

Coordinating Children's Coverage Expansions With Employer-Sponsored Coverage

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¹ The revision includes a correction in Trade-Offs: Choosing Between Medicaid and CHIP. Earlier versions suggested that Medicaid expansions for targeted low-income children could not exclude children who are currently insured. On the contrary, the definition of targeted low income children in the new Medicaid section 1905(u) would apply to Medicaid expansions qualifying for enhanced matching payments. That section defines targeted low-income children are those who are not be insured.

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OVERVIEW

The following document describes “crowd-out” and proposes approaches states can pursue under child health insurance initiatives to minimize it through carefully structuring financial incentives and eligibility policies. Programs that coordinate with private employer sponsored insurance by providing subsidies toward the cost of that insurance are proposed as a way to maximize coverage of uninsured children and encourage private contributions toward health insurance coverage. Some sections draw extensively from two other IHPS papers; *Employer Coverage and the Children’s Health Insurance Program Under the Balanced Budget Act of 1997: Options for States*, (August 1997) by Mark Merlis and *Extending Health Care Coverage for Modest-Income Children and Pregnant Women: Public (Medicaid) & Employer-Financed Coverage Lessons* (December, 1996) by Rick Curtis and Ann Page. Those papers include more detailed discussions of the financial incentives inherent in alternate subsidy schemes and the experience of Medicaid programs that have attempted to coordinate with employer sponsored insurance. This document takes a step back and provides some simple descriptions of the dimensions of “firewalls” or policies intended to directly minimize incentives for switching from private to public coverage. Examples of such policies from existing programs and proposed child health initiatives are included when applicable. In addition, a description of the trade-offs with respect to crowd-out policies that states will need to consider in choosing whether to expand Medicaid or establish a new program under Title XXI, the State Child Health Insurance Program. Two new appendices are included. (Appendix A is from the earlier IHPS paper by Mark Merlis.) Appendix B includes an example of a set of eligibility policies including firewalls that could work to reduce incentives for switching from private to public coverage. Appendix C includes a description of the distribution of employer contributions towards the cost of health insurance premiums drawn from the 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey.

The Balanced Budget Act of 1997, signed by the President in August, established a new federal-state program intended to increase health insurance coverage of children. The new Title XXI of the Social Security Act, the State Children’s Health Insurance Program, provides about \$21 billion for federal fiscal years 1998 to 2007 to be distributed among the states for child health insurance initiatives. States must submit a state child health plan to the Secretary of Health and Human Services detailing their program characteristics and receive approval from the Secretary before the states’ allotted funds are available. The law includes requirements for minimum benefits, maximum cost

sharing, and state matching requirements for claiming allotments. Once the plans are approved, states may use Title XXI funds to expand or initiate programs to purchase or to provide health insurance coverage to children who are uninsured. States can provide benefits to children under the states' Medicaid program or may expand or establish a new health insurance program. Because the program is a federal matching program, the matching funds are available to states once states make payments toward the cost of a plan or service on behalf of eligible children.²

In drafting Title XXI federal policymakers were concerned, in part, due to research findings regarding Medicaid experience, that the availability of public subsidies would encourage individuals or employers to replace their private insurance funds with the public program funds ("crowd out"). As a result, the legislation includes requirements that state plans for child health initiatives include descriptions of procedures states will use to ensure that only targeted low-income children are furnished child health assistance and that the insurance provided under the state child health plan does not substitute for private sector coverage.³

States must establish policies that minimize the extent to which public program funds substitute for private funds for insurance coverage among the target population and are encouraged to structure financial incentives to reinforce continued private contributions toward coverage of low-income children. By carefully crafting programs that discourage crowd-out among those who are already insured and coordinating with private sector employers to cover children who have access to insurance but are currently uninsured, a scenario could be created in which everyone wins.

The notion of minimizing crowd-out generally and specifically with respect to children's health insurance is controversial. Little is known about what policies can be effective in reducing crowd-out. Only a handful of states have state-only programs that pre-date CHIP and offer comprehensive health benefits coverage for children in families with income up to 200% of poverty. Even fewer have implemented direct measures intended to reduce crowd-out. Further, no empirical evaluations have been conducted of the programs that have had such policies in effect. As a result, it is not clear how much crowd-out can be avoided. In the near-term certain eligibility provisions and restrictions known as "firewalls" may deter individuals and their employers from making decisions to move from one kind of coverage to another. Over the long term, however, individuals and their employers are likely to respond to economic advantages offered as circumstances change.

Further, policymakers don't uniformly agree that all crowd-out should be avoided. By subsidizing only low-income children whose families have chosen to forego the expense of health insurance while leaving out similarly low-income children whose families devote a large percentage of wages to the purchase of such insurance presents an inequity. Federal lawmakers have, in effect, settled this disagreement for the purposes of establishing child health initiatives under Title XXI by defining targeted low-income

² Funds can be made available to states based on advance estimates of expenditures. Those amounts would then be reduced or increased as necessary to adjust for any overpayment or underpayment for prior quarters.

³ Section 2102(b)(3)(C)

children as only those who do not have health insurance coverage. Children who have health insurance are not eligible for those programs.

Widely differing views exist about the relative importance of crowd-out as an issue for child health insurance programs. Based on interviews with state officials, the Alpha Center found that states with health benefits programs for relatively low-income near poor populations have devoted little attention to crowd out while other states that have extended assistance to higher income groups perceived crowd-out to be a bigger problem.⁴ Advocacy groups hoping to influence the direction of child health insurance policies assert that crowd-out is not likely to be a significant problem. Individuals objecting to discussions about crowd-out may be legitimately concerned that the crowd-out debate may hinder efforts to establish new programs to cover low-income uninsured children and that states, attempting to diminish crowd-out, will establish eligibility restrictions that are so stringent that many uninsured will not be able to access coverage. On the other hand, many agree that careful policies to avoid crowd out will result in more stable child health insurance programs and greater coverage of uninsured children. Coordinating with employer-financed coverage may provide a mechanism to both minimize crowd-out and reach out to the large number of uninsured children with access to employer health insurance whose families cannot afford to purchase that coverage. Without such policies, child health initiatives extending coverage to children with higher family incomes will too often merely replace private coverage and, as a result, have far fewer dollars left to cover uninsured children.

⁴ Chollet, D., Birnbaum, M., Sherman, M., *Deterring Crowd-Out in Public Insurance Programs: State Policies and Experience*, Alpha Center, October 1997, Washington, DC.

CROWD-OUT

Legislators' concerns about "crowd out" stem from recent evidence that Medicaid program expansions enacted in the late 1980s resulted in shifts of individuals from private to public coverage. During the late 1980s Medicaid eligibility for children and pregnant women was expanded. States were required to cover pregnant women, infants, and children under age six in families with income below 133% of poverty. Older children were required to be covered if they were under age 19 and in families with income below 100% of poverty although this provision is being phased-in one year at a time.⁵ While these expansions have protected millions of women and children who would otherwise have been uninsured, they also may have encouraged a significant number of families to drop their employer-based coverage and enroll in Medicaid instead. While available studies differ in their estimates of the magnitude of the crowd-out effect, they agree that it exists, and seem to point to very little crowd-out resulting from policies covering individuals with income below poverty with an increasing impact as income rises. This finding seems sensible simply because the higher the income cohort, the more members of the target population have employer coverage.

Crowd-out can be characterized along a number of dimensions. Over the short term, decisions resulting in crowd out are likely to take place at the individual rather than firm level. An example of crowd out at the individual level would be a family with insured children that, when faced with the option of continuing to pay for insurance for their children through their employer (or individual policy) or dropping dependents in order for them to qualify for the state child health program, choose to do the latter. Over the long term, however, crowd-out at the firm level could become a bigger problem. Firms contributing to dependent coverage could be placed at a disadvantage relative to competing firms that pay similar wages but whose workers' dependent coverage is financed or subsidized by the public sector. As new firms are created and existing firms re-evaluate their positions, fewer employers may choose to provide health insurance benefits or to reduce contributions for dependents' coverage.

