

**Comments by the Institute for Health Policy Solutions  
On Proposed Implementing Regulations for the  
State Children's Health Insurance Program  
(HCFA-2006-P)**

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**IHPS Comments on Proposed SCHIP Regulations**

Both title XXI and the regulations clearly contemplate that one of the ways in which States may provide health insurance to targeted low-income children is by providing Premium Assistance to enable working parents to enroll their eligible children in employer-sponsored coverage that is available to them.

Despite fears, articulated in the preamble, that public Premium Assistance could “crowd-out” private contributions parents and/or employers previously made out of their own funds, we believe that well-designed Premium Assistance is a highly desirable and valuable component of the S-CHIP program, for several reasons:

- By taking advantage of employer contributions, Premium Assistance allows States to serve more uninsured children with the public funds available.
- Because it builds on enrollment in mainstream, employment-based health coverage, Premium Assistance may be able to reach uninsured children whose parents would not enroll them directly in a separate public program.
  - “One-stop shopping” for a health plan is convenient for parents who may prefer their children to be covered by the same health plan as they are (i.e., their employment-based plan), not by a separate program.
  - Many working people take pride in their achievements and want to be seen as paying their own way, rather than participating in what they may perceive as a public assistance program. People’s desire for self-reliance is not an attitude that public policy can (or should) change. Instead, public programs aimed at socially desirable goals such as insuring children are more likely to be successful if they take these attitudes into account.
- As the preamble recognizes [p. 69032], “keep[ing] families together under one health plan ... may result in increased access to and utilization of preventive and other necessary health services for children.”
  - Common sense suggests that children will be better served by a health plan that their parents are familiar with and know how to use because they have used it for themselves. Available research tends to support this view<sup>1</sup>; and we therefore believe it is important for government subsidies to help maintain families in the single medical home they have chosen.
  - Further, Premium Assistance may help to maintain continuity of care by permitting children to remain in the same health plan if wage increases raise their parents’ income

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<sup>1</sup> Hanson, K., 1998, “Is Insurance for Children Enough? The Link Between Parents’ and Children’s Health Care Revisited.” *Inquiry* 35:294-302, (Fall 1998).

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above the S-CHIP eligibility threshold, and State experiments with Premium Assistance through small employer purchasing pools could enhance continuity of care even when such parents change jobs.

- Many States believe Premium Assistance is consistent with the welfare reform goal of encouraging self-sufficiency through employment and is a logical part of transitioning parents into the workforce. It should help to strengthen low-income parents' attachment to the labor force by encouraging participation in employment-based health benefits.
- With respect to "crowd-out," we believe that, in the long run, well-designed Premium Assistance programs should reduce substitution of public subsidies for private contributions.
  - Many children are uninsured for relatively short periods. Most (almost 60 percent) of newly uninsured children regain coverage within 6 months.
  - Once their children are on S-CHIP, working parents will likely realize that, if a new employer offers health coverage and no Premium Assistance program is available, they would have to pay much more out of their own pocket to enroll their children in the employer's coverage. Thus, they will have strong incentives to keep their children on publicly funded S-CHIP (assuming, of course, that the children remain eligible based on family income.)
  - Thus, over time, many children for whom employer-financed coverage is available will continue to be enrolled in S-CHIP, with the full cost (other than modest family premiums) paid by the State and federal governments. Employer contributions available to these children will not be accessed.
    - Analysis of the 1992 SIPP panel shows that 53 percent of children who became uninsured during FY1993 and who were uninsured for 12 months or less subsequently became covered by employer-sponsored insurance.<sup>2</sup>
  - On the other hand, if Premium Assistance is available, parents will be able to enroll their S-CHIP-eligible children in their employer-sponsored plan and pay only an amount comparable to the State's S-CHIP premium. For families that prefer this approach, the State will be able to reduce its costs by taking advantage of the employer contribution that is available and/or extend coverage to other family members at no additional cost to the State.

Many States with which we work have expressed these reasons for wanting to implement Premium Assistance programs under S-CHIP. Because we and the States we have been working with believe that these attributes of Premium Assistance are compelling, we are greatly

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<sup>2</sup> John L. Czajka, "Analysis of Children's Health Insurance Patterns: Findings from the SIPP," prepared for the Office of the Assistant Secretary for Planning and Evaluation by Mathematica Policy Research, May 12, 1999. Appendix B, Table 5.

