

Supplementing Cost-Sharing Provisions of Employer-Based Insurance Plans

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States seeking to develop an employer-based insurance subsidy program under the State Children's Health Insurance Program (CHIP) must comply with a number of federal requirements regarding cost-sharing. If a program participant's employer-based coverage does not meet the requirements, the State may provide a "fill-in" plan to bring the resulting coverage into compliance. Specifically, the CHIP statute includes the following requirements:

- There may be no cost-sharing for well-baby, well-child, and immunization visits;
- Families with incomes under 150% of the federal poverty level (FPL) may pay no more than the Medicaid-level of copays, which includes \$3 office visits;
- Families with incomes over 150% FPL may pay no more than 5% of their total income for cost-sharing in a given year (including both premium contributions and cost-sharing at the point of service).¹

States must comply with these cost-sharing provisions whether a child is covered under the regular CHIP program or under employer-based coverage through a subsidy program. In most cases, however, employer-based coverage will not include such limited cost-sharing provisions. In these cases, states must "fill in" the cost-sharing provisions of the private coverage to bring it into compliance with the federal rules. Perhaps the simplest means of covering excess cost-sharing expenses would be for families to keep cost-sharing receipts and submit them to the State for reimbursement. However, the Health Care Financing Administration (HCFA) has indicated that it is not permissible for families to incur *any* expenses beyond these specified cost-sharing limits, even if the State reimburses families for such expenses.

Given this restriction, a more viable approach to a cost-sharing fill-in is to have providers and carriers charge the appropriate copay up front (e.g., \$3 for an office visit for families with incomes under 150% FPL), and stop charging copays after a family has reached its out-of-pocket limit (5% of family income

¹ To comply with this last provision, states must keep track of each family's spending on cost-sharing. The most administratively simple method of tracking a family's cost-sharing would be to have families keep track of their own expenses. This method requires families to save copay receipts and inform the State or, in some scenarios, the insurance carrier, when they reach the limit. The State would be responsible for calculating the dollar amount that corresponds to the 5% limit for each family, so that families would know when they had reached that amount. It is possible, however, that in certain circumstances, carriers would be able to track enrollees' cost-sharing for them, thus obviating the need for families to keep receipts.

for families with income over 150% FPL). In some cases, carriers may have the capacity to track enrollees' cost-sharing and to "switch off" copay requirements at the appropriate time. In other cases, families may need to keep track of their own cost-sharing expenditures and inform the State and the carrier when the limit has been reached.

The following is a description of several options for administering a cost-sharing fill-in. In general, the simplest options rely on active participation by insurance carriers. However, because states may be unable to find carriers willing to perform the required tasks, options that do not rely on carrier participation are also included. Options are divided into two types:

- Those that address both the specific dollar limitations on different types of copays *and* the overall cost-sharing limit of 5% of family income (for families at or above 150% FPL); and,
- Those that address *only* the overall cost-sharing limit of 5% of family income.

These distinctions are important because it is likely that only a small number of children will ever exceed the 5% of income maximum, thus allowing this issue to be addressed with more *ad hoc* solutions. Analysis by the Institute for Health Policy Solutions suggests that under typical commercial HMO benefit packages, such as the ones offered by many employers, fewer than 0.2% of children would spend more than 5% of income on cost-sharing.² However, states will need to address the specific dollar limits on copays (e.g., no copay for well-child care) for nearly every child participating in a CHIP/employer-based coverage program, thus requiring more systematic solutions.

Options that address both the specific dollar limitations and the overall cost-sharing maximum

- 1. Carrier-Administered Fill-In.** Under this approach, carriers serving employers/employees participating in the subsidy program would develop and administer a supplemental cost-sharing plan for eligible children. For example, the supplemental plan would include no copays on well-baby etc., the Medicaid level of copays on all other services, and an automatic "shut-off" of copays once a family had reached the 5% overall cost-sharing maximum. Although the rest of the employer group would enroll in the employer's normal coverage, children eligible for CHIP would be enrolled in the enhanced plan instead, with the State paying the cost of the extra cost-sharing fill-in.³ To administer such a fill-in, carriers would most likely need to create a different "group number" for children participating in the subsidy program, versus employees and dependents of the same group who are not participating in CHIP.

