

Subsidizing Employer-Sponsored Insurance Under State Children's Health Insurance Programs

Working with a Supplemental Carrier

Background Paper for the Institute for Health Policy Solutions Conference "Coordinating Public Subsidies with Employer-Financed Coverage: Children's Health Insurance Program Issues and Lessons"

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Note: This paper draws from insights developed by a technical working group convened by the Institute for Health Policy Solutions. A list of working group participants is included as Attachment A.

Background: Why is it necessary to supplement employer-based plans?

Many states are interested in developing employer-based insurance subsidy programs (or "premium assistance" programs) under Title XXI – the State Children's Health Insurance Program (CHIP). Under such programs, states would pay to enroll children in available employer-based coverage, rather than enrolling them in the regular CHIP. This action would allow states to take advantage of a single source of coverage for children and their parent(s) and avoid crowd-out of available employer contributions. Other advantages include reaching uninsured children whose parents would prefer this private single coverage source for their children and themselves.

States seeking to develop an employer-based insurance subsidy program must comply with a number of federal requirements regarding benefits and cost-sharing. These requirements are described in the Institute for Health Policy Solutions paper "Subsidizing Employer-Sponsored Insurance Under State Children's Health Insurance Programs: Supplementing Benefit and Cost-Sharing Provisions of Employer-Based Insurance Plans," September, 1999.

In cases where an applicant's private employer coverage does not meet program requirements, states can either disqualify the health plan from the subsidy program, or they can develop a rider or "wrap-around" plan to supplement the applicant's coverage. (It is important to note that such coverage must meet a cost effectiveness test. That is, the total cost of state contributions toward

employer-based coverage plus any state payments for supplemental coverage must not exceed the cost of covering the children under the regular CHIP.)

Depending on benchmark plan and employer plan characteristics, riders to cover otherwise non-covered services may be unnecessary. However, in many cases riders to address cost-sharing requirements will be needed. Private coverage will rarely, if ever, meet the required cost-sharing provisions, so states will need to develop approaches to covering benefits and/or cost-sharing expenses that exceed these limits.¹

This issue brief focuses on an approach that appears most promising for many states - contracting with a supplemental carrier to administer a cost-sharing and/or benefit upgrade for participants whose employer-based plans do not meet the program requirements. The approach is probably most attractive for states with fairly fragmented employer-based insurance markets (i.e., where many plans have relatively moderate market shares or where there is great variation in the types of coverage offered by employers).