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concerned that the cumulative effect of the proposed regulations is to strongly discourage States from undertaking Premium Assistance programs.

Implementing Premium Assistance programs consistent with title XXI requires administrative functions that States would not otherwise have to set up and operate. These functions are likely to be arduous, time-consuming and relatively expensive. To justify making this kind of administrative investment, States need to know that Premium Assistance can reach a significant number of uninsured children. Unfortunately, the proposed regulations impose a series of requirements that, taken together, severely reduce the pool of potentially Premium Assistance-eligible children. Specifically:

- The initial pool of potential eligibles is the approximately 37% of uninsured children who have a parent who either is enrolled in or could enroll in employer-sponsored insurance.<sup>3</sup> (Some States hope to increase this initial pool by encouraging previously uninsured employers to offer coverage, using S-CHIP subsidies as one part of a package of incentives.)
- Of the children who are uninsured in a particular month, only 63 percent have been uninsured for 6 months or more,<sup>4</sup> as required (for Premium Assistance eligibility) by the proposed regulations at 42 CFR 457.810(a). Longer term uninsured children are less likely to have access to employment-based coverage.<sup>5</sup>
- Of all workers in firms that offer insurance, only about two-thirds work for firms that contribute 60 percent or more of the cost of family coverage, as required by the proposed regulations at 42 CFR 457.810(b). Workers facing less than a 60-percent employer contribution are more likely to decline family coverage,<sup>6</sup> suggesting that the proportion of uninsured children whose parent works for a firm that contributes 60 percent or more toward family coverage is likely to be significantly lower. Children who have been uninsured for more than 6 months almost certainly have relatively low employer contributions available to them.

Cumulating these factors suggests that only a small fraction—our rough calculations suggest well under 10 percent—of uninsured children might potentially qualify for Premium Assistance

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<sup>3</sup> IHPS analysis of data from the 1996 Medical Expenditure Panel Survey and more recent Current Population Surveys.

<sup>4</sup> Czajka, *op.cit.* Appendix B, Table 2.

<sup>5</sup> Children whose spells of uninsurance lasted 13-18 months were more likely to go on Medicaid (56.8%) than to obtain employer-sponsored coverage (31.5%). For children whose spells of uninsurance lasted 12 months or less, the reverse was true: 52.9% became covered by employer-sponsored insurance, while 40.5% went on Medicaid. *Ibid.* Appendix B, Table 5.

<sup>6</sup> Based on a 1997 survey, when the employer contributed less than 60%, only 37% to 39% of enrollees elected family coverage, compared to 54% to 59% when the employer contributed 60 percent or more of the cost. These data come from a 1997 survey of employer-based health insurance sponsored by the Robert Wood Johnson Foundation. Federal and State officials who attended the October 5<sup>th</sup> IHPS/NGA conference on “Coordinating Children’s Health Insurance Programs with Employer-Based Coverage” have copies of the relevant materials. Further distribution of these results has been embargoed pending their formal publication in a scholarly journal.

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under the proposed rules. Benefit coverage requirements and the cost-effectiveness test will reduce the potential pool even further. As noted earlier, a small eligible pool makes it much harder for States to justify the administrative investment necessary to develop and implement a Premium Assistance program.

Moreover, as suggested earlier, a long-term shift of low-income children from employment-based coverage to public coverage, i.e., growing longer-term crowd-out of employer contributions, seems very likely where there is no Premium Assistance program.

Perhaps just as important, the proposed regulations make it less likely that States will pursue innovations many are now considering to combine public and private funds to cover uninsured working families. If these initiatives are dropped, the potential advantages for uninsured children that derive from “one-stop shopping” will be lost.

In our detailed comments, which follow, we note potential problems in the proposed regulations that could make Premium Assistance even more difficult to implement; and we propose additional flexibility for States aimed at simplifying implementation and increasing the number pool of potentially eligible children.

