

Employer Coverage and the
Children's Health Insurance
Program Under the Balanced
Budget Act of 1997:
Options for States

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INTRODUCTION

The Balanced Budget Act of 1997 (P.L. 105-33) establishes a new Children's Health Insurance Program (CHIP), under which Federal funds will be made available to states either to expand Medicaid eligibility or to assist uninsured low-income children with the costs of public or private coverage meeting certain minimum requirements.¹ The new program builds on variety of existing state children's health insurance initiatives, including extensions of Medicaid eligibility beyond federally mandated minimums, development of public insurance plans, or assistance with private plan premiums.

Nearly all children's coverage initiatives, implemented or proposed, share one common feature: they provide public funds to assist low- or moderate-income children who do not qualify for Medicaid under standard rules and whose families are thought to have insufficient income to purchase coverage on their own.² Programs and proposals vary in target populations--such as the maximum income or age for participation--and in the extent to which they require families to contribute to the costs of their own coverage, for example through a sliding (income-based) premium scale. If the target population is defined solely in terms of income (e.g., all children below x percent of the Federal poverty level), it will include a mix of:

- children who are currently insured through an employer plan or private nongroup coverage;
- children who are eligible for employer coverage but have not obtained it; and
- children who are not eligible for employer coverage and whose families cannot afford a nongroup plan.³

Given limited public funds and the primary goal of reducing the number of uninsured children, a key focus of many proposals has been to target subsidies in such a way as to reach as many children as possible in the third (and sometimes the second) of these groups and as few as possible in the first one.

In particular, there are concerns that newly available public subsidies might lead some employers to reduce or eliminate contributions towards coverage of employees' dependents, in order to encourage lower-income employees to shift their children to the public program. Even without any action by employers, some workers who must now make large payments towards dependent coverage might find that they could pay less under a public program or a plan with income-based subsidies for private insurance.

There is considerable evidence that the Medicaid expansions enacted in the late 1980s resulted in shifts from private to public coverage. Federal Medicaid eligibility has been extended to children with family incomes as high as 133 percent of the federal poverty

¹ Appendix A provides a description of key provisions of the CHIP legislation.

² This characterization excludes the "Caring" programs and similar initiatives under which private insurers offer limited children's benefit plans at low premiums that are generally paid entirely by families.

³ It will also likely include some number of children covered under Medicaid or an existing state-funded program. The possibility that coverage under a new public program will substitute for existing public coverage has important implications, because of the potential for cost-shifting between Federal and state budgets, but is beyond the scope of this paper.

level, and to pregnant women and infants up to 185 percent of poverty. These expansions have protected millions of women and children who would otherwise have been uninsured, but they have also encouraged a significant number of families to drop employer-based coverage and enroll in Medicaid instead. While available studies differ in their estimates of the magnitude of this "crowding out" effect, they agree that it exists. Medicaid coverage growth for poor pregnant women and children has largely been for otherwise uninsured individuals. However, one recent study has estimated that 14 percent of the increase in Medicaid enrollment of pregnant women between 1988 and 1992, and 17 percent of the increase in enrollment of young children was attributable to crowd-out. The degree of crowd-out is closely tied to income. There was very little crowding out for women and children below 100 percent of the Federal poverty level (FPL). For those above poverty, however, crowd-out accounted for 45 percent of increased enrollment of pregnant women and for 21 percent of increased enrollment of children.⁴ The percent of crowd out for children would almost certainly be greater for those with higher incomes. The estimated crowd out for pregnant women with incomes between 100 and 133 percent of poverty was 27 percent comparable to the 21 percent crowd rate for children in this income range, while for pregnant women between 134 percent and 185 percent of poverty it was 59 percent.

Crowding out may be even more likely if eligibility thresholds for Medicaid or another public program are set at higher income levels. For example, over half of all children between 150 and 200 percent of poverty had employer coverage in 1995.⁴ Modest-income families often have to incur significant costs to obtain this coverage. In 1993, 25 percent of all workers in firms with health benefits faced contribution requirements of \$200 or more per month for family coverage.⁵ If public coverage were available, many of these workers could be expected to enroll their children in the public plan while retaining employer-sponsored coverage for themselves.

If such shifts occurred, they would have at least two effects. First, some share of the participants in the public program would be previously insured children; this could limit the number of uninsured children who could be reached under a given budgetary allotment. Second, some amount of current spending by employers would be replaced by public spending. As a result, the problem of crowd-out has emerged as a significant design issue in children's coverage proposals.

To address this issue, the CHIP legislation requires states to assure that the new insurance plan not substitute for existing employer group coverage; like preexisting programs in some states, CHIP also includes provisions that have come to be known as "firewalls." They seek to prevent shifts in coverage by limiting or prohibiting participation in the public program by children who are enrolled in or have access to employer coverage. (Some earlier Federal proposals would also have restrict employers from modifying their benefit plans or contribution schemes in ways meant to take advantage of the public program. CHIP does not contain a provision of this kind.)⁶

⁴ Employee Benefit Research Institute. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1996 Current Population Survey*. Washington, November 1996.

⁵ RAND tabulations of the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey.

⁶CHIP does include a provision, comparable to that in current Medicaid law, specifying that employer benefit plans may not make themselves secondary payers to a CHIP program. This relates only to coordination of benefits and does not prevent an employer from modifying its eligibility or contribution rules for low-income children.

The aim is to lock current arrangements in place so that new expenditures can be focused solely on uninsured children. CHIP excludes children already covered by a group health plan from its "targeted" population.

Under CHIP, states also can adopt additional eligibility standards, or "firewalls," with respect to uninsured children who have access to other health insurance. While firewalls appear to be a simple and direct way of limiting coverage shifts, they have a number of important disadvantages. First, they raise equity concerns. Some families now covering their children through employer plans are paying a substantially larger share of the cost than families at the same income levels with pay under a public program. Second, and in consequence, some firewalls might paradoxically promote, rather than limit, the erosion of employer-based coverage; low income workers would have incentive to exchange health benefits for wages or other fringe benefits; employers with lower income workers would have little reason to offer the benefit. Finally, and perhaps most critically, poorly conceived firewalls could prevent any coverage initiative from reaching the large number of uninsured children who are potentially eligible for coverage through an employed parent.

An alternative that may be both more equitable and more stable over the long term might be to structure a subsidy program that assists modest-income families with the costs of coverage regardless of whether that coverage is obtained through a public program or through an employer plan. Although the CHIP legislation limits the ability of states to use the new Federal funds for this purpose, it does allow premium assistance for at least some uninsured children with access to employer plans. Such a program must be carefully designed if it is to encourage continued provision of coverage by employers while targeting assistance to the individuals and families who most need it.

This paper will attempt to suggest possible solutions to some of the key design problems in structuring a subsidy system for employee contributions. As will be seen, however, the problems are very complex, and it is difficult to be certain how any particular option will play out over time. The most workable approaches are likely to be identified only as states actually implement subsidized coverage systems. Some states, such as Colorado and Oregon, already have enacted legislation authorizing subsidies for employee contributions. As these initial experiments get under way, they can provide lessons for other states in implementing CHIP or future initiatives.

The first part of this paper will review the experience of crowd-out under Medicaid and assess the extent to which crowd-out might occur under a sliding-scale subsidy program such as the one contemplated by CHIP. The next section examines firewall options, including the relevant provisions of CHIP and options included in earlier Federal proposals, as well as those actually implemented in existing state child health insurance programs. The remainder of the paper considers some key issues in designing subsidies for employee contributions, including setting a contribution scale, addressing the problem of rate tiers in employer benefit plans, improving targeting of the subsidies, and evaluating employer benefit packages.

THE POTENTIAL FOR CROWD-OUT UNDER COVERAGE EXPANSIONS

Current Coverage of Modest Income Children

Table 1 shows primary sources of coverage for children under 18 in 1995. Most, 60%, had employer-based coverage, almost always as dependents.⁷ Another 20% had public coverage, such as Medicaid, Medicare, or CHAMPUS. Another 6 percent of children had private non-group coverage or were covered through someone outside the household, such as an absent parent. The remaining 14 percent of children were uninsured. This figure includes almost 3 million children who were eligible for Medicaid under mandatory Federal income standards but were not reported as covered.⁸

Table 1. Primary Sources of Coverage, Children Under 18, 1995

	Number (millions)	Percent
Employer-based	42.9	60.3%
Public	14.1	19.8%
Private nongroup or other private	4.4	6.1%
Uninsured	9.8	13.8%
Total	71.2	100.0%

Source: IHPS analysis of March 1996 Current Population Survey.

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

Table 2 shows coverage by income. At any income level, most children who are not enrolled in Medicaid or another public program have employer coverage. In the absence of restrictions, even a new program targeted solely at children below 150 percent of FPL would potentially reach more children with current employer coverage than uninsured children. The ratio would rise as the income maximum for the program rose. Among children between 150 percent and 200 percent of FPL, for example, there are 2.7 children with employer coverage for every one uninsured.

Table 2. Children Under 18 by Primary Source of Coverage and Family Income, 1995

(Percent with coverage source within income group)					
% of FPL	Employer coverage	Public	Private non-group	Uninsured	Total
Under 100%	13.3%	61.1%	4.1%	21.5%	100.0%
100-149%	38.3%	28.2%	8.7%	24.8%	100.0%

⁷ About 156,000 workers under age 18 had coverage through their own employment.

⁸ This figure includes both children who did not obtain Medicaid coverage and children who did obtain coverage but whose coverage was not reported by the survey respondent.

150-199%	58.3%	13.6%	7.7%	20.4%	100.0%
200-249%	71.6%	8.0%	7.5%	12.9%	100.0%
250-299%	77.3%	5.0%	7.8%	9.9%	100.0%
300% and over	87.6%	2.0%	5.2%	5.2%	100.0%
Total	60.3%	19.8%	6.1%	13.8%	100.0%

Source: IHPS analysis of March 1996 Current Population Survey.