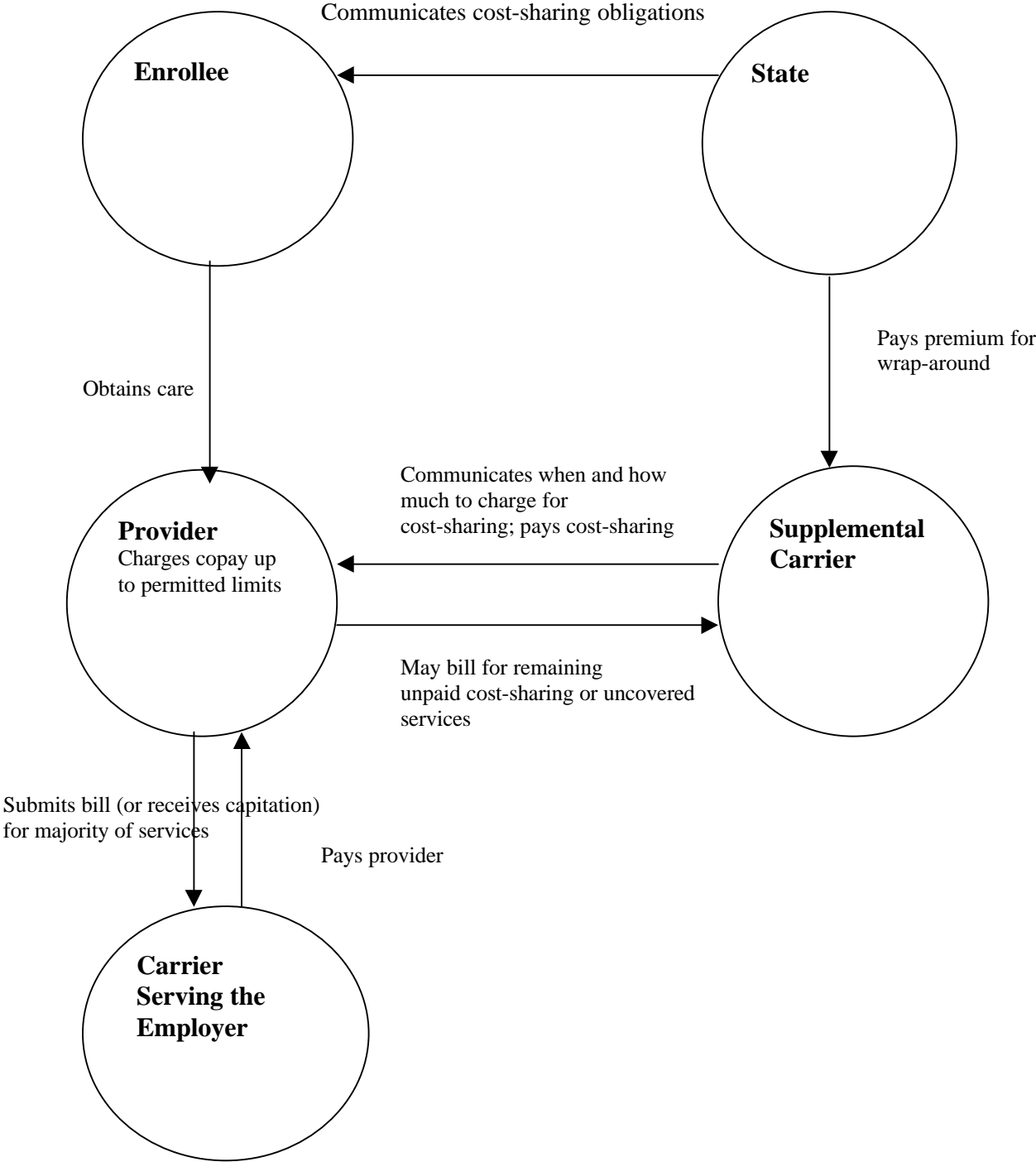
The Supplemental Carrier Approach

To supplement employer-based plans that do not meet the Title XXI benefit and/or cost-sharing requirements, states could contract with a single supplemental carrier to administer a wrap-around. To a private carrier, this function might be similar to traditional coordination of benefits (COB) administration. Figure 1 illustrates the framework of a supplemental carrier approach.

This approach is similar to the approach used under many states' (Medicaid) Health Insurance Premium Payment (HIPP) Programs, in which providers bill the State for benefits or cost-sharing fill-ins that are not provided under the employer's plan. However, there are important potential differences. For example, some states' Medicaid programs treat such employer-based plans as a third-party liability recovery source, rather than as the primary source of coverage. Many states have a limited capacity to administer a HIPP program and only do so for a relatively few high-cost cases. Further, under the supplemental carrier approach, providers would bill a State-contracted carrier for cost-sharing, rather than billing the State (as they do under HIPP programs). This approach could be preferable in situations where a large number of providers contracting with employer-based plans generally do not also participate in the state's Title XIX or Title XXI programs directly. In such situations, providers might balk at contracting, billing, and payment through the Medicaid or public program. In contrast, a supplemental carrier or intermediary with established relationships with private, mainstream providers may already have contracts and systems in place to pay such providers. This could translate to better continuity of care for children receiving supplemental coverage.

¹ 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 has indicated that it is not permissible for families to incur expenses beyond the specified cost-sharing limits, even if the State reimburses families for such expenses.

Figure 1: Supplemental Carrier



Potential Advantages and Limitations of this Approach

The greatest advantage to the supplemental carrier approach is that it would utilize private market expertise and capacity and would be simple for states. It would require states to negotiate only one contract, rather than attempting to contract with many providers or carriers in the commercial market.

A concern with this approach is that it would require subsidy program participants to carry two health plan cards; one for the majority of benefits, and one for any supplemental benefits and/or cost-sharing wrap-arounds the State must purchase. Providers would often need to bill both the employer's plan and the supplemental plan. Problems could arise over provider fee schedules and related cost-sharing requirements. However, it should be noted that many states currently use such systems under their Medicaid Health Insurance Premium Payment programs. In addition, many providers are already accustomed to split-billing for patients with double coverage (e.g., patients who have coverage through their own and a spouse's employer).

Families of Title XXI children would also need to understand that those children have access to broader benefits than provided under the employer-based plan. This may cause confusion for families and for providers' billing offices.

Current Regulatory Status

The Health Care Financing Administration has approved the single supplemental carrier approach for Mississippi's Title XXI employer-based insurance subsidy program. That state has issued an RFP to solicit carriers to serve in this role in an at-risk capacity.

Supplemental Carrier Attributes

As an initial step in implementing a supplemental carrier strategy, states will need to identify criteria for carrier selection. A working group convened by the Institute for Health Policy Solutions identified the following important criteria for selecting a single supplemental carrier/TPA:²

- Substantial experience and capacity regarding coordination of benefits with employer-based plans in the state;
- A broad provider network to facilitate the supplementing of many different employer-based health plans;
- Strong claims payment and adjudication skills (including for subrogation);
- Billing limits /fee schedule expertise for out-of-network services;
- Knowledge of the market;
- Plan design flexibility and experience with coordination of benefits;
- Capacity to obtain and evaluate certificates of coverage and SPDs for Title XXI children;

² The working group was convened on June 28, 1999. For a list of working group participants, see Attachment A.