### **Subpart E – Beneficiary Financial Requirements - §457.515**

**Section 457.560, “Cumulative cost sharing maximum,”** requires in paragraph (b)(2) that “[a] State must count cost sharing amounts that the family has a legal obligation to pay in computing whether a family has met the cumulative cost sharing maximum.”

In paragraph (a), “legal obligation” is defined to mean “liability to pay *amounts a provider actually charges* and any other amounts for which payment may be required under applicable State law for covered services to eligible children, even if payment is never actually made.” [emphasis supplied]

We interpret this provision to mean that, for any and all out-of-network health services, provider charges in excess of the amount (if any) paid by the health plan must count toward the family’s cumulative cost-sharing maximum. No private health plan works this way. Certainly, employer-sponsored plans do not, and we cannot imagine that any private plan would agree to attempt to implement such a requirement. Even under old-style indemnity plans, annual out-of-pocket limits only apply to charges recognized by the plan, not to provider balance-billing.

Because the cost-sharing maximum is based on family income, most States will elect to set up a separate State-administered process to track families’ cost sharing liabilities. Being required to recognize out-of-network provider charges would greatly complicate this process by requiring States to verify that provider bills submitted by families as evidence of having reached the maximum were not in fact paid by the health plan in which the children are enrolled.

Most importantly, we do not believe this interpretation is required by title XXI. Section 2103(e)(3)(B) reads: “Other children. For children not described in subparagraph (A), subject to

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paragraphs (1)(B) and (2), *any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan* may be imposed on a sliding scale related to income, except that the total annual aggregate cost-sharing with respect to all targeted low-income children in a family under this title may not exceed 5 percent of such family's income for the year involved.” [emphasis supplied]

The portion of an out-of-network provider’s charge that exceeds the plan’s allowable charge (or the entire charge, if the plan provides no out-of-network coverage) is not a “deductible, cost-sharing or similar charge” imposed by the State.

Under fee-for-service Medicaid, there is no coverage and the State makes no payment if a Medicaid patient sees a non-participating provider. Medicaid managed care plans are all closed panel plans—no coverage is available and no payment is made when out-of-plan providers are used (except in limited circumstances required under Medicaid law and regulations).

Viewed in this context, allowing S-CHIP-eligible children to enroll in plans—employer-sponsored or otherwise—that do offer out-of-network coverage should be viewed as providing an additional benefit that families may use at their option, subject to the reasonable rules the plans have established to discourage out-of-network use, including higher copayments and liability for provider balance-billing. Families who feel they cannot afford these additional charges are free to continue to use only in-network providers.

In a related provision, **Sections 457.515(f) and 457.555** require States to assure that enrollees will not be held liable for additional costs associated with **emergency services** provided at a facility that is not a participating provider in the enrollee’s managed care network, beyond the State’s specified co-payment amount.

Until the “prudent layperson” standard for coverage of emergency services, on which this provision is apparently based, becomes applicable to all private health plans, we object to applying this requirement under S-CHIP. The requirement literally cannot be imposed on employer-sponsored health plans, because the State is not the contracting entity. With respect to health plans that may contract directly with the State to enroll S-CHIP-eligible children, attempting to impose any requirement that requires them to set up a special procedure to handle a small number of enrollees is likely to dissuade many of them from participating in S-CHIP.

**Subpart H – Substitution of Coverage/Premium Assistance - §457.810**

As noted in the proposed regulation, section 2101(b)(3)(C) of the Act requires that State plans include descriptions of procedures to ensure that the insurance provided under the State child health plan does not substitute for coverage under group health plans. The proposed rule outlines such procedures for States providing direct S-CHIP coverage and for those providing coverage through Premium Assistance programs.

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While the goal of preventing substitution of coverage is worthy, the rules regarding Premium Assistance programs are sufficiently strict that they are likely to deter many States from implementing such programs and to keep existing programs at low levels of enrollment.

**Employer Contributions.**

Paragraph (b)(2) of proposed §457.810 requires, as a condition of eligibility for CHIP payment of employer-sponsored group health coverage, that the employer must make a substantial contribution to the cost of family coverage, equal to 60 percent of the total cost of family coverage. The purpose of this requirement, as stated in the preamble [p. 60923], is “to discourage employers from lowering or eliminating their existing contributions for dependent coverage.”