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

In addition, there are a substantial number of uninsured children who could have been covered either under employer plans or under Medicaid. Table 3 shows, by income, the proportion of uninsured children with potential available coverage. Almost 28 percent of uninsured children were eligible for Medicaid under mandatory Federal standards. In addition, 17 percent of uninsured children—almost 1.7 million—have a parent with employer coverage. Most of these children could presumably have been covered as dependents under their parents' plans. As will be seen, however, their parents might have had to cover much or all of the cost of such coverage.

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Table 3. Percent of Uninsured Children with Potential Coverage by Family Income, 1995

Percent of FPL	Medicaid eligible	Parent has employer coverage
Under 100%	72.1%	5.6%
100-149%	16.1%	17.7%
150-199%	2.0%	17.5%
200-249%	1.5%	26.4%
250-299%	0.1%	27.4%
300% and over	0.7%	32.2%
All incomes	27.9%	17.1%

Source: IHPS analysis of March 1996 Current Population Survey.

Note: Children are classed as Medicaid-eligible if (a) they were reported as receiving welfare but not Medicaid; (b) they were under age 13 and had family income below 100% of FPL; or (c) they were under age 6 and had family income below 125% of FPL.

Many more children have parents who were eligible for an employer plan but declined coverage both for themselves and for their dependents. Table 4 shows a preliminary analysis of data from the first round of the 1996 Medical Expenditure Panel Survey (MEPS) conducted by the Agency for Health Care Policy and Research. Of uninsured children, 42 percent had parents who were themselves covered through employment or who had declined available coverage.

Table 4. Uninsured Children by Coverage Status of Parents, 1996

	Number (millions)	Percent
Uninsured children in parent-headed household ¹	9.6	100.0%
One or both parents has employer coverage	2.1	22.4%
One or both parents declined employer coverage	1.7	18.0%
No employer coverage available	5.7	59.7%

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

¹Includes only children identified as natural or adopted children of the reference person in the surveyed household; omits an additional 1.4 million uninsured children not living with parents or whose parent was not the reference person in the household. Income breaks are not included in MEPS data available at this writing.

The MEPS figures are similar to those found in a 1993 RAND survey of families in Colorado. Of uninsured children below 185 percent of poverty, 38 percent had access to employer coverage. This included 14 percent whose parents had covered themselves and not dependents and 24 percent whose parents had declined coverage entirely.⁹

⁹ Data supplied by Colorado Department of Health Care Policy and Financing, May 1997.

Parents Declining Potential Coverage of Children

Why are so many children not receiving available employer coverage? The most likely explanation is cost. Many employers contribute more generously to health benefits for workers than to coverage of their dependents. In addition, the premium structures of some health benefit plans may discourage enrollment by certain types of families.

Employee contribution requirements. Table 5 shows premiums and contribution levels reported in a ten-state survey conducted in 1993. While the average employee contributed 18 percent of the cost of his or her own health coverage, employees contributed an average of 36 percent of family premiums. The difference between average single and family premiums was \$250, while the difference between employee contributions for single and family coverage was \$113. The average employee was, then contributing 45 percent of the incremental cost of covering dependents.

Table 5. Provisions of Employment-Based Health Insurance Plans in Ten States, by Employee Earnings Level, 1993

	Annualized earnings level ¹		
	All	Less than \$14,000	\$14,000 or more
Average single premium (monthly)			
Total (\$)	\$153	\$145	\$156
Employee share (%)	18%	24%	17%
Employee share (\$)	\$27	\$32	\$25
Average family premium (monthly)			
Total (\$)	\$403	\$385	\$409
Employee share (%)	36%	42%	34%
Employee share (\$)	\$140	\$154	\$136

Source: RAND tabulations of the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey.

¹For hourly workers, reported hourly earnings are annualized using formulas.

Current employee contribution amounts are probably very similar to the 1993 data shown here. While there is a widespread perception that employee contribution requirements for family coverage have recently been escalating, available data indicate that this is not the case. KPMG's annual survey of employer plans, for example, shows that the average worker's contribution for family coverage rose from \$109 in 1993 to \$116 in 1997, an increase of less than 1.6 percent per year (less than the rate of general inflation).¹⁰

¹⁰ KPMG Peat Marwick, *Health Benefits in 1997*. Data in this report also indicate that from 1993 to 1997 employee contribution requirements for family coverage rose less rapidly than for single coverage.

Even if the overall ratio of family to single contributions has remained stable or even dropped slightly, the averages mask very substantial differences in the costs faced by workers in different firms. As table 6 shows, a small percentage of workers paid nothing towards dependent coverage, while 25 percent of workers faced required contributions of \$200 a month or more. Lower-wage workers were somewhat more likely to work for firms having contribution requirements at the higher end of the distribution.

Table 6. Distribution of Employee Contributions for Family Coverage in Ten States, by Employee Earnings Level, 1993

Employee contribution	Annualized earnings level ¹		
	All	Less than \$14,000	\$14,000 or more
No employee contribution	13%	11%	14%
\$1 - 49	11	9	12
\$50 - 99	20	18	21
\$100 - 149	20	21	19
\$150 - 199	11	13	11
\$200 or more	25	30	24

Source: RAND tabulations of the Robert Wood Johnson Foundation 1993 Employer Health Insurance Survey.

¹For hourly workers, reported hourly earnings are annualized using formulas.

Family structures and rate tiers. The expenses faced by parents in covering their children through an employer plan depend, not only on the employer's contribution policies, but also on the plan's rate tiers: the way in which it establishes prices for different types of families. Some plans offer a choice only between employee-only coverage and family coverage, while others have more categories: employee-plus-spouse, employee-plus-children, and so on. Larger employers make their own decisions about rate structure, while small groups must generally accept the plans offered by health insurers. (Some state small group reform laws require insurers to offer a specific set of rate tiers.) The rate structure adopted by an employer can have an important impact on the effective cost to a parent of covering a child.

Table 7 shows a breakdown of participants in the health plan of a hypothetical group with 100 employees, along with the actuarial value of coverage for each type of participant.

Table 7. Hypothetical Breakdown of Cases and Costs in a Group with 100 Members

	Cases	Price
Employee only	45	\$ 2,000
Employee + 1 child	4	\$ 2,800
Employee + 2 or more children	6	\$ 4,200
Employee + spouse	15	\$ 4,000
Employee + spouse + 1 child	8	\$ 4,800
Employee + spouse + 2 or more children	22	\$ 6,200

Table 8 shows the actual prices that might be charged if the plan adopted alternative rate structures. Under Plan A, a single mother with one child would face the same premium as a two-parent family with several children. If, as is typical, the employer contributed half of the difference between the single and family premium, the effective cost to the mother of adding coverage for one child would be \$1,466; the cost to a coworker of adding a spouse and five children would be the same amount. The single mother would fare even worse under Plan B, paying \$1,640 to cover her child.

Table 8. Premiums Under Different Rate Structures, Hypothetical Group

Plan A	
Single	\$ 2,000
Family	\$ 4,931
Plan B	
Single	\$ 2,000
Couple	\$ 4,000
Family	\$ 5,280
Plan C	
Single	\$ 2,000
Single + 1 dependent	\$ 3,747
Single + 2 or more dependents	\$ 5,556
Plan D	
Single	\$ 2,000
Single + children	\$ 3,640
Couple	\$ 4,000
Couple + children	\$ 5,827

Larger firms are beginning to adopt larger numbers of rate tiers, possibly in order to encourage two-worker families to split coverage between their two employers.¹¹ The

¹¹ For example, suppose a woman with a husband and two children works at a firm with plan D; the firm pays employee-only coverage in full, plus 50 percent of the incremental cost for dependents. The husband works at a firm that pays 80 percent of the cost for employee-only coverage. If the wife covers the children and the husband is covered through his own firm, total cost to the family is \$1,220. If the wife elects full family coverage, cost to the family is \$1,825.

General Accounting Office has reported the following breakdown for large firms in 1995:

Table 9. Coverage Tiers for Major Firms in 1995

Two tiers	24%
Three tiers	45%
Four tiers	24%
Other, including no Employee contributions	7%

Source: U.S. General Accounting Office, *Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases*, GAO/HEHS-97-35, Feb. 1997, p. 16, citing Hewitt Associates, *Salaried Employee Benefits Provided by Major U.S. Employers in 1995, 1996*.

Smaller firms may be less likely to have adopted multiple tiers. In any case, the effect of rate structures on coverage of children is uncertain. While small families in firms with a two-tier structure face high costs for coverage of a child, large families benefit. The reverse is true in multiple-tier structures. The relative numbers of winners and losers cannot be assessed with available data. However, it is likely that rate structures affect workers' decisions about whether to obtain coverage for dependents.

Likelihood of Crowd-Out Under Coverage Expansions

How likely is it that a coverage expansion would result in crowd-out at the levels observed under Medicaid? However income levels are established for an expansion, clearly more at higher levels have access to employer plans than the Medicaid expansions did. But there are a number of factors besides the mere existence of employer coverage that could affect the rate of coverage shifts.

Effect of sliding-scale premiums. CHIP legislation allows states to impose some premium costs on all but the lowest-income families. Instead of facing a choice between paying for dependent coverage under an employer plan and obtaining Medicaid for free, many parents would instead face at least some costs under both options. Even if the public program were somewhat cheaper, inertia or a desire to keep the entire family under a single plan might prevent families from shifting their children for a small price advantage.¹²

However, depending on the premium structure of the public program, the potential savings for many families could be considerable. Some proposals would offer free, or virtually free, coverage well up the income scale.

Even requiring somewhat larger contributions (i.e., 5 percent of family income) from families at 150 percent of poverty could still be significantly less costly than employer coverage. Tables 10 and 11 provide an example.