Table 1. shows premium and contribution levels reported in a ten-state survey conducted in 1993. On average employees paid 18% of the cost of single coverage and 36% of the cost of family coverage. Employers paid the remaining shares. As shown in Appendix C, however, the amount a given worker must pay for family coverage varies dramatically. While 20% of workers employed by firms offering coverage would pay nothing for family coverage, 19.8% would pay more than half of the cost of the premium (Table C-2).

⁵ States are required to cover children born after September 31, 1983 with income below 100% of poverty. In 1998 this translates into all children under age 13 under poverty must be covered. Many states have used other Medicaid provisions allowing optional eligibility expansions for children that go beyond mandatory requirements. See National Governors' Association (NGA) "State Medicaid Coverage of Pregnant Women and Children" , September 30, 1997.

Table 1. Provisions of Employment-Based Health Insurance Plans in Ten States, 1993		
	Average Single Premium	Average family premium (monthly)
Total (\$)	\$153	\$403
Employee share (%)	18%	36%
Employee share (\$)	\$27	\$140
Source: RAND tabulations of the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey		

Since the employee usually shares the cost of employer-sponsored health insurance, either employee or employer payments (or a combination of both) could become replaced by public funds. Because it is not clear that crowd-out can be avoided altogether, states may consider this distinction in creating practices to minimize crowd-out and in setting up the program's financial incentives. States will undoubtedly need to work to structure program operations so that they do not represent a burden on employers. State should even consider program operations that are transparent to the employers, presenting them with fewer potential opportunities to offset their contributions for dependents coverage with the public subsidies.

The Title XXI statute requires states to establish policies or engage in activities intended to prevent or minimize crowd out, but it doesn't provide guidance on which activities would be considered acceptable, nor is there much available information about which activities are effective in minimizing such incentives. Several factors can help to inform about the degree of crowd out that could be expected among the target population for child health initiatives. The amount of employer-sponsored coverage in the potentially eligible population is one important determinant of the degree of crowd-out that could be expected. Compared with the Medicaid target population, children targeted by initiatives under Title XXI will be in families with higher family incomes. A number of studies to date indicate that the degree of crowd-out is closely tied to income. For example, under the Medicaid expansions of the 1980s, researchers at the Urban Institute found very little crowd out occurred for expansion populations with family income below 100% of poverty. However, for those above poverty, crowd-out accounted for 45% of increased enrollment of pregnant women with income up to 185% and for 21% of increased enrollment of children with income up to 133%.⁶ The percent of crowd out for children would almost certainly be greater for those with higher incomes. The reason for this is presumably due, in large part, to the greater presence of employer-sponsored coverage among children with higher incomes.

Table 2. shows the increasing presence of employer coverage for children with higher family incomes. In 1995, only 13.3% of children in families with income under 100% of poverty were insured with employer coverage as their primary source of

⁶ Lisa Dubay and Genevieve Kenney, Did the Medicaid Expansions for Pregnant Women Crowd Out Private Coverage? The Urban Institute. November 1995

insurance, while 58.3% of children with income between 150% and 199% of poverty had employer coverage.

**Table 2. Primary Insurance Status of Children under age 18
By Family Income, 1995**

Percentage of FPL	Employer Coverage	Public	Private non-group	Uninsured	Total
Under 100%	13.3%	61.1%	4.1%	21.5%	100%
100-149%	38.3%	28.2%	8.7%	24.8%	100%
150-199%	58.3%	13.6%	7.7%	20.4%	100%
200-249%	71.6%	8.0%	7.5%	12.9%	100%
250-299%	77.3%	5.0%	7.8%	9.9%	100%
300% and over	87.6%	2.0%	5.2%	5.2%	100%
Total	60.3%	19.8%	6.1%	13.8%	100%

Source: IHPS analysis of March 1996 Current Population Survey.

Note. Children with multiple reported coverage sources are assigned to a primary source in the following sequence: employer-based, public private non-group.

The amount of payment the family would be required to make to join a public plan relative to the required contribution toward their employer-sponsored insurance is another important determinant of the degree of crowd out that could occur. Families with strong financial disincentives to maintain their employer-sponsored plan would be likely to drop the private plan to become uninsured and thereby qualify for the public plan. A family's cost will be determined by the price of the employer-sponsored plan compared with the price of the public plan, the amount of the contributions available to the families from their employers compared with the subsidies available to uninsured children under the public plan. Data from the Robert Wood Johnson Foundation's 1993 Employer Health Insurance Survey of ten states, conducted by RAND, indicate that, on average, employers contribute about 82% towards the cost an individual worker's insurance coverage. When contributing to coverage for a worker and dependents, the average contribution from employers declines to about 64% of the cost of the family premiums.⁷ Further, about 80% of workers who are in firms that offer coverage have employer contributions of more than 75% of the cost of the insurance available, but only 50% of workers in firms offering insurance have similarly large contributions available toward the cost of covering dependents.⁸ While almost half of all workers pay less than \$50 per month extra to obtain family rather than single coverage, almost one in four have to pay more than \$150 extra each month. (Appendix C, Table C-4)

⁷ RAND tabulations of the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey

⁸ IHPS tabulations of the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey

CHIP legislation allows states to impose some premium costs on all but the lowest-income families, so most families would face at least some costs under both options. However, depending on the premium structure of the public program, the potential savings for many families who move to the public plan could be considerable.

The way in which employers establish prices for different numbers of family members, or rate tiers, could also have a significant effect on parents' financial decisions to shift children to a public program. The rate structure determines the cost of adding children to employer-sponsored insurance plans. Some employers have only two rate tiers: a single policy at one rate and a family policy at a higher rate. Other employers may offer a number of combinations; for example, a firm with four tiers may have a single worker rate, a couple rate, a worker plus single child rate, and a two-parent family rate. The cost of adding a child to an employee's plan can be quite different depending upon the number of rate tiers the employer uses. For example, a single parent adding one child would be required to pay the entire difference between a single and a family rate if employed by an employer with only two tiers. A two-parent family working for the same employer would pay nothing at all to add a child to an existing family plan. If working for an employer with many tiers, the additional cost of adding a child onto any of the plans may be the similar. Generally, though, the cost of adding each additional child to a family plan declines quickly since very few employers provide for more than four tiers.⁹

Other non-financial factors may impact the amount of crowd-out child health initiatives will face. Inertia or a desire to keep the entire family covered under a single health insurance plan as well as a perceived stigma associated with public welfare programs might prevent families from shifting their children for a small price advantage. Furthermore, some families may prefer not to join the public plan if such a change in coverage would force a change in providers, reducing continuity of care and requiring families to learn new reimbursement and benefits rules.

APPROACHES TO ADDRESS CROWD-OUT

Firewalls

In defining the target population, state policy-makers may establish "firewall" provisions, or eligibility rules intended to prevent shifts in coverage by limiting or prohibiting participation in the public program by children who are enrolled in or have access to employer coverage. In the absence of firewalls, further erosion in the populations covered through employer plans may be expected, limiting the effectiveness of the new law in reducing the number of uninsured children. On the other hand, firewalls that are too restrictive will simply leave uninsured children without access to coverage, undermining the goal of covering uninsured children.

⁹ For a more detailed discussion of rate tier issues, see IHPS paper by Mark Merlis.