We do not believe that using a uniform standard in any State, whether 60 percent or a lower percentage “if the State can show that the *average* contribution [emphasis supplied] in the State is lower than 60 percent,” will accomplish the intended purpose (with which we strongly agree).

In our view, whether or not employers will seek to adjust their contributions for dependent coverage in response to the availability of S-CHIP subsidies will depend more on the income of the employer's work force than on any other factor. Employers' health insurance contributions are part of the overall compensation package they use to attract workers in a competitive labor market. If only a minority of its employees earn low wages (and therefore could potentially benefit from S-CHIP subsidies for their children), no employer is likely to risk alienating the majority of its employees by lowering its contribution. On the other hand, if the vast majority of its employees are low-wage, even the (rare) low-wage employer who currently contributes 80 or 90 percent for dependent coverage might be tempted to lower its contribution and encourage its employees to seek S-CHIP subsidies for their share of the premium.

A number of large employers who have predominately low-wage work forces do offer health coverage, but they tend to make lower contributions to dependent coverage than other employers. Data presented at an October 1999 conference co-sponsored by IHPS and the National Governors' Association show that, among firms that offer health coverage to any of their employees, about half of all low-wage workers work in low-wage firms, and about half work in other firms. (In this analysis, a firm is called “low-wage” if two-thirds or more of its work force earns less than \$7 per hour or \$14,000 per year.)<sup>7</sup> Low-wage firms were found to be less likely to meet the 60-percent-employer-contribution standard for family coverage.

In low-wage firms, 42% of workers were in firms that contributed less than 60 percent, compared to 31% of workers in other firms. Employer contribution levels were also strongly

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<sup>7</sup> This analysis is based on data from a 1997 survey of employer-based health insurance sponsored by the Robert Wood Johnson Foundation. Federal and State officials who attended the October 5<sup>th</sup> IHPS/NGA conference on “Coordinating Children's Health Insurance Programs with Employer-Based Coverage” have copies of the relevant materials. Further distribution of these results has been embargoed pending their formal publication in a scholarly journal.

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correlated with enrollment in family coverage. For both low-wage and other firms, 54% to 59% of enrollees elected family coverage when their employer contributed 60 percent or more of the cost. When the employer contributed less than 60%, only 37% to 39% of enrollees elected family coverage.

These findings suggest two conclusions:

- First, it appears that proportionately more uninsured children who have access to employer-sponsored coverage but are not enrolled in it have parents who work for employers that contribute less than 60 percent to family coverage.
- Second, refusing even to consider providing Premium Assistance if the employer does not contribute at least 60 percent of the cost of family coverage will significantly reduce the pool of children who can potentially benefit from a Premium Assistance program. As noted earlier, the smaller this pool, the less likely it is that the program can reach the critical mass necessary to justify the administrative investment required to operate a Premium Assistance program.

We recommend that the 60-percent-contribution standard be dropped entirely and that States simply be required to describe how they plan to monitor employer contribution percentages to detect any reductions and assess whether reductions may be related to S-CHIP Premium Assistance. (Of course, the cost-effectiveness test would continue to apply.)

Alternately, if it is felt that some minimum contribution standard is required, we recommend that States be permitted to establish different standards for different kinds of employers. Critical distinctions include whether or not the employer has previously offered health coverage and the wage distribution of the employer's work force.

It is well known that many of the uninsured work for small firms and earn low wages. Data from AHCPR's 1996 Medical Expenditure Panel Survey show why: Small firms with low-wage work forces are highly unlikely to offer health benefits. Of firms with fewer than 10 employees and predominately low-wage work forces, only 14.3 percent offer health insurance. For low-wage firms with 10 to 24 employees, only 33.6 percent offer coverage. Clearly, previously uninsured, small, low-wage firms cannot be expected to contribute 60 percent toward family coverage.

