**	**IL**	**KS**	**NY**	**UT**
Ambulatory patient services	Provider office visits		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Outpatient surgery		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Emergency care			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inpatient hospital	Facility		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Professional		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Ancillary		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Maternity care			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mental health	Inpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Outpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Substance abuse	Inpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Outpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prescription drugs			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Outpatient therapies	Physical	Rehabilitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Habilitative	✓	✓	☒	✓	✓	✓	✓	✓	✓	✓
	Speech	Rehabilitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Habilitative	✓	✓	☒	✓	✓	✓	✓	✓	✓	✓
	Occupational	Rehabilitative	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
		Habilitative	✓	✓	☒	✓	✓	✓	✓	✓	✓	✓
Laboratory services	Inpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Outpatient		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Preventive care	Well-child		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Immunizations		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Chronic disease management		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pediatric dental	Routine		✓	✓	✓	✓	✓	☒	☒	☒	✓	☒
	Emergency		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Other		✓	✓	✓	✓	✓	☒	☒	☒	✓	☒
Pediatric vision	Exams		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Corrective lenses		✓	✓	✓	✓	☒	✓	✓	✓	✓	☒
Pediatric hearing	Testing (screening and/or exam)		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	Hearing aids		✓	✓	✓	✓	☒	✓	✓	✓[a]	✓	☒

		CHIP plan					QHP				
Service		**CO**	**IL**	**KS**	**NY**	**UT**	**CO**	**IL**	**KS**	**NY**	**UT**
Durable medical equipment		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Home- and community-based health care		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospice		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Enabling services	Non-hospice respite care	☒	☒	✓	☒	☒	☒	☒	☒	☒	☒
	Translation during office visits	✓	☒	✓	✓	✓	☒	☒	☒	☒	☒
	Care coordination/case management	✓	✓	✓	✓	✓[b]	☒	✓	☒	☒	☒
	Routine transportation[c]	☒	✓[d]	✓	☒	☒	☒	☒	☒	☒	☒

Legend: ✓= yes; ☒ = no.

Source: GAO analysis of information from states and QHPs. | GAO-15-323

Notes: CHIP plan information was provided by state officials for the Colorado Access CHIP plan, Illinois CHIP and Medicaid State plans, Kansas Sunflower State Health CHIP plan, Fidelis Care New York CHIP plan, and Utah CHIP Select Health plan. QHP information is from Evidences of Coverage for the Colorado Humana Connect Silver 4600/6300 plan, Illinois Blue Choice Silver PPO 003 plan, Kansas Coventry Health and Life Silver Integrated $10 Copay PPO KC Exchange plan, New York MetroPlus SilverPlus S1 plan, and the Utah Humana Connect Silver 4600/6300 plan, and state and QHP officials.

The Patient Protection and Affordable Care Act (PPACA) allows exchanges in each state to make available coverage of pediatric dental services as an embedded benefit in a QHP or through a stand-alone dental plan (SADP), which consumers may purchase separately. In exchanges with at least one participating SADP, QHPs were not required to include the pediatric dental benefit. Consumers in these five states were not required to purchase SADPs in 2014, even if their QHP did not include the pediatric dental benefit.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While PPACA and its implementing regulations do not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]The plan covers bone anchored hearing aids and cochlear implants only. Bone anchored hearing aids are used when traditional hearing aids are not efficient because of complications such as chronic infections or blockage. Cochlear implants are for patients with severe hearing loss where traditional amplification is no longer beneficial.

[b]The plan covers care coordination and case management for children with special health care needs only. Utah CHIP defines children with special health care needs as enrollees who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by adults and children generally.

[c]Routine transportation includes transportation to and from medical appointments.

[d]Routine transportation is covered for CHIP children greater than 142 and up to 209 percent of the federal poverty level only.

Appendix II: Coverage Limits for Selected Services in CHIP Plans and QHPs GAO Reviewed in Five States

Tables 1 and 2 provide information on coverage limits for selected services in State Children's Health Insurance Program (CHIP) plans and qualified health plans (QHP) in each of the five states we reviewed: Colorado, Illinois, Kansas, New York, and Utah. For coverage limits on pediatric dental services, see Appendix III.

Table 1: Annual Coverage Limits for Selected Services in State Children's Health Insurance Program (CHIP) Plans GAO Reviewed in Five States, Calendar Year 2014

		CHIP plan				
Service		**CO**	**IL**	**KS**	**NY**	**UT**
Ambulatory patient services: office visits	Primary care physician	None	None	None	None	None
	Specialty physician	None	None	None	None	None
Emergency care		None	None	None	None	None
Inpatient hospital		30 days for rehabilitation therapies[a]	None	None	None	None
Maternity care		1 metabolic screening, 1 postpartum visit, and 1 prescreening visit	None	None	1 home care visit for early discharge	None
Mental health and substance abuse	Inpatient	None	None	None	None	None
	Outpatient	None	None	None	None	None
Prescription drugs		None	None	None	None	None
Outpatient therapies (occupational, physical, speech)	Rehabilitative	30 visits[b]	None	None	Physical and occupational: 6 weeks; speech: none	20 visits per therapy type per year
	Habilitative	30 visits[b]	None	Not covered	Physical and occupational: 6 weeks; speech: none	20 visits per therapy type per year
Preventive care		None	None	None	None	None
Pediatric vision	Optometrist exam	1 exam	None	None	1 exam[c]	1 exam
	Corrective lenses	$50	None	4 pair contacts	1 pair[d]	Not covered
Pediatric hearing	Testing	None	None	None	1 test	1 test
	Hearing aids	1 aid every 5 years	None	Various[e]	None	Not covered[f]
Durable medical equipment		$2,000	None	None	None	None
Home- and community-based health care		None	None	None	40 visits	None

		CHIP plan				
Service		**CO**	**IL**	**KS**	**NY**	**UT**
Hospice		9 months[g]	None	None	None	None
Enabling services	Non-hospice respite care	Not covered	Not covered	None	Not covered	Not covered
	Translation services—office visits	None	Not covered	None	None	None
	Care coordination/case management	None	None	None	None	None
	Routine transportation[h]	Not covered	None	None	Not covered	Not covered

Source: GAO analysis of information from states. | GAO-15-323

Notes: CHIP plan information was provided by state officials for the Colorado Access CHIP plan, Illinois CHIP and Medicaid State plans, Kansas Sunflower State Health CHIP plan, Fidelis Care New York CHIP plan, and Utah CHIP Select Health plan.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While federal law does not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]Rehabilitation therapies are occupational, physical, and speech therapies.

[b]Outpatient therapy visit limits are per diagnosis, per calendar year. Service is unlimited to children under 3 years of age and speech therapy is unlimited for those with a cleft palate or lip.

[c]Optometrist exams are limited to one per year, unless they are required more frequently and the enrollee has the appropriate documentation.

[d]Enrollees are limited to one frame and one set of lenses per year, unless they are required more frequently and the enrollee has the appropriate documentation.

[e]Hearing aid batteries are limited to 6 batteries per month for monaural aids and 12 per month for binaural aids. Batteries for use with cochlear devices are limited to lithium ion (3 per 30 days) or zinc air (6 per 30 days). Batteries for cochlear devices are covered for CHIP-eligible beneficiaries only. Only one type of battery is allowed every 30 days.

[f]Hearing aids are not covered by CHIP unless following cochlear implants.