The CHIP eligibility rule limiting the majority of funds for use on currently uninsured children could be considered a firewall. States have the flexibility under Title XXI to add other firewalls as well. An example would be a provision to exclude children from eligibility who had been insured during some period prior to application. Such “minimum uninsured period” provisions seek to keep families from dropping dependents’ coverage (or provide incentives for families to pressure employers so that they do not reduce contributions toward the cost of dependents coverage) to take advantage of the state child health initiative by requiring they go without insurance for some period of time before being able to qualify for the public program. Those minimum uninsured periods are different from traditional waiting periods which employer plans often subject new employees to before they are eligible to enroll in an employer-offered plan. Traditional waiting periods do not take into account employees’ insurance status. If the goal of minimum uninsured period provision is achieved, that is, families do not drop current coverage to apply for the public program, few insured children will become uninsured as a result of those policies.

Existing state health insurance programs have experimented with various minimum uninsured period firewalls. The Florida Healthy Children program included a minimum uninsured period of 6 months for individuals whom, upon application for the program reported that they’ve had insurance coverage. The firewall was subsequently dropped because it was viewed as too punitive. Families who became uninsured involuntarily and physicians who saw the rule as preventing children from receiving needed care objected to the policy.¹⁰ State officials later inquired about prior coverage in a survey of 1300 participating families. Very few of their enrollees reported having coverage during the twelve months preceding enrollment.¹¹ A number of factors may have contributed to the very low rate of reported crowd-out. Premium charges under the Healthy Children program are not insubstantial. For families between 133% and 185% they are between \$15 and \$25 per month. Secondly, enrollment in the program, while growing rapidly, is still low. About 35,000 children residing in 16 of 67 counties were participating in the summer of 1997.¹² (Florida is estimated to have about 600,000 uninsured children under age 18¹³.) Finally, Florida is the state with the eighth lowest rate of employer coverage among its non-elderly population.¹⁴ For all of these reasons, the Florida experience should be considered cautiously.

Two programs with very different firewall policies in terms of the stringency of the minimum uninsured period requirements are MinnesotaCare and the recently enacted California Healthy Families program. MinnesotaCare¹⁵ subjects applicants to 4 month waiting period if they were covered by health insurance, and an 18 month wait if they had

¹⁰ Chollet, et.al, Alpha Center, October 1997, prepublication copy.

¹¹ In Merlis, M., IHPS, cited as personal communication with Elizabeth Shenkman, Ph.D. principal investigator, health Kids Program Evaluation, University of Florida, Gainesville.

¹² Personnal communication, Rose McNaff, Executive Director, Florida Healthy Children Program.

¹³ Based on 3 year average of March 1995, 1996 and 1997 supplements of Current Population Survey, IHPS tabulations.

¹⁴ Employee Benefits Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, EBRI Issue Brief No. 179, Washington, Nov. 1996

¹⁵ MinnesotaCare provides coverage for entire families with income below 275% of poverty.

access to any employer-subsidized covered.¹⁶ Under the MinnesotaCare firewall, employer-subsidized coverage is defined as a plan under which the employer pays at least 50 percent of the cost for the employee (whether or not additional contributions towards dependent coverage exist at all). By looking back to the family's access to coverage, the Minnesota policy would exclude families even if they were no longer eligible for an employer plan at the time of application. Families could also be excluded if the employer has modified its benefit plan in the past 18 months before becoming eligible for MinnesotaCare, for example, by reducing the level of contributions for coverage. As long as families are eligible to enroll in the employer plan, they could be excluded even if they were never insured and the employer would have contributed little or nothing to dependent coverage. The aim of this provision is to discourage employers from modifying their plans in an attempt to take advantage of the availability of the public plan. Because ERISA prevents states from regulating employer plans directly, Minnesota does so indirectly, in effect penalizing the families in the expectation that they will put pressure on their employers not to reduce benefits.

A more lenient firewall policy is included in the recent legislative action in California creating the Healthy Families Program.¹⁷ The Healthy Families program is intended to be consistent with the requirements of Title XXI and to be funded with the state's Title XXI allotment and state matching funds. Applicants to that program will be subject to an uninsured period of three months for those who were insured by a group health insurance plan. (There is no uninsured period firewall for those who were insured by a non-group policy recognizing that individual insurance plans are generally more expensive and individuals purchasing them generally have low or no employer contributions toward the cost of such plans.) The California program legislation provides for a 6-month minimum uninsured period if it is determined at a later date that the 3-month period included in the legislation is an insufficient deterrent to crowd out.

Firewalls that require a minimum uninsured period can vary along a number of dimensions, for example, such provisions could:

- ◆ **Restrict enrollment of only those children who were *covered by other insurance during the look back period, or could also include restrictions for those who had *access to* (but were not covered by) other insurance during the minimum uninsured period.***

The MinnesotaCare policy, as discussed above, includes a very long uninsured period policy of 18 months for those who had access to employer-sponsored coverage. The firewall, however, does include a number of exceptions including when employees and their dependents lose such coverage because of the death of an employee or divorce, or because an individual became ineligible for coverage as a child or dependent, or if such loss were not for reasons that would disqualify the individual for unemployment benefits. (Even if the loss of insurance were due to reasons that would disqualify the individual from receiving

¹⁶ Children with family income below 150% of poverty are excluded from this policy.

¹⁷ AB 1126, SB 903, AB 217, 1572

unemployment benefits, children of that individual would not be subject to the 18-month restriction and could be covered under MinnesotaCare.)

Provisions that limit coverage to only those children without access to insurance could potentially leave up to 37%¹⁸ of all uninsured children uncovered, greatly diminishing the success of a state child health initiative in reducing the number of uninsured children. However, some may argue that this type of policy is more equitable across workers who have access to employer sponsored insurance since those who already chose to cover their children are not eligible for assistance under Title XXI.

◆ **Restrict enrollment of children who were covered by a *group plan* during the uninsured period or by *any plan* including individual plans.**

A policy that is more restrictive for individuals with access to group insurance than for individuals who purchase individual policies implicitly recognizes that individual policies are generally more expensive and, most times, enrollees do not have employer contributions available toward the cost. On the other hand, some view employer contributions toward group coverage as being foregone wages since there is presumably a trade-off between wages and benefits. Further, many of the lowest wage employees simply cannot afford coverage despite available contributions from their employers. The California Healthy Families program includes a policy that distinguishes between those covered by group plans and other individual plans. Individuals covered by group health plans must go without coverage for three months before becoming eligible for the program of subsidies while those covered by individual plans are not subject to an uninsured period.

◆ **Vary by length of the minimum uninsured period.**

New Jersey's Health Access program provides subsidies for children with income below 250% of poverty and requires a minimum 12-month uninsured period, while Pennsylvania's Children's Health Insurance Program only considers other health insurance coverage at the time of application – and does not require any uninsured period.

◆ **Restrict enrollment of children who were covered by *any (previous or current) employer-sponsored plan* during the look-back period.**

MinnesotaCare's 18-month uninsured period policy pertains to previous as well as current employer plans. This apparently was to discourage switching jobs to access the public program.

◆ **Restrict enrollment of children with employer-sponsored plans that include *employer contributions at a certain threshold*.**

¹⁸ See page 14 for data describing children's access to health insurance.

A minimum uninsured period could be implemented that defines employer-sponsored insurance as policies that include employer contributions at some minimum percentage of the cost of family coverage. MinnesotaCare defines available employer-sponsored plans as those that include an employer contribution of at least 50%, of the cost of the worker's coverage. (This has been problematic for previous employers' plans, because most applicants simply do not know what the contribution amount was.)¹⁹

◆ **Vary for children with different characteristics.**

A state may apply varying minimum uninsured periods for children in families with relatively constant income as opposed those in families with very large drops in family income. An example of this type of approach would be MinnesotaCare policy that includes exceptions for those who lost employer-subsidized insurance for reasons that would not disqualify the individual for unemployment benefits.