A number of States are designing or refining strategies to encourage small, previously uninsured low-wage employers to begin offering (and contributing what they can) toward health coverage, in an effort to extend coverage to families employed by such firms. The availability of S-CHIP Premium Assistance for children as one part of a broader package of incentives will often make a critical difference in the feasibility of such approaches. In particular, we note that a few States are considering working with existing (or pursuing development of new) consumer-choice health purchasing groups that serve small employers to implement such a program. Working with an existing purchasing group can simplify many of the administrative functions associated with a Premium Assistance program and also provides a ready means of monitoring employer

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contribution levels, since the purchasing group has access to such data from all participating employers.

We believe that such innovative approaches can help to develop better models for reaching uninsured children in modest-income working families and should be encouraged rather than thwarted. Therefore, we recommend that a lower minimum contribution for family coverage—perhaps 20 or 25 percent—be allowed for previously uninsured small employers with low-wage work forces.

We strongly urge the Department to allow States flexibility on the contribution standard, particularly with respect to small low-wage employers who have not previously offering health coverage. Failure to do so will stifle many potential innovative approaches to reach uninsured children of low-wage workers. Without such a flexible standard, States will be unable to enroll sufficient numbers of children in their Premium Assistance programs to justify the administrative expense. In addition, and more importantly, the 60% standard may result in many families who would prefer Premium Assistance being forced to enroll their children in the regular S-CHIP, thus forcing the State to forego *any* employer contribution.

We also note that, if more and more low-wage workers decline dependent coverage when it is offered, employers with many low-wage workers may stop offering covering. This dynamic could cause a long-term, population-wide shift from private to public sources of coverage.

**Cost-Effectiveness.**

The proposed regulation requires that a State pay no more for a child to enroll in an employer-sponsored plan than it would have paid to enroll the same child in the regular S-CHIP. We concur with the goal of this rule and believe it provides protection against the possibility of employers reducing their contributions when S-CHIP funds become available. (If an employer contribution is too low, the cost-effectiveness test will not be met, i.e., the State will have to pay more for employer-based coverage than for the regular S-CHIP.)

However, HCFA should clarify whether and, if so, how the preamble's discussion of methods of determining cost-effectiveness under family coverage waivers [at §457.1015, pp. 60931-33] also applies here. Our detailed comments on cost-effectiveness determinations are discussed under that heading.

**Information Gathering.**

Section 457.810(d) requires States to “*evaluate* the amount of substitution that occurs as a result of payments for employer-sponsored group health plans and the effect of those payments on access to coverage.” [emphasis supplied]

We agree that States ought to collect information that will assist in assessing the degree to which crowd-out may be occurring, but we caution that it is very difficult—and potentially very

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expensive—to determine what *would have happened* in the absence of a Premium Assistance program.

**Subpart G – Strategic Planning, Reporting and Evaluation– (§457.700 ff.)**

**and**

**Subpart I – Program Integrity and Beneficiary Protections – (§457.900 ff.)**

These proposed subparts incorporate a significant number of reporting requirements, anti-fraud provisions, and internal process requirements, many of which are intended to apply to S-CHIP-participating health plans. The requirements tacitly assume that the State will have a direct, contractual relationship with all S-CHIP-participating health plans, including employer-sponsored plans. In fact, for employer-sponsored coverage, no such contractual mechanism will exist. The employer, not the State, is the entity that contracts with the health plan; and the State is simply providing Premium Assistance to enable families to enroll their S-CHIP-eligible children in employer-sponsored coverage that is available to them.

Because there is no mechanism States can use to enforce these requirements on employer-sponsored health plans, we have assumed that they were not intended to be applicable to such plans. However, to be sure we have made the correct interpretation, we suggest that the preamble to the final regulations clarify this point.

We caution that any attempt to apply requirements of this sort directly to employer-sponsored plans will mean that no employer plans will ever qualify for Premium Assistance. There is simply no incentive for an employer or its contracted health plan to invest any administrative resources to comply with requirements that go beyond what they are routinely required to do for private sector enrollees.

**Subpart J – Allowable Waivers – Family Coverage (§457.1010)**

The Department is specifically seeking comment on two issues under this Subpart. We would like to respond to those requests and then suggest a clarification with respect to when a family coverage waiver is required.

