

## **Coordination of Title XXI Coverage with Employer-Based Coverage through Consumer-Choice Health Purchasing Groups**

**Based on an Institute for Health Policy Solutions Round-Table**

**December 6 and 7, 1998**

**Vail, Colorado**

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### ***Background***

In the summer of 1997, Congress enacted Title XXI of the Social Security Act, creating the State Children's Health Insurance Program. Since that time, there has been a flurry of activity from the states, as health program officials have begun to establish child health insurance programs using the new federal matching funds. Under Title XXI, children in families with incomes up to 200% of the federal poverty level (or 50 percentage points above a state's highest applicable Medicaid eligibility level, whichever is higher) may be eligible for free or reduced-premium health insurance. Prior to the passage of Title XXI, families with incomes at these levels were generally excluded from publicly-funded coverage. (While income thresholds for Medicaid programs vary from state to state, few states provide Medicaid coverage for families with incomes above 133% FPL.)

By increasing the income threshold for participation in publicly-funded health insurance programs, Title XXI has significantly increased the likelihood that public program participants will be employed (or have an employed parent) and may have access to employer-based insurance. As a result, many states are beginning to explore ways of coordinating Title XXI programs with employer-based coverage in order to do the following:

- take advantage of private funds where available;
- facilitate coverage of uninsured children where parents prefer "one stop shopping" family coverage; and,
- minimize "crowd-out" of existing private coverage.

Specifically, states are looking at options for using Title XXI funds to buy into children's employer-based coverage when it is available (but unaffordable) to the family.<sup>1</sup>

State program officials who are working to establish such Title XXI/employer-based coverage coordination programs must address a number of requirements contained in the federal law. For example, states may use Title XXI funds to buy into employer-based coverage *only* when the resulting coverage meets the benefit and cost-sharing requirements of the regular Title XXI program.<sup>2</sup> Due to the extremely large number of employer-based benefit plans and carriers available in the open market, it would be difficult to assess and coordinate coverage with any potentially eligible employer-based plan. This difficulty is more pronounced in the fragmented small employer market, where any employer group's benefit plan is likely to include only a small number of eligible children. As a result of this and other administrative difficulties, some states are exploring pilot program options that will ease the administration of an employer-based premium subsidy program under Title XXI.

One way to simplify the administration of a Title XXI/employer-based coverage premium subsidy program is to make use of an existing Consumer-Choice Health Purchasing Group (CHPG). Such purchasing groups exist in a number of states, although their structures vary considerably.<sup>3</sup> One common feature of CHPGs is that they buy a limited number of standardized benefit plans from competing carriers on behalf of a large number of different employers. They also allow workers and their families to enroll in the plan of their choice. As a result, they have administrative structures that facilitate contracting with a number of insurance carriers, collecting premiums from multiple sources, enrolling families in their choice of health plans, and making premium payments to the appropriate carriers for the duration of enrollment.

Title XXI programs that provide employer-based coverage premium subsidies through CHPGs could have large advantages over programs that attempt to coordinate with employer-based coverage in the open market. A premium subsidy program administered through a CHPG could be structured as follows:

- Existing or new benefit plans from the CHPG's carriers could be "certified" as meeting benefit and cost-sharing requirements of Title XXI.
- Title XXI-eligible children of workers employed by businesses participating in the CHPG could receive subsidized coverage if the family enrolled in a benefit plan from a carrier that also offered the Title XXI-compliant benefit plans.
- The CHPG could use its existing administrative structure to do the following: gather information about employer premium contributions; collect employer and employee premium contributions from employers; collect applicable payments from Title XXI programs (e.g., premium costs for benefit upgrades); enroll children (or their families) in qualifying benefit plans; and, pay premiums to participating carriers.

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<sup>1</sup> For a more detailed discussion of the rationale for states to coordinate Title XXI and employer-based coverage, see "Using SCHIP Funds for Health Insurance Premium Contributions: Policy Issues and Operational Challenges," an issue paper developed by the Institute for Health Policy Solutions and the National Governors' Association. This paper is available at [www.ihps.org/10-98HenHea.htm](http://www.ihps.org/10-98HenHea.htm).

<sup>2</sup> The term "resulting coverage" refers to the employer-based coverage for which the Title XXI child is eligible, plus any additional riders or cost-sharing fill-ins the State must purchase in order to bring the coverage into compliance with the federal statute.

<sup>3</sup> For more information about Consumer Choice Health Purchasing Groups in general, see the Institute for Health Policy Solutions' web site at [www.ihps.org/CHPGs.html](http://www.ihps.org/CHPGs.html).

### ***Title XXI/CHPG Coordination Tasks***

The major tasks required for implementation of a Title XXI/CHPG coordination program include:

- I. Assessment of CHPG employer-based benefit plans and, if needed, upgrade to Title XXI-required level of benefits and cost-sharing;
- II. Determination of Title XXI eligibility;
- III. Administration of subsidies (i.e., payment of subsidies to eligible families);
- IV. Assessment of employer contribution levels; and
- V. Determination of cost-effectiveness.

#### **I. Benefit Plans**

The State must determine whether the benefit plans offered by the CHPG's carriers meet the requirements of Title XXI. If the CHPG coverage does not meet the requirements, the State may provide a wrap-around plan to bring the resulting coverage into compliance with Title XXI standards. In general, for states to use Title XXI funds to buy into employer-based coverage, there are three parameters under which resulting coverage must meet federal requirements:

- A. Covered Services. Coverage must include the Title XXI required services: inpatient and outpatient hospital care, physician care, laboratory and x-ray services, well-baby and well-child care, and age-appropriate immunizations. In addition, if the state's applicable benchmark plan(s) cover any of the "ancillary services" - mental health, prescription drugs, vision services, and/or hearing services - the state's Title XXI coverage (and any employer-based plan purchased under Title XXI) must also provide for these services.<sup>4</sup> If the CHPG's plans do not meet the Title XXI covered services requirements, the State must determine what type of benefit rider would be necessary to bring the coverage into compliance.
- B. Actuarial equivalence. In addition to covering the Title XXI required services, coverage must be at least actuarially equivalent to the state's benchmark plan(s) for Title XXI.<sup>5</sup> The actuarial value of coverage for required services must be at least 100% of the value of the benchmark(s), while the value of coverage for any required "ancillary services" (see above) must be at least 75% of the value of the benchmark.<sup>6</sup> If the CHPG benefit plan does not meet the actuarial equivalency tests, states must determine the value of the additional benefits that would need to be added to bring the plan into compliance with Title XXI.

