Benefits and Cost Sharing: Meeting CHIP Rules When Subsidizing Employer-Sponsored Plans

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Jean Hearne
Kathy Patchan
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The enactment of the State Children's Health Insurance Program (CHIP), Title XXI of the Social Security Act, is the single largest federal commitment to child health since Medicaid and Medicare were passed more than three decades ago. Over the next 10 years, CHIP will provide federal matching funds to states to expand health insurance coverage for children whose families have income below 200% of poverty and who are ineligible for Medicaid. Under Title XXI, states can expand public programs providing health coverage, subsidize employer-sponsored health coverage, or both. On January 22, 1998, the Institute for Health Policy Solutions (IHPS) held a roundtable discussion to discuss approaches for states intending to subsidize the cost of employer coverage for CHIP-eligible children and address operational and administrative complications that may arise. Participants included executives from state health agencies, health plans, HMOs, and private industry. The goal of the session from which the following report was developed was to design approaches that assure access to required minimum CHIP benefits while maximizing access to health insurance coverage. This report suggests two approaches states can take to comply with minimum benefits and maximum cost sharing standards of Title XXI when subsidizing employer insurance coverage.

Under federal Title XXI, a number of states are designing child health initiatives to include both a public program providing health benefits coverage to uninsured children and a subsidy program to assist with the premium cost for uninsured children who have access to employer-sponsored benefits. Those states face a number of challenges in complying with the statute's benefits and cost-sharing requirements. In particular, while states can design their *public* plans to meet the federal rules, the premium subsidy or buy-in programs must coordinate with existing employer plans that have wide variation in benefits and cost sharing.

There are several alternate approaches states could use to ensure that subsidized employer plans meet CHIP benefits and cost-sharing rules. States could develop contracts with health plan carriers and HMOs to offer CHIP-qualified plans to employers. CHIP-eligible children with a parent working at a firm that offers those carriers' plans could be enrolled in the CHIP-qualified plan while their parents retain regular coverage through the same carrier. Alternatively, states could supplement subsidized employer plans with publicly offered benefits to ensure benefits and cost sharing meet minimum standards. Finally, an approach underway in Massachusetts, but not discussed at the roundtable, would be for states to subsidize only those employer plans that meet the CHIP benefits and cost-sharing rules.

BACKGROUND

To obtain enhanced matching funds under CHIP, states' programs must cover health benefits that meet minimum standards. Coverage funded under CHIP must be: (1) those provided under a benchmark benefit plan, (2) benchmark-equivalent coverage, or (3) any other health benefits plan that the state endorses and the Secretary of the Department of Health and Human Services (HHS) approved.[1]

Benchmark benefit plans can be any of the following: the standard Blue Cross/Blue Shield preferred provider option offered under the Federal Employees Health Benefits program, a health plan offered and generally available to state employees in the state, or the health coverage that is offered by an HMO with the largest commercial enrollment in the state.

[1] In addition, the benefits provided under three state programs in existence before the passage of Title XXI; in New York, Pennsylvania, and Florida, were grandfathered in as meeting minimum benefits standards under Title XXI.

"Benchmark-equivalent coverage" is defined as a package of benefits that is certified in an actuarial memorandum[2] as having the same or greater actuarial value as one of the benchmark benefit packages.[3] Benchmark-equivalent coverage must include each of the four basic benefits - inpatient and outpatient hospital services, physicians' surgical and medical services, lab and x-ray, and well-baby/well-child care including age-appropriate immunizations. They must also include at least 75% of the actuarial value of the coverage provided under the benchmark for benefits grouped in "categories of additional services" – prescription drugs, mental health, vision and hearing services.

The federal law imposes cost-sharing ceilings for families contributing towards CHIP coverage. Families with incomes below 150% of poverty can be subject to no more than nominal cost sharing fees.[4] Total cost sharing for premiums, copayments and deductibles for families with incomes above 150% of poverty cannot exceed 5% of gross family income. Finally, regardless of income level, there can be no cost sharing for preventative services, such as well-baby, well-child care, and immunizations.