**Supplemental Coverage for Adults.**

The Department is seeking comments on whether the benefits specified in Title XXI should also apply to adults where States have obtained a family coverage waiver. We strongly believe that no such requirement should be imposed. First, we do not believe there is any statutory basis for the Department to promulgate rules regarding benefits provided to adults. Second, federal regulation in this area could further complicate an aspect of Premium Assistance programs that is already very difficult for States to implement, i.e., administering benefit upgrades. Third, requiring a benefits upgrade for adults would specifically divert limited S-CHIP funds away from eligible children and would, in the process, make it more difficult for Premium Assistance

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programs to meet the statutory cost-effectiveness test. Therefore, we believe the decision whether or not to provide S-CHIP-equivalent benefits for the adults in families receiving Premium Assistance should be left to each State, with federal matching available if the State does elect to do so.

We know from our work with States that developing benefit and/or cost-sharing upgrades is one of the most administratively challenging tasks that must be performed in implementing a Premium Assistance program. Because States are taking different approaches in this area, it cannot be determined *a priori* whether a uniform benefit upgrade for the entire family would be easier to implement than a benefit upgrade for only the children in the family or, even if that were found to be the case, whether the administrative simplification and savings are sufficient to justify the additional benefits cost.

It is also not entirely clear what a benefits upgrade for adults would include. The statute and regulations prohibit any copayments or cost-sharing for well-baby or well-child care. Would the proposal for adults be a prohibition on cost-sharing for adult preventive care visits and services? If so, the cost could be significant.

**Definition of "Family."**

The Department is seeking input on a definition of "family" for purposes of this Subpart. We do not believe such a definition is necessary, nor would it be helpful.

The preamble to this section [at p. 60931] states that "[a] specific definition may be important for this subpart because it may define what types of adult family members can receive health benefits coverage under a family coverage waiver."

While theoretically a State might provide family coverage directly through its regular S-CHIP program, as a practical matter, covering the adults in a family in addition to the children will not meet the cost-effectiveness test unless the coverage is provided through an employer-sponsored plan for which the employer is making a significant contribution. That being the case, States will not have the ability to define which family members may and may not be included under the employer's plan. The family members eligible under the various coverage categories of the employer's plan are already defined in the insurance contract or the plan documents.

Insurance carriers, regulated by States, have strict rules regarding the family members that can legitimately be included under a "family coverage" policy. Provided that a given employer and employee comply with the insurance carrier's own rules on this subject, we believe the States and the federal government do not need to (and, in fact, cannot) develop a standard definition.

Insurance carriers also have a financial incentive to ensure that only those family members meeting their definitions are covered under "family coverage." It is not, therefore, necessary for States or the federal government to attempt to regulate or monitor this aspect of the program. Attempting to do so would only add another unrealistic administrative requirement and make Premium Assistance for family coverage entirely unworkable.

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**When Is a Family Coverage Waiver Required?**

The preamble to the proposed regulations at §457.1010 [p. 60931] states that “[a] State must apply for a family coverage waiver when any title XXI funds are used to purchase coverage for adult family members in addition to targeted low-income children.”

As we understand the extended discussion in the preamble, a State can “purchase” employer-sponsored coverage for S-CHIP-eligible children without a family coverage waiver if the tier structure of the employer’s coverage permits the State to determine (and, presumably, pay) an amount that represents only the additional cost of covering the child(ren) in the family.

Unfortunately, most employers offer only the traditional two coverage tiers—employee-only and family coverage—which do not permit this kind of determination<sup>8</sup>. Moreover, coverage tiers are not uniform within States; rather, they vary from employer to employer.<sup>9</sup> As a result, any State seeking to reach significant numbers of uninsured children through the Premium Assistance program will most likely find it necessary to obtain a family coverage waiver under the proposed regulation.

However, States that want to stretch their limited title XXI funds as far as possible may wish to make employer-sponsored coverage available to S-CHIP-eligible children without subsidizing coverage for the adults in the family. We suggest that States ought to be permitted to pay a portion of the cost of employer-sponsored family coverage without obtaining a family coverage waiver, so long as the portion the State pays is based on a reasonable actuarial estimate about what proportion of the cost of family coverage is attributable to the children. The family would be responsible for the remainder of the employee-share of premium for family coverage. The cost-effectiveness test would, of course, apply to the payment the State makes. For the sake of administrative efficiency, the actuarial determination about the proportion or percentage to be paid could be made once per year, based on typical group health coverage available in the State. The percentage would then be applied to the actual required employee contribution for family coverage under the particular employer’s plan.