[g]Hospice is available in 3 month increments, which do not have to be consecutive.

[h]Routine transportation includes transportation to and from medical appointments.

Table 2: Annual Coverage Limits for Selected Services in Qualified Health Plans (QHP) GAO Reviewed in Five States, Calendar Year 2014

		QHP				
Service		**CO**	**IL**	**KS**	**NY**	**UT**
Ambulatory patient services: office visits	Primary care physician	None	None	None	None	None
	Specialty physician	None	None	None	None	None
Emergency care		None	None	None	None	None
Inpatient hospital		None	None	None	Rehabilitation: 1 consecutive 60 day period per condition, per lifetime	None
Maternity care		1 home care visit for early discharge	1 inpatient newborn exam and hearing screening	None	1 home care visit for early discharge	1 home care visit for early discharge
Mental health and substance abuse	Inpatient	None	None	None	None	None
	Outpatient	None	None	Partial day programs: 20 visits[a]	20 visits for family counseling (substance abuse only)	None
Prescription drugs		None	None	None	None	None
Outpatient therapies (occupational, physical, speech)	Rehabilitative	20 visits per therapy	None	20 visits per therapy[b]	60 visits per condition, per lifetime, all therapies combined	20 visits per therapy type per year[c]
	Habilitative	20 visits per therapy[d]	None		60 visits per condition, per lifetime, all therapies combined	
Preventive care		None	None	None	None	None
Pediatric vision	Optometrist exam	1 exam	1 exam	None	1 exam	1 exam
	Corrective lenses	1 pair lenses; 1 frame every 2 years	1 pair lenses and frames or contacts	3 lenses or contacts; 3 frames	1 pair lenses and frames	Not covered
Pediatric hearing	Testing	None	None	None	None	None
	Hearing aids	1 aid every 5 years[e]	2 every 3 years	None[f]	Hearing aid: 1 every 3 years; cochlear implant and bone anchored: 1 per ear per time covered	Not covered
Durable medical equipment		None	None	None	None	None

		QHP				
Service		**CO**	**IL**	**KS**	**NY**	**UT**
Home- and community-based health care		7 visits per week	None	3 home care education visits	40 visits per year	60 visits per year
Hospice		None	None	Inpatient: 15 days	210 days	Part-time nursing and home health aide care: 8 hours a day each
Enabling services	Non-hospice respite care	Not covered	Not covered	Not covered	Not covered	Not covered
	Translation services—office visits	Not covered	Not covered	None	Not covered	None
	Care coordination/case management	Not covered	None	Not covered	Not covered	Not covered
	Routine transportation[g]	Not covered	Not covered	Not covered	Not covered	Not covered

Source: GAO analysis of information from states and QHPs. | GAO-15-323

Notes: QHP information is from Evidences of Coverage for the Colorado Humana Connect Silver 4600/6300 plan, Illinois Blue Choice Silver PPO 003 plan, Kansas Coventry Health and Life Silver Integrated $10 Copay PPO KC Exchange plan, New York MetroPlus SilverPlus S1 plan, and the Utah Humana Connect Silver 4600/6300 plan, and state and QHP officials.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While federal law does not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

[a]A partial day program is any program 4 hours or longer per day.

[b]There is a combined visit limit for rehabilitative and habilitative physical, occupational, and speech therapies per therapy type.

[c]There is a combined visit limit for all rehabilitative and habilitative physical, occupational, and speech therapies.

[d]Habilitative outpatient therapies for treatment of congenital defects and birth abnormalities for a covered dependent are covered from a child's third to sixth birthday only.

[e]There are no limits if the existing hearing aid can't be altered to adequately meet the needs of the child.

[f]There are no coverage limits for bone-anchored hearing aids and cochlear implants, which are the only types of hearing aids covered by the plan.

[g]Routine transportation includes transportation to and from medical appointments.

Appendix III: Coverage, Coverage Limits, and Cost-Sharing for Selected Dental Services in CHIP Plans, QHPs, and SADPs

Tables 3 through 12 provide information on coverage, coverage limits, and cost-sharing—deductibles, copayments, and coinsurance—for selected dental services in State Children's Health Insurance Program (CHIP) plans we reviewed in five states: Colorado, Illinois, Kansas, New York, and Utah; a qualified health plan (QHP) in New York; and stand-alone dental plans (SADP) in Colorado, Illinois, Kansas, and Utah. For selected CHIP plans and the QHP in New York, we note differences in cost-sharing amounts by income level.[1] For selected SADPs, we note the cost-sharing amounts for the "high" and "low" level options, which have actuarial values of 85 and 70 percent, respectively.

For all five states, cost-sharing amounts were subject to out-of-pocket maximum costs. For CHIP enrollees in each state, cost-sharing and premium amounts were subject to a federally established out-of-pocket-maximum cost equal to 5 percent of a family's income. For QHP enrollees, issuers established an out-of-pocket maximum cost for each plan that was equal to or less than the out-of-pocket maximum cost established under the Patient Protection and Affordable Care Act (PPACA). PPACA out-of-pocket maximum costs for households with incomes between 100 and 400 percent of the federal poverty level (FPL) in 2014 ranged from $2,250 to $6,350 for individuals and $4,500 to $12,700 for families. In 2014, each exchange established out-of-pocket maximum costs for SADPs. Annual out-of-pocket maximum costs for the selected SADPs in Colorado, Illinois, and Kansas were $700 for one child and $1400 for two or more children. The selected SADP in Utah imposed an out-of-pocket maximum cost of $40 for the low plan and $20 for the high plan. In contrast to CHIP, the out-of-pocket maximum costs for QHPs and SADPs do not include premiums.

[1]For the QHP in New York, cost-sharing amounts reflect PPACA-established subsidies that are available to certain enrollees through lower out-of-pocket maximum costs and, if necessary, through lower deductibles, copayments, or coinsurance. Once the adjustments from the subsidies are made, the actuarial value of the plan effectively increases from 70 percent to 73, 87, or 94 percent, depending on income.

Table 3: Coverage and Coverage Limits for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Colorado, Calendar Year 2014

		CHIP plan		High SADP		Low SADP	
Service		**Covered**	**Limits**	**Covered**	**Limits**	**Covered**	**Limits**
Routine	Periodic oral exam	Y	2 per year	Y	2 per year	Y	2 per year
	Cleaning	Y	2 per year	Y	2 per year	Y	1 per year
	X-rays[a]	Y	• Complete or panoramic: 1 every 5 years • Bitewings: 1 per year	Y	• Complete: 1 every 5 years • Bitewings: 1 per year	Y	• Complete and bitewings: 1 every 5 years • Bitewings: 1 per year • Panoramic: 1 every 5 years
	Fluoride treatment (gel or foam)	Y	2 per year	Y	2 per year, covered to age 19	Y	2 per year
	Sealants[b]	Y	1 every 3 years	Y	None, covered to age 19	Y	1 every 3 years; permanent molars only
	Space maintainers[c]	Y	None	Y	None, covered to age 19	Y	None
Other	Fillings	Y	1 every 2 years per tooth	Y	1 every 2 years per tooth	Y	1 every 2 years per tooth
	Crowns[d]	Y	1 prefabricated every 2 years per tooth	Y	None, covered to age 19	Y	1 prefabricated every 2 years
	Root canals	Y	None	Y	1 per tooth	Y	None, permanent teeth only
	Dentures	Y	1 every 5 years, not covered < 16 years of age	Y	1 every 5 years, not covered < 16 years of age	N	Not covered

Source: GAO analysis of information from the state and SADPs. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Colorado Anthem Dental Pediatric (low SADP) and Delta Dental Family Plan – Mesa (high SADP) and state officials.