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<sup>4</sup> Title XXI permits states to choose one or more "benchmark" plans from among four options: a) the commercial plan in the state with the largest enrollment; b) the state employee plan with the largest enrollment; c) the Federal Employees Health Benefit Plan PPO option; or, d) a Secretary-approved alternative.

<sup>5</sup> Alternately, states may provide the benchmark plan itself, rather than attempting to provide a plan that is actuarially equivalent.

<sup>6</sup> If these "ancillary" services are not covered under the benchmark, they do not need to be covered under the Title XXI program or employer-based coverage purchased through that program.

- C. Cost-sharing. Title XXI includes the following requirements regarding cost-sharing, whether coverage is provided under a public program or an employer-based coverage buy-in program:
- 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).<sup>7</sup>

Because CHPGs offer only a limited number of benefit plans across competing carriers, assessment of compliance with these three requirements would be simple and would only need to be performed once for all employers participating in the CHPG. Where CHPG benefit plans fell short of the Title XXI requirements in terms of covered benefits, actuarial equivalence, or cost-sharing, the State would need to make arrangements for “filling in” the existing plans to bring them into compliance. The differential cost would be paid by the State, rather than by the employer or by the family of a Title XXI-eligible child.

A fill-in could take the form of either a rider to an existing CHPG-offered plan, or a new plan offered by the CHPG and its carriers. In either case, development of such fill-ins is far simpler in a CHPG environment than it would be in the open employer-based insurance market, due to the limited number of benefit plans and the previously-established contracting/negotiating relationship between the CHPG and its participating carriers. (In other words, because CHPGs offer only a small number of benefit plans, carriers would need to administer only a small number of fill-ins to supplement those plans.)

While development of fill-ins or riders to cover previously non-covered services is straight-forward, the development of fill-ins to address the Title XXI cost-sharing requirements is somewhat more complicated. If the CHPG’s plans do not include the cost-sharing provisions described above, the State or CHPG must make arrangements to cover cost-sharing expenses that exceed these limits. Perhaps the simplest method for covering these 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 imposed by HCFA, 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 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.

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<sup>7</sup> To comply with this last provision, states must keep track of each family’s spending on cost-sharing. Vail round-table participants assumed that the most administratively simple method of tracking a family’s cost-sharing was to have families keep track of their own expenses (i.e., the “shoebox” approach). 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.

The following is a description of how a carrier-administered fill-in might work in the context of a CHPG. The narrative description is followed by a graphic illustration.

### **Carrier-Administered Fill-In for Title XXI-Eligible Children in the CHPG**

Carriers participating in the CHPG would agree to develop and administer a supplemental cost-sharing plan for Title XXI-eligible children. This 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.<sup>8</sup> Although the rest of a child’s family may have the standard cost-sharing requirements offered by plans in the CHPG (e.g., \$10 office visit), the child’s cost-sharing requirements would be “filled in” to meet the Title XXI requirements.<sup>9</sup>

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.<sup>10</sup> As a result of such requirements, carriers offering a fill-in or reduced-copay plan to employer groups with Title XXI-eligible children in the CHPG might also have to offer such a plan to the market outside the CHPG. Such a requirement could impact carriers’ willingness to implement this approach to a Title XXI fill-in. However, as described previously, children, as Title XXI beneficiaries, could be separately enrolled in a supplemental benefit plan contracted and paid for by the State, rather than the 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, just as Medicaid benefits are sold to the State.

From the perspective of the CHPG, this approach would require the purchasing group to create a separate enrollment group made up of children enrolled in the reduced copay plan. Under normal circumstances, when an employer group joins a CHPG, the employees choose among the participating carriers. For example, assume that an employer group includes 20 lives, and there are four carriers offered in the CHPG. The employees divide themselves evenly among these four plans, with five employees choosing each plan. When the CHPG enrolls the employees in their chosen plans, its systems create “synthetic” groups (i.e., not actual *employer* groups) made up of all the employees from many different employers who have chosen a given carrier and plan. From the carrier’s perspective, this is the “CHPG group.” The carrier often does not know to which real employer group each enrollee belongs. If, under a Title XXI/CHPG coordination program, carriers also administer a cost-sharing fill-in (in addition to their normal plans), children who enroll in that plan would be placed into their own synthetic group. This would require that the children be enrolled in a separate group from their parents.

As an alternative to this approach, instead of offering the reduced copay plan only to qualified children in certain families (where the rest of the family has a different benefit package), carriers and

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<sup>8</sup> Alternately, carriers could develop two supplemental cost-sharing plans - one with the Medicaid-level of copays (for families under 150% FPL), and one with more commercial-like levels of copays but with an automatic copay “shut-off” once the family had spent 5% of its income on cost-sharing (for families over 150% FPL). If carriers chose to administer only one supplemental plan, it is possible that the Medicaid-level of copays would obviate the need to develop a plan that limits cost-sharing to 5% of family income.

<sup>9</sup> 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.

<sup>10</sup> 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>).