Contracting with Carriers to Meet Benefits and Cost Sharing Rules

To ensure that employer plans provide coverage for CHIP-eligible children that meets the benefits and cost sharing rules of Title XXI, states could negotiate directly with carriers and HMOs to establish such plans. Carriers could offer those CHIP-certified plans to CHIP-eligible children when they are added as dependents of workers covered by an employer plan offered through that carrier. For example, Acme Dry Cleaners offers Primo HMO coverage to its employees. Joe is an employee whose child, Susie, is CHIP eligible. The state contracts with Primo to offer a CHIP-certified plan. Joe provides Primo with a certificate attesting to Susie's CHIP eligibility and elects family coverage through Acme. Primo automatically provides Susie with the CHIP benefit plan while Joe receives the normal Primo HMO coverage.

Under this approach, states could identify carriers and/or HMOs that comprise a large share of the employer market and solicit them to develop a plan with benefits and cost-sharing that conform to CHIP rules. States would pay a per child price directly to the carriers for cost of the upgraded benefits and cost sharing relative to the normal employer benefit plan.[5]

This approach is simple for beneficiaries and families, employers, and states. Families are not required to do anything to ensure that CHIP-eligible children receive coverage that meets CHIP standards. Employers are not required to offer

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[2] Actuarial reports must a) be prepared by a member of the American Academy of Actuaries, b) use generally accepted actuarial principles and methods and a standardized population representative of privately insured children of the same age as those to be covered, c) must apply the same principles and factors in comparing the value of different coverage not taking into account differences in coverage resulting from method of delivery or cost and utilization control, and e) may reflect reduced benefits accounted for by the increase in the value of the benchmark when the cost sharing ceilings are applied to the benchmark benefits.

[3] For estimates of the actuarial value of benchmark benefits packages for certain states see: The Hay Group, **Value of Benefits Offered in Benchmark Plans for State Children's Health Insurance Program (SCHIP)**, November 1997.

[4] For children in families with income below 150% of the federal poverty level, premiums may not exceed those allowable under section 1916(b)(1) of the Medicaid statute. The current implementing regulation (42 CFR 447.52) would apply; this rule sets out maximum monthly enrollment fees by gross family income and family size. The Secretary has issued guidelines which propose the following limits on coinsurance, copayments and similar charges for CHIP children: $1 for services of $15 or less; $2 for services between $15.01 and $0; $3 for services between $40.01 and $80; and $5 for services over $80.

[5] In the small employer market, appealing directly to carriers to provide a CHIP package may be difficult to implement because of the large number of carriers, the degree of benefit plan variation, and potential problems in negotiating related administrative costs with carriers. As one venue for simplifying these issues, participating states with small employer purchasing cooperatives are also considering arranging for these organizations to make Title XXI benefit packages available for participating small firm workers' children and negotiating with participating plans price differential over the HIPCs other standardized benefits.

special benefits to some of their modest income employees' children. States do not need to "wrap-around" employer benefits plans or administer complex coordination of employer benefits plans with public benefits plans.

This approach, however, would require carriers to identify CHIP-eligible children within families and within employer groups in order for those children to receive the CHIP packages. Carrier executives participating in our discussions disagreed about the abilities of their systems to identify CHIP-eligible children within employer groups. One participant suggested that those processes would not be significantly different from the kind of coordination done when one family member has Medicare or Medicaid coverage. In this scenario, carriers would face a one-time only cost to develop systems that provide a second plan code so that all benefits for CHIP-eligible children can be identified separately. Another suggested that it may be easier to "carve out" CHIP children from family plans, thereby treating those children as separate policy-holders, than to coordinate with other family members' coverage.

The carriers or HMOs would do the bulk of the work under this approach. The carriers or HMOs would provide coverage that is "benchmark equivalent", would set copayments and deductibles for families with income below 150% at levels that meet the HHS guidelines, and would ensure families with income over 150% of poverty do not pay cost-sharing amounts (including premiums) that exceed 5% of family income.[6] States choosing this approach would need to establish a system to verify that ceilings are properly implemented and that CHIP-eligible children are not asked to pay cost-sharing amounts in excess of ceilings.