SADPs are categorized as "high" and "low" level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

[a]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[b]A sealant is a thin, clear or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[c]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place. The selected CHIP plans and SADPs cover space maintainers for the premature loss of baby back teeth only.

[d]Prefabricated crowns are used on permanent teeth primarily as a temporary measure. For children, prefabricated crowns are commonly used on primary, or baby, teeth.

Table 4: Coverage and Coverage Limits for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Illinois, Calendar Year 2014

		CHIP plan		High SADP		Low SADP	
Service		**Covered**	**Limits**	**Covered**	**Limits**	**Covered**	**Limits**
Routine	Periodic oral exam	Y	2 per year[a]	Y	2 per year	Y	2 per year
	Cleaning	Y	2 per year[b]	Y	2 per year	Y	2 per year
	X-rays[c]	Y	• Complete, panoramic, or vertical bitewings: 1 every 3 years • Bitewings: 1 per year	Y	• Complete or panoramic: 1 every 3 years • Bitewings: 1 per year	Y	• Complete or panoramic: 1 every 3 years • Bitewings: 1 per year
	Fluoride treatment (gel or foam)	Y	• 1 per year age 3-20[d] • 3 per year age 0-2[d]	Y	1 per year	Y	1 per year
	Sealants[e]	Y	1 per tooth per lifetime[f]	Y	1 per tooth per lifetime	Y	1 per tooth per lifetime
	Space maintainers[g]	Y	• 1 per quadrant per lifetime (4) • 1 per arch per lifetime (2)	Y	• 1 per quadrant per lifetime (4) • 1 per arch per lifetime (2)	Y	• 1 per quadrant per lifetime (4) • 1 per arch per lifetime (2)
Other	Fillings	Y	1 per tooth surface per year	Y	1 per tooth surface per year	Y	1 per tooth surface per year
	Crowns[h]	Y	• 1 permanent every 5 years • 1 prefabricated per tooth per lifetime (primary and anterior) • 1 prefabricated per tooth every 5 years (permanent)	Y	• 1 permanent every 5 years • 1 prefabricated per tooth per lifetime (1 every 5 years for primary teeth)	Y	• 1 permanent every 5 years • 1 prefabricated per tooth per lifetime (1 every 5 years for primary teeth)
	Root canals	Y	1 per tooth per lifetime	Y	1 per tooth per lifetime	Y	1 per tooth per lifetime
	Dentures	Y	1 every 5 years	Y	1 every 5 years	Y	1 every 5 years

Source: GAO analysis of information from the state and SADP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Illinois Dentegra Dental PPO Children's 70 (low SADP) and 85 (high SADP) plan and state and SADP officials.

SADPs are categorized as “high” and “low” level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

[a]The Illinois CHIP plan also covers one cleaning per year at a school that is at least 270 days from the last school exam. The benefit limitations for these services are unique based upon the place of service, school or office.

[b]The Illinois CHIP plan also covers 2 cleanings per year at a school. The benefit limitations for these services are unique based upon the place of service, school or office.

[c]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[d]The Illinois CHIP plan also covers 1 fluoride treatment per year at a school. The benefit limitations for these services are unique based upon the place of service, school or office.

[e]A sealant is a thin, clear or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[f]Sealants are covered for the following teeth: 2, 3, 14, 15, 18, 19, 30, and 31.

[g]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place. The mouth has four quadrants and two arches.

[h]Prefabricated crowns are used on permanent teeth primarily as a temporary measure. For children, prefabricated crowns are commonly used on primary, or baby, teeth.

Table 5: Coverage and Coverage Limits for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Kansas, Calendar Year 2014

		CHIP plan		High SADP		Low SADP	
Service		**Covered**	**Limits**	**Covered**	**Limits**	**Covered**	**Limits**
Routine	Periodic oral exam	Y	2 per year	Y	2 per year	Y	2 per year
	Cleaning	Y	2 per year	Y	2 per year	Y	2 per year
	X-rays[a]	Y	Complete or panoramic and bitewings: 1 every 3 years	Y	• Complete or panoramic: 1 every 5 years • Bitewings: 2 per year	Y	• Complete or panoramic: 1 every 5 years • Bitewings: 2 per year
	Fluoride treatment (gel or foam)	Y	3 per year	Y	2 per year	Y	2 per year
	Sealants[b]	Y	1 per tooth per year	Y	1 every 3 years[c]	Y	1 every 3 yearsc
	Space maintainers[d]	Y	1 per quadrant per year (4) 1 per arch per year (2)	Y	None[e]	Y	None[e]
Other	Fillings	Y	1 per year	Y	None	Y	None
	Crowns[f]	Y	• 1 permanent every 5 years • 1 prefabricated every 2 years	Y	• 1 permanent every 5 years • 1 prefabricated per tooth every 5 years for children less than 15 years of age	Y	• 1 permanent every 5 years • 1 prefabricated per tooth every 5 years for children less than 15 years of age
	Root canals	Y	1 per tooth per lifetime	Y	None	Y	None
	Dentures	Y	1 every 5 years	Y	1 every 5 years	Y	1 every 5 years

Source: GAO analysis of information from the state and SADP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Kansas Best One Dental Basic- Silver (low SADP) and Best Life Best One Dental Plus- Gold (high SADP).

SADPs are categorized as "high" and "low" level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

[a]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[b]A sealant is a thin, clear or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[c]Sealants are covered only for unrestored permanent molars and children less than 19 years of age.

[d]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place. The mouth has four quadrants and two arches.

[e]Space maintainers are covered for children less than 19 years of age.

[f]Prefabricated crowns are used on permanent teeth primarily as a temporary measure. For children, prefabricated crowns are commonly used on primary, or baby, teeth. Prefabricated crowns in this table are available in stainless steel.

Table 6: Coverage and Coverage Limits for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Qualified Health Plan (QHP) GAO Reviewed in New York, Calendar Year 2014

		CHIP plan		QHP	
Service		**Covered**	**Limits**	**Covered**	**Limits**
Routine	Periodic oral exam	Y	2 per year	Y	2 per year
	Cleaning	Y	2 per year	Y	2 per year
	X-rays[a]	Y	Complete 1 every 3 years and bitewings 1 every 2 years or panoramic: 1 every 3 years	Y	Complete 1 every 3 years and bitewings 1 every 2 years or panoramic: 1 every 3 years and other x-rays if medically necessary
	Fluoride treatment (gel or foam)	Y	2 per year[b]	Y	2 per year[b]
	Sealants[c]	Y	None	Y	None
	Space maintainers[d]	Y	None	Y	None
Other	Fillings	Y	None	Y	None
	Crowns	Y	None	Y	None
	Root canals	Y	None	Y	None
	Dentures	Y	None	Y	None

Source: GAO analysis of information from the state and QHP. | GAO-15-323

Note: CHIP plan information was provided by state officials. QHP information is from the Evidence of Coverage for the New York MetroPlus SilverPlus S1 plan and state and QHP officials.

[a]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[b]Fluoride is available in places where the local water is not fluoridated.

[c]A sealant is a thin, clear or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[d]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place. The mouth has four quadrants and two arches.