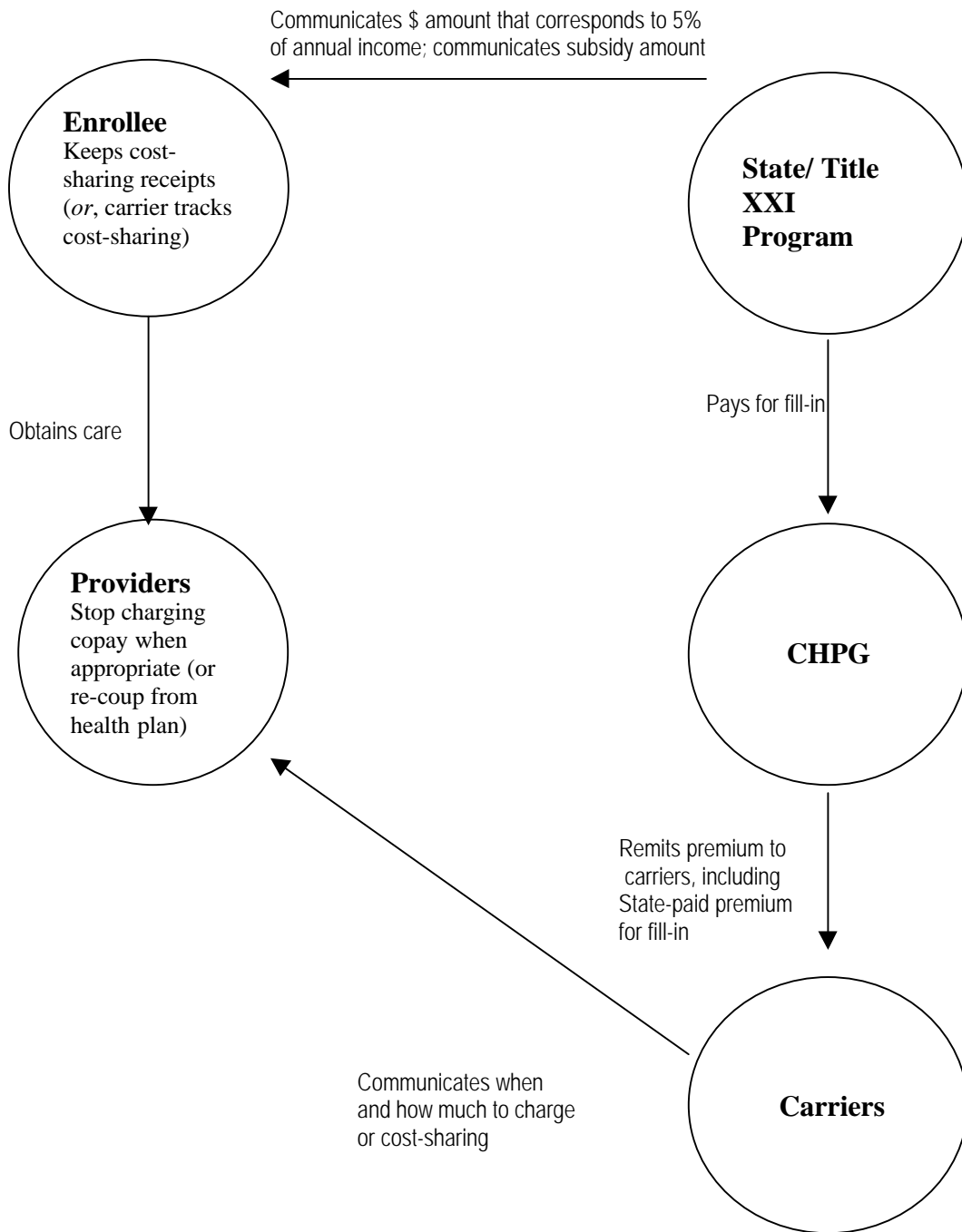
the CHPG could make the reduced copay package available to all employers in the CHPG.<sup>11</sup> In some cases, employers would choose this package, and there would be no need for any additional cost-sharing fill-in for children in families employed by such employers. However, if a family's employer did not choose the reduced copay plan, the applicable children and/or families would need to be enrolled at different benefit levels as described above.

Although the approach described above requires some work on the part of carriers, it is the simplest method of administering a cost-sharing fill-in from the perspectives of both the enrolled families and the State. However, in some instances, structural and administrative barriers may make it difficult for carriers to administer separate plans for children participating in a Title XXI/CHPG coordination program. In such cases, there are other options for administration of a cost-sharing fill-in that do not rely on carrier participation. These options, described in Appendix B, might also be viable alternatives in the open market, where no CHPG is available to work with carriers on the development of cost-sharing fill-ins based on standardized plans.

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<sup>11</sup> However, given federal and state requirements regarding guarantee issue in the small group market, carriers selling the reduced copay plan to employers through the CHPG would most like also be required to sell such a plan to the market outside the CHPG.

### Carrier-Administered Fill-In (for benefits and/or cost-sharing)



## II. Determination of Title XXI Eligibility

The timing of Title XXI eligibility determination is of concern when previously uninsured employer groups apply for CHPG coverage, particularly if the group might not meet carriers' or the CHPG's minimum participation requirement without the participation of the Title XXI-eligible families. For a small group (e.g., fewer than 10 people), the participation of even one worker and his dependent child could make the difference between the whole group meeting the participation requirement or not.

A typical enrollment process for an employer wishing to join a CHPG might be as follows: An agent informs an employer about the coverage available under the CHPG and mentions that a subsidy may be available for some of his employees' family coverage costs. The employer decides to sign up, with coverage effective the first of the following month. It is unlikely that Title XXI eligibility determination, calculation of the subsidy amount, and pre-payment (to the family) of the first month's subsidy can take place before the first of the month.

To avoid delaying enrollment for the entire employer group while Title XXI eligibility determinations are being made, the rest of the group should be able to enroll. In the meantime, the potentially Title XXI-eligible children would be covered under the regular Title XXI program (because coverage is retroactive to the date of application under federal law). Once the Title XXI eligibility determination is complete, the children would join the employer plan. The children should not be considered late entrants. Rather, CHPGs need to consider Title XXI eligibility a "qualifying event."

One complication associated with having Title XXI eligibility determinations come after the employer has made a decision regarding coverage is that the employer won't know exactly how many people he will be covering. Based on the likely Title XXI eligibility of certain employees' children, the employer may tell the CHPG he will be able to achieve, for example, 75% participation. However, after eligibility determinations are made, families that find they do not qualify for Title XXI may not be able to afford to join the employer plan. As a result, participation could drop below 75% after the fact. CHPGs need to accept such employers' good-faith estimates of the number of people that will participate. If fewer than the minimum actually enroll in the CHPG, the CHPG should permit such a group to remain in the cooperative for some reasonable period (e.g., 6 months).

## III. Subsidy Administration

States wishing to subsidize employer-based coverage, whether through a CHPG or in the open market, must develop a mechanism for ensuring that the subsidy reaches its ultimate destination – the carrier providing coverage. States could pay the subsidy directly to the employer, who would remit the funds to the appropriate carrier or CHPG, along with premiums for the rest of the employer group. However, this approach raises several concerns. First, under this scenario, the employer would be required to reduce the employee's payroll deduction by the amount of the subsidy received (assuming the employee portion of the premium is normally paid through a payroll deduction). Employers may be unwilling or unable to make this change in the payroll deduction system for only a few employees. In addition, this approach requires that the employer know the employee is participating in the Title XXI program. Some employees may not be comfortable with this lack of confidentiality and may view it as a barrier to participation. Finally, if the employer receives the subsidy directly, there is a strong incentive for him to reduce the *employer* contribution to premium by the amount of the subsidy. This phenomenon is known as "crowd-out" of employer contributions.

Alternately, states could pay the subsidy directly to the carrier or CHPG, who would, in turn, reduce the billing to the employer. Under this option, the employer would still be required to reduce the employee's

health insurance premium payroll deduction by the amount of the subsidy, to avoid paying the carrier twice for this portion of the premium.

The only option for subsidy administration that does not place this administrative burden on employers and does not breach employee confidentiality is to pay the subsidy directly to the employee. Under this option, the employer would continue to deduct the standard employee portion of the premium from the employee's paycheck, just as the employer does for all other employees. The State would then pay the employee for a portion of this expense.

