

INSTITUTE FOR HEALTH POLICY SOLUTIONS

Meeting Cost-Sharing Requirements Under CHIP Premium Subsidy Programs

Prepared with support from the David and Lucile Packard Foundation

Jennifer Sexton
July 30, 1998

A number of states are developing programs to assist parents with the cost of obtaining employer-sponsored coverage for their children. These premium subsidy or buy-in programs may be implemented as part of the Child Health Insurance Program (CHIP) established by the Balanced Budget Act of 1997. The Act allows subsidies for an employee's required contribution for coverage of a child not already enrolled under the employer's plan. The cost must be no more than what would have been incurred if the same child were enrolled under the state's regular CHIP program.

States designing buy-in programs face a number of administrative issues, including developing payment mechanisms, assessing cost-effectiveness, and assuring access to required minimum CHIP benefits. This document was developed to provide some insight into the types of cost-sharing issues that states may face when implementing CHIP in coordination with employer-sponsored plans. Cost sharing rules and requirements under Title XXI are summarized. This is followed by a brief discussion of typical cost sharing procedures developed by states in their submitted CHIP plans. Massachusetts' approach to cost-sharing when coordinating with employer-financed health insurance is described. A simple alternative approach, in which states contract directly with insurance carriers to provide a CHIP benefit package that meets all CHIP cost sharing rules, is proposed.

As outlined in HCFA's February 13, 1998 "Dear State Official" letter, the following is a description of the cost-sharing requirements under the Child Health Insurance Program:¹

- If a state chooses to implement CHIP as an expansion to its Medicaid program, the current federal Medicaid cost-sharing rules apply.
- If a state chooses to implement CHIP as a separate, non-Medicaid program, the following requirements apply:
 - Any premiums, deductibles, coinsurance or other cost-sharing mechanisms, must be imposed according to a public schedule.
 - The amount that the state is allowed to charge for any of these cost-sharing methods is determined by whether the child's family is above or below 150 percent of the Federal poverty line.
 - For a family with income at or below 150 percent FPL, the maximum amount allowed for premium charges is determined by current Medicaid rules and must be based on an income-related sliding scale. Similarly, the charges that are allowed for any other cost sharing besides premiums must be an amount that is considered to be nominal under federal Medicaid rules. 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.

¹ Letter to state officials from Sally Richardson, Health Care Financing Administration, and Claude Earl Fox, M.D., M.P.H., Health Resources and Services Administration, Feb. 13, 1998.

- For a family with income above 150 percent FPL, states may impose cost-sharing mechanisms in any amount so long as cost-sharing is not set lower for higher income children than it is for lower income children. In addition, the total annual aggregate cost sharing, including premium contributions and copayments, cannot exceed five percent of total family income for the year. States are required to inform families of these limits and to provide a mechanism for families to stop paying once their limits have been reached.

Currently, forty-six states have submitted state plans to HCFA and twenty-five have been approved.² Of the submitted plans, twenty-four are developing a Medicaid expansion and fourteen are developing a separate state child health plan. Eight states are developing a combination plan. At this time, Massachusetts is the only state plan that includes provisions to subsidize employer-sponsored coverage. It was approved May 29, 1998. Its mechanisms for implementing the caps on cost sharing are outlined below.

Of states enacting a separate state program, cost-sharing mechanisms and amounts differ greatly; however, some generalizations can be made. Typically, neither premiums nor other types of cost sharing are required in the case of families with gross incomes less than or equal to approximately 150% of FPL. For families above this income level, premium contribution charges average about \$15 - \$30 per family per month. If copayments are being used, they typically range anywhere from \$2 - \$10 with higher charges for emergency room visits and other special services. (State plans for implementing cost-sharing arrangements are outlined in Appendix 1).

Although state plans do not include details about how the state will determine when the family reaches their five-percent cost-sharing cap, we assume that cost sharing amounts have been set so low that, in most cases, the five-percent cap will not be reached, and that beneficiaries will discontinue paying cost sharing amounts if the cap should be reached.