"Filling-In" to Meet Benefits and Cost Sharing Rules

Rather than recruit carriers to administer CHIP plans through employers, states could establish programs that "fill in" on benefits and cost sharing where employer coverage falls short of CHIP standards. This administratively burdensome approach bears great similarity to the "wrap-around" coverage provided under Medicaid health insurance purchasing programs (HIPP). Under those programs, Medicaid agencies provide benefits separately when they are not covered by the beneficiary's group plan.[7]

To make this approach workable for states and for families, states would need to simplify considerably. To increase the possibility that an employer plan meets the CHIP standards without supplementation, states should identify all alternate benchmark plans. By identifying and comparing employer plans to all three benchmark benefit plans and any secretary-approved plans, the likelihood that employer plans are found to be equivalent or better than a benchmark plan improves.

But when plans fall short of the benchmark test, states should avoid establishing a "fill-in" approach that requires analyzing individual employer plans, comparing each one to the benchmarks, and providing "fill in" benefits that are uniquely tailored to the individual employer plan. A shortcut may be to offer only one or two discrete benefits, such as prescription drugs or mental health, which are not usually provided in the employer market but are a part of the benchmark plan(s). For example, the California Healthy Families plan will provide separate dental and vision coverage for children whose employer plans do not offer this coverage.[8] States should explore the employer market for insurance to determine if such separate supplemental benefits would make sense. In markets where there is a lot of variation in benefits, it may not make sense to establish supplemental benefits packages since too much variation in the supplemental packages would be necessary to make employer plans meet the benchmark tests.

States that "fill-in" to pay some of a beneficiary's cost sharing charges when they exceed the CHIP ceilings will need to have procedures in place to ensure that lower-income families pay "nominal" amounts (as defined by the Secretary of

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[6] State agencies could provide carriers with an estimated cost sharing cap amount – equal to 5% of family income less any family premium contributions. Carriers could administer the cost-sharing cap just like a stop-loss policy.

[7] An IHPS paper entitled "Extending health Care Coverage for Modest-Income Children and Pregnant Women: Public and Employer-Financed Coverage Lessons" by Rick Curtis and Ann Page discuss the difficulties and barriers state Medicaid agencies encountered in administering "Health Insurance Purchasing Plans" including the administratively burdensome "wrap-around" coverage.

[8] Dental services are not included under the federal law as a category of additional services required under Title XXI if included in a benchmark. State legislation in California requires dental benefits.

HHS) at each encounter and families with income above 150% of poverty pay no more than 5% of family income. For both groups, states will have to ensure that beneficiaries are not subject to any cost-sharing for preventive and well-child care.

States can use two approaches to "fill-in" when cost-sharing exceeds nominal levels for the lower income group or 5% of income for the higher income group. One way is for CHIP-eligible children to pay the normal co-pays or co-insurance amounts and seek reimbursement from the state for the portion that exceeds the CHIP-allowed level. It is unlikely that such an approach will be approved, though. For children in families with income below 150%, the CHIP limits are intended to eliminate financial barriers to accessing services. A similar view would probably be taken with children whose cost sharing exceeded 5% of income.

Instead of a reimbursement approach, states could establish a procedure to pay cost sharing amounts on behalf of CHIP-eligible children. The state could pay amounts that exceed the limits directly to providers for each encounter or arrange for carriers to do so.

An obvious disadvantage for states administering a cost-sharing "fill-in" for individual encounters with providers is the large administrative burden. Large numbers of providers would bill states for many very small costs. Further complications could arise because providers would have a financial incentive to charge for services based on retail rates rather than the fee scales used under the employer plan or for Medicaid beneficiaries. The major advantage of this approach, however, is that states would have ultimate responsibility for tracking cost-sharing and ensuring that CHIP-eligible children are protected from cost-sharing charges that can be barriers to seeking care.

An alternative for states would be to have carriers administer the cost-sharing "fill in". States would negotiate an amount to pay to carriers that would reflect per child cost-sharing amounts in excess of the CHIP cost-sharing ceilings that CHIP-eligible children are likely to generate. Carriers would identify services where a cost-sharing "fill-in" payment should be made to a provider and make those payments. Children who participate in CHIP would be given an identification card that denotes their CHIP-copayment group – one group being subject to nominal amounts with no ceiling and a second group subject to normal amounts with 5% ceiling. (The 5% ceiling could be administered like other stop-loss policies.)

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Questions and Comments can be directed to: Jean Hearne, 202/857-0810 ext. 108