One potential problem with this approach is that it may cause cash flow difficulties for participants who have employee contribution deductions taken from their paychecks before the State makes its subsidy payment. To address this potential problem, the State could *pre-pay* the employee the first month's subsidy amount, before the first payroll deduction is made.<sup>12</sup> In other words, prior to the first payment being deducted from the employee's paycheck, the State would send the employee a check for the subsidy amount.<sup>13</sup> Although this approach may raise concerns about fraud (i.e., employees might accept the subsidy and then not enroll in the health plan), the risk is probably minimal, as well as unavoidable. In addition, fraud would be a concern only in the first month of enrollment. At the end of the first month (and at the end of every subsequent month), the employee would submit a copy of a pay-stub to the State, showing that the employee contribution had been deducted. If the State did not receive this proof of continuing enrollment in the health plan, the State would not send another subsidy check to the family.

Vail round-table participants discussed the possibility use of CHPG enrollment data to verify continuing enrollment in the employer's plan. However, employers often do not notify their health plan administrators of disenrollment on a timely basis. For example, it is common for a CHPG administrator to learn that an employee has left the employer group only a month or two after the fact.

#### **IV. Assessment of Employer Contribution**

States will need to gather information about the total premiums for employer-based coverage, in addition to information regarding the employer and employee contributions toward coverage. This information is required for three purposes:

- a) to determine whether buying into the employer-based plan will be cost-effective for the state (i.e., whether it will be no more costly than enrolling the child in the regular Title XXI program);
- b) to determine whether the employer complies with any minimum contribution requirements, such as a HCFA guideline which requires employers to contribute at least 60% of the cost of family coverage to participate in a Title XXI coordination program;<sup>14</sup> and,
- c) to calculate the subsidy necessary to cover the appropriate portion of the employee's contribution.<sup>15</sup>

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<sup>12</sup> This is the approach that has been taken under the state-only Oregon Family Health Insurance Assistance Program.

<sup>13</sup> It is not yet known whether the Health Care Financing Administration will approve pre-payment of subsidies to families.

<sup>14</sup> This guideline is contained in a "Dear State Health Official" letter from the Health Care Financing Administration, dated February 13, 1998. It is important to note that this is a *guideline* and has not yet been adopted as rule. The February 13 letter is available at <http://www.hcfa.gov/init/chsub213.htm>.

<sup>15</sup> At low income levels, the subsidy will likely cover 100% of the employee's share of premium, while at higher levels, the subsidy will cover a smaller percentage of the cost.

The CHPG should collect employer contribution information from every employer upon enrollment and renewal. CHPGs may need to modify their information systems to perform this function.

An additional advantage to structuring a Title XXI/employer-based coverage program through a CHPG is that assessment of employer contributions can be more streamlined than it would be in the open market. Because the CHPG offers only a limited number of benefit plans and carriers, it would be possible for the State to determine up-front what level of employer contribution would make the purchase of each benefit plan cost-effective. In the open market, the State would need to make this determination separately for every employer wishing to participate.

## V. Determination of Cost-Effectiveness

As discussed above, for states to use Title XXI funds to subsidize employer-based coverage, it must be cost effective for them to do so. In this case, “cost effective” means that the subsidy the State pays to a family must be no more than the amount the State would spend to cover the family’s eligible children under the regular Title XXI program.

If HCFA requires the cost-effectiveness test to be met by every family, CHPGs (and most employer-based plans) may encounter a problem regarding their current insurance rating tiers. Most CHPGs use rating structures that include a tier for “employee plus child or children,” but they do not tend to have a tier for *one* child.” The “employee plus child or children” tier assumes, in most cases, an average of close to two children. As a result, it will rarely be cost effective for a state to buy into employer coverage for a single-child/single-parent family. Instead, children in such families would often need to be enrolled in the regular Title XXI program.

Vail round-table participants discussed the feasibility of CHPGs dis-aggregating their current “employee plus child or children” tier into “employee plus one child” and “employee plus two or more children.” This type of change would likely result in a premium decrease for single adult/single child families on the order of 50%. However, this change would also result in a (more modest) premium increase for single-parent families with multiple children, perhaps on the order of 15 to 20%. As a result, fewer of these larger families would meet the cost-effectiveness test for an employer buy-in under Title XXI. In addition, such a change may disadvantage the CHPG’s pricing structure relative to the non-CHPG employer market. If they believe a tier structure change will create such a disadvantage, it is unlikely that CHPGs or their participating carriers would be willing to implement this change.