Administering cost sharing requirements under a public plan is relatively easy. Meeting the requirements when coordinating with existing employer-sponsored plans is more difficult because of the wide variation in cost sharing for insurance in the private market.

Coordinating with an Employer-Sponsored Plan

Understanding how CHIP cost sharing requirements might be met is a particularly important issue for states interested in coordinating with employer coverage. Many employers offer plans (e.g. comprehensive HMO benefits) that might meet a state's benchmark equivalence requirements but cannot assure that cost sharing for those with income below 150% is nominal and for those with income about 150% will be within five percent of family income. Because there is substantial variation in employer plan copayment structures, it could be extremely expensive and cumbersome to implement a program that "fills in" copayments on an encounter by encounter basis for CHIP children, in order to achieve a uniform level for all services received by all eligible children.

Federal CHIP rules do not necessarily require health plans' copayment structures to be absolutely uniform; they do require states to protect families from aggregate cost sharing amounts in excess of federal standards. An approach that eliminates copayments above these thresholds can meet these standards. Massachusetts is the first state to implement such an approach for families with income >150% (those below are enrolled in MassHealth direct coverage, the Medicaid demonstration program which does not charge copayments.)

Massachusetts Approach

² Health Care Financing Administration Website. July 21, 1998. www.hcfa.gov/init/chip-map.htm

Under the Massachusetts plan, families with income above 150% of FPL receiving a subsidy to purchase employer-sponsored coverage will be subject to the co-payments/co-insurance and deductibles normally charged under the employer plan, with the exception of well-child and well-baby services which will be covered in full. Massachusetts will set a family cap on cost sharing at five percent of family gross income.³

These families will be provided with estimates of their cost sharing limit, will track their payments against the limit and will inform the state when their limit has been reached. The limit is calculated by subtracting the family share of premiums from five-percent of the family's gross income (obtained during eligibility determination). The remainder is the amount of co-payments and deductibles for which they will be responsible under the five-percent ceiling. The family will be asked to keep track of any cost-sharing payments that they make and to submit appropriate bills to the state agency for payment. Payment for well childcare services will be sent to the provider after the family has submitted the bill to the state. To ensure that families are not required to pay their bill at the point of service, the state will educate the provider community regarding the procedures for payment through bulletins and newsletters.⁴

Once the family has reached their cap, they will be responsible for submitting proof of payments totaling the amount equal to their five-percent cap to the state. The state will review and verify the payments in a timely manner. Once the review is complete, the family will be notified to submit all future bills to the state. The family will then use this notification as documentation to show the provider that they are no longer responsible for payment. State payment to the provider will be generated within one to two weeks of receiving the bill.

The approval of the Massachusetts plan could indicate that HCFA would approve this simple approach for other states coordinating with employer-financed coverage — with certain limitations, families would pay whatever the employer plan normally charges. The states would not be required to enter into the very complicated business of filling-in to ensure that all cost-sharing amounts for CHIP children are lower than those normally charged to all of the other group plan enrollees.

While the Massachusetts approach gives the state direct responsibility for assuring that families are protected from excess cost-sharing charges, it may prove somewhat burdensome to families, the state and providers. Under its approach, the state continues to require the family to submit bills to it in order to cover cost sharing payments in excess of the five-percent cap. Consequently, the state is responsible for administering the reimbursement of providers for what will usually be extremely small amounts, generating an increased amount of paperwork for both the state and for providers. It may prove to be that so few families reach their limit that the administrative burden for the state and for providers is not a substantial problem. But, just as under many states' public CHIP programs, there is a possibility that some parents, for example, parents of chronically ill children, will not keep track of their expenses and face copayments that exceed their ability to pay.