¹²This paper uses the term "public program" to include systems that provide publicly funded subsidies for private coverage, as well as those that provide coverage directly through Medicaid or another public plan.

Table 10 illustrates a linear sliding scale premium structure under which families up to 150 percent of FPL pay 1 percent of the cost of coverage (the approximate amount allowed under the CHIP legislation), while families at 250 percent of FPL pay the full cost of coverage. Costs are shown for coverage of two children in a two-parent family, assuming annual premiums of \$800 per child. Expressed as a percentage of total family income, required family contributions range from 0.1 percent at 150 percent of FPL to 5 percent at the top of the scale. (A state's sliding scale might in fact need to "cap out" at a lower level, e.g., 4 percent income amounts, so as not to violate the 5 percent limit on total cost-sharing for those above 150 percent of poverty. However, as we discuss later, a state might want to be able to separately reimburse for excess copayment expenses.)

Table 10. Family Contribution for Two Children as Share of Family Income, Public Program with Linear Sliding Scale from 150% to 200% of Federal Poverty Level

Family income as % of FPL	Annual income	Family share under public program	Family cost, 2 children, \$800 premium	Subsidy cost	Cost as % of family income
150%	\$ 24,075	1%	\$ 16	\$ 1,584	0.1%
160%	\$ 25,680	20%	\$ 320	\$ 1,280	1.2%
170%	\$ 27,285	40%	\$ 640	\$ 960	2.3%
180%	\$ 28,890	60%	\$ 960	\$ 640	3.3%
190%	\$ 30,495	80%	\$ 1,280	\$ 320	4.2%
200%	\$ 32,100	100%	\$ 1,600	\$ -	5.0%

Note: Based on 1997 poverty income guideline of \$16,050 for a family of four.

Table 11 shows how the same families might fare under different employer contribution schemes. The table assumes that the employer has adopted Plan D under table 8: that is, a married couple can add its children to coverage for a premium increase of \$1,827. Thus, in an employer that covers 80 percent of the incremental costs for dependents, the cost to the family of covering the children is \$365; if the employer covers only 50 percent, the cost to the family is \$914, and so on. Some families at higher income levels do much better under the employer plan than they would under the sliding scale in table 10. Others, however, do much worse. The lowest income workers in firms that contribute nothing towards dependent coverage would face annual premium costs of as much as 7.6 percent of family income, compared to almost nothing in the public program.

Table 11. Family Contributions as Share of Family Income Under Varying Levels of Employer Contributions

Family cost with employee contribution equal to--						
	20%		50%		100%	
	Family cost=\$365		Family cost=\$914		Family cost=\$1,827	
Family income as % of FPL	Cost as % of family income	Excess (savings) over public program	Cost as % of family income	Excess (savings) over public program	Cost as % of family income	Excess (savings) over public program
150%	1.5%	1.5%	3.8%	3.7%	7.6%	7.5%
160%	1.4%	0.2%	3.6%	2.3%	7.1%	5.9%
170%	1.3%	-1.0%	3.3%	1.0%	6.7%	4.4%
180%	1.3%	-2.1%	3.2%	-0.2%	6.3%	3.0%
190%	1.2%	-3.0%	3.0%	-1.2%	6.0%	1.8%
200%	1.1%	-3.8%	2.8%	-2.1%	5.7%	0.7%

Again, the tradeoffs for any particular family will depend both on the employer's contribution scheme and the subsidy scale of the public program. Many previous coverage expansion proposals include provisions to prevent employers from modifying their current contributions; the efficacy of such provisions is discussed below. However, even if all employers kept their current arrangements in place, many low-income families would face very strong incentives to shift coverage for their children.

Rate structures. The rate tiers adopted by employers could have a significant effect on parents' decisions to shift children to a public program. The possible effects vary for different families with different employers.

For example, a single parent with one child may be disadvantaged under employer plans with only two tiers, or plans that charge by number of dependents regardless of whether they are adults or children. If the public program charges a fixed premium for each child covered, this parent might find the price in the public program attractive even if the employer contributed relatively generously to dependent coverage. On the other hand, a two-parent family in an employer with only two tiers would have no incentive to shift the children, because the cost for covering the spouse would be the same with or without the children. But the same family might well have incentives to shift the children if the employer adopted a multiple tier scheme under which the incremental cost for children was charged separately.

Stigma. Enrollment of children under recent Medicaid expansions is thought to have been limited by the "stigma" associated with Medicaid. As was noted earlier, nearly three million children within Medicaid income limits were not reported as covered in 1995. While the figure reflects some undercounting, as well as lack of awareness of the Medicaid option among many parents, it has long been known that some parents are

reluctant to apply for Medicaid because they associate it with welfare. The application process may be complex and intrusive; providers may limit access for Medicaid beneficiaries; and parents may not wish the community to know that they are receiving a "welfare" benefit.¹³ Stigma may also have limited the crowd-out effect. About 2 million children below the poverty level had employer coverage in 1995; of these, 72 percent were under age 13 and could have qualified for Medicaid. Some of these children may have been in plans that covered the full cost of dependent coverage. However, it appears that at least some very low-income parents were willing to contribute to employer premiums rather than move their children to Medicaid.

Parents at slightly higher income levels might be even less willing to shift their children to a new public program, but only if the program was perceived as resembling Medicaid. If a program had a different name, allowed mail-in or other simplified applications, and contracted with health plans also serving employer groups (unlike the separate plans used in some Medicaid programs), there might be no stigma at all attached to participation. Even if the program was operated as a Medicaid expansion but included sliding scale premiums, stigma might be markedly reduced. (The Medicare experience suggests that individuals paying any premium, no matter how heavily subsidized, do not conceive of themselves as recipients of public largesse.)

Splitting families. All other things being equal, most families would presumably prefer to have the entire family covered by a single health plan. Multiple coverage sources, especially in the era of managed care, can mean that different family members would have to use different medical care providers and that families would have to learn to negotiate several different sets of rules for accessing care. For many families, this factor might override price advantages and discourage shifting of children to public programs. However, many employers are already adopting policies intended to encourage split coverage among two-earner families, such as excluding coverage of spouses who have access to employer coverage through their own work, adopting multiple tier systems, and even paying bonuses to employees who decline dependent coverage.¹⁴ In 1996, 13 percent of children with employer coverage had parents who were in two different employer plans.¹⁵ Thus, a number of workers are accustomed to the idea of splitting their families among multiple plans. Reluctance to split the family is likely to be a continuing factor in limiting crowd-out, but its importance might diminish over time. If families did split coverage to take advantage of a public children's program the effect would be, not only replacement of employer dollars, but also potentially some barriers to access. In order to receive medical benefits, families that already have difficulty dealing with the bureaucracy, access rules and provider networks of one health plan would have to learn to maneuver in multiple plans.

¹³ In Minnesota, some parents with Medicaid-eligible children, especially in rural areas, will pay a premium to enroll the children in MinnesotaCare rather than apply for free Medicaid coverage at the welfare office. Personal communication, Kathleen Henry, Director, Health Care for Families and Children, Minnesota Department of Human Services.

¹⁴ U.S. General Accounting Office, *Employment-Based Health Insurance: Costs Increase and Family Coverage Decreases*, GAO/HEHS-97-35, Feb. 1997.

¹⁵ IHPS analysis of data from Medical Expenditure Panel Survey, 1996 Panel, Round 1.

FIREWALLS

Restrictions Under CHIP

The CHIP legislation sharply restricts the ability of states to use the new Federal funds to assist children already covered under employer health plans. Federal funds to states would have to be used chiefly for Medicaid expansion or provision or purchase of health benefits coverage for "targeted low-income children." These are children under age 19 with family income below 200 percent of poverty or, if higher, 50 percentage points above the applicable Medicaid limit in the state (including any higher limit established by the state under a waiver or under the 1902(r) income methodology rule) as of June 1, 1997.

As we discussed in the Appendix A, CHIP does allow buy-in to employer plans. However, "targeted" children do not include children who are already covered by a group health plan. The language is at 2110(b)(1):

- (1) IN GENERAL. Subject to paragraph (2), the term 'targeted low-income child' means a child--
 - (C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).
- (2) CHILDREN EXCLUDED- Such term does not include--
 - (B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

This provision does not restrict coverage of children who are eligible for, but not actually covered under, an employer plan at the time they apply for child health assistance. (As was shown in Table 4, approximately 40% of uninsured children have a parent with access to employer coverage.) Such children fit within the definition of "targeted" low-income children; the only exception is for children eligible for a state employee plan. However, low-income children who are actually receiving coverage under an employer plan are not "targeted" low-income children, but "other" low-income children.¹⁶ (The possibility that a state could provide at least some limited assistance to "other" children will be discussed below.)

In addition to allowing assistance for children who have access to – but are not enrolled in – employer plans, CHIP does not require retrospective review of coverage. This means that a parent could drop a child from employer coverage during an annual open enrollment period and immediately apply for public assistance. Thus, if a state were merely to adopt the specifications contained in CHIP, it might merely delay, rather than prevent, large-scale shifts from private to public coverage.

¹⁶ Note that the income limit for "low-income" children who are not "targeted low-income" children is defined (21.10(c)(4)) as 200 percent of poverty, even in States with a higher Medicaid income limit.

However, CHIP requires that states take some further steps to address this problem. The state plan for CHIP that must be submitted for Federal approval must describe the procedures the state will use to ensure "that the insurance provided under the State child health plan does not substitute for coverage under group plans."¹⁷ In meeting this requirement, most states are likely to consider establishing more stringent firewalls. This option appears to be explicitly contemplated by the legislation; state eligibility standards may explicitly include standards relating to "access to or coverage under other health coverage."¹⁸

This section reviews the various firewalls adopted by states, or included in the Federal legislative proposals that were the precursors of CHIP, and considers their likely impact.