Table 7: Coverage and Coverage Limits for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Utah, Calendar Year 2014

		CHIP plan		High SADP		Low SADP	
Service		**Covered**	**Limits**	**Covered**	**Limits**	**Covered**	**Limits**
Routine	Periodic oral exam	Y	None	Y	2 per year	Y	2 per year
	Cleaning	Y	2 per year	Y	2 per year	Y	2 per year
	X-rays[a]	Y	None	Y	• Complete or panoramic: 1 every 3 years • Bitewings: 2 per year	Y	• Complete or panoramic: 1 every 3 years • Bitewings: 2 per year
	Fluoride treatment (gel or foam)	Y	None	Y	2 per year	Y	2 per year
	Sealants[b]	Y	None	Y[c]	1 every 5 years	Y[c]	1 every 5 years
	Space maintainers[d]	Y	None	N	Not covered	N	Not covered
Other	Fillings	Y	None	N	Not covered	N	Not covered
	Crowns	Y	None	N	Not covered	N	Not covered
	Root canals	Y	None	N	Not covered	N	Not covered
	Dentures	Y	None	N	Not covered	N	Not covered

Source: GAO analysis of information from the state and SADP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Utah SelectHealth Dental Fundamental $22 Copay (low SADP) and $10 Copay (high SADP).

SADPs are categorized as "high" and "low" level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

[a]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[b]A sealant is a thin, clear or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[c]Sealants in the High and Low SADPs are only covered for permanent molars and bicuspids without decay or restoration for children under age 15.

[d]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place. The mouth has four quadrants and two arches.

Table 8: Cost-Sharing Amounts for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Colorado, Calendar Year 2014

		CHIP plan			SADP	
		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)				
		143-156%	157-213%	214-260%	High	Low
Deductible	Individual	None	None	None	$50	$50
	Family	None	None	None	$150	N/A[a]
Routine Services (copayment=$, coinsurance=%)						
Oral Exam/Evaluation		$0	$0	$0	0%[b]	10%[b]
Cleaning (prophylaxis)		$0	$0	$0	0%[b]	10%[b]
X-rays[c] (Complete, panoramic, and/or bitewings)		$0	$0	$0	0%[b]	10%[b]
Fluoride treatment (no varnish)		$0	$0	$0	0%[b]	10%[b]
Sealants[d]		$0	$0	$0	0%[b]	10%[b]
Space maintainers[e]		$0	$0	$0	0%[b]	10%[b]
Other Services (copayment=$, coinsurance=%)						
Fillings		$0	$5	$10	40%	50%
Crowns		$0	$5	$10	40%	50%
Root canals (endodontics)		$0	$5	$10	40%	50%
Dentures		$0	$5	$10	40%	Not covered

Source: GAO analysis of information from the state and SADPs. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Colorado Anthem Dental Pediatric (low SADP) and Delta Dental Family Plan – Mesa (high SADP) and state officials.

SADPs are categorized as "high" and "low" level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the SADPs, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost.

[a]There was no family option with the selected Low SADP for Colorado.

[b]This coinsurance is not subject to the deductible.

[c]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[d]A sealant is a thin, clear or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[e]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place.

Table 9: Cost-Sharing Amounts for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Illinois, Calendar Year 2014

		CHIP plan				
		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)			SADP	
		>142-157%	>157-209%	>209-313%	High	Low
Deductible	Individual	None	None	None	$25	$45
	Family	None	None	None	N/A	N/A
Routine Services (copayment=$, coinsurance=%)						
Oral Exam/Evaluation		$0	$0	$0	0%[a]	0%
Cleaning (prophylaxis)		$0	$0	$0	0%[a]	0%
X-rays[b] (Complete, panoramic, and/or bitewings)		$0	$0	$0	0%[a]	0%
Fluoride treatment (no varnish)		$0	$0	$0	0%[a]	0%
Sealants[c]		$0	$0	$0	0%[a]	0%
Space maintainers[d]		$0	$0	$0	0%[a]	0%
Other Services (copayment=$, coinsurance=%)						
Fillings		$3.90	$5	$10	20%	50%
Crowns[e]		$3.90	$5	$10	20/50%[f]	50%
Root canals (endodontics)		$3.90	$5	$10	50%	50%
Dentures		$3.90	$5	$10	50%	50%

Source: GAO analysis of information from the state and SADP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Illinois Dentegra Dental PPO Children's 70 (low SADP) and 85 (high SADP) plan and state and SADP officials.

SADPs are categorized as "high" and "low" level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the SADP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost.

[a]This coinsurance is not subject to the deductible.

[b]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[c]A sealant is a thin, clear or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[d]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place.

[e]Prefabricated crowns are used on permanent teeth primarily as a temporary measure. For children, prefabricated crowns are commonly used on primary, or baby, teeth

[f]Prefabricated crowns are a basic service and are covered with 20 percent coinsurance to enrollees. Permanent (porcelain, cast, etc) crowns are a major service and covered at 50 percent.

Table 10: Cost-Sharing Amounts for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Kansas, Calendar Year 2014

		CHIP plan		
		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)	SADP	
		134-242%	High	Low
Deductible	Individual	None	$50	$50
	Family	None	N/A	N/A
Routine Services (copayment=$, coinsurance=%)				
Oral Exam/Evaluation		$0	0%	0%
Cleaning (prophylaxis)		$0	0%	0%
X-rays[a] (Complete, panoramic, and/or bitewings)		$0	0%	0%
Fluoride treatment (no varnish)		$0	0%	0%
Sealants[b]		$0	0%	0%
Space maintainers[c]		$0	0%	0%
Other Services (copayment=$, coinsurance=%)				
Fillings		$0	20%	40%
Crowns[d]		$0	20/50%[e]	40/50%[f]
Root canals (endodontics)		$0	50%	50%
Dentures		$0	50%	50%

Source: GAO analysis of information from the state and SADP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Kansas Best One Dental Basic- Silver (low SADP) and Best Life Best One Dental Plus- Gold (high SADP).

SADPs are categorized as "high" and "low" level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the SADP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost.

[a]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[b]A sealant is a thin, clear, or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[c]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place.

[d]Prefabricated crowns are used on permanent teeth primarily as a temporary measure. For children, prefabricated crowns are commonly used on primary, or baby, teeth.

[e]Prefabricated crowns are a basic service and are covered with 20 percent coinsurance to enrollees. Permanent (porcelain, cast, etc.) crowns are a major service and covered at 50 percent.

[f]Prefabricated crowns are a basic service and are covered with 40 percent coinsurance to enrollees. Permanent (porcelain, cast, etc.) crowns are a major service and covered at 50 percent.

Table 11: Cost-Sharing Amounts for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Qualified Health Plan (QHP) GAO Reviewed in New York, Calendar Year 2014

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)				
		CHIP plan	QHP			
		>154-400%	100-150%	>150-200%	>200-250%	>250-400%
Deductible	Individual	None	$0	$250	$1,750	$2,000
	Family	None	$0	$500	$3,500	$4,000
Routine Services (copayment=$, coinsurance=%)						
Oral Exam/Evaluation		$0	$10	$15	$30	$35
Cleaning (prophylaxis)		$0	$10	$15	$30	$35
X-rays[a] (Complete, panoramic, and/or bitewings)		$0	$10	$15	$30	$35
Fluoride treatment (no varnish)		$0	$10	$15	$30	$35
Sealants[b]		$0	$10	$15	$30	$35
Space maintainers[c]		$0	$10	$15	$30	$35
Other Services (copayment=$, coinsurance=%)						
Fillings		$0	$10	$15	$30	$35
Crowns		$0	$10	$15	$30	$35
Root canals (endodontics)		$0	$10	$15	$30	$35
Dentures		$0	$10	$15	$30	$35

Source: GAO analysis of information from the state and QHP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. QHP information is from Evidences of Coverage for the New York MetroPlus SilverPlus S1 plan and state and QHP officials.