States may also consider including exceptions from minimum uninsured periods for people whose changes in insurance status took place prior to the implementation of the new program or passage of Title XXI.

Balancing all of the competing policy interests and developing the mix of firewall dimensions will be difficult particularly without experience to provide guidance on what works and what does not. It will be important to remember that the goal is to provide uninsured children with access to coverage and that firewall policies should not be so restrictive as to leave large numbers of target uninsured children without access to assistance.

Federal policy-makers clearly intended the children's health initiatives under Title XXI to be a limited initiative meant to address the immediate needs of uninsured children. To the extent that firewall policies are successful, however, equity issues will arise. Providing financial assistance to only those low-income children's families that have not already purchased or have access to group or individual coverage suggests an assumption that those families are in greater need of such assistance. Many economists would argue, though, that low-income families covered by employer-sponsored plans are in fact paying the entire cost of their coverage: their health benefits are not simply given to them by their employer, but are part of a total compensation package. They have forgone higher wages or other benefits to obtain them. Thus to foreclose them from the public program, or to discourage them from renegotiating their benefits might be seen as imposing a permanent penalty for the trade-off they have made in the past. While some families would obtain a public benefit, others at the same income would have to maintain employer coverage, in effect at their own expense.

Such inequities may reduce the probability that firewall provisions can eliminate the erosion of employer-sponsored insurance. Even if all current benefit plans could be

¹⁹ California legislation will provide for subsidies for the purchase of employer-sponsored insurance when there is a "meaningful" employer contribution available. State officials are struggling to determine how to define a "meaningful contribution" in dollars.

maintained intact, a new public program could give workers an incentive to shift from firms that offered dependent coverage to ones that did not but paid higher wages, or employers an incentive to shift them from direct employment to some form of contractual arrangement. It seems unlikely that many people would act on such incentives in the short term. Over time, however, people do change jobs, and it must be expected that the market will respond to the incentives established by large-scale initiatives. Even a comprehensive firewall, then, might fail to prevent erosion in dependent coverage and might exclude from coverage children who nominally have access to employer plans but whose parents cannot continue to afford the required contribution.

COORDINATING WITH EMPLOYER-SPONSORED INSURANCE

Title XXI allows states to establish programs that coordinate with private employer-sponsored insurance as long as only children who are currently uninsured are eligible. Under such programs states would establish subsidies toward the cost of private coverage that take into account employer contributions and rate tiers. This approach has a number of advantages, foremost of which is to potentially extend the reach of child health allotments. By allowing children with access to employer coverage an opportunity to receive assistance, rather than disallowing them from participating in the state's child health initiative, more uninsured children could be reached. A coordinated approach would also leverage rather than displace private contributions toward the cost of coverage. Since such an approach would only make sense to the state when there is an employer contribution available toward the cost of insurance, the cost of covering those children on a per child basis would be lower than the cost of enrolling those children on the public plan. This approach could also make it easier for working parents to obtain and use coverage for their children. All family members could be covered under the same plan (one-stop shopping for one family health plan) instead of requiring children to use a public plan with different providers and reimbursement rules than the plan that the working parent is enrolled in.

Surveys indicate that there are a substantial number of uninsured children who could potentially be covered under employer plans. Tabulations of the 1996 Current Population Survey reveal that almost 1.7 million children had a parent with employer coverage.²⁰ Most of these children could presumably be covered as dependents under their parent's plans. Many more children may have parents who are eligible for an employer plan but decline coverage either both for themselves and for their dependents or only for their dependents. A preliminary analysis of data from the first round of the 1996 Medicaid Expenditure Panel Survey (MEPS) indicates that of uninsured children, about 37% (or 4.4 million) had parents who were themselves covered through employment (21.5%) or who had declined available coverage (15.3%).²¹ A recent report by the Agency for Healthcare Policy and Research using the same data finds that between 1987 and 1996 a larger percentage of employees who were offered insurance by their employers but more of those workers declined such coverage. They found an increase of

²⁰ IHPS analysis of March 1996 Current Population Survey

²¹ IHPS analysis of data from Medical Expenditure Panel Survey, 1996 Panel, Round 1.

about 13 percentage points in the number of workers without employment based covered who had access to employer-sponsored coverage.²²

Cost is the most likely explanation for so many children not receiving available employer coverage. On average, employees must contribute about 18% of premium costs for their own coverage and 36% for family premiums; a cost averaging \$140 each month. For families in the target income group (between 100% and 200% of poverty), \$140 per month is equal to between 5% and 10% of family income. The number of rate tiers or prices for different types of families offered by employers could also provide disincentives for families to purchase coverage for dependents under an employer-sponsored plan. Adding one dependent child to an employer plan with few combinations could become prohibitively expensive for modest-income families.

On the other hand, coordinating with private insurance can potentially leverage a significant source of financing for expanding children's coverage. The same data indicates that over 80% of workers in firms that offer coverage work for employers that contribute more than 75% toward the cost of insuring the worker. Almost 50% of all workers in firms offering coverage work for employers that pay more than 75% of the cost of family coverage.²³ Such contributions have been fairly level during the 1990's following erosion in employer contributions toward family coverage through the 1980's. Data from the Bureau of Labor Statistics employee benefits survey shows that in large and medium-size firms, the employee share of premium for family coverage rose between 1985 and 1989 and leveled off from 1991 to 1993. Other surveys reflect similar patterns. KPMG's annual survey of employer plans, for example, shows that the average worker's contribution for family coverage rose from \$109 in 1993 to \$116 in 1997, an increase of less than 1.6 percent per year (less than the rate of general inflation).²⁴ Unfortunately, there are indications that health insurance premiums are again beginning to rise. While it is not clear that the average percentage of premium cost borne by employers would decline, the amount of the employee share of premium costs will almost certainly rise as overall premiums rise.

The financial burden on employers of adding targeted low-income children to insurance plans when available is likely to be extremely low. Assuming an average employer contribution of 50% toward the cost of dependent coverage, and a 50% take up rate among those uncovered dependents who are eligible for such coverage, total employer contributions toward health insurance coverage would rise by only about .1%. This increase in costs translates to about \$4.35 per covered employee.²⁵ Since most

²² Cooper, P.E., and Schone, B.S., More Offers, Fewer Takers For Employment-Based Health Insurance: 1987 and 1996, *Health Affairs*, Volume 16, N. 6, p 142.

²³ IHPS tabulation of Robert Wood Johnson Foundation 1993 Employer Health Insurance survey conducted by RAND.

²⁴ KPMG Peat Marwick, *Health Benefits in 1997*.

²⁵ 10.1million uninsured children multiplied by 36% (those between 100 and 200% of poverty) multiplied by 40% (those with access to employer-sponsored coverage) equals 1.5 million children eligible for subsidies. 1.5 million eligible children multiplied by 50% participation rate equals .75 million potential new enrollees. If each enrollee costs \$900 to add to an employer plan and employers pay 50% of the additional costs for dependents, then the total cost of adding these children is \$330 million. Compared with total employer contributions in 1993 toward health insurance of \$235.6 billion (EBRI Databook on Employee Benefits, Third Edition, 1995), only .14% additional costs to employers.

employers probably do not cover a homogenous workforce of low-income workers, those costs would not be highly concentrated among a few employers, but disbursed widely over many employers.

On a per child basis, it could cost the public less to pay some or the entire employee share of an employer plan where a substantial employer contribution exists. This approach allows an alternative for families who could obtain “one stop shopping” coverage for the entire family and would potentially include no welfare stigma. If the state charges a premium for the public program, and if its subsidies for employee contributions leave the family at least as well off or even better off taking the employer coverage, then both the state and the family win. If states structure the subsidies so that families are responsible for some of the employee share of the cost, incentives for currently insured individuals to drop their employer-sponsored coverage could be reduced. Coupled with firewalls that limit eligibility of those who have employer contributions toward dependents coverage, this approach could reduce the longer-term problem of employers dropping or reducing their contributions towards coverage for dependents, since the workers would continue to have incentives to bargain to maintain those contributions.