State Programs

As was noted earlier, many states have already undertaken some form of children's health insurance initiative. Some of these states have attempted to address the crowd-out issue, chiefly through the use of firewalls. The following discussion reviews the efforts only in six states that have established comprehensive programs--that is, programs that include inpatient coverage--for children above Medicaid levels.¹⁹

Florida's Healthy Kids program provides coverage through contracting health plans to children of school age enrolled through a school-based system. Eligibility for premium subsidies is limited to children eligible for the Federal school lunch program (which provides free meals up to 130 percent of FPL and reduced price meals up to 185 percent of FPL). All families must make some premium contribution, on a scale developed by individual communities; on average, families pay 35 percent of program costs.²⁰ Children must be ineligible for Medicaid at the time of application, but there is no exclusion of children covered through other sources. (The precursor demonstration program required applicants to have been uninsured for 6 months; this requirement was dropped early on, on the grounds that it was too punitive.)

Minnesota's MinnesotaCare provides coverage through contracting health plans to entire families (including adults) below 275 percent of FPL. The family pays a fixed percentage of gross family income for coverage; the percentage ranges from 1.5 percent for the lowest income families to 8.8% for families at the upper end of the scale. Applicants are excluded if (a) they had any form of health coverage in the 4 months prior to application, or (b) they had access to employer-subsidized coverage at any time in the 18 months prior to application.²¹ Employer-subsidized coverage is defined as a plan under which the employer pays at least 50 percent of the cost for the *employee*,

¹⁷ Sec. 2102(b)(3)(C).

¹⁸ Sec. 2102(b)(1).

¹⁹ Programs that have provided outpatient-only coverage are not discussed, on the grounds that parents are less likely to shift children from comprehensive employer coverage to a limited ambulatory plan. Programs that are basically Medicaid expansions are also omitted; these programs are subject to the Medicaid rules regarding available employer coverage, discussed above.

²⁰ Florida Healthy Kids Corporation, *Annual Report*, Feb. 1997.

²¹ These restrictions do not apply to children below 150% of FPL. These children are Medicaid-eligible under Minnesota's waiver and can choose between Medicaid and MinnesotaCare coverage.

regardless of contributions towards dependent coverage. So long as children are eligible to enroll in the employer plan, they could be excluded even if the employer contributed nothing to their coverage. The exclusion does not apply if employer coverage is lost because of death, disability, or termination of employment (for reasons that would not disqualify the individual for unemployment benefits). However, the exclusion does apply if coverage is lost because the employer terminates health coverage as an employee benefit.

New Jersey's Health Access program provides subsidies for private nongroup coverage for children below 250 percent of FPL. (The program was closed to new enrollees at the end of 1995, although new slots will be opening in 1997.) Children are ineligible if they had employer group coverage at any time during the 12 months before applying. The exclusion applies even if the employer, rather than the family, terminated the coverage, and regardless of the amount of the employer contribution.

Pennsylvania's Children's Health Insurance Program offers coverage through contracting insurers to children below 235 percent of FPL through age 5 or below 185 percent through age 15. Families below 185 percent of FPL pay nothing; those between 185 percent and 235 percent pay 50 percent of the cost. Applicants may not participate if they are eligible for other coverage.

Tennessee's TennCare program offers coverage in contracting health plans; enrollment is now closed except for children with no access to other coverage, workers displaced by plant closings, and individuals rejected as uninsurable by insurers. Coverage is free below 100 percent of FPL, with sliding scale subsidies up to 400 percent of FPL. Children are defined as having access to coverage if an employer plan is available, regardless of benefits or contributions.

Washington's Basic Health Plan (BHP) offers coverage in contracting health plans to any individuals (including adults) or families wishing to enroll. Required premium contributions are a flat \$10-\$15 per month for participants below 125 percent of FPL, then rise on a sliding scale up to 200 percent of FPL. No premium is imposed for children below 200 percent of FPL; they are eligible for Medicaid under Washington's section 1115 waiver but are enrolled in BHP if the rest of the family enrolls. Businesses can enroll employees in BHP by paying a monthly contribution of \$45 per employee. (As this amount often exceeds what a low-income employee would have to pay if enrolling in BHP directly, this option is rarely used.) There are no restrictions to enrollment on the basis of current or prior alternative coverage. However, enrollment in the program is capped at 130,000 non-Medicaid participants and there is currently a waiting list of 90,000 applicants.

In summary, and speaking only of employer coverage:

- Two states (Florida and Washington) have no rules to restrict coverage shifts.
- One state (New Jersey) excludes applicants who were *enrolled* in employer coverage during a fixed period before application.
- Two states (Pennsylvania and Tennessee) exclude applicants who are *eligible* for employer coverage at the time of application.

- One state (Minnesota) excludes applicants who were *eligible* for employer coverage during a fixed period before application.

The Minnesota rules warrant particular attention because at least two features have been adopted in some current Federal proposals.

First, it is the only state that considers the employer's contribution level before excluding a child from coverage; the other states may exclude a child if the employer is offering coverage but making no contribution to the health plan. Note, however, that Minnesota examines the contribution for the worker, not for the child. The 50 percent threshold screens out the least generous employers, but many employers contributing more than this amount for employee-only coverage may contribute little or nothing to dependent coverage. The children would nevertheless be ineligible for MinnesotaCare.

Second, Minnesota looks retrospectively at the child's access to coverage and may exclude some children who are no longer eligible for an employer plan at the time of application. A child may be excluded if the parent has voluntarily moved from an employer that offers dependent coverage to one that does not. More importantly, the child may be excluded if the employer has modified its benefit plan in the past 18 months. If an employer eliminates dependent coverage, the child must wait 18 months before becoming eligible for MinnesotaCare. If the employer reduces its employee-only contribution from 55 percent to 45 percent, the child must again wait 18 months for MinnesotaCare eligibility.

The aim of this provision is to discourage employers from modifying their plans in an attempt to take advantage of the availability of MinnesotaCare. Because ERISA prevents the state from regulating employer plans directly, it must do so indirectly, in effect penalizing the families in the expectation that they will put pressure on their employers not to reduce benefits.²² Whether the provision is actually working is uncertain. States attempting to buy into employer plans on behalf of Medicaid beneficiaries have found it difficult enough to verify current availability of employer coverage, much less ascertain availability of coverage 18 months before application.²³ However, Minnesota has enacted legislation that will require inclusion of coverage information in payroll tax reporting; this may improve the ability to track applicants' coverage over time.

How well have firewalls worked in the states that have adopted them? There has been little systematic analysis of the extent to which participants shifted from other coverage or employers modified their benefit plans in response to the availability of public subsidies.

²² That similar provisions have appeared in some Federal proposals, even though Federal legislation could regulate employer plans directly, presumably reflects a reluctance to impose any form of employer requirements.

²³ The Medicaid experience is reviewed in Institute for Health Policy Solutions, *Improving Health Care Coverage for Low-Income Children and Pregnant Women: Optimizing Medicaid and Employer-Financed Coverage Relations*, Washington, November 1996.

Florida, which has no firewall, did inquire about prior coverage in a survey of 1300 participating families.²⁴ Of these, 93 percent reported no coverage in the preceding 12 months. For the remaining 7 percent, reported previous sources of coverage were:

Medicaid or Title V 41 %
Employer group 30 %
Private nongroup 20 %
CHAMPUS 4 %

At least two factors may have contributed to the very low rate of reported crowd-out. First, premium charges to families are not insubstantial; per child costs for families between 133 percent and 185 percent of poverty are \$15 to \$25 per month. Second, Florida has the eighth lowest rate of employer coverage for the nonelderly in the nation, 56.1 percent compared to a national average of 63.8 percent.²⁵

Minnesota reports that of Minnesota Care participants, 13% had employer coverage. It is not certain how many of these qualified because their employer contribution was not large enough to disqualify them. Further, these data are not available by income; however, 72% of all Minnesota Care recipients are under 150% of poverty.

State officials contacted were generally of the view that their programs created little incentive for coverage shifting:

- Washington, although it has no formal restrictions on coverage-shifting, believes that such shifts are rare; because of the long waiting list for applicants, anyone dropping other coverage would have to wait a year or more before enrolling in the Basic Health Plan.²⁶
- New Jersey's program was designed to meet a short-term crisis in the availability of private nongroup coverage and has served a very limited number of applicants. The state has received some complaints about the unfairness of its exclusion of individuals required to make large contributions under employer plans.²⁷
- Tennessee believes that its subsidy structure is such that few applicants face lower costs under TennCare than they would under private employer plans.²⁸

No state was able to provide any information about employer responses. Minnesota did report some anecdotal accounts of newly formed businesses choosing not to offer health benefits because of the availability of MinnesotaCare.

²⁴ Personal communication, Elizabeth Shenkman, Ph.D., principal investigator, Healthy Kids Program Evaluation, University of Florida, Gainesville.

²⁵ Employee Benefit Research Institute, *Sources of Health Insurance and Characteristics of the Uninsured*, EBRI Issue Brief No. 1179, Washington, Nov. 1996.

²⁶ Personal communication, Gary Christenson, Administrator, Washington State Health Care Authority.

²⁷ Personal communication, Kathleen Brennan, New Jersey Health Access, Department of Health and Senior Services.

²⁸ Personal communication, Ginger Parra, Tennessee Department of Finance and Administration.

Federal Proposals

A number of the children's health insurance bills introduced in the 105th Congress before the adoption of CHIP contained firewall provisions, as did the children's health packages passed by the House and Senate before the conference agreement on CHIP. The following is an overview of provisions related to employer coverage in these packages and in three other proposals that received wide discussion earlier in the year.