For the QHP in this table, the FPL ranges correspond with the following actuarial value (AV) levels: 100-150 percent FPL (94 percent AV), >150-200 percent FPL (87 percent AV), >200-250 percent FPL (73 percent AV), and >250-400 percent FPL (70 percent AV).

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the QHP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and count toward the out-of-pocket maximum cost.

[a]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[b]A sealant is a thin, clear, or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[c]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place.

Table 12: Cost-Sharing Amounts for Selected Dental Services in the State Children's Health Insurance Program (CHIP) Plan and Stand-alone Dental Plan (SADP) GAO Reviewed in Utah, Calendar Year 2014

		CHIP plan			
		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)		SADP	
		134-150%	151-200%	High	Low
Deductible	Individual	None	$50	$0	$0
	Family	None	$150	N/A	N/A
Routine Services (copayment= $, coinsurance=%)					
Oral Exam/Evaluation		$0	$0	$10	$22
Cleaning (prophylaxis)		$0	$0	$10	$22
X-rays[a] (Complete, panoramic, and/or bitewings)		$0	$0	$10	$22
Fluoride treatment (no varnish)		$0	$0	$10	$22
Sealants[b]		$0	$0	$10	$22
Space maintainers[c]		$0	$0	Not covered	Not covered
Other Services (copayment=$, coinsurance=%)					
Fillings		5%[d]	20%	Not covered	Not covered
Crowns		5%[d]	20%	Not covered	Not covered
Root canals (endodontics)		5%[d]	20%	Not covered	Not covered
Dentures		5%[d]	20%	Not covered	Not covered

Source: GAO analysis of information from the state and SADP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. SADP information is from Evidences of Coverage for the Utah SelectHealth Dental Fundamental $22 Copay (low SADP) and $10 Copay (high SADP).

SADPs are categorized as "high" and "low" level plans, with 85 and 70 percent actuarial value (AV), respectively. AV indicates the proportion of allowable charges that a health plan will pay, on average—the higher the AV, the lower the cost-sharing expected to be paid by consumers.

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the SADP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and count toward the out-of-pocket maximum cost.

Plan officials indicated that the SADP reviewed would be discontinued effective 12/31/2014, as the dental benefits offered would be embedded in SelectHealth's medical plans in 2015.

[a]Complete x-rays cover the entire mouth. Panoramic x-rays show the entire mouth area on a single x-ray. Bitewings show details of the upper and lower teeth in one area of the mouth.

[b]A sealant is a thin, clear, or white resin substance that is applied to the biting surfaces of teeth to prevent decay.

[c]A space maintainer is an appliance for a child that keeps space open to allow a permanent tooth to erupt and come into place.

[d]This coinsurance is not subject to the deductible.

Appendix IV: Cost-Sharing for Selected Services in CHIP Plans and QHPs GAO Reviewed in Five States

Tables 13 through 17 provide information on cost-sharing—deductibles, copayments, and coinsurance—for selected services in State Children's Health Insurance Program (CHIP) plans and qualified health plans (QHP) we reviewed in five states: Colorado, Illinois, Kansas, New York, and Utah. For selected CHIP plans and QHPs, we note differences in cost-sharing amounts by income level. For selected QHPs, these variations reflect the cost-sharing subsidies that are available to certain enrollees.[1] For all five states, cost-sharing amounts were subject to out-of-pocket maximum costs. For CHIP enrollees in each state, cost-sharing and premium amounts were subject to a federally established out-of-pocket maximum cost equal to 5 percent of a family's income. For QHP enrollees, issuers established an out-of-pocket maximum cost for each plan that was equal to or less than out-of-pocket maximum costs established under the Patient Protection and Affordable Care Act (PPACA). PPACA out-of-pocket maximum costs for households with incomes between 100 and 400 percent of the federal poverty level (FPL) in 2014 ranged from $2,250 to $6,350 for individuals and $4,500 to $12,700 for families. These out-of-pocket maximum costs do not include costs associated with services provided through a SADP and, in contrast to CHIP, these out-of-pocket maximum costs do not include premiums.

[1]The plan variations reflect the PPACA-established cost-sharing subsidies through lower out-of-pocket maximum costs and, if necessary, through lower deductibles, copayments, or coinsurance. Once the adjustments from the subsidies are made, the actuarial values effectively increase from 70 percent to 73, 87, or 94 percent, depending on income.

Table 13: Cost-Sharing Amounts for Selected Services in the State Children's Health Insurance Program (CHIP) Plan and Qualified Health Plan (QHP) GAO Reviewed in Colorado, Calendar Year 2014

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)						
		CHIP plan			QHP			
		143-156%	157-213%	214-260%	100-150%	>150-200%	>200-250%	>250-400%
Plan deductible	Individual	None	None	None	$500	$900	$3,250	$4,600
	Family	None	None	None	$1,000	$1,800	$6,500	$9,200
Prescription drug deductible	Individual	None	None	None	$250	$500	$1,000	$1,500
	Family	None	None	None	$500	$1,000	$2,000	$3,000
Service (copayment=$, coinsurance=%)								
Ambulatory patient services: office visits	Primary care physician	$2	$5	$10	$25	$25	$25	$25
	Specialty physician	$2	$5	$10	$35	$35	$35	$35
Emergency care		$3	$30	$50	20%	20%	20%	20%
Inpatient hospital		$2	$20	$50	20%	20%	20%	20%
Maternity care		$0	$0	$0	20%	20%	20%	20%
Mental health and substance abuse	Inpatient	$2	$20	$50	20%	20%	20%	20%
	Outpatient	$2	$5	$10	20%	20%	20%	20%
Prescription drugs	Generic	$1	$3	$5	$10[a]	$10[a]	$10[a]	$10[a]
	Brand-name	$1	$10	$15	$50[b]	$50[b]	$50[b]	$50[b]
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$2	$5	$10	20%	20%	20%	20%
	Habilitative	$2	$5	$10	20%	20%	20%	20%
Preventive care		$0	$0	$0	0%[c]	0%[c]	0%[c]	0%[c]
Pediatric vision	Optometrist exam	$0	$0	$0	0%[c]	0%[c]	0%[c]	0%[c]
	Corrective lenses	$0	$0	$0	50%	50%	50%	50%
Pediatric hearing	Testing	$0	$0	$0	0%[c]	0%[c]	0%[c]	0%[c]
	Hearing aids	$0	$0	$0	20%	20%	20%	20%
Durable medical equipment		$0	$0	$0	20%	20%	20%	20%
Home- and community-based health care		$0	$0	$0	20%	20%	20%	20%

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)						
		CHIP plan			QHP			
		143-156%	157-213%	214-260%	100-150%	>150-200%	>200-250%	>250-400%
Enabling Services	Non-hospice respite care	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Translation services—office visits	$0	$0	$0	Not covered	Not covered	Not covered	Not covered
	Care coordination/ case management	$0	$0	$0	Not covered	Not covered	Not covered	Not covered
	Routine transportation[d]	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

Source: GAO analysis of information from the state and QHP. | GAO-15-323

Notes: CHIP plan information is from state officials. QHP information is from Evidences of Coverage for the Colorado Humana Connect Silver 4600/6300 Plan and state and QHP officials.