ADMINISTRATIVE ISSUES

States coordinating with employer-sponsored coverage under CHIP are likely to face a number of complex administrative tasks. The Medicaid program, which includes an option for states to contribute to the cost of employer-sponsored health insurance when available and cost effective, may offer insights into solutions for the tricky administrative issues. For a complete discussion of issues faced by Medicaid agencies administering health insurance purchasing program (HIPP) see the August 1997 IHPS paper by Page and Curtis. Although only a very small minority of Medicaid enrollees have been “bought in” to private group plans, the administrative procedures for enrolling those beneficiaries in private group coverage may be similar to enrolling targeted low-income children in employer plans under child health initiatives.

A first hurdle for CHIP programs will be to identify children who have access to group health insurance and an employer contribution toward such coverage. Several Medicaid programs report that Medicaid applicants often are not eager to tell a state Medicaid agency that their employer offers health insurance because it may result in extra work for themselves as well as administrative ‘hassle’ for their employer’s personnel office. As an alternative for states depending on self-reported applicant information on employer-sponsored coverage, states might identify an applicant’s employer through new hire registries or other employer databases. For example, the Iowa Medicaid agency uses an employer verification form as part of the Medicaid eligibility determination process that includes questions for the employer to answer about whether or not they offer health insurance, thus bypassing the employee as the source of

the information. Texas has a State Employment commission, which collects information on all workers for whom an employer pays unemployment insurance and matches individuals contained in this database with its Medicaid beneficiaries data base to identify employers of Medicaid beneficiaries. From those matches, the agency identifies and contacts employers directly to ascertain information on available employer insurance.

Medicaid agencies also report difficulty obtaining information from employers on the benefit package and costs of the group policies. Such information will be essential for CHIP programs for determining the cost-effectiveness of purchasing the available group health coverage relative to the cost of covering those individuals under the public plan and identifying “wrap-around” services that must be provided to meet statutory benefits rules. (See Appendix A for relevant provisions of CHIP legislation relating to employer coverage.) Several states are investigating alternative means of obtaining the necessary information on employer contribution policies and benefit plan designs under proposed CHIP programs. For states that have personal income taxes that mirror federal exemptions and deductions for employer contributions, the state could require employers to submit basic information regarding how much (i.e. contribution amounts) and what (i.e. benefits package) the tax breaks are taken for.

Two promising sources for states to obtain information on employer contribution are health plan carriers and Medicaid third party liability contractors. Generally, because carriers require minimum contributions from employers with whom they contract, the carriers collect information on employer contributions toward the cost of those policies. Agencies that contract with state Medicaid programs on third party liability may also be developing databases with employer insurance and contribution information that child health insurance programs may be able to tap into.

Generally, Medicaid agencies’ approach to meeting Title XXI benefits rules for their HIPP programs has been to identify each group plan’s scope of benefits and provide “wrap-around coverage”. This approach is administratively burdensome, probably contributing to the overall lack of popularity of HIPP programs. Such an approach is not recommended for CHIP programs, particularly in states with many small employers or a myriad of plans. States might consider alternatives to providing such “wrap around coverage”. A potentially more efficient way of meeting benefits and cost sharing rules would be for states to solicit a group of carriers to submit benefit plans for certification as meeting standards for Title XXI benefits. Where a larger employer offers insurance through one of those carriers but with a lesser benefit plan, states might pay the carrier a price differential for extending the more generous CHIP certified benefit package to any Title XXI children covered through that employer group. This approach might avoid excessive administrative burdens for the state, but, more importantly, might make the process of accessing coverage easier for children’s families through “one stop shopping”. For the small employer market, this approach might be unworkable because of the large number of carriers, a high degree of benefit plan variation, and potential problems in negotiating related administrative costs with carriers. States with small employer purchasing cooperatives might consider arranging for such organizations to make Title XXI benefit packages available for participating small firm workers’ children. Future

IHPS documents will further develop alternative scenarios for benefits packages design under CHIP employer buy-in programs.

Similar issues arise with the maximum cost-sharing requirements under CHIP. Under CHIP, a state may impose premiums, deductibles, coinsurance, or other cost sharing that are mostly “nominal” for children below 150% of poverty and for children above 150% percent of poverty, annual aggregate premiums and cost-sharing can not exceed 5% of family income. Since employer-sponsored health plans are likely to have varying cost sharing requirements, state programs could either use a claims submittal approach to administer the cost sharing limits, or, as discussed above, create a plan that is pre-certified to meet the CHIP benefits and cost-sharing requirements. A claims submittal approach or (“shoe box” approach) is one in which the beneficiaries collect proof of cost-sharing payments made. Once cost-sharing amounts paid by the beneficiary sum to the maximum allowed cost sharing amounts, they may begin to be reimbursed for any additional cost sharing amounts. Despite careful calculations based on estimated costs and use of services to set average cost sharing amounts at 5% of income or below, outliers may exist. Outliers are individuals whose use of health services or cost of services exceeds, by large amounts, the average use or cost of the majority of the population. States would need to have policies in effect that assure that even outliers do not face cost sharing that exceeds the 5% of income limit imposed under Title XXI. Thus, all states that include cost sharing under their Title XXI plans may need to utilize a “shoe-box” approach to some extent. In addition, states would need to ensure that the approach used to implement the cost sharing limits would not be too complex for families to access.

A last administrative hurdle for state CHIP programs may be in dealing with limited open enrollment periods available under employers’ health coverage. Many employers only allow workers (other than new employees) to enroll in their health plan during a once-a-year open enrollment period. Thus a low-income worker who could not afford the employee premium share for family coverage could often not enroll in the employer’s plan for many months even if a subsidy were available. This effectively precludes workers from accessing employer-sponsored insurance even where it would be preferable. States could enact laws that define CHIP eligibility as a qualifying event for enrolling in employer-sponsored plans. (This approach would not work for self-insured plans because they are exempt from state regulation.) A precedent is a law enacted in Iowa as part of the states’ welfare reform, which defines loss of AFDC eligibility as a qualifying event for enrollment in an insured ESI.²⁶ Another possible approach may be to allow the child or children to enroll in the public plan until the employer’s next open enrollment period, at which point the parent would be required to enroll the child in the employer plan.

²⁶ Curtis, R, Page, A, *Extending Coverage for Modest-Income Children and Pregnant Women: Public & Employer-Financed Coverage Lessons*, Institute for Health Policy Solutions, December 1997.

TRADE OFFS: CHOOSING BETWEEN MEDICAID AND CHIP

The program under which children are covered with Title XXI funds will affect the state programs' ability to use firewalls and to coordinate with the private coverage. If a state expands Medicaid, all Medicaid program rules and laws of the Medicaid program would apply (except that the definition of children who would be eligible for the enhanced Medicaid matching rate is the same as in Title XXI – uninsured targeted low-income children). The CHIP statute includes its own rules for states establishing new programs or expanding existing non-Medicaid programs. States would need to consider the trade-offs in choosing between establishing new or existing health coverage programs under CHIP or expanding Medicaid. (The following discussion does not consider programs established under Medicaid Section 1115 comprehensive demonstration waiver programs).