H.R. 2015 (Kasich), Balanced Budget Act as passed by House. Provided funds to states to expand Medicaid, subsidize individual and group premiums, or otherwise extend coverage or direct services to children. The state would have been required to assure that coverage under its program did not substitute for coverage under group health plans. In states choosing to pay group health plan premiums, the Secretary of HHS would have established when it would be permissible to pay contributions for coverage of the entire family, using a cost-effectiveness test similar to that under current Medicaid. A child in a group health plan could have been limited to the benefits available under that plan, in place of minimum benefits required for child health programs, and coverage could have been subject to pre-existing condition limitations (to the extent permitted by the Health Insurance Portability and Accountability Act of 1996, or HIPAA).

Senate amendment to H.R. 2015. The Senate amendment would have allowed Federal funds to be used only for Medicaid expansion or for provision or purchase of health insurance, and only for children below 200 percent of FPL. The state would have been required to assure that coverage provided under its program did not "reduce the number of children who are provided such coverage through any other publicly or privately funded health plan."

S. 13 (Daschle), Children's Health Coverage Act. Provided premium discounts (recovered by insurer/employer through federal tax credits) on a sliding scale for children in families with gross income up to \$75,000. The discount could have been applied to employee contributions for family or children's coverage. A child would have been ineligible to participate if the parent's employer offered a plan in the last 12 months under which the employer paid 80 percent of the premium for family or child coverage (for children up to 200 percent of FPL), or 50 percent (for children at 200-300 percent of FPL). The exclusion would have been waived if the coverage was lost because of lost employment or because the employer terminated the plan (but only if the health plan was terminated because the employer ceased operations, or for other reasons unrelated to the availability of the subsidy program). Employers would have been prohibited from varying contributions on the grounds that a child was eligible for a subsidy; an employer could have eliminated all contributions for all employees.

S. 525 (Hatch)/H.R. 1263 (Pallone)/H.R. 1363 (Johnson)/H.R. 1364 (Johnson), Child Health Insurance and Lower Deficit Act. Provided grants to states for premium assistance and/or direct contracts with community health centers and similar entities. The premium subsidy could have been applied to employee contributions for an employer plan, but only for the part of the contribution attributable to the child. The subsidy would not have been available if the child had been covered under an employer

plan in the 6 months prior to application, unless the coverage was terminated by a change in employment. Employers would have been prohibited from varying contributions on the grounds that a child was eligible for a subsidy; an employer could have eliminated all contributions for all employees.

S. 674 (Chafee)/H.R. 1491 (Dingell), Children's Health Insurance Provides Security Act (CHIPs). Allowed optional expansion of state Medicaid plans and continuous eligibility for children, with increased federal matching. The only provision related to employer coverage would have prohibited an employer from reducing contributions for Medicaid eligibles; again, the employer could have eliminate all contributions for all employees. As the expansion under the bill would generally have operated under current Medicaid law, the existing provisions for buy-in of employer coverage when cost-effective would have applied.²⁹

Potential Effects of Firewalls

The range of firewall provisions included in CHIP or potentially adopted by states in implementing their CHIP programs may be broken down into a few categories.

- **Exclusion of currently insured children.** CHIP requires this exclusion. Most state programs allow an exception for children currently enrolled in private nongroup coverage, and therefore exclude only children already in other public programs or covered under employer plans. Note, however, that the CHIP language excludes children covered under any health insurance coverage as defined in section 2791 of the Public Health Service Act; this definition embraces nongroup as well as group coverage.
- **Exclusion of children covered in the recent past.** CHIP does require but permits states to make this exclusion. States could make exceptions for children who have lost coverage because a parent changed employment or an employer modified its health plan.
- **Exclusion of children with current or past access to employer coverage.** CHIP does not require but permits states to make this exclusion. States could make an exception for children eligible for an employer plan under which the employer does not make a specified minimum contribution to premiums. (This exception is discussed in the section on target populations for employee contributions, p.36.)

One additional form of restriction, included in earlier Federal proposals but notably absent from the CHIP legislation, is maintenance of effort requirements or non-discrimination rules for employers. As noted earlier, this is an option only under Federal and not state proposals.

While all of these options seek to reduce the potential for crowd-out, they imply different conceptions of why crowd-out might occur. Some focus on preventing families from dropping or forgoing existing employer coverage because they find the

²⁹ The Balanced Budget Act makes Medicaid purchase of group coverage optional, rather than mandatory, but retains the current section 1906 rules allowing such coverage only when cost-effective.

public program more attractive. Others seek to prevent employers from modifying their plans, either directly or by temporarily excluding families whose employers do so.

The assumption in either case is that families with access to an employer plan are less in need of assistance than families without such access. This is made clear by the fact that few proposals prior to CHIP would have excluded current purchasers of private nongroup coverage. Except in the case of "uninsurable" children with serious medical problems, any uninsured child could in theory be covered in the nongroup market (although it may often have been impossible to find health insurance for children without paying for coverage for the entire family). To exclude families that have purchased such coverage while providing assistance to other families at the same income level would clearly be inequitable.³⁰

However, this argument applies equally to current enrollees of employer plans. As has been discussed, many of these families must already pay a significant share of family income in the form of employee contributions. And economists would argue that they are in fact paying the entire cost of their coverage: their health benefits are not simply given to them by their employer, but are part of a total compensation package. They have forgone higher wages or other benefits to obtain them. Thus to foreclose them from the public program, or to discourage them from renegotiating their benefits, might be seen as imposing a permanent penalty for the trade-offs they have made in the past. While some families would obtain a public benefit, others at the same income would have to maintain employer coverage, in effect at their own expense.

Whatever the strength of this view in equity terms, the counter-argument is clear. Children's health programs represent a limited initiative meant to address the immediate needs of uninsured children. In the absence of firewalls, the ongoing erosion in populations covered through employer benefits will accelerate. It is not clear, however, that any of the firewall options can in fact stem this erosion.

CHIP does not, and states may not, directly regulate employer plans. However, a firewall adopted by a state may be designed to encourage employees to bargain for continuation of their benefits. This is the purpose of provisions, under some state programs and earlier Federal proposals, that employees who ceased to receive employer contributions for health benefits would be unable to cover their children under the public program for 6 months, or 12, or 18. Rather than accept this break in coverage, they would press their employers to maintain current plans. However, a provision of this kind is easily gamed. For example, an employer could drop contributions to dependent coverage but provide an offsetting wage increase for the duration of the exclusion period.

Even if all current benefit plans could be maintained intact, a new public program could give workers an incentive to shift from firms that offered dependent coverage to ones that did not but paid higher wages, or from direct employment to some form of contractual arrangement. It seems unlikely that many people would act on such incentives in the short term. Over time, however, people do change jobs, and it must be

³⁰ Again, the CHIP provision does not prevent parents from dropping existing coverage and then applying for assistance, although a State could establish a period-of-uninsurance requirement.

expected that the market will respond to the incentives established by large-scale initiatives. If there is no advantage to workers who receive, or employers who offer, compensation in the form of dependent health benefits, the structure of compensation will gradually change.

A comprehensive firewall, then, might fail to prevent erosion in dependent coverage and might principally exclude from coverage children who nominally have access to employer plans, but whose parents cannot continue to afford the required contributions. A firewall poorly conceived could permanently preclude coverage of a significant proportion of all uninsured children - those whose parents have access to employer coverage.

One solution permitted under CHIP (see the discussion in Appendix A) and adopted in recently enacted Oregon legislation, would be to assist these children with the costs of contributions, but not provide assistance for children already enrolled at the time the subsidy program became available. The equity problem with this approach is clear: workers who had always paid for their children would receive no assistance, while other workers in the same firm might receive subsidies. It is unlikely that a large-scale approach only limits spending temporarily; over time excluded children would be replaced by new children qualifying under the rule. At a minimum, however, this approach might reach many uninsured children whose parents have access to employer coverage and who might more readily avail themselves of an approach allowing them to enroll all family members in one plan. Some of these parents might be less likely to obtain coverage for their children if they have to apply to a separate public program.

For reasons both of equity and of long-term stability, assistance would ideally be based on ability to pay, without discriminating on the basis of current coverage status. A carefully designed subsidy program could help both modest-income families who are already, at whatever difficulty, obtaining employer coverage for their children, as well as those who have found themselves unable to take advantage of available employer benefits. Assistance would need to be targeted appropriately to retain incentives for workers to bargain for, and employers to offer, health benefits, while reaching those most in need.

Whether the CHIP legislation allows this option is uncertain. Section 2105(a) allows up to 10 percent of a state's Federal allotment to be used for, among other purposes, "health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children)". Again, the group of "other" children includes those with current coverage. However, a state would have to show that providing premium assistance to such children constituted an initiative to improve their health. There are a number of arguments that could be raised in support of this contention. First, in the absence of assistance, parents or employers might drop coverage. Second, assistance would reduce the financial burdens on very low-income families, freeing resources to meet other essential needs of their children that have a bearing on their health (such as housing and nutrition).

Even if Federal approval could be secured, the available funds would be very limited; states must also pay for administration and required outreach within the 10 percent allotment. Eligibility thresholds and premium assistance scales would therefore have to be designed in such a way as to reach a limited number of the most needy children.

If such use of Federal CHIP funds is not allowed or is very limited, a state might consider using other funds (e.g., tobacco settlement funds) to assist low-income families who now bear substantial costs to cover their children.

STRUCTURING SUBSIDIES FOR EMPLOYEE CONTRIBUTIONS

Basic Models

If subsidies are to be provided on a sliding scale for the employee share of health plan premiums – either for uninsured children with potential coverage or possibly for some currently covered children – there are at least two basic ways the subsidy amounts could be computed:

A. Cost-effectiveness model. In this model, the available public subsidy is the lesser of (a) the subsidy that would have been available for the child under the public program or (b) the required employee contribution for the child. (This is the test now used by state Medicaid programs in determining when it would be cost-effective to buy into employer coverage available to Medicaid beneficiaries.)