For the QHP in this table, the FPL ranges correspond with the following actuarial value (AV) levels: 100-150 percent FPL (94 percent AV), >150-200 percent FPL (87 percent AV), >200-250 percent FPL (73 percent AV), and >250-400 percent FPL (70 percent AV).

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the QHP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While federal law does not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The Patient Protection and Affordable Care Act (PPACA) required that, effective January 1, 2014, states determine Medicaid and CHIP income eligibility for certain categories of individuals using a uniform modified adjusted gross income (MAGI) methodology that is derived from a federal tax based definition of income. To accomplish this, states were required to convert their net income eligibility standards to MAGI equivalent income standards. The CHIP eligibility FPL ranges in this table reflect this conversion. Additionally, PPACA specifies that an income disregard equal to five percentage points of the FPL be deducted from an individual's income when determining Medicaid and CHIP eligibility. The FPL eligibility ranges in this table do not reflect this income disregard.

[a]If generic prescription drugs are ordered through the mail, the cost per prescription is $20 for a 90-day supply and is subject to the prescription deductible.

[b]Brand-name prescription drugs are subject to the prescription deductible. If brand-name prescription drugs are ordered through the mail, the cost per prescription is $100 for a 90-day supply and is subject to the prescription deductible. Brand- name drugs include drugs designated by the plan as "preferred" or included in their formulary.

[c]This coinsurance is not subject to the deductible.

[d]Routine transportation includes transportation to and from medical appointments.

Table 14: Cost-Sharing Amounts for Selected Services in the State Children's Health Insurance Program (CHIP) Plan and Qualified Health Plan (QHP) GAO Reviewed in Illinois, Calendar Year 2014

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)						
		CHIP plan			QHP			
		>142-157%	>157-209%	>209-313%	100-150%	>150-200%	>200-250%	>250-400%
Plan deductible	Individual	None	None	None	$500	$1,500	$5,000	$6,000
	Family	None	None	None	$1,500	$4,500	$10,400	$12,700
Service (copayment=$, coinsurance=%)								
Ambulatory patient services: office visits	Primary care physician	$3.90	$5	$10	$30	$30	$30	$30
	Specialty physician	$3.90	$5	$10	$50	$50	$50	$50
Emergency care		$0	$5	$30	0%	0%	0%	0%
Inpatient hospital		$3.90[a]	$5[a]	$100	0%	0%	0%	0%
Maternity care		$0	$0	$0	0%	0%	0%	0%
Mental health and substance abuse	Inpatient	$0	$0	$0	0%	0%	0%	0%
	Outpatient therapy	$3.90[b]	$5[b]	$10[b]	0%	0%	0%	0%
Prescription drugs	Generic	$2	$3	$3	$0[c]	$0[c]	$0[c]	$0[c]
	Brand-name	$3.90	$5	$7	$50[d]	$50[d]	$50[d]	$50[d]
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$0	$0	$0	0%	0%	0%	0%
	Habilitative	$0	$0	$0	0%	0%	0%	0%
Preventive care		$0	$0	$0	0%[e]	0%[e]	0%[e]	0%[e]
Pediatric vision	Optometrist exam	$3.90	$5	$10	$0	$0	$0	$0
	Corrective lenses	$0	$0	$0	0%	0%	0%	0%
Pediatric hearing	Testing	$0	$0	$0	$30	$30	$30	$30
	Hearing aids	$0	$0	$0	0%	0%	0%	0%
Durable medical equipment		$0	$0	$0	0%	0%	0%	0%
Home- and community-based health care		$0	$0	$0	0%	0%	0%	0%
Hospice		$0	$0	$0	$250[f]	$250[f]	$250[f]	$250[f]

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)						
		CHIP plan			QHP			
		>142-157%	>157-209%	>209-313%	100-150%	>150-200%	>200-250%	>250-400%
Enabling services	Non-hospice respite care	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Translation services—office visits	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Care coordination/ case management	Not covered	Not covered	Not covered	0%	0%	0%	0%
	Routine transportation[g]	$0	$0	Not covered	Not covered	Not covered	Not covered	Not covered

Source: GAO analysis of information from the state and QHP. | GAO-15-323

Notes: CHIP plan information is from state officials. QHP information is from Evidences of Coverage for the Illinois Blue Choice Silver PPO 003 Plan and state and QHP officials.

For the QHP in this table, the FPL ranges correspond with the following actuarial value (AV) levels: 100-150 percent FPL (94 percent AV), >150-200 percent FPL (87 percent AV), >200-250 percent FPL (73 percent AV), and >250-400 percent FPL (70 percent AV).

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the QHP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and count toward the out-of-pocket maximum cost.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While federal law does not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The Patient Protection and Affordable Care Act (PPACA) required that, effective January 1, 2014, states determine Medicaid and CHIP income eligibility for certain categories of individuals using a uniform modified adjusted gross income (MAGI) methodology that is derived from a federal tax based definition of income. To accomplish this, states were required to convert their net income eligibility standards to MAGI equivalent income standards. The CHIP eligibility FPL ranges in this table reflect this conversion. Additionally, PPACA specifies that an income disregard equal to five percentage points of the FPL be deducted from an individual's income when determining Medicaid and CHIP eligibility. The FPL eligibility ranges in this table do not reflect this income disregard.

[a]The copayment amount is charged per day.

[b]Listed copayment is charged when mental health and substance abuse outpatient therapy is provided in a Federally Qualified Health Center or Rural Health Center.

[c]If generic prescription drugs are ordered through the mail, the cost per prescription is $0.

[d]If brand-name prescription drugs are ordered through the mail, the cost per prescription is $100. Brand- name drugs include drugs designated by the plan as "preferred" or included in their formulary.

[e]This coinsurance is not subject to the deductible.

[f]Hospice care has a $250 per admission deductible. For inpatient covered services, 100 percent of the eligible charge is covered.

[g]Routine transportation includes transportation to and from medical appointments.

Table 15: Cost-Sharing Amounts for Selected Services in the State Children's Health Insurance Program (CHIP) Plan and Qualified Health Plan (QHP) GAO Reviewed in Kansas, Calendar Year 2014

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)				
		CHIP plan	QHP			
		134-242%	100-150%	>150-200%	>200-250%	>250-400%
Plan deductible	Individual	None	$0	$0	$2,000	$2,000
	Family	None	$0	$0	$4,000	$4,000
Prescription drug deductible	Individual	None	None	None	$2,000	$2,000
Service (copayment=$, coinsurance=%)						
Ambulatory patient services: office visits	Primary care physician	$0	$0	$5	$5	$10
	Specialty physician	$0	$20	$40	$75[a]	$75[a]
Emergency care		$0	$100	$250	$500[b]	$500[b]
Inpatient hospital		$0	10%	30%	30%	50%
Maternity care		$0	Various[c]	Various[d]	Various[d]	Various[e]
Mental health and substance abuse	Inpatient	$0	10%	30%	30%	50%
	Outpatient therapy	$0	10%	30%	30%	50%
Prescription drugs	Generic	$0	$5[f]	$10[f]	$15[f]	$10[f]
	Brand-name	$0	$30[g]	$35[g]	$45[g,h]	$45[g,h]
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$0	10%	30%	30%	50%
	Habilitative	Not covered	10%	30%	30%	50%
Preventive care		$0	$0	$0	$0	$0
Pediatric vision	Optometrist exam	$0	$0	$0	$0	$0
	Corrective lenses	$0	$0	$0	$0	$0
Pediatric hearing	Testing (screening or exam)	$0	0%[i]	0%[i]	0%[i]	0%[i]
	Hearing aids	$0	10%	30%	30%	50%
Durable medical equipment		$0	10%	30%	30%	50%
Home and community-based health care		$0	10%	30%	30%	50%
Hospice		$0	10%	30%	30%	50%