Firewalls. States expanding Medicaid would not be able to establish firewalls intended to prevent crowd-out. The Medicaid program is a federal entitlement to individuals. Therefore all individuals in eligibility categories who meet the definition of targeted low-income children in the new section 1903(u) are entitled to Medicaid benefits regardless of their current insurance status. Without firewalls, there is a risk of CHIP funds being used merely to replace private contributions toward the cost of health insurance for the 40% to 60% of children in the CHIP target income group who already have employer-sponsored health insurance coverage. While it may be attractive to cover uninsured children and provide relief for children in families that are paying a high percentage of family income for health insurance, far fewer funds will be left to cover uninsured children. States that don't want to use firewalls, however, might prefer expanding Medicaid with Title XXI funding. Those states could still be motivated to improve coordination with employers when employer contributions toward the coverage of beneficiaries are available, taking advantage of employer contributions and potentially covering more uninsured children.

Cost Sharing Limits. Medicaid limits cost sharing more than the CHIP requirements for programs established under Title XXI. Most children eligible for the Medicaid program cannot be charged premiums for their Medicaid coverage. Under CHIP, cost sharing for children in families with income below 150% of poverty must be mostly "nominal" while cost sharing for those in families with income over 150% of poverty would be allowed as long as preventative services do not require cost sharing and as long as the 5% of income cap is not exceeded. Cost sharing restrictions under Medicaid would severely limit the ability of states to structure financial incentives for families to minimize crowd out.

Coordination Rules. Medicaid law provides very clear authority for states to coordinate with employers' benefits plans by buying Medicaid beneficiaries out into group plans as long as it is cost-effective to do so. Under Title XXI, the authority, though

less clear, is present but such activities will require secretarial approval. It seem unlikely, though, such approval will present a major barrier as long as state employer buy-programs meet the requirements under Title XXI for benefits and limits on cost-sharing and have adequate policies to ensure that the insurance provided does not substitute for coverage under group health plans.

Administrative Efficiencies. Finally, an established program like Medicaid would have advantages in terms of administrative volume efficiencies. On the other hand, states establishing a CHIP program could use the Medicaid administration to administer a CHIP program that is a Medicaid look-alike, thereby taking advantage of the existing administrative structure but allowing variations such as firewalls and family contributions toward the cost of coverage.

Benefits. Medicaid benefits are structured to meet the needs of the very poor and as a result are more extensive than mainstream coverage. Coverage expansions under Medicaid, as a result, may increase crowd-out decisions because of the rich benefits package. Benefits under Title XXI child health initiatives, on the other hand, can be patterned after federal or state employee benefits plans or popular private market benefits packages, thereby reducing incentives among privately covered children's families to drop their insurance to obtain the richer public benefit plan.

Flexibility. Title XXI may be considered to be more flexible than the Medicaid statute. It doesn't include provisions on setting payment rates for providers, requirements for comparability or state-wideness, and it is not tied to other federal or state welfare programs.

The best choice depends on a state's policy priorities, the strengths of existing programs, and available resources. To take advantage of the flexibilities of Title XXI, the child health initiative must be distinct from Medicaid. But states could take an approach that combines the best features of both sets of program rules. For example, New Jersey's child health proposal, as announced by the Governor during October of 1997, will utilize the Medicaid agency to administer the child health initiative under Title XXI for children in families with income over 133% of poverty. Those children will be eligible for the same set of benefits as Medicaid children, but will be enrolled in the new child health initiative. By using Medicaid to administer the program, the state is able to take advantage of administrative efficiencies of Title XIX and establish firewalls under Title XXI. Since the potential for crowd-out is likely to increase as the income of the target population rises, states with child health initiatives targeted at higher income children may need to consider the importance of firewall provisions in choosing the program under which children will be covered.

Carefully crafted child health initiatives under Title XXI present an exciting opportunity for states to maximize the reach of child health allotments. States can establish a public plan for children without access to a private plan but can also leverage private dollars for the significant number of children who are uninsured and have access to group health insurance coverage. With firewall policies to minimize erosion of private coverage, those policies can reach the most uninsured children while promoting family

friendly coverage. Children could become covered under the same policies as their parents, complexity could be minimized, and a welfare stigma avoided.

APPENDIX A - Provisions of the Children's Health Insurance Program (CHIP) Legislation Relating to Employer Coverage

Mark Merlis

The following is a preliminary analysis of the effect of the CHIP provisions included in the Balanced Budget Act of 1997 on state initiatives to buy into/coordinate with group health plan coverage.

The legislation creates a new Title XXI of the Social Security Act. (References in the following discussion are to sections of this new title.) Federal funds to states would have to be used chiefly for Medicaid expansion or provision or purchase of health benefits coverage for "targeted low-income children." These are children under age 19 with family income below 200 percent of poverty or, if higher, 50 percentage points above the applicable Medicaid limit in the state (including any higher limit established by the state under a waiver or under the 1902(r) income methodology rule) as of June 1, 1997 and are uninsured.

If a state expands Medicaid to cover targeted low-income children, then the Medicaid rules and laws would govern those program expansions. States establishing a new or expanding an existing state program to cover targeted low-income children will be subject to the provisions of Title XXI that follow.

In general, the language suggests that health benefits coverage could include buy-in to employer plans. (Whether special approval by the Secretary is required will be discussed below.) However, "targeted" children do not include children who are already covered by a group health plan. The language is at 2110(b)(1):

(1) IN GENERAL. Subject to paragraph (2), the term "targeted low-income child" means a child--

(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

(2) CHILDREN EXCLUDED- Such term does not include--

(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

This does not appear to restrict coverage of children who are eligible for, but not actually covered under, an employer plan at the time they apply for child health assistance; the

only exception is for children eligible for a state employee plan. There is no provision for retrospective review of coverage, apparently meaning that a parent could drop a child from employer coverage and immediately apply for assistance. There are provisions that would allow states to assist children currently enrolled in employer plans. These are discussed below.

The remainder of this appendix provides a section-by-section analysis of relevant provisions.

2102. State Child Health Plan

The state plan must include a description of eligibility standards ((b)(1)), including standards relating to “access to or coverage under other health coverage.” This presumably means that a state, in addition to excluding children currently covered under an employer plan, could exclude children with access to such coverage, or some subset of these children (e.g., those for whom the employer was contributing more than x percent of premiums). A state could also restrict eligibility for children who are not currently covered under an employer plan but were covered during some recent period. (This would not be true for states expanding Medicaid to cover targeted low-income children.)

The plan must also ((b)(3))--

include a description of procedures to be used to ensure—
(C) that the insurance provided under the State child health plan does not substitute for coverage under group plans;

This seems to mean that the state must take some steps to prevent migration of children from such plans to a public program or subsidized nongroup coverage.

2103. Coverage Requirements

Minimum benefits

The benefits provided under child health assistance must be—

- (1) Benchmark coverage—the benefits under the Federal employees’ Blue Cross standard PPO; a plan “offered or generally available to State employees”; or a plan offered by the HMO in the state with the largest commercial enrollment;
- (2) Benchmark-equivalent coverage (discussed below);
- (3) Existing comprehensive state-based coverage (this is a grandfather provision for New York, Florida, and Pennsylvania only); or
- (4) Secretary-approved coverage.

States contributing to employer offered plans will presumably have to ascertain that an

employer's plan is benchmark-equivalent or perhaps provide wrap-around coverage. Another option appears to be for states to arrange for benchmark equivalent plans to be offered by carriers to employers for their employees with CHIP eligible dependents.

“Benchmark-equivalent” is defined ((a)(2)) as follows:

- a. The plan covers inpatient and outpatient hospital, physician, lab, x-ray, and well-baby and well-child care, including immunizations.
- b. The “aggregate actuarial value” of the plan is at least equal to that of one of the four benchmark plans. (The bill includes rules for making this determination, which will not be detailed here.)
- c. For each of 4 additional services (prescription drugs, mental health, vision, and hearing), the plan includes coverage with an actuarial value equal to 75 percent of the actuarial value of the benefit for the service under the benchmark plan used for the aggregate comparison.