Contracting with Insurance Carriers

A simpler approach may be to have the state contract with insurance carriers to administer a program that would meet CHIP requirements. The carrier could develop a package that meets the CHIP benefits requirements and use its administrative structure to ensure that CHIP families do not pay beyond their five-percent limit. Employers could offer this upgraded CHIP benefit package to dependents of employees who meet the program requirements. The state would pay the carrier for the additional cost of the upgraded benefits. Using their encounter databases, the carriers could presumably administer the cap much like any other stop-loss policy. By monitoring the amounts of copayments, coinsurance and premiums

³ Massachusetts' Title XXI State Plan

⁴ Letter from the Massachusetts Division of Medical Assistance to HHS in response to questions about the MA Title XXI State Plan. May 1, 1998

made, the carrier would be in the position to notify a family immediately when their maximum has been reached. While having carriers track cost sharing against a varying ceiling would admittedly be more work for the carrier, it would be much easier for families. This approach would reduce the burden on families substantially by eliminating the need for families to be involved in the payment of bills after they have reached their cap.⁵ In addition, by reducing the amount of paperwork involved, it could be more administratively efficient for both the state and for providers. The carrier would be in a position to generate one periodic check to individual providers instead of the state generating any number of checks in smaller amounts. However, just as under the Massachusetts approach, the state would need to assure that providers did not in fact charge copayments to families once their applicable limit was reached.

The Institute for Health Policy Solutions, the National Academy for State Health Policy, and the National Conference of State Legislatures have received funding from the David and Lucile Packard Foundation. IHPS, NASHP, and NCSL are providing technical assistance to states that are implementing CHIP.

Questions or comments can be directed to: Jennifer Sexton 202/857-0810 x101

⁵ Fox, Harriette B., McManus, Margaret A., Rodgers, Jack and Hayden, Kathy-Jo B. “Cost-Sharing Options Under the State Children’s Health Insurance Program.” Maternal and Child Health Policy Research Center, Washington, DC

Appendix: Examples of Cost Sharing Under Title XXI

<i>State</i>	Type of Program	Premiums	Other Cost Sharing
Alabama	Medicaid Expansion	None	None
Arkansas	Medicaid Expansion	None	None
California	Combination	Depends on Type of Plan: \$4 - \$7 per child 100 – 150% FPL; \$14 max \$6 - \$9 per child 150 – 200% FPL; \$27 max Families who prepay three months will get fourth free	Co-pays for most services: <100% FPL= None \$5 and are limited to \$250 annually
Colorado	State Designed Program	<100%FPL= None 101-159% FPL=\$15 160-185%=\$25; Also, for SFY 98-99: 150-185% = \$2.50/ additional child For SFY 99-00: \$5/additional child	Copays, except for preventive care: 101-150% FPL: \$2; >150%=\$5 \$1 to \$5 for Rx
Connecticut	Combination	<235% FPL= None 236-300% FPL=\$30 per child/\$50 max >300%=pay entire premium	<185%=None >185% =None for list of covered benefits \$5 copay for outpatient physician visits, eye exams, nurse midwives, nurse practitioners, podiatrists, chiropractors, and naturopaths; \$25 copay for non-emergency use of emergency services 185 – 235% \$650 max cost share 235 – 300% \$1250 max >300% no limit
Florida	Combination	101 – 185% FPL \$15 per month max;	will modify copay structure to conform to Title XXI, Mental health copay=\$3; Non-emergency use of emergency room=\$10
Georgia	State designed program	≤200% FPL= Age 0-5:\$0 Age 6-18:\$7.50 for one child; \$15.00 for 2 or more Must submit first month payment with application; coupon book; can pay multiple months If cancelled due to nonpayment, can be reinstated if still eligible but must pay for next 2 months.	None
Idaho	Medicaid Expansion	None	None
Illinois	Medicaid Expansion	None	None
Indiana	Medicaid Expansion	None	None
Iowa	Medicaid Expansion	None	None
Kentucky	Combination	100 – 133% FPL= \$10 max/ 6months 134 – 149% FPL=\$20 max/6 months 150 – 200% FPL=\$20/month (\$120 max for 6 month period)	None
Maine	Combination	<150%=None 150-160%FPL=\$5 per month/per child; \$10 max per family 160-170%FPL=\$10 per month/per child; \$20 max per family 170-185% FPL=\$15 per month/per child; \$30 max per family The premium is never higher than the equivalent of 1.6% of family income for those at the lowest end of the FPL range.	None
Maryland	Medicaid Expansion through Section 1115 demonstration waiver	None	None
Michigan	Combination	≤150% FPL= None 151-200%=\$5 per family	None
Minnesota	Medicaid Expansion under Section 1115 demonstration waiver	≤150% FPL=\$4 per month; 150-275% FPL=sliding scale from 1.8% to 8.8% of gross income; 275-280%= full cost	None