B. Hold-harmless model. In this model, the available public subsidy is the lesser of (a) the subsidy that would have been available for the child under the public program or (b) the amount required to assure that the family's share of premium cost is no greater than it would have been if the child were enrolled in the public program.

Tables 12 and 13 illustrate the two different models. Both assume that the sliding scale premiums for children *without* access to employer coverage are the same as shown in table 10. That is, annual premiums are \$1,600 for two children, and the family share of this cost rises on a linear scale from zero at 133 percent of FPL to full cost at 250 percent of FPL. In addition, it is again assumed, as in table 11, that the total premium for employer coverage is \$1,827 (the incremental premium for a couple adding 2 or more children under rate plan D.) Note that this figure is higher than the cost under the public program, not because the private coverage is more costly, but because the private family rate reflects an average of slightly more than two children in each family, while the public program charges a per-child premium.

**Table 12. Cost-Effectiveness Model (Model A)
for Computing Subsidies of Employer Contributions**

Employee contribution equal to--						
	20%		50%		75%	
Family income as % of FPL	Subsidy amount	Family cost	Subsidy amount	Family cost	Subsidy amount	Family cost
150%	\$ 365	\$ -	\$ 914	\$ -	\$ 1,370	\$ -
160%	\$ 365	\$ -	\$ 914	\$ -	\$ 1,280	\$ 90
170%	\$ 365	\$ -	\$ 914	\$ -	\$ 960	\$ 410
180%	\$ 365	\$ -	\$ 640	\$ 274	\$ 640	\$ 730
190%	\$ 320	\$ 45	\$ 320	\$ 594	\$ 320	\$ 1,050
200%	\$ -	\$ 365	\$ -	\$ 914	\$ -	\$ 1,370

Under Model A, as shown in table 12, the cost to the public of subsidizing two children without employer coverage is compared to the cost to the family of buying employer coverage for two children. For a family at 150 percent of poverty, the public program cost would be almost the entire premium, or \$1,584. If the employer is contributing 80% of premiums, the cost of buying into the employer plan is only \$365. It is therefore cost-effective to pay the employee contribution. This remains true most of the way up the income scale. Only at 190 percent of poverty does the \$365 cost of the employee contribution exceed the \$320 subsidy that would have been provided for the same two children under the public program. The family must then contribute the remaining \$45. Overall, the public saves money and the participants pay less than they would have paid under either the public program or the unsubsidized employer plan.

When the same scheme is applied to workers whose employer pays only 50 percent of the cost, potentially undesirable effects appear. While the participants are still saving money, the public subsidies are much higher and savings therefore would drop sharply. In effect, the public program shelters the participants from most of the new expense resulting from the reduced employer contribution. For a family at 190 percent of poverty, the new cost of \$594 is still significantly less than the \$1,280 they would have paid under the public program, and is only slightly more than the \$365 they would have paid if the employer had maintained its contribution at 80 percent and no public subsidy had been available. The cost-effectiveness model, then, provides very little incentive for employees to bargain for higher employer contributions.

**Table 13. Hold-Harmless Model (Model B)
for Computing Subsidies of Employee Contributions**

Employee contribution equal to--						
	20%		50%		75%	
Family income as % of FPL	Subsidy amount	Family cost	Subsidy Amount	Family cost	Subsidy amount	Family cost
150%	\$ 349	\$ 16	\$ 898	\$ 16	\$ 1,354	\$ 16
160%	\$ 45	\$ 320	\$ 594	\$ 320	\$ 1,050	\$ 320
170%	\$ -	\$ 365	\$ 274	\$ 640	\$ 730	\$ 640
180%	\$ -	\$ 365	\$ -	\$ 914	\$ 410	\$ 960
190%	\$ -	\$ 365	\$ -	\$ 914	\$ 90	\$ 1,280
200%	\$ -	\$ 365	\$ -	\$ 914	\$ -	\$ 1,370

Under Model B, as shown in table 13, this effect is sharply reduced. The family's share of costs is held to no more than it would have been if there had been no employer plan and the children had joined the public program. The public cost, however, is considerably less than it would have been under either the public program or Model A. For example, under the public program a family at 170 percent of poverty would have received a \$960 subsidy, leaving \$640 in family cost. Under Model A, if the employer's contribution was at the 50 percent level, the family would receive a \$914 subsidy and would have a family cost of zero. Under Model B, the family would receive a \$274 subsidy and would have the same family cost, \$640, as under the public plan. In effect, the family is never worse off than it would have been if there had been no employer coverage, but feels more directly the effects of any reduction in employer contributions. The family thus retains an incentive to bargain for higher employer contributions and their employers have some incentive to increase contributions for all employees, and the family's success in this bargaining reduces costs to the public plan.

Table 14. Family Costs After Subsidies as Share of Family Income Under Model A, Model B, and Public Program

	Employee contribution equal to--						
	20%		50%		75%		
Family income as % of FPL	Family cost as % of family income, model A	Family cost as % of family income, model B	Family cost as % of family income, model A	Family cost as % of family income, model B	Family cost as % of family income, model A	Family cost as % of family income, model B	Family cost as % of income, public program
150%	0.0%	0.1%	0.0%	0.1%	0.0%	0.1%	0.1%
160%	0.0%	1.2%	0.0%	1.2%	0.4%	1.2%	1.2%
170%	0.0%	1.3%	0.0%	2.3%	1.5%	2.3%	2.3%
180%	0.0%	1.3%	0.9%	3.2%	2.5%	3.3%	3.3%
190%	0.1%	1.2%	1.9%	3.0%	3.4%	4.2%	4.2%
200%	1.1%	1.1%	2.8%	2.8%	4.3%	4.3%	5.0%

The price of this improvement is, however, some loss in progressivity. Table 14 compares family cost as a share of family income under Model A and Model B with costs for families participating in the public program with no employer coverage. Under the public program, the family's cost as a share of income goes from 0.1 percent at 150 percent of FPL to 2.3 percent at 170 percent of FPL and so on up. Model A retains the same pattern, though it reduces most families' share of costs. Under Model B, however, some families at higher income levels pay a smaller share of income than lower-income families. This was, of course, the case under employer plans in the absence of public subsidies, as shown in table 11. Model B has simply flattened the curve somewhat. Note also that the effect diminishes as employer contributions decline. With employer contributions at 50 percent, a family at 190 percent of FPL pays 3 percent of income under Model B; a family at 180 percent of FPL pays 3.2 percent of income. However, if the employer contribution drops to 25 percent, a family at 190 percent of FPL pays 4.2 percent of income, while the family at 180 percent of FPL is paying 3.3 percent. Again, Model B seems more successful in maintaining incentives to bargain for or provide higher employer contributions.

It should be emphasized that the effects shown in this illustration are highly dependent on its assumptions--in particular the key assumption that the basic cost of coverage for children under the employer plan is only slightly higher than the cost under the public program. (Again, it is slightly higher because it reflects an average of slightly more than two children per family.) Given this assumption, nearly every dollar contributed by the employer reduces costs to the public, the family, or both. However, if the employer plan is significantly more costly than the public program, some of what the employer contributes is in effect going to make up that cost difference; potential savings to the public and to the family are reduced accordingly.

At the same time, the difference between Model A and Model B diminishes. Tables 15 and 16 compare the two models when the employer cost for two children rises about

30%, to \$2,100, while the public program cost remains at \$1,600. While subsidy costs under Model B are still lower than those under Model A, the difference has narrowed: Model B subsidies must rise more in order to assure that the family's costs are no more than they would have been under the public program.

**Table 15. Cost-Effectiveness Model (Model A)
with Employer Premium Increased to \$2,100**

Employer contribution equal to--						
	20%		50%		75%	
Family income as % of FPL	Subsidy Amount	Family Cost	Subsidy Amount	Family Cost	Subsidy Amount	Family Cost
150%	\$420	\$ - -	\$1,050	\$ - -	\$1,575	\$ - -
160%	\$420	\$ - -	\$1,050	\$ - -	\$1,280	\$295
170%	\$420	\$ - -	\$960	\$90	\$960	\$615
180%	\$420	\$ - -	\$640	\$410	\$640	\$935
190%	\$320	\$100	\$320	\$730	\$320	\$1,255
200%	\$ - -	\$420	\$ - -	\$1,050	\$ - -	\$1,575

**Table 16. Hold-Harmless Model (Model B)
with Employer Premium Increased to \$2,100**

Employee contribution equal to--						
	20%		50%		75%	
Family income as % of FPL	Subsidy Amount	Family Cost	Subsidy Amount	Family Cost	Subsidy Amount	Family Cost
150%	\$404	\$160	\$1,034	\$16	\$1,559	\$16
160%	\$100	\$320	\$730	\$320	\$1,255	\$320
170%	\$ - -	\$420	\$410	\$640	\$935	\$620
180%	\$ - -	\$420	\$90	\$960	\$615	\$960
190%	\$ - -	\$420	\$ - -	\$1,050	\$295	\$1,280
200%	\$ - -	\$420	\$ - -	\$1,050	\$ - -	\$1,575
	\$504	\$2,016	\$2,264	\$4,036	\$4,659	\$4,791

The relative costs of employer coverage and the public program are obviously closely related to the respective benefits offered under each. Assuming identical benefits, what is the likelihood that employer coverage will be more costly? This may depend on the nature of the public plan. If it is a Medicaid expansion, buying services at steeply discounted rates and incurring the relatively low Medicaid administrative costs, it is likely to be considerably cheaper than employer plans. At the other extreme, if the public plan consists of vouchers for the purchase of private nongroup coverage, it may be more costly than most employer plans, because of the very high administrative loadings associated with nongroup policies. A public program that contracts with a

limited number of private health plans, directly or through another health purchasing organization, might have costs very much like those of typical large employers.

Even if employer coverage were significantly more costly than the public program, it would still be advantageous to subsidize the employee's share of children's premiums, unless the cost difference was greater than the total amount contributed by the employer. However, there is one factor that dramatically complicates this comparison: rate tiers. The consequences, and possible solutions, are discussed in the next section.