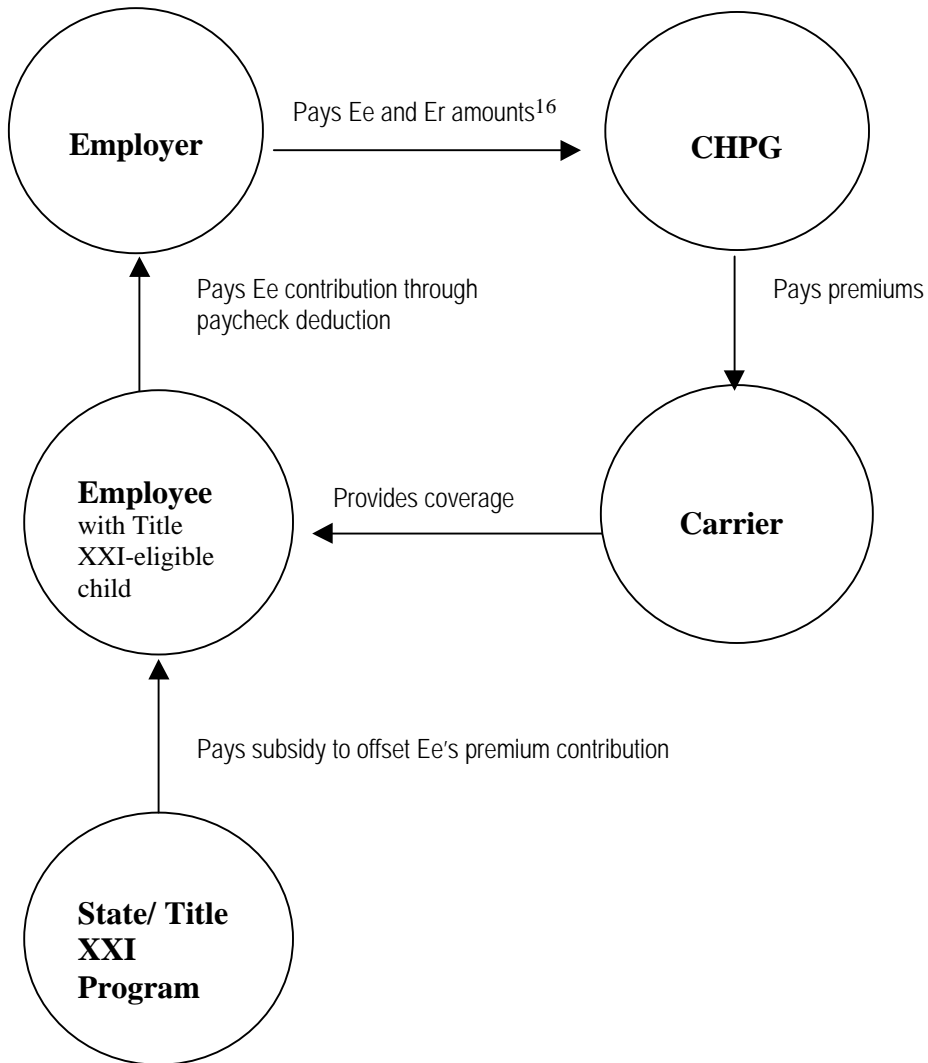
As an alternative to a tier structure change, when family tiers in a CHPG (or employer plan) do not include a separate tier for single-child families, the State might compare average premium contribution requirements against public program costs that would be incurred for the average number of children in families. For example, assume the average number of children in the “employee plus child or children” tier (in the insurance market) is two. Assume that the State’s average public program costs are \$800 per child. Under this scenario, the cost-effectiveness test would be met as long as children’s subsidies toward employer-sponsored coverage were no more than \$1,600, or the amount required for the *average*-sized family in the “employee plus child or children” tier. Although this method of calculating cost effectiveness would allow the State to pay more than the \$800 in some cases for a single child family, it would also prevent the state from paying more than \$1,600 for a family with three, four, or more children. On average, cost-effectiveness would be achieved. While Title XXI statutory language would seem to allow this method of determining cost-effectiveness, it is not yet known whether HCFA will permit this approach.

*Additional Graphic Illustrations*

The following pages include flow-charts illustrating:

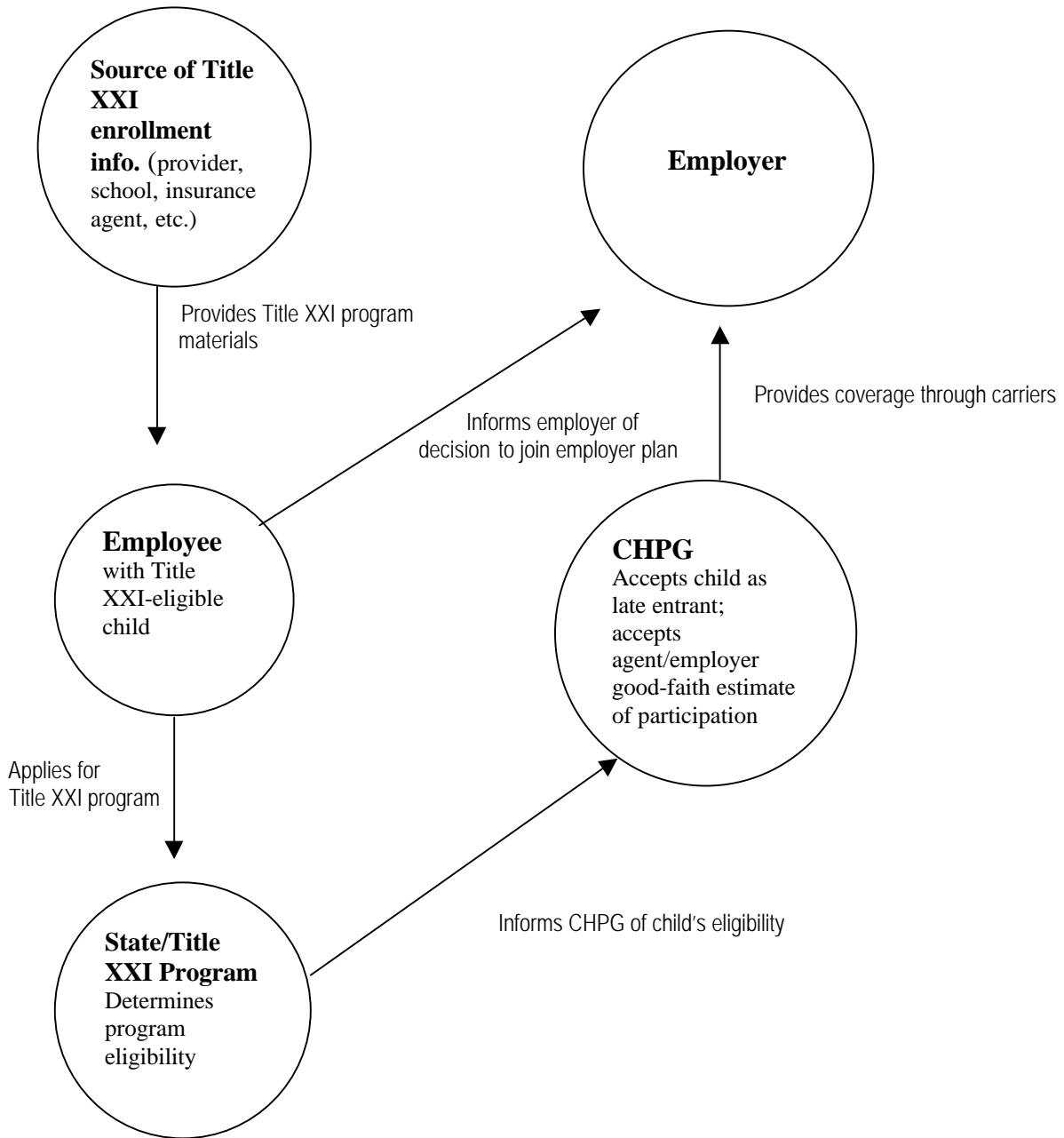
- How health plan premiums might flow from employees, employers, and the State, through the CHPG and to the participating carriers;
- How the CHPG enrollment/intake process might take place in coordination with Title XXI eligibility determination.; and,
- How subsidies might be paid to families.