In our view, obtaining a family coverage waiver under the proposed regulations should be straightforward and not particularly difficult. So long as the cost-effectiveness test is met, the State will be covering both children and adults at a cost no greater than the cost of enrolling the children alone under the regular S-CHIP program. Unfortunately, some States that have discussed the matter informally with HCFA report significant additional requirements and roadblocks. To the extent that this continues to be a problem (or to the extent States wish to

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<sup>8</sup> In 1993, fewer than half of employees in 10 States surveyed worked for employers that offered more than the traditional two coverage tiers, although there is some evidence from later surveys that large employers were moving toward more coverage tiers. Fewer still had a tier structure that permits the cost of adding another adult to be clearly separated from the cost of adding a child or children. IHPS analysis of data from the Robert Wood Johnson Foundation Employer Health Plan Survey, 1993.

<sup>9</sup> Although, in some States, insurance reform has standardized coverage tiers in the small group market (but not the large group market).

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minimize per-child spending under a Premium Assistance program), allowing a reasonably estimated partial contribution toward family coverage, as suggested above, would provide an alternative. It would permit States to subsidize children's enrollment in employer-sponsored group coverage without subsidizing the cost of that coverage for the adults in the family, thus avoiding any additional complications involved in obtaining a family coverage waiver.

**Subpart J – Allowable Waivers – Cost Effectiveness of Family Coverage -  
 (§457.1015)**

We endorse the cost-effectiveness requirement in concept, and we applaud the Department for permitting States to propose means of performing cost-effectiveness tests. We believe this type of flexibility encourages innovation to address a range of new and challenging issues.

We also strongly support the proposed regulation permitting States to perform cost-effectiveness evaluations on an aggregate, annual basis. We anticipate that, given the administrative demands of Premium Assistance programs, most States will prefer to perform cost-effectiveness calculations on an aggregate, rather than a case-by-case basis. Such an aggregate assessment must, by definition, be performed retrospectively. It is therefore beneficial to States that the Department will allow annual assessment and will not require case-by-case (prospective) assessment unless it is proven that the retrospective method of assessment is inadequate. We will be happy to work with States to help them develop means of estimating and controlling aggregate program costs such that the annual, retrospective assessment of cost-effectiveness is successful.

We do believe the preamble discussion of cost-effective effectiveness comparisons should be clarified. The first illustration [p. 60932] lacks reality in that it omits any cost for the supplemental coverage the State will likely need to provide when “buying-in” to employer-sponsored coverage. (Few employer plans will meet title XXI's requirement that there be no cost-sharing for well-baby and well-child care, and some plans may not provide all the required services. States should still be permitted to provide Premium Assistance in these instances, so long as the cost of the employer plan plus the cost of the supplemental or “wraparound” coverage meets the cost-effectiveness criterion.)

One possible problem involves the issue of whether to use the actual number of children in the family or the average number of children in S-CHIP families generally when performing the cost-effectiveness calculation for a particular employer plan. If using the actual number of children is required, families with one child will rarely qualify for Premium Assistance<sup>10</sup>, while their similarly situated co-workers with two or more children will qualify. This potential inequity could be avoided if the cost-effectiveness determination used an average number of children per family. This average could be based on the average number of children in low-income working families in the State or on the average number of children in S-CHIP-enrolled families. Using an average number of children should produce results similar to conducting the

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<sup>10</sup> This is so because few employers offer a coverage tier for the employee plus one child.

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cost-effectiveness in the aggregate. It should also simplify the administrative process of determining whether or not to provide Premium Assistance in the case of a particular employer plan, by allowing an “apples-to-apples” comparison with costs in employer plans that usually do not have separate tiers for families with single v. multiple children.

Unfortunately, the preamble, in a section we found very difficult to understand [“Cost-Effective Comparison to Actual Coverage Available in the State” on p. 60932] disapproves using average numbers of family members. We strongly recommend that the use of average number of children in families be approved for use in determining the cost-effectiveness of purchasing employer-sponsored coverage.