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)				
		CHIP plan	QHP			
		134-242%	100-150%	>150-200%	>200-250%	>250-400%
Enabling services	Non-hospice respite care	$0	Not covered	Not covered	Not covered	Not covered
	Translation services—office visits	$0	Not covered	Not covered	Not covered	Not covered
	Care coordination/ case management	$0	Not covered	Not covered	Not covered	Not covered
	Routine transportation[j]	$0	Not covered	Not covered	Not covered	Not covered

Source: GAO analysis of information from the state and QHP. | GAO-15-323

Notes: CHIP plan information is from state officials. QHP information is from Evidences of Coverage for the Kansas Coventry Health and Life Integrated Silver $10 Copay PPO KC Exchange Plan and state and QHP officials.

For the QHP in this table, the FPL ranges correspond with the following actuarial value (AV) levels: 100-150 percent FPL (94 percent AV), >150-200 percent FPL (87 percent AV), >200-250 percent FPL (73 percent AV), and >250-400 percent FPL (70 percent AV).

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the QHP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and count toward the out-of-pocket maximum cost.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While federal law does not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The Patient Protection and Affordable Care Act (PPACA) required that, effective January 1, 2014, states determine Medicaid and CHIP income eligibility for certain categories of individuals using a uniform modified adjusted gross income (MAGI) methodology that is derived from a federal tax based definition of income. To accomplish this, states were required to convert their net income eligibility standards to MAGI equivalent income standards. The CHIP eligibility FPL ranges in this table reflect this conversion. Additionally, PPACA specifies that an income disregard equal to five percentage points of the FPL be deducted from an individual's income when determining Medicaid and CHIP eligibility. The FPL eligibility ranges in this table do not reflect this income disregard.

[a]The first two specialist visits are charged at $75 and are not subject to the deductible. Three visits or more are charged at $75 and are subject to the deductible.

[b]The first emergency visit is charged at $500 and is not subject to the deductible. Two visits or more are charged at $500 and are subject to the deductible.

[c]Costs for maternity services varied. Prenatal office visits are charged at $0; physician charges, prenatal, postnatal, ultrasound, and delivery are charged a one-time $250; and outpatient ultrasounds are charged at 10 percent.

[d]Costs for maternity services varied. Prenatal office visits are charged at $0; physician charges, prenatal, postnatal, ultrasound, and delivery are charged a one-time $250; and outpatient ultrasounds are charged at 30 percent.

[e]Costs for maternity services varied. Prenatal office visits are charged at $0; physician charges, prenatal, postnatal, ultrasound, and delivery are charged a one-time $250; and outpatient ultrasounds are charged at 50 percent.

[f]The prices displayed are Preferred Generic (Tier 1) prescription drugs. The Kansas QHP also has Best Value Generics (Tier 1A), which is a select list of tier one drugs determined by Coventry to be available for a reduced copayment. Alavert OTC and Chlorpropamide are examples of drugs on this tier. Tier 1A drugs are charged at $3 for the 100-150 percent plan variation and $5 for the >150-200 percent, >200-250 percent and >250-400 percent plan variations.

[g]If brand-name prescription drugs are ordered through the mail, the cost per prescription is $75, $87.50, $112.50 (subject to the prescription deductible) and $112.50 (subject to the prescription deductible) for 100-150 percent, >150-200 percent, >200-250 percent, and >250-400 percent FPL, respectively. Brand-name drugs include drugs designated by the plan as “preferred” or included in their formulary.

[h]Brand-name prescription drugs in the >200-250 percent and >250-400 percent FPL ranges are subject to the prescription deductible.

[i]The prices displayed are not subject to the deductible and apply for preventive hearing testing only. If the service is not billed as preventive, hearing testing would be charged at 10%, 30%, 30% and 50% for 100-150 percent, >150-200 percent, >200-250 percent and >250-400 percent FPL, respectively.

[j]Routine transportation includes transportation to and from medical appointments.

Table 16: Cost-Sharing Amounts for Selected Services in the State Children's Health Insurance Program (CHIP) Plan and Qualified Health Plan (QHP) GAO Reviewed in New York, Calendar Year 2014

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)				
		CHIP plan	QHP			
		>154-400%	100-150%	>150-200%	>200-250%	>250-400%
Plan deductible	Individual	None	$0	$250	$1,750	$2,000
	Family	None	$0	$500	$3,500	$4,000
Service (copayment=$, coinsurance=%)						
Ambulatory patient services: office visits	Primary care physician	$0	$10	$15	$30	$30
	Specialty physician	$0	$20	$35	$50	$50
Emergency care		$0	$50[a]	$75[a]	$150[a]	$150[a]
Inpatient hospital		$0	$100	$250	$1,500	$1,500
Maternity care		$0	Various[b]	Various[c]	Various[d]	Various[d]
Mental health and substance abuse	Inpatient	$0	$100	$250	$1,500	$1,500
	Outpatient therapy	$0	$10	$15	$30	$30
Prescription drugs	Generic	$0	$6[e]	$9[e]	$10[e]	$10[e]
	Brand-name	$0	$15[f]	$20[f]	$35[f]	$35[f]
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$0	$15	$25	$30	$30
	Habilitative	$0	$15	$25	$30	$30
Preventive care		$0	$0	$0	$0	$0
Pediatric vision	Optometrist exam	$0	$10	$15	$30	$35
	Corrective lenses	$0	5%	10%	25%	30%
Pediatric hearing	Testing (screening or exam)	$0	$0	$0	$0	$0
	Hearing aids	$0	5%	10%	25%	30%
Durable medical equipment		$0	5%	10%	25%	30%
Home- and community-based health care		$0	$10	$15	$30	$30
Hospice		$0	$100[g]	$250[g]	$1,500[g]	$1,500[g]
Enabling services	Non-hospice respite care	Not covered	Not covered	Not covered	Not covered	Not covered
	Translation services—office visits	$0	Not covered	Not covered	Not covered	Not covered

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)				
		CHIP plan	QHP			
		>154-400%	100-150%	>150-200%	>200-250%	>250-400%
	Care coordination/ case management	$0	Not covered	Not covered	Not covered	Not covered
	Routine transportation[h]	Not covered	Not covered	Not covered	Not covered	Not covered

Source: GAO analysis of information from the state and QHP. | GAO-15-323

Notes: CHIP information is from state officials. QHP information is from Evidences of Coverage for the New York MetroPlus SilverPlus S1 Plan and state and QHP officials.

For the QHP in this table, the FPL ranges correspond with the following actuarial value (AV) levels: 100-150 percent FPL (94 percent AV), >150-200 percent FPL (87 percent AV), >200-250 percent FPL (73 percent AV), and >250-400 percent FPL (70 percent AV).