Cost-sharing

A state may impose premiums, deductibles, coinsurance, or other cost-sharing ((e)(1)). No cost-sharing may be imposed for preventive services (defined as well-baby and well-child care, including immunizations).

For children below 150 percent of poverty ((e)(3)(A)), premiums may not exceed those allowable under section 1916(b)(1) of the Medicaid statute. Presumably, 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 (see Appendix B). Deductibles and cost-sharing would have to be “nominal” as defined in the implementing regulation for Medicaid section 1916(a)(3), subject to updating for inflation or other adjustments. The rule (42 CFR 447.54) limits deductibles for non-institutional services to \$2 per month, coinsurance to 5 percent, and copayments to \$3.²⁷ For institutional services, cost-sharing may not exceed 50 percent of the cost of the first day of care.

For children above 150 percent of poverty ((e)(3)(B)), annual aggregate premiums and cost-sharing could not exceed 5 percent of family income.

Again, although there is no specific mention of employer plans, it must be assumed that children receiving premium assistance would be subject to the same limits.

Preexisting condition exclusions

For a child enrolled in a group health plan, benefits could be subject to a preexisting condition limitation imposed by that plan, so long as the limit complied with HIPAA rules ((f)(1)(B)).

²⁷ Copayments may be doubled for nonemergent use of an emergency room.

Compliance with other requirements

Section 2103(f)(2) reads:

Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

The effect of this provision is unclear. The reference is to HIPAA requirements for insurers in the small group market to guarantee issue and renewability. The conference report sheds no light on what (f)(2) is supposed to do. Possibly it means that states cannot buy into an employer plan purchased from a non-compliant insurer. Possibly it means that a state that provides assistance with the purchase of nongroup private coverage must impose HIPAA-like requirements on participating insurers.

2105. Payments to States

Up to 10 percent of a state's Federal allotment could be spent for activities other than providing health benefits coverage to targeted low-income children. This 10 percent limit would include spending ((a)(2)):

- (A) for payment for other child health assistance for targeted low-income children;
- (B) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);
- (C) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and
- (D) for other reasonable costs incurred by the State to administer the plan.

It is possible that category (B) could include premium assistance for low-income children currently in employer plans, even though these children are excluded from the definition of "targeted" children. (This would depend on whether such assistance could be interpreted as part of an initiative to improve children's health.) Note that the income limit for "low-income" children who are not "targeted low-income" children is defined (2110(c)(4)) as 200 percent of poverty, even in states with a higher Medicaid income limit.

Section (c)(3) is the one part of the legislation (other than the provision on pre-existing condition exclusions cited earlier) that directly addresses assistance with employee contributions to group health plans:

Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that--

(A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and

(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

This language has been interpreted to mean that secretarial approval is required if the state assists family members other than the targeted children (for example, by contributing towards the premium for a parent who has previously declined coverage and must cover herself in order to cover her children). This provision would then be similar to the provision of Medicaid law requiring that a state show that it is cost-effective to buy into employer coverage for non-Medicaid eligible family members in order to cover Medicaid-eligible family members.

Section (c)(6)(A) provides:

No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

This provision parallels similar language in the Medicaid statute and is intended to prevent private plans, including employer plans, from making themselves secondary to coverage under child health assistance. (It does not prevent employers from modifying their plans in other ways to take advantage of the existence of a child health insurance program—for example, by modifying their rules on dependent coverage.)

Finally, section (c)(7) prohibits payment “for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion... [except] if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.” This provision appears to preclude any contribution to an employer plan coverage of these services. As such coverage is quite common since employer plans might often include such coverage in their scope of benefits, this could be a major barrier to any buy-in initiative. Possibly it could be argued that premiums for coverage of a

child below child-bearing age do not include any amount for abortion even if abortion is nominally included in the benefit package. This argument could not be raised if the state chose to contribute towards family coverage.

2107. Strategic Objectives and Performance Goals; Plan Administration

Section (c) makes section 1115 of the Social Security Act applicable to CHIP; this means that States can seek demonstration waivers comparable to those under which many Medicaid programs are now operating.

2109. Miscellaneous Provisions

Section (a)(2) specifies that nothing in Title XXI shall be construed as modifying the ERISA preemption of State regulation of employee benefit plans.

APPENDIX B - Hypothetical State Policy Package To Coordinate Public And Employer Coverage

Rick Curtis

As discussed in the text of this report, there are many possible policies to maximize the use of available dollars to cover more uninsured children and parlay, rather than crowd out, employer-sponsored coverage. However, there is no single magic bullet to address the complicated issues involved. Rather, a combination of policies is needed to deter shifting costs from private to public sources and to encourage use of available employer financed coverage. An example of a combined approach that may work for CHIP programs coordinating with employer coverage follows.

1. To avoid employers or workers dropping coverage of already insured children, establish a firewall making persons ineligible for CHIP if they have recently (e.g., within the last nine months) had employer coverage. However, such a firewall could leave a number of children uninsured that lost coverage for reasons unrelated to employer or employee “gaming” of CHIP eligibility. Therefore, exceptions to this firewall should be allowed when the following events occurred during the look-back period that resulted in loss of insurance coverage.
 - (a) The parent became unemployed, or changed jobs to a new employer who either does not offer or does not contribute to dependent coverage;
 - (b) The family’s income has been substantially reduced, causing the worker to drop coverage because the contribution requirement is no longer affordable. States may set the threshold for this exception so that families whose income dropped and the cost of the insurance became greater than 10% of family income would qualify for the program. (It would make sense to set the threshold at a percentage that is above the 5% maximum family contribution amount allowed in the CHIP legislation.
 - (c) The family lost employer-sponsored coverage because of a death of an employee, or divorce, or because an individual became ineligible for coverage as a child or dependent.
2. To better reach uninsured children in working families through “one stop shopping” for family coverage and to help assure that subsidies for uninsured children are not used in lieu of available employer contributions, a state could establish a subsidy or voucher program that assists workers with uninsured children in paying their employer plan premium contribution. The state might take further measures to:
 - (a) assure optimal use of funds for subsidy programs by using this approach only when it is cost-effective to do so - when the cost of the subsidy is enough to

assure that the children become insured but is no more than the cost of covering the children under the public program. (To make optimum use of state dollars when such cost-effective employer coverage is available, the state might require the children enroll in the employer plan as opposed to the public plan. Oregon legislation includes a similar requirement.)

- (b) align incentives so that the family's and the state's interests are compatible. For example, the state could include a contribution requirement for its public program that provides incentives for families with income above 150% of poverty that are *already insured* under employer plans to continue that insurance. If set properly, families, when faced with required contributions for both the public plan and the employer plan, may continue to find the employer financed coverage financially attractive. If the state's public program required a \$50 per month contribution to cover a family's children, four out of ten modest wage workers with access to employer coverage could pay less than this amount extra to purchase family (rather than worker only) coverage through their employer. (See Table C-4 in Appendix C.) (Note: For families with only one child, a \$50 per month contribution toward the public coverage would probably be too high, effectively precluding programs from reaching the uninsured child.)

To encourage cost-effective use of employer coverage for *uninsured* children, the state could establish somewhat lower contribution requirements (e.g. \$40 per month) for the subsidy program. The state would, in effect, share with the family some of the savings that result from using employer-sponsored plans that include employer contributions rather than a public approach financed entirely by the government.

- (c) Assure that children who are covered under a subsidy approach have timely access to coverage by making Title XXI eligibility a "qualifying event" for adding uninsured children to a worker's coverage rather than waiting for an annual open enrollment period (the California Healthy Children legislation includes such a provision). This approach might be extended to include making Title XXI eligibility a qualifying event for adding workers as well as their families when they have Title XXI eligible uninsured children.