This approach may raise concerns regarding federal and (in some cases) state requirements that carriers offer all small group benefit plans to all small employers (i.e., "guarantee issue" laws).⁴ As a result of such requirements, carriers offering a fill-in or reduced-copay plan to employer groups with CHIP eligibles might also have to offer such a plan to the market at large. However, the wrap-around or fill-in plan would be contracted and paid for by the State, rather than the

² This analysis was performed using data from the 1996 Medical Expenditure Panel Survey (MEPS). The data are for all children, rather than for children in the CHIP-eligible income levels, as the MEPS does not include income data. The analysis assumes utilization of services by children in the CHIP-eligible income range is the same as utilization of services by all children.

³ It is not known at this time how much carriers would charge for such a fill-in or reduced-copay plan, nor whether the purchase of such a plan would be cost-effective.

⁴ This requirement for "guaranteed issue" is contained in the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and in many states' small group reform laws. (For a summary of HIPAA, see the U.S. Department of Labor at <http://www2.dol.gov/dol/pwba/public/pubs/q&aguide.htm>).

employer. As a result, the fill-in is not actually made available or “sold” to *any* small employer, and therefore does not need to be sold to *all* small employers. Instead, the fill-in is “sold” to the State for the benefit of individuals.

2. **Vouchers.** The State could issue vouchers that families would give to providers in lieu of copays when required. For example, if a CHIP child is enrolled in a \$10 copay plan, but the family’s income is under 150% FPL, an office-visit voucher would be worth \$7, and the family would pay the remaining \$3. For families over 150% FPL, vouchers would be necessary only after the family reached its out-of-pocket maximum. (In this case, the voucher would cover the entire cost of the copay.) This approach would work best when the private coverage includes flat dollar-amount copays (e.g., \$10 per office visit), rather than variable coinsurance amounts (e.g., 20% of charges). A draw-back to this approach is that providers would be required to submit vouchers to the State for reimbursement. This activity represents an administrative burden for providers and for the State.
3. **Cash.** The State could determine, based on actuarial analysis, expected copay expenditures for a family. The State could pre-pay the family for the expected copay amount on a quarterly or some other basis. Families would then have sufficient cash in hand at the time of service to cover the full copay. State officials may be concerned that families would spend the cash on items other than copays (such as food or utilities). Although some families may do this, it is likely that many families, after having gone to the trouble to enroll in the program and receive the subsidy, would be motivated to use the money for medical care. On the other hand, in the few cases where the family does spend the money on other items, they may forego accessing medical care because they don’t have money left for copays. In addition, there are concerns related to pre-paying copays based on expected average utilization. For families that use less than the average amount of care, the State will have pre-paid too great an amount and will likely be unable to collect the excess. For families that use greater than the average amount of care, the State would need to create another mechanism to pay additional funds to the family.
4. **Supplemental Carrier.** If the carrier providing the employer-based coverage does not wish to (or is unable to) administer a fill-in, states might retain an additional carrier to administer supplemental cost-sharing plans. Many states use a similar approach under their Medicaid Health Insurance Premium Payment (HIPP) programs. However, under HIPP programs, the entity administering the wrap-around is normally the Medicaid program itself. The supplemental carrier approach, if it involves an intermediary with established relations with private, mainstream carriers, is probably preferable to using a state program (e.g., Medicaid) without such existing contractual relationships with commercial carriers.

One of the concerns with this approach is that it would require subsidy program participants to carry two health plan cards; one for the majority of the benefits, and one for any supplemental cost-sharing fill-ins the State must purchase. This may cause confusion for families as well as for providers’ billing offices.

Options that address only the overall cost-sharing maximum

5. **“Red Dot” Approach.** When a family reaches its out of pocket maximum amount and so informs the State, the State would issue the family a “red dot” or other sticker to place on the child’s health plan identification card. Providers seeing this sticker would know that they are not permitted to collect a copay from the family. Providers would either take a loss for the copay amount or be reimbursed by the carrier, depending on the provider-carrier contract provisions. Some providers may be unlikely to request reimbursement for such small amounts and may take a loss if they have no other recourse through the

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contracting carrier. However, because the number of children reaching the out of pocket maximum is likely to be very small, this approach would not represent a financial hardship for providers.