## Payment of Health Plan Premiums

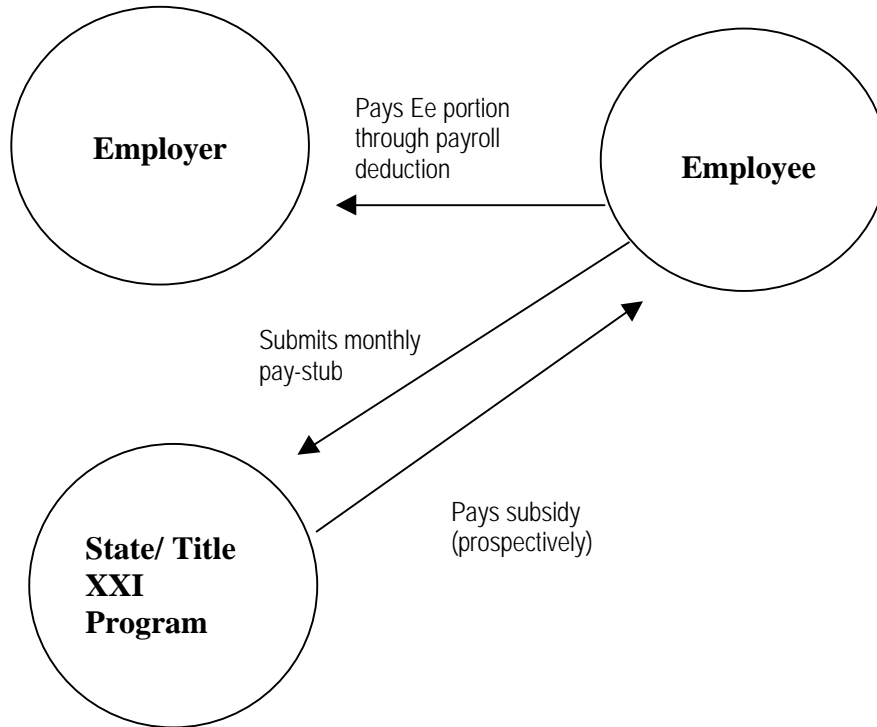


<sup>16</sup> The abbreviation “Ee” stands for “employee.” The abbreviation “Er” stands for “employer.”

### Intake Process



### Subsidy Administration



***Appendix A: Vail Round-Table Participants***

On December 6<sup>th</sup> and 7<sup>th</sup>, 1998, the Institute for Health Policy Solutions held a round-table meeting of state officials, Consumer-Choice Health Purchasing Group (CHPG) representatives, and CHPG administrative vendors to discuss options for coordination of Title XXI and employer-based coverage through CHPGs. Meeting participants included:

Rick Curtis	Institute for Health Policy Solutions
Bob DiPrete	Oregon Health Council
Susan Dodge	Kirke-Van Ordsdel, Inc.
Kevin Earls	Associated Oregon Industries (Health Choice)
Kevin Haugh	Institute for Health Policy Solutions
Jean Hearne	Institute for Health Policy Solutions
Mark Hogan	Gallagher Byerly, Inc.
Michelle Kennedy	Oregon Family Health Insurance Assistance Program
Bill Lindsay	Benefit Management and Design, Inc.
Sarah Schulte	Colorado Department of Health Care Policy and Financing
Jennifer Sexton	Institute for Health Policy Solutions
Lucinda Stinson	Southwest Michigan Purchasing Alliance
Laura Tollen	Institute for Health Policy Solutions
Cathy Van Doren	The Alliance (Cooperative for Health Insurance Purchasing)

The preceding paper is based on ideas discussed at the round-table. Inclusion of options in this paper does not necessarily represent endorsement of the options by the meeting participants.

## ***Appendix B: Additional Options for Administration of a Benefit and/or Cost-Sharing Fill-In***

In many cases, it will be necessary for states to develop and administer a cost-sharing fill-in plan to bring employer-based coverage into compliance with the Title XXI requirements. By far the simplest option for administration of such a fill-in, and the one that takes best advantage of a CHPG's unique structure, is for carriers to develop and administer the fill-in themselves. (A full description of this approach is included in the body of the report. This approach is also summarized below and labeled "Option 1" for purposes of comparison to additional approaches included in this Appendix.) However, in some instances, structural and administrative barriers may make it difficult for carriers to administer separate plans for children participating in a Title XXI/CHPG coordination program. In such cases, there are other options for administration of a cost-sharing fill-in that do not rely on carrier participation. These options, which might also be viable alternatives in the open market, 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 very 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 most CHPGs, fewer than 0.2% of children would spend more than 5% of income on cost-sharing.<sup>17</sup> 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 Title XXI/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 for Title XXI-Eligible Children in the CHPG**

*Note: This option is described in detail on pages 5 and 6 of this report. A graphic illustration of this approach can be found on page 7.* Under this option, carriers participating in the CHPG would agree to develop and administer a supplemental cost-sharing plan for Title XXI-eligible children. This 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 a child's family may have the standard cost-sharing requirements offered by plans in the CHPG (e.g., \$10 office visit), the child's cost-sharing requirements would be "filled in" to meet the Title XXI requirements.

As an alternative, instead of offering the reduced copay plan only to qualified children in certain families (where the rest of the family has a different benefit package), carriers and the CHPG could make the reduced copay package available to all employers in the CHPG.

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<sup>17</sup> 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 Title XXI-eligible income levels, as the MEPS does not include income data. The analysis assumes utilization of services by children in the Title XXI-eligible income range is the same as utilization of services by all children.

## 2. Vouchers

The State could issue vouchers that families would give to providers in lieu of copays when required. For example, if a 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 better in a CHPG than in the open market because the range of copay amounts is limited in the CHPG and is normally a flat dollar amount (because CHPGs tend to offer HMOs), rather than a variable amount (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. A variation on this approach is that the "vouchers" would actually be checks that providers could deposit directly into their accounts. However, if the vouchers were negotiable checks, even if the dollar amount were pre-printed, there is a great potential for fraud (e.g., families could make out the checks to other parties).

Another variation on the voucher concept would be to provide enrollees with a "smart-card," rather than a voucher or a check. A "smart-card" would be similar to a pre-paid debit card. Families would receive pre-paid cards with an actuarially-determined dollar amount. A draw-back to this approach is that many providers will not have systems in place to read such cards. Providers are unlikely to put such systems in place solely for the Title XXI/CHPG coordination program.