- Ability to communicate effectively with Title XXI beneficiaries (and their parents), providers, and other parties;
- Ability to meet state and federal reporting requirements;
- Ability to collect and analyze encounter data in a manner that distinguishes among claims paid as a wrap-around to an employer-based benefit, versus those paid because a service wasn't covered by the employer-based plan, versus those paid because a benefit was covered by the employer-based plan but had been exhausted; and,
- (Possibly) a capacity to determine eligibility for premium subsidies.

Issues/Questions

The following is a list of major issues and questions related to implementation of the supplemental carrier approach. Many of these are questions that a state would need to discuss with potential supplemental carriers in determining whether this approach is feasible.

1. In general, are there any policy or design features that states can implement to make this approach simple and efficient for carriers while meeting policy objectives? Alternately, are there any design features that would make this approach unworkable?
2. What types of “supplements” would a supplemental carrier be asked to provide? Employer-based plans may fall short of Title XXI requirements in any of four ways: 1) they may not provide the appropriate level of cost-sharing; 2) they may not cover a required service; 3) they may cover a required service at an inadequate level; or, 4) the actuarial value of the whole benefit package may be too low. In what kinds of environments and in which of these instances (or combination of instances) would a state wish to provide supplemental coverage?
3. Are there any related administrative functions that a supplemental carrier could (and would be willing to) perform? For example, could the supplemental carrier gather information about an applicant’s employer-based coverage, perform cost-effectiveness testing (as required under Title XXI), or assess the value of employer-based plans? Could the supplemental carrier assist in determining program eligibility? Which functions should be included in a state’s RFP to solicit a supplemental carrier? Are there any concerns regarding conflicts of interest if a supplemental carrier performs any of these functions? How might such conflicts of interest be addressed?
4. If the supplemental carrier is at risk, how will premiums be calculated? What will be the cost per child to “fill in” the cost-sharing or benefits under an employer’s plan? The supplemental carrier will know the level of coverage employer-based plans need to be upgraded “to,” but it will not know what level all employers’ plans are starting “from.” One approach to setting premiums (as suggested by John Bertko, FSA, of Reden and Anders in San Francisco) would be to categorize employer plans into broad groupings and calculate a premium for the upgrade associated with each grouping (i.e. use “risk corridors”).
5. A supplemental carrier will initially have difficulty predicting its liability, given the wide variety of employer-based plans in the market. Given this uncertainty, can states enter into a

risk-sharing or partial-premium arrangement with a supplemental carrier? For example, states could:

- a. Limit the total liability of the supplemental carrier (i.e. set an annual maximum payment limit); and/or,
 - b. Limit the benefit-by-benefit liability of the carrier. For example, the capitation payment to the supplemental carrier could include coverage of up to 40 inpatient hospital days. The supplemental carrier would be responsible for everything up to 40 days. For days exceeding 40, the State would assume some of the risk. As the days increase, the State would assume a greater share of the risk.
 - c. Self-insure for the supplemental benefits/services and contract with a third party administrator (TPA). However, in contracting with a TPA, states will need to build in financial incentives for cost management. In addition, under such a self-insured arrangement, costs that would otherwise be part of an insured premium for health benefits (and would not, therefore, count toward a state's 10% cap on administrative expenses under Title XXI) would likely be considered administrative expenses by federal regulators. This could have important implications for the federal matching rate for supplemental carrier expenses.
6. Ideally, the supplemental carrier would have established relationships with most of the providers in the state, including contracts and fee schedules that could pertain. What will happen when there are differences in the fee schedules of the supplemental carrier and the employer's carrier? For example, assume a child obtains vision services and exhausts the vision benefits available under the employer's plan. Additional benefits are available under the supplemental coverage program. The vision service provider would bill the employer's carrier for the services covered by that plan and then bill the supplemental carrier for the additional Title XXI benefits. In this scenario, which carrier's fee schedule would prevail? How could the system be designed to prevent providers from balance-billing patients for any amount not reimbursed by either carrier?
7. Is the overall concept practical from an administrative, cost, and legal standpoint? How expensive is such an arrangement to administer, and would carriers with pertinent capacity be willing to participate?

Attachment A: Supplemental Carrier Working Group Participants (6/28/99)

Anna Marie Barnes	Mississippi Office of the Governor
John Bertko	Reden and Anders, Ltd.
Rick Curtis	Institute for Health Policy Solutions
Susan Cypert	Arizona Health Care Cost Containment System
Therese Hanna	Mississippi State Insurance Administrator, MS Department of Finance and Administration
John Kenyon	Virginia Department of Medical Assistance
Joyce Raichelson	MediKids Administrator, Florida Agency for Health Care Administration
Caroline Roth	Florida Agency for Health Care Administration
Cheri Tomlinson	Arizona Health Care Cost Containment System
Laura Tollen	Institute for Health Policy Solutions