To assure that the benefit package equals or exceeds the actuarial value of child health program benefits, states could certify insurance carriers' plans that meet those levels. As a condition of receiving a subsidy for coverage through an employer, the state could require the use of such a certified plan made available by one of the employer's carriers, or, for small employers, by a HIPC.¹ Alternatively, where an employer's plan covers the services required by the state's CHIP but includes higher cost-sharing requirements, the state might reimburse families for spending that exceeds out-of-pocket cost ceilings.

APPENDIX C – Distribution of Employer Contributions

Jean Hearne
Mark Merlis

The distribution of employer contributions toward the cost of health insurance will be essential information for setting up health insurance purchasing programs that coordinate with employer coverage. Data from the 1993 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey conducted by RAND provides some insight into the distribution of those contributions. The RWJF surveyed employers in 10 states to investigate the barriers to employer coverage and to describe premiums and other characteristics of health plans offered by employers. The 10 states together are believed to be similar to the nation as a whole in terms of measures of employment, earnings and health systems. (See Cantor, J.C., Long, S.H, Marquis, M.S., **Private Employment-Based Health Insurance in Ten States**, *Health Affairs*, Summer 1995, p. 199.)

The following tables are IHPS tabulations of the RWJF data for all 10 states surveyed. The tabulations reflect only the experience of private firms reporting firm size greater than one. In addition, for tables reflecting employers' contributions toward dependents coverage, employers that reported not offering dependents coverage were categorized as offering a zero contribution toward the cost of such coverage.

Employer Shares of Single and Family Premiums

1. The majority of workers that were offered health insurance by their employers were in firms in which their employers offer to pay a significant portion of single coverage. The portion of employers, however, offering a high percentage contribution toward family coverage is significantly lower than the portion of those offering a high percentage toward single coverage.

Table C-1. Percentage of Workers in Firms Offering Health Coverage by Employee Contribution to Cost of Single and Family Plans, 10 States, 1993		
Employer share of premium	Single premium	Family premium
0-24%	2.6%	10.6%
25-49%	1.9%	12.5%
50-74%	14.7%	20.7%
75-99%	31.6%	29.5%
100%	49.2%	26.8%
Total	100.0%	100.0%
Source: IHPS tabulations of data from the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey Conducted by RAND.		

When an employer offered health insurance, the employer generally made a significant contribution toward the cost of the employee's coverage. Over 80% of workers in firms that offered coverage worked for employers that contributed more than 75% toward the cost of single health insurance coverage. Almost 50% of all workers in those firms that offered coverage worked in firms that contribute 100% toward the cost of single coverage.

On the other hand, just over half of all workers in firms that offered health insurance coverage were in firms in which the employers contributed more than 75% toward the cost of family premiums.

2. Low-wage workers in firms that offer coverage were somewhat less likely to be in firms that offered generous contributions.

Employer share of family premium	Workers wages: Under \$14,000/year	Between \$14,000 and \$20,000/year	Over \$20,000/year
0-24%	14.9%	10.4%	8.4%
25-49%	14.5%	12.4%	11.4%
50-74%	22.5%	22.5%	19.1%
75-99%	23.2%	30.1%	32.4%
100%	25.0%	24.6%	28.7%
Total	100.0%	100.0%	100.0%

Source: IHPS tabulations of data from the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey Conducted by RAND.

Overall, there is about a 10-percentage point difference between the percentage of low wage and higher wage workers in firms where the employers offered coverage and contributed generously (over 75% of the cost of the family premium) toward the cost of family coverage. In 1993, about 50% of those workers earning less than \$14,000 per year in firms that offered health insurance coverage had at least a 75% employer contribution available to them. About 60% of such workers earning more than \$20,000 per year had a similarly generous employer contribution toward the cost of family coverage available to them.

3. Most workers in firms that offer health insurance coverage are in firms that contribute substantially to single and to family plans.

Employer share of family premium	Employer share of single premium					Total
	0-24%	25-49%	50-74%	75-99%	100%	
0-24%	100.0%	42.7%	16.2%	3.6%	7.3%	10.6%
25-49%	0	56.9%	13.7%	8.0%	13.8%	12.5%
50-74%	0	.5%	69.0%	17.8%	10.1%	20.8%
75-99%	0	0	1.1%	70.1%	14.6%	29.5%
100%	0	0	0	.4%	54.2%	26.8%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: IHPS tabulations of data from the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey Conducted by RAND.

About 70% of workers in firms that offered health insurance coverage and provided a contribution of over 75% toward the cost of single coverage also had at least 75% employee contribution toward the cost of family coverage available. Buying into employer coverage for the dependents of those employees may potentially be a very good buy for the public program. A subsidy for the purchase of dependents coverage of employer sponsored insurance may be well below the cost of covering the dependents under the public program. Indeed a subsidy toward the entire family plan for this population could still be cost-effective for the state.

4. A state program requiring a family contribution of \$50 each month may be more expensive than staying with employer coverage for almost half of those families who have coverage.

Table C-4. Workers in Firms Offering Health Coverage by Wages and Minimum Difference in Employee Shares for single and Family Coverage, 10 States, 1993				
Difference between employee contribution for single and for family coverage	Workers by Wages			
	Under \$7/hour, \$14,000/year	\$7-\$10/hour, \$14,000 to \$20,000/year	Over \$10/hour, \$20,000/year	All Workers
\$0-\$49	42.8%	44.6%	51.4%	47.6%
\$50 to \$99	18.1%	21.8%	19.0%	19.4%
\$100 to \$149	12.0%	10.4%	8.7%	9.9%
\$150 to \$199	8.6%	6.8%	6.0%	6.9%
\$200 to \$299	12.2%	10.0%	9.1%	10.1%
\$300 and over	6.3%	6.4%	5.8%	6.1%
Total	100.0%	100.0%	100.0%	100.0%
Source: IHPS tabulations of data from the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey Conducted by RAND.				

Table C-4 compares the least amount that an employee would have had to pay for single coverage with the least amount the employee would have had to pay for family coverage.ⁱⁱ The tables shows that just over half (51.4%) of all workers in firms offering health insurance coverage were in firms that required at least an additional \$50 contribution over the cost of single coverage to add dependents. The rest (47.6%) had to pay at least between 0 and \$49 to add dependents. If state CHIP programs were designed to require a \$50 contribution for the dependents coverage, then the almost half who are paying between 0 and \$49 now would have little incentive to drop their employer coverage and join into the public plan.

Table C-4 also indicates that almost a quarter of all employees in firms that offer health insurance coverage were required to pay at least an additional \$150 per month to add dependents to their policy. For a family of four with income at 150% of the federal poverty level, a monthly contribution of \$150 per month

ⁱ In many states, the small employer health insurance market consists of myriad carriers and benefit packages offered through a large number of small firms. This could make it very difficult to efficiently coordinate public subsidies on a small employer by small employer plan basis. (The likelihood is that any given small employer offering coverage would have very few workers with Title XXI eligible children.) However, a state could coordinate such coverage through a HIPC that adds the state children's health insurance package to its available standardized benefit levels. A state could also allow employers who don't offer qualified coverage to make their contributions available toward HIPC qualified coverage for workers with Title XXI eligible children. States could require that such families be excluded from or counted as covered in a carrier's calculation of employee participation rates (analogous to how a worker with a coverage through a spouse is treated). However, where a state's small group insurance rules allow

carriers to charge much higher premiums for higher risk small employer groups, it may be altogether impossible to design a cost-effective interface with small employer coverage. In such a state, the addition of a high risk child to an employer group could cause a very small employer to drop coverage due to a rate hike.

ⁱⁱ Employees are often offered the choice between multiple plans. Each plan may require different amount in contribution toward single and family policies. This table compares the differences between the least of those two amounts.