## 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 pay the full copay. Vail round-table participants raised the question of whether families might be expected to spend the cash on items other than copays (such as food or utilities). Although some families might do this, round-table participants believed that most 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. While a number of round-table participants viewed this approach as a fair and workable solution, some participants were concerned that federal agencies may have some reservations about this approach. One concern may be that 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

The Institute for Health Policy Solutions (IHPS) is developing a separate paper regarding this approach, which was discussed at an IHPS round-table meeting on general employer market approaches.<sup>18</sup> Particularly when a state is not using a CHPG, it might retain a carrier or third-party administrator to administer supplemental benefits and cost sharing fill-ins to bring a given employer plan up to state Title XXI benefit standards. The consensus of participants at that round-table discussion was that this approach, if it involved an intermediary with established relations with

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<sup>18</sup> This round-table meeting was held on November 9 and 10, 1998, in Chicago.

mainstream providers, was preferable to using a state program (e.g., Medicaid) without such existing contractual relationships with commercial providers.<sup>19</sup>

One of the concerns with this approach is that it would require families to carry two health plan cards for the same child; one for the majority of the benefits, and one for any supplemental benefits and/or 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 (5% of annual income) 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. Vail round-table participants believed providers would be unlikely to request reimbursement for such small amounts. Some providers may take a loss if they have no other recourse through the 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 5% cost-sharing limit. The greatest 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 Title XXI Program**

Under this option, when a family reached the copay maximum and submitted its copay receipts to the State, the child would be enrolled in the regular Title XXI program under a no-cost-sharing plan. Alternately, a child in such a situation could be dual-enrolled in both the CHPG-based and the regular coverage, with the regular coverage being primary. While this approach is, in a sense, inconsistent with the goals of the Title XXI/CHPG coordination project, 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 (at least in a CHPG pilot program). In addition, children

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<sup>19</sup> A specific strategy discussed at the round-table was for states to designate the state employees' benefit plan as the Title XXI benchmark. States could then contract with the carrier administering the state employees' plan to also administer supplemental benefits and cost sharing fill-ins to bring a given employer plan up to Title XXI benchmark standards.

COORDINATION OF TITLE XXI COVERAGE WITH EMPLOYER-BASED COVERAGE  
THROUGH CONSUMER-CHOICE HEALTH PURCHASING GROUPS

who do exceed the 5% of income cost-sharing limit may very well be special-needs children who may be better served in the regular Title XXI program than in a commercial plan.

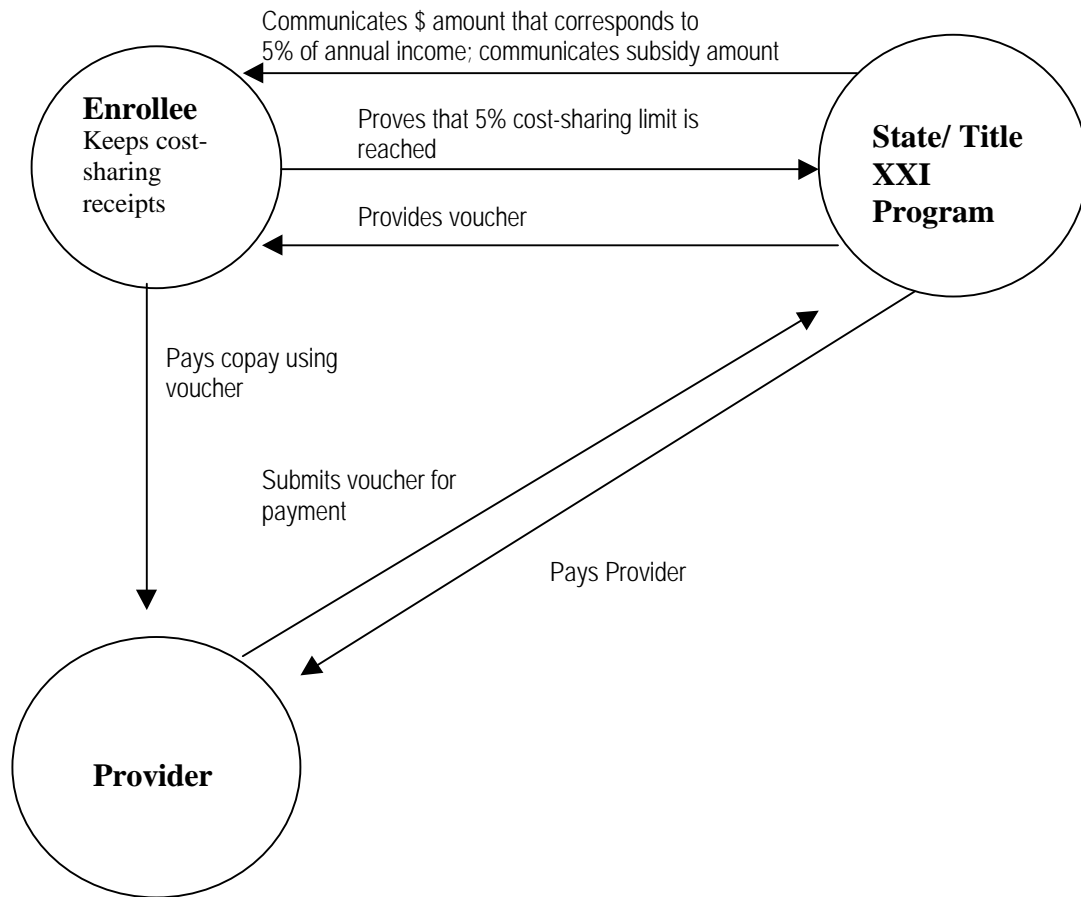
The following table lists each of the above seven options and the major parties involved in administration. The table indicates how each option would impact the relevant parties in terms of ease of administration.

<b>Options for Administration of a Benefits and/or Cost-Sharing Fill-in Plan under Title XXI/CHPG Coordination</b>					
<b>Simplicity/Ease of Administration for Relevant Parties</b>					
<b>Option</b>	<b>Family</b>	<b>Provider</b>	<b>Health Carrier</b>	<b>CHPG</b>	<b>State</b>
1. Carrier-administered cost-sharing fill-in for Title XXI-eligible children (in the context of a CHPG)	Most simple	Simplicity/ ease depends on arrangement with contracting carrier	Requires administration of new benefit plan for small number of children	Requires creation of new enrollment group for children qualifying for the fill-in	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	Simple – requires no action on the part of the CHPG	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	Simple – requires no action on the part of the CHPG	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	Relatively simple, but requires separate contract, administration, and expenses for extra plan/carrier