<i>State</i>	Type of Program	Premiums	Other Cost Sharing
Montana	Private Plan	≤ 100%= \$25 per child per year, \$100 max 101- 150%=\$50 per child per year, \$200 max	\$3 copay per emergency room visit
Nebraska	Medicaid Expansion	None	None
Nevada	State Designed Program	Initial enrollment fee and quarterly premium based on family size and income.	≤150%=None >150% \$5 copay for dental and drugs; \$10 copay for vision and hearing
New Hampshire	Combination	185-300%FPL=\$15 per month/per child; premium not to exceed 5% of family annual income	\$5 office copay (except preventive visits); \$5 prescription; \$25 non-emergency use of emergency room
New Mexico	Medicaid Expansion	136 – 235% FPL= \$15 per month per family	None
New Jersey	Combination	≤150% FPL= None 151-200% FPL=\$15 per month per family	≤150%= None 151-200% FPL= \$5 for physician other than required coverage, \$10 emergency, \$1 Rx generic, \$5 Rx brand
New York	State designed program	≤160% FPL= None 161-222%=\$9 per child per month, \$36 max	\$2 physician, except well child, \$1-\$3 drug, \$35 emergency for failure to notify or inappropriate use
North Carolina	State designed program	150-200%=\$50 per child, \$100 max 200-225%FPL=Full cost	copays for <150%=Rx \$6, \$5 physician except for preventive, unnecessary emergency case \$20
Ohio	Medicaid expansion	None	None
Oregon	State Designed Program	Same as state’s 1115 waiver	None
Pennsylvania	State Designed Program	None	\$5 Rx
Rhode Island	Medicaid Expansion	Families between 185-250% FPL choose between a premium or a copayment Premium range \$1.57- \$12.46 per month depending on age and sex	Families between 185-250% FPL choose between a premium or a copayment \$5 physician except well baby, \$25 hospital,\$15 Outpatient surgery, \$35 non-emergency use of emergency room, \$2 Rx Different rates apply for family planning and pregnant women
South Carolina	Medicaid Expansion	None	None
South Dakota	Medicaid Expansion	None	None
Tennessee	Medicaid expansion through an approved Section 1115 waiver	≤100% = None Based on sliding scale, 101-119 \$24.50 per family, per month 120-139 \$32.25 140-169 \$47.50 170-199 \$70.50	≤100%= None 101-199% 2% copay
Texas	Medicaid Expansion	None	None
Utah	State designed program	None	Copay 100-150% FPL=\$10 emergency, \$5 hospital, \$1 Rx, \$500 per year per family out of pocket max 151-200%FPL=\$30 emergency, 10% of charge for Hospital, \$10 physician, \$1 Rx, \$800 per year out of pocket max
Vermont	Medicaid expansion through state’s 1115 demonstration waiver	Dr. Dynasaur: 225-300% \$20 per month per household uninsured, \$10 per month per household underinsured	\$10 copay for physician (other than preventive services including dental)
Wisconsin	Medicaid expansion	<150%FPL=None 151-185%FPL=3% to 3.5% of family income	None

Sources:

National Governors’ Association, “Implementation of The State Children’s Health Insurance Program: Title XXI.” July 8, 1998. www.nga.org

National Conference of State Legislatures, “Cost Sharing Provisions in Title XXI Plans.” July 8, 1998 www.stateserv.hpts.org.