Employer Rate Tiers

The examples up to this point have assumed that an employee can simply add children to his or her employee coverage by paying a share of the cost for those children. However, the various contribution structures established by employers can make the incremental cost for the children complicated to compute. Table 17 repeats the alternative rate structures shown in table 8 and shows the actual per child premium cost for one-parent and two-parent families (assuming both parents obtain coverage through the plan). The premium cost for one child is the excess cost of adding the child relative to the cost of covering the parent or parents alone. The per child cost for multiple children may be a fraction of this amount (one-half for two children, one-third for three, and so on); or it may be a different figure because the premiums vary by number of children or total number of dependents. Thus the total incremental cost of adding a child can range from as little as \$427 (for the third child in a two-parent family under Plan B) to as much as \$3,280 (for the first child of a single parent, again under Plan B). For a two-parent family under Plan A, children cost nothing, because the full family rate is already charged for coverage of the spouse.

Table 17. Per-Child Increase in Total Premium for Adding Children to Coverage Under Various Rate Structures

	Premium	Single Parent			Two Parents		
		Premium cost per child for adding - -			Premium cost per child for adding - -		
		1 child	2 children	3 children	1 child	2 children	3 children
Plan A							
Single	\$2,000						
Family	\$4,391	\$2,931	\$1,466	\$977	\$ - -	\$ - -	\$ - -
Plan B							
Single	\$2,000						
Couple	\$4,000						
Family	\$5,280	\$3,280	\$1,640	\$1,093	\$1,280	\$640	\$427
Plan C							
Single	\$2,000						
Single +1 dependent	\$3,747	\$1,747					
Single +2 or more dependents	\$5,556		\$1,778	\$1,185	\$1,809	\$905	\$603
Plan D							
Single	\$2,000						
Single + Children	\$3,640	\$1,640	\$820	\$547			
Couple	\$4,000						
Couple + children	\$5,827				\$1,827	\$914	\$609

However, these increments are not those actually faced by an employee. The real cost to the employee is the difference between what the employee had to contribute for self-only or self-plus-spouse coverage and what the employee must contribute with the children added. Table 18 shows the actual change in employee contributions when the employer pays 80 percent of the \$2,000 cost for employee-only coverage and 50% of the added cost for any dependent option. Under Plan A, for example, the employer pays \$1,600 for employee-only coverage, and \$3,000 for family coverage (\$1,600 plus half the difference between \$2,000 and the \$4,800 family rate). The employee pays \$400 for

single coverage and \$1,800 for family coverage. For a single parent, then, the extra cost for adding one child is \$1,400; the cost for three children is \$467 per child.

Table 18. Per-Child Change in Family Cost for Adding Children to Coverage Under Various Rate Structures

		Single Parent			Two Parents		
		Effective cost per child for adding --			Effective cost per child for adding --		
	Employee share	1 child	2 children	3 children	1 child	2 children	3 children
Plan A							
Single	\$400						
Family	\$1,866	\$1,466	\$733	\$489	\$ --	\$ --	\$ --
Plan B							
Single	\$400						
Couple	\$1,400						
Family	\$2,040	\$1,640	\$820	\$547	\$640	\$320	\$213
Plan C							
Single	\$400						
Single +1 dependent	\$1,274	\$874					
Single +2 or more dependents	\$2,178		\$889	\$593	\$904	\$452	\$301
Plan D							
Single	\$400						
Single + children	\$1,220	\$820	\$410	\$273			
Couple	\$1,400						
Couple + children	\$2,314				\$914	\$457	\$305

Note: Employer pays 80 percent of employee-only premium and 50 percent of difference between employee-only premium premiums for dependent coverage options.

Considered in these terms, nearly all the plans are requiring real per-child contributions that are less than, or only slightly above, the cost of covering the child through the public program. Either of the two basic methods for establishing subsidies—cost-effectiveness or hold-harmless—could be applied to the per child contribution figure. (The key exception is for a single child in a one-parent family unless the employer has a single + 1 child tier; it might generally be preferable to allow such a child to shift to the public program rather than to pay for employer coverage.)

A major policy question for a system that subsidizes employee contributions is whether contributions should be made for adults when this is necessary to obtain coverage for the children. CHIP appears to allow the Secretary to authorize such contributions:

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

- (A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and
- (B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.³¹

(Possible interpretations of this somewhat ambiguous language are discussed in Appendix A.)

As was noted earlier, there are a significant number of uninsured children whose parents declined available employer coverage both for themselves and for their dependents. There are clearly instances in which it would be cost-effective to assist with the entire employee contribution, rather than just the incremental cost for the children. Under plan A, for example, a single mother with three children could cover herself and the children for \$1,800; the per child cost of \$600 is still less than the cost of covering the children alone under the public program. In several of the plans, it would even be cost-effective to cover both the employee and the employee's spouse. This is often the approach used in State Medicaid programs that "buy in" to employer coverage for eligible recipients' families when it is cost effective to do so.

Nevertheless, a state plan could specify that assistance can be provided only for costs specifically attributable to coverage of children. One argument for this view is that, given a limited amount of public funding that is unlikely to be sufficient to reach all uninsured children, no part of the funds should be spent to cover individuals outside the target population. The question, about which it is only possible to speculate, is whether workers who are now declining coverage entirely will accept coverage if they are assisted with only part of the cost. Will the parent who has not spent \$400 to cover herself make this payment on her own if she receives the \$1,400 necessary to cover her three children as well? Or will the entire family remain uncovered? Even if they would,

³¹ Sec. 2105(c)(3).

is it appropriate to address this concern by potentially replacing large shares of the contributions that parents are now making for their own coverage?

A potential counter-argument is that a system that subsidized children but excluded payment for adults might simply encourage employers to load costs on dependents and reduce the contribution required for employee-only coverage. This could be done in a way that was cost-neutral for the employer and for employees as a group--that is, the ratios of employee and dependent contributions could be changed without modifying total compensation. Lower income employees would receive a larger public subsidy for their increased dependent coverage costs. Higher-income employees seeking to cover dependents would pay the added costs themselves; this would presumably discourage employers from modifying their plans. However, existing Federal non-discrimination rules apply only to self-insured firms; firms that purchase coverage from insurers are free to establish a scheme under which higher-paid workers would receive greater subsidies for dependent coverage than workers eligible for assistance.

TARGET POPULATION

The discussion to this point has not distinguished between children who are already covered by employer plans and children who are eligible for employer coverage but have not been enrolled. The CHIP legislation does, however, distinguish between these groups. Under the legislation, states have several basic options with respect to children with access to employer coverage. All of these options raise equity concerns and raise the risk of promoting further erosion in employer coverage.

1. Exclude currently covered children and allow uninsured children with employer access to receive child health assistance through the public program or through subsidized nongroup coverage (but not through assistance with employer contributions).

This may be regarded as the default option under CHIP. It obviously encourages parents who are now contributing to their children's coverage to drop that coverage in order to make the children eligible for assistance. These shifts could be limited only through a retrospective firewall, such as exclusion of children who have had employer coverage during some period before the date of application. This solution, however, permanently penalizes parents who have contributed to their children's coverage and rewards those who have not. At the same time, it prevents the state from leveraging available employer dollars for the substantial portion of uninsured children with employer access.

2. Exclude both currently covered children and uninsured children with employer access.

This option reduces the incentive for parents to drop existing coverage, but at the price of leaving uninsured children with employer access uncovered. It also creates a general disincentive for employers to provide and low-income parents to bargain for dependent coverage, and an incentive for parents to shift to jobs that do not offer such coverage.

3. Exclude currently covered children and assist with required employee contributions for uninsured children with employer access.

This option reaches more uninsured children and leverages the employer dollars available for them. As with option 1, this approach requires a retrospective firewall and creates serious equity problems.

Low Income Children with Employer Coverage

As was noted earlier, one additional option may or may not be permissible with Federal funding under CHIP, depending on the interpretation of the new legislation. This is to assist with required employee contributions for both currently covered and uninsured children, but limit spending for currently covered children to something less than 10 percent of total spending. States could, of course, pursue this option with other funds (such as the tobacco settlement funds) it could target to assist low-income families already contributing to employer coverage.

This option offers some promise of addressing the incentive and equity concerns raised by the other three approaches, but may be very difficult to implement. Of children between 100 percent and 200 percent of poverty, 7.7 million had employer coverage in 1995, while 3.6 million were uninsured. To remain within the CHIP limit, a state would have to sharply limit eligibility for premium assistance and/or limit the dollar amount of such assistance. This would leave families with access to employer coverage potentially exposed to significantly higher costs than families without such access. In addition, many children would remain uninsured because the premium assistance available was insufficient to encourage their parents to obtain available dependent coverage.

The CHIP legislation does allow for demonstration waivers (under the same section 1115 waiver authority used for Medicaid). A state might conceivably be able to show that a more generous premium subsidy scheme would, over the long term, lead to less replacement of employer coverage than would occur under the other three options. In the absence of a waiver, however, any state considering assisting currently covered children will need to find some way of targeting assistance to children in the greatest need. The following are two possible approaches. Note that the decision rules cited might also be adopted under option 3 (premium assistance only for uninsured children with employer access).

Share of income differential. A family could be made eligible for assistance only if the share of family income needed to obtain employer coverage exceeded the share required to participate in the public program by a given amount. For example, a family might receive subsidies if the employee contribution were 5 percent of income and the sliding-scale public premium only 2 percent of income; the family would not be subsidized if the difference amounted to less than three percentage points, or less than two. The rationale would be that families would not shift their children unless there was a significant price advantage under the public program; assistance would be targeted at those most likely to shift.