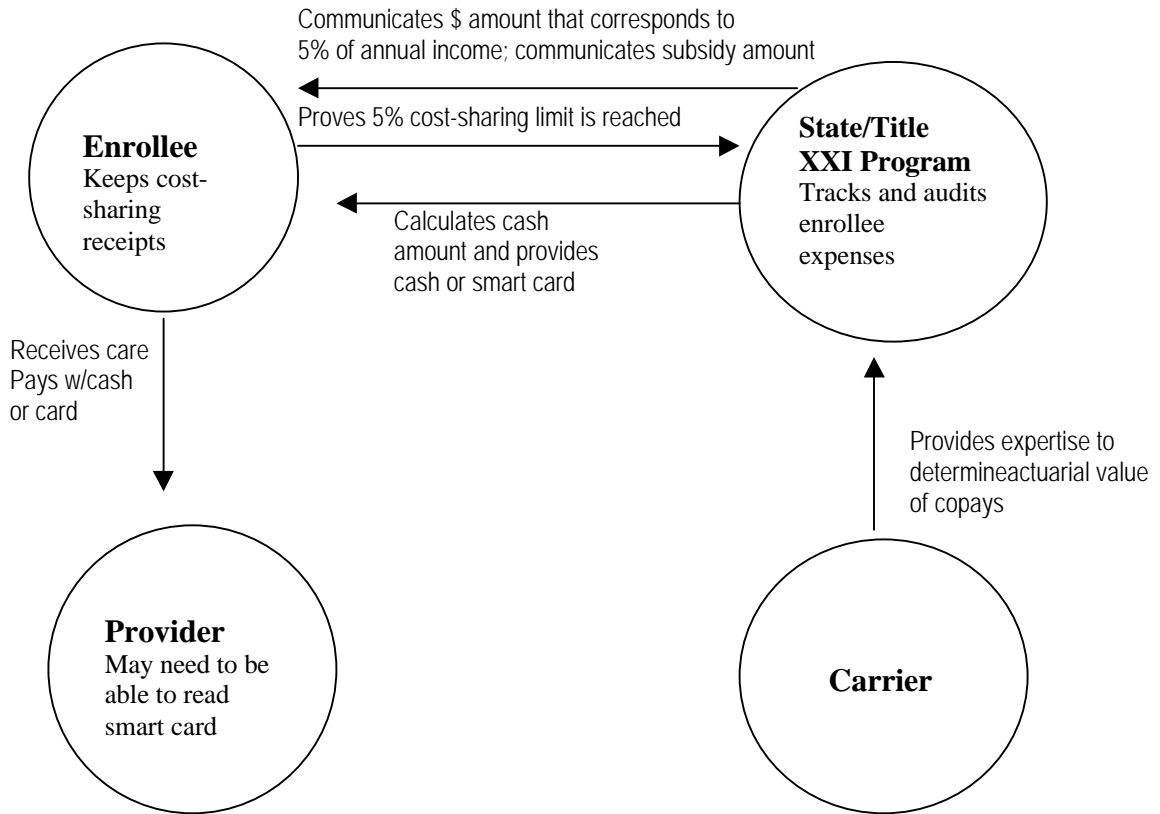
<b>Options for Administration of a Benefits and/or Cost-Sharing Fill-in Plan under Title XXI/CHPG Coordination</b>					
<b>Simplicity/Ease of Administration for Relevant Parties</b>					
<b>Option</b>	<b>Family</b>	<b>Provider</b>	<b>Health Carrier</b>	<b>CHPG</b>	<b>State</b>
<b>5.</b> “Red Dot”	Relatively 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	Simple – requires no action on the part of the CHPG	Relatively simple, but requires development of structure to distribute “red dot” (simpler than voucher system)
<b>6.</b> “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	Simple – requires no action on the part of the CHPG	Relatively simple, but require establishment and staffing of 1-800 number
<b>7.</b> Regular Title XXI program enrollment for children reaching 5% of income copay maximum	May be most disruptive for family, unless the same carrier participates in both the CHPG and the Title XXI 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)	Requires the CHPG to disenroll the child from the employer-based plan, potentially during middle of contract year	Most simple

Graphic illustrations of Options 2, 3, 5, and 6 follow. An illustration of Option 1 is included in the body of this report (see page 7).

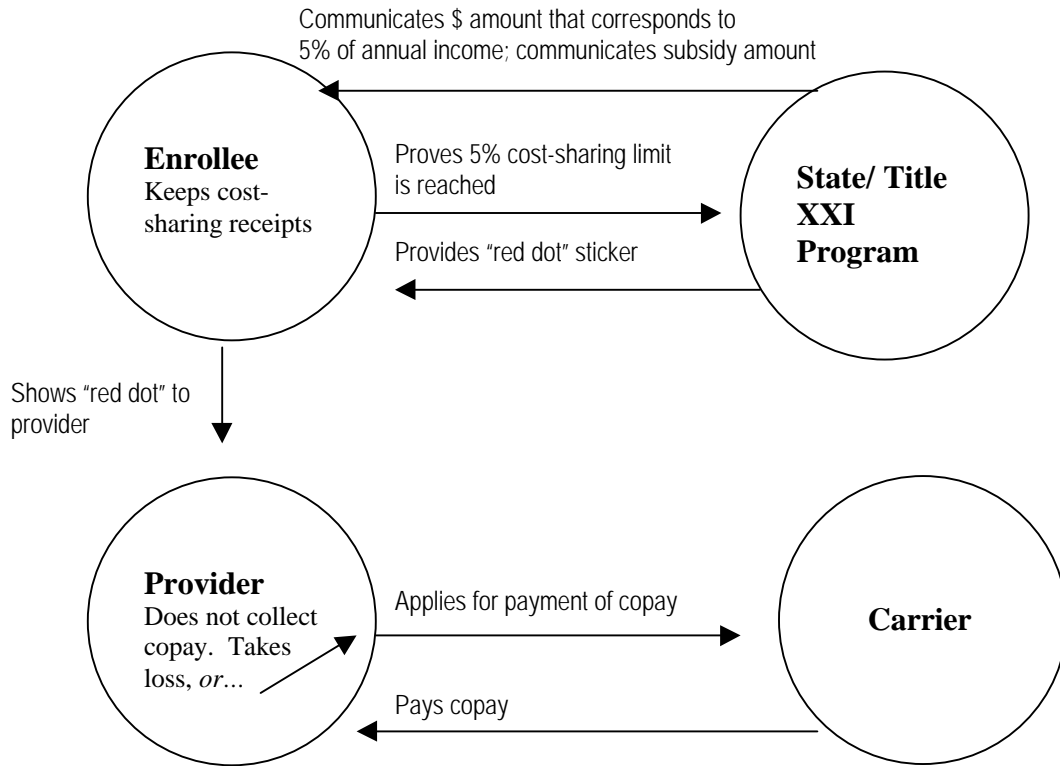
## Option 2 Vouchers



### Option 3 Cash



### Option 5 “Red Dot”



**Option 6**  
**“1-800” Number**