6. **“1-800” Number.** Under this approach, when a family reaches its out of pocket maximum, the State would issue the family a sticker to place on the child’s health plan identification card (similar to option #5, above). The sticker would indicate that, rather than collect a copay, the provider must call a 1-800 number. State staff or contractors would answer the number and give the provider a credit card number against which to charge the copay. If the provider didn’t accept credit cards, the funds could be couriered, wired, or mailed to the provider. This case-by-case approach would work well because there will be very few instances in which families exceed the 5% of income copay maximum. Any given physician would see a small portion of these children, and most physicians would never encounter a child who had met the cost-sharing limit. The largest draw-back to this approach is that providers may not wish (or may not have time) to call the 1-800 number.
7. **Enrollment in the regular CHIP program.** Under this option, when a family reached the 5% of income copay maximum and submitted its copay receipts to the State, the child would be enrolled in the regular (non employer buy-in) CHIP program under a no-cost-sharing plan. Alternately, a child in such a situation could be dual-enrolled in both the employer-based and the regular CHIP program, with the regular coverage being primary. While this approach is, in a sense, inconsistent with the goals of the CHIP/employer-based insurance subsidy program, the number of families reaching the 5% maximum will likely be so few that it may not be cost effective to develop other administrative structures for dealing with such children. In addition, children who do exceed the cost-sharing limit may be special-needs children who may be better served in the regular program than in a commercial plan.

The following table lists each of the above seven options and the major parties involved in administration. The table indicates how each option would impact the relevant parties in terms of ease of administration.

<p align="center">Options for Administration of a Cost-Sharing Fill-in Plan under a CHIP/Employer-Based Insurance Subsidy Program</p> <p align="center">Simplicity/Ease of Administration for Relevant Parties</p>				
Option	Family	Provider	Health Carrier	State
1. Carrier-administered cost-sharing fill-in for buy-in program eligibles in an employer group	Most simple	Simplicity/ ease depends on arrangement with contracting carrier	Requires administration of new benefit plan and creation of new "group number" for small number of people	Most simple
2. Vouchers	Requires families to bring vouchers to appointments and to use them	Requires providers to submit vouchers to the State for reimbursement	Most simple –likely requires no action on the part of the carrier	Requires development of new administrative structure to distribute and redeem vouchers
3. Cash	Requires family to refrain from spending cash on other (potentially necessary) items; otherwise simple for family	Most simple – requires no action on the part of the provider	Most simple –requires no action on the part of the carrier	Requires development of actuarial estimate of appropriate cash value; also requires disbursement of cash to families
4. Supplemental Carrier	May require presenting two health plan cards, more paper work	May often require "split" billing to separate carriers	Requires coordination of benefits among carriers	Relatively simple, but requires separate contract, administration, and expenses for extra plan/carrier
5. "Red Dot"	Relatively simple, assuming provider understands meaning of "red dot"	Requires provider to either take a loss for the copay or to develop other arrangements for reimbursement from contracting carrier	May require carrier to develop arrangements to reimburse providers for copays they may not collect from patients	Relatively simple, but requires development of structure to distribute "red dot" (simpler than voucher system)

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Option	Family	Provider	Health Carrier	State
6. '1-800 'Number	Relatively simple, assuming provider calls 1-800 number and does not attempt to collect copay	Requires provider to call 1-800 number to be paid (likely to be necessary in only a small number of cases)	Most simple –requires no action on the part of the carrier	Relatively simple, but requires establishment and staffing of 1-800 number
7. Regular CHIP program enrollment for children reaching 5% of income copay maximum	May be most disruptive for family, unless the same carrier serves both the employer group and the CHIP program	Requires no action on the part of the provider, unless the child must join a new carrier with which the provider does not contract	Requires no new action on the part of the carrier (other than normal action when individual disenrolls from a plan and enrolls in another)	Most simple