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the QHP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and count toward the out-of-pocket maximum cost.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While federal law does not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The Patient Protection and Affordable Care Act (PPACA) required that, effective January 1, 2014, states determine Medicaid and CHIP income eligibility for certain categories of individuals using a uniform modified adjusted gross income (MAGI) methodology that is derived from a federal tax based definition of income. To accomplish this, states were required to convert their net income eligibility standards to MAGI equivalent income standards. The CHIP eligibility FPL ranges in this table reflect this conversion. Additionally, PPACA specifies that an income disregard equal to five percentage points of the FPL be deducted from an individual's income when determining Medicaid and CHIP eligibility. The FPL eligibility ranges in this table do not reflect this income disregard.

[a]Copayment is waived if the patient is admitted as an inpatient directly from the emergency room.

[b]Costs for maternity services varied. Prenatal care is charged at $0, inpatient hospital services are charged at $100, physician and nurse midwife services for delivery are charged at $25, and a breast pump is charged at $0.

[c]Costs for maternity services varied. Prenatal care is charged at $0, inpatient hospital services are charged at $250, physician and nurse midwife services for delivery are charged at $75, and a breast pump is charged at $0.

[d]Costs for maternity services varied. Prenatal care is charged at $0, inpatient hospital services are charged at $1,500, physician and nurse midwife services for delivery are charged at $100, and a breast pump is charged at $0.

[e]If generic prescription drugs are ordered through the mail, the cost per prescription is $15, $23, $25 and $25 for 100-150 percent, >150-200 percent, >200-250 percent and >250-400 percent FPL, respectively, for a 90-day supply.

[f]If brand-name prescription drugs are ordered through the mail, the cost per prescription is $38, $50, $88 and $88 for 100-150 percent, >150-200 percent, >200-250 percent and >250-400 percent FPL, respectively, for a 90-day supply.

[g]QHP cost-sharing displayed is for inpatient hospice. Outpatient hospice is charged at $10, $15, $30 and $30 for 100-150 percent, >150-200 percent, >200-250 percent and >250-400 percent FPL, respectively.

[h]Routine transportation includes transportation to and from medical appointments.

Table 17: Cost-Sharing Amounts for Selected Services in the State Children's Health Insurance Program (CHIP) Plan and Qualified Health Plan (QHP) GAO Reviewed in Utah, Calendar Year 2014

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)					
		CHIP plan		QHP			
		134-150%	151-200%	100-150%	>150-200%	>200-250%	>250-400%
Plan deductible	Individual	$40	$500	$500	$900	$3,250	$4,600
	Family	$40	$1,500	$1,000	$1,800	$6,500	$9,200
Prescription drug deductible	Individual	$0	$0	$250	$500	$1,000	$1,500
	Family	$0	$0	$500	$1,000	$2,000	$3,000
Service (copayment=$, coinsurance=%)							
Ambulatory patient services: office visits	Primary care physician	$5	$25	$25	$25	$25	$25
	Specialty physician	$5	$40	$35	$35	$35	$35
Emergency care		$5	$300[a]	20%	20%	20%	20%
Inpatient hospital		$150[a]	20%	20%	20%	20%	20%
Maternity care		20%	20%	20%	20%	20%	20%
Mental health	Inpatient	$150[a]	20%	20%	20%	20%	20%
	Outpatient therapy	$5	$0	20%	20%	20%	20%
Substance abuse	Inpatient	20%	20%	20%	20%	20%	20%
	Outpatient therapy	20%	0%	20%	20%	20%	20%
Prescription drugs	Generic	$5	$15	$10[b]	$10[b]	$10[b]	$10[b]
	Brand-name	5%[d]	25%[d]	$20[c]	$20[c]	$20[c]	$20[c]
Outpatient therapies (occupational, physical, speech)	Rehabilitative	$5	$40[a]	20%	20%	20%	20%
	Habilitative	Not covered	Not covered	20%	20%	20%	20%
Preventive care		$0	$0	0%[d]	0%[d]	0%[d]	0%[d]
Pediatric vision	Optometrist exam	$5	$25	0%[d]	0%[d]	0%[d]	0%[d]
	Corrective lenses	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
Pediatric hearing	Testing	$5	$25	0%[d]	0%[d]	0%[d]	0%[d]
	Hearing aids	Not covered[e]	Not covered[e]	Not covered	Not covered	Not covered	Not covered
Durable medical equipment		5%	20%	20%	20%	20%	20%
Home- and community-based health care		5%	20%	20%	20%	20%	20%
Hospice		5%	20%	20%	20%	20%	20%

		Deductibles and copay/coinsurance by household income as percent of federal poverty level (FPL)					
		CHIP plan		QHP			
		134-150%	151-200%	100-150%	>150-200%	>200-250%	>250-400%
Enabling services	Non-hospice respite care	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered
	Translation services—office visits	$0	$0	Not covered	Not covered	Not covered	Not covered
	Care coordination/case management	$0	$0	Not covered	Not covered	Not covered	Not covered
	Routine transportation[f]	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

Source: GAO analysis of information from the state and QHP. | GAO-15-323

Notes: CHIP plan information was provided by state officials. QHP information is from Evidences of Coverage for the Utah Humana Connect Silver 4600/6300 Plan and state and QHP officials.

For the QHP in this table, the FPL ranges correspond with the following actuarial value (AV) levels: 100-150 percent FPL (94 percent AV), >150-200 percent FPL (87 percent AV), >200-250 percent FPL (73 percent AV), and >250-400 percent FPL (70 percent AV).

A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a $25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. Health plans may also have an explicit limit on the maximum out-of-pocket costs a consumer could incur.

For the QHP, the coinsurance amounts (numbers depicted in the table as a percentage) apply once the deductible is met and count toward the out-of-pocket maximum cost. Copayments (numbers depicted in the table with a dollar sign) are paid each time a consumer receives a service, are not subject to the deductible, and do not count toward the out-of-pocket maximum cost.

Rehabilitation is provided to help a person regain, maintain or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. While federal law does not define habilitative services, habilitation has been defined by several advocacy groups as a service that is provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The Patient Protection and Affordable Care Act (PPACA) required that, effective January 1, 2014, states determine Medicaid and CHIP income eligibility for certain categories of individuals using a uniform modified adjusted gross income (MAGI) methodology that is derived from a federal tax based definition of income. To accomplish this, states were required to convert their net income eligibility standards to MAGI equivalent income standards. The CHIP eligibility FPL ranges in this table reflect this conversion. Additionally, PPACA specifies that an income disregard equal to five percentage points of the FPL be deducted from an individual's income when determining Medicaid and CHIP eligibility. The FPL eligibility ranges in this table do not reflect this income disregard.

[a]Copayment paid after deductible met.

[b]If generic prescription drugs are ordered through the mail, the cost per prescription is $20 and is subject to the prescription deductible.

[c]If brand-name prescription drugs are ordered through the mail, the cost per prescription is $40 and is subject to the prescription deductible. Brand- name drugs include drugs designated by the plan as "preferred" or included in their formulary.

[d]This coinsurance is not subject to the deductible.

[e]Not covered unless following a cochlear implant.

[f]Routine transportation includes transportation to and from medical appointments.

Appendix V: GAO Contact and Staff Acknowledgments

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Staff Acknowledgments

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Related GAO Products

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