Table 19 gives an example of this approach, based on the comparison in tables 10 and 11 of family costs in the public program and in employer plans with various contribution levels. Subsidies would be available only when the required employee contribution, as a percent of family income, was two percentage points higher than the percent of family income required to join the public plan. Thus, a family that had to pay 3 percent of income plan would be assisted only if the employee contribution was 5 percent of income or more, and assistance would be available only to the extent necessary to bring the family contribution down to 5 percent. Under this criterion, no family whose employer is paying 80 percent of dependent premiums qualifies for assistance, and only the very lowest income families qualify when the employer is paying a more typical 50 percent.

Table 19. Subsidy Available Only When Percent of Family Income for Employee Contribution Exceeds Percent of Family Income Paid Under Public Program by 2 Percentage Points

Family income as % of FPL	Employee contribution equal to--					
	20%		50%		100%	
	Subsidy amount	Family cost	Subsidy amount	Family cost	Subsidy amount	Family cost
150%	\$ -	\$ 365	\$ 416	\$ 498	\$ 1,330	\$ 498
160%	\$ -	\$ 365	\$ 80	\$ 834	\$ 993	\$ 834
170%	\$ -	\$ 365	\$ -	\$ 914	\$ 641	\$ 1,186
180%	\$ -	\$ 365	\$ -	\$ 914	\$ 289	\$ 1,538
190%	\$ -	\$ 365	\$ -	\$ 914	\$ -	\$ 1,827
200%	\$ -	\$ 365	\$ -	\$ 914	\$ -	\$ 1,827

Employer contribution threshold. A somewhat similar approach would be to assist with the employee share of premiums only when the employer's contribution for dependents was a fixed threshold. In the Daschle proposal, for example, assistance would have been available only if the employer contributed less than 80 percent of premiums for families below 200 percent of FPL or 50 percent for families between 200 percent and 300 percent of FPL. That is, a family below 200 percent of FPL would have received subsidies if it was required to contribute more than 20 percent of the cost of child coverage.³² The specific threshold in the Daschle proposal might not in fact have excluded very many children from subsidies; most employers don't in fact contribute 80 percent or more to family coverage.

Table 20 provides an example of a more stringent rule, under which assistance is available only for the amount by which the required employee contribution exceeds 50 percent of the total premium for dependent coverage. The total cost for 2 children is

³² Note that this approach is not the same as the Minnesota provision. First, Minnesota applies its 50% test to the employer's contribution for employee-only, not dependent coverage. Second, families at a firm that contributes less than 50% do not receive assistance with employee contributions, but are instead allowed to enroll in MinnesotaCare.

again assumed to be \$1,827, and the subsidy amount cannot exceed the subsidy that would be available for the family under the public program. The scheme, at least in this example, appears to be less workable than the percent-of-income approach shown in table 19. For families with required employee contributions of 60 percent of the dependent premium, the subsidy is a flat 10 percent of the premium, regardless of income; Families contribute more as income rises only at the level where required employee contribution approaches 100 percent. In addition, the after-subsidy cost to the lowest-income families remains a flat 50 percent of premium no matter what the employer is contributing; there is no loss to the employee if the employer raises required employee contributions from 50 percent to 80 percent.

Table 20. Subsidy Available Only to the Extent That Required Employee Contribution Exceeds 50% of the cost of Dependent Coverage

Family income as % of FPL	Employee contribution equal to--					
	60%		80%		100%	
	Subsidy amount	Family cost	Subsidy amount	Family cost	Subsidy amount	Family cost
150%	\$ 183	\$ 914	\$ 548	\$ 914	\$ 914	\$ 914
160%	\$ 183	\$ 914	\$ 548	\$ 914	\$ 914	\$ 914
170%	\$ 183	\$ 914	\$ 548	\$ 914	\$ 914	\$ 914
180%	\$ 183	\$ 914	\$ 548	\$ 914	\$ 640	\$ 1,187
190%	\$ 183	\$ 914	\$ 320	\$ 1,142	\$ 320	\$ 1,507
200%	\$ -	\$ 1,096	\$ -	\$ 1,462	\$ -	\$ 1,827

The problem might be addressed if the 50 percent contribution figure were used simply as an eligibility cutoff and subsidies for families with contributions in excess of this level were computed in some other way. However, equity would dictate that the family cost after subsidies could never be less than 50 percent of the premium, because the family would then be paying less than other families eliminated by the eligibility rule. In addition, as table 18 suggests, cutoffs would have to be set differently for different types of rate structures. Two employers who contributed the same percentage of dependent coverage could expose workers with children to very different costs, depending on the rate tiers adopted. Measures would also be needed to discourage employers from reducing their contributions, possibly by excluding children for whom employer contributions were above the threshold in the last twelve (12) or eighteen (18) months.

Finally, if assistance is available only for families with very low employer contributions, the corollary is that relatively few employer dollars are leveraged by the subsidies. It is not certain that this approach would be much more cost-effective than simply allowing uninsured children with access to employer coverage to enter the public program.

BENEFITS

The CHIP legislation specifies minimum benefits that must be included in child health assistance. In general, a state must select a benchmark plan--the benefits under the Federal employees' Blue Cross standard PPO; a plan "offered or generally available to state employees"; or a plan offered by the HMO in the state with the largest commercial enrollment. The benefits provided to children must either be identical to those of the benchmark plan or be determined to be "benchmark-equivalent," using specified actuarial criteria. While the benefit package should be carefully assessed as a critical detriment of children's access to needed care, we limit the discussion here to statutory requirements and related administrative issues.

Although there is no specific reference to benefits under employer plans, it must be assumed that any contribution to such a plan would constitute "child health assistance." This means that a state will presumably have to ascertain that an employer's plan is benchmark-equivalent.³³ How burdensome this process might be will depend on the benchmark selected and on the nature of the employer group market in the state. For example, if the benchmark is a commercial HMO product, and if many employers are buying similar products from that HMO or other managed care plans, it should be relatively easy to evaluate the standard packages offered by carriers in the state and determine which meet the minimum equivalence standards. On the other hand, each self-insured plan would have to be evaluated individually (although even self-insured employers are often buying standard managed care packages on a non-risk basis.)

The CHIP limits on cost-sharing are likely to present a more serious administrative challenge. For children below 150 percent of poverty, for example, copayments must be limited to the amounts permissible under Medicaid -- generally no more than \$3.00. These limits, too, apparently apply in the case of children receiving assistance with employee premiums. Most employer plans are likely to impose cost-sharing above the permissible levels. There are several possible solutions:

- Increase premium assistance to each family by an amount equal to the actuarial value of the excess cost-sharing requirements. The approach may well be unacceptable, since any particular family might still be exposed to excess costs, and it might create an access barrier to needed medical care for children.
- Establish a system under which families could seek reimbursement from the state for excess cost-sharing. This would technically comply with the law, although it would place on families the burden of documenting excess payments that are likely to be a few dollars at a time. Therefore, this approach might be more acceptable if families could choose between the public program and their employer plan.
- Negotiate a supplemental package with carriers or employers, under which subsidy-eligible children would be exempt from excess cost-sharing in return for a monthly payment by the state. This approach might be most workable if the state workers with an employer health purchasing organization that uses standardized benefits to adopt this package for low income eligible children as dependents through participating employers.

³³ Note that a state's core public program could be benchmark-equivalent. It is unclear whether an individual employer plan should be compared to the benchmark or to the state-defined equivalent.

For families with incomes over 150 percent of poverty, CHIP imposes an aggregate cost-sharing limit of 5 percent of family income, applicable to the sum of premiums, deductibles, coinsurance, and copayments for all participating children in the family. Public programs and designated employer purchasing groups could design benefit packages consistent with this limit, which would equal \$1,000 per year for a single parent with two children just above 150 percent of poverty.

Depending on the state's subsidy scale and the cost sharing provisions of employer health plans, a family with one or more sick children might well exceed this limit. Again, for most employer plans the simplest solution might be to establish a system under which such a family could seek reimbursement of excess costs from the state.

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

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

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

In general, no language suggests that health benefits coverage could not include buy-in to employer plans. (Whether special approval by the Secretary is required will be discussed below.) However, "targeted" children do not include children who are already covered by a group health plan. The language is at 2110(b)(1):

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

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

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

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

This does not appear to restrict coverage of children who are eligible for, but not actually covered under, an employer plan at the time they apply for child health assistance; the only exception is for children eligible for a state employee plan. There is no provision for retrospective review of coverage, apparently meaning that a parent could drop a child from employer coverage and immediately apply for assistance. In addition, there are provisions that might be interpreted as allowing states to assist children currently enrolled in employer plans. These are discussed below.

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

2102. State Child Health Plan

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

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

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

This does not seem to mean that the state can't buy into employer plans, but only that it must take some steps to prevent migration of children from such plans to a public program or subsidized nongroup coverage.

2103. Coverage Requirements

Minimum benefits

The benefits provided under child health assistance must be --

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

The House provision, which allowed benefits for children in employer plans to be restricted to whatever the employer offered, has been dropped. Although there is now no specific reference to benefits under employer plans, it must be assumed that any contribution to such a plan would constitute "child health assistance." This means that a state will presumably have to ascertain that an employer's plan is benchmark-equivalent (or perhaps, though this is not specifically mentioned as an option, provide wrap-around coverage).

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

- a. The plan covers inpatient and outpatient hospital, physician, lab, x-ray, and well-baby and well-child care, including immunizations.

- b. The "aggregate actuarial value" of the plan is at least equal to that of one of the four benchmark plans. (The bill includes rules for making this determination, which will not be detailed here.)
- c. For each of 4 additional services (prescription drugs, mental health, vision, and hearing), the plan includes coverage with an actuarial value equal to 75 percent of the actuarial value of the benefit for the service under the benchmark plan used for the aggregate comparison.

Cost-sharing

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

For children below 150 percent of poverty ((e)(3)(A)), premiums may not exceed those allowable under section 1916(b)(1) of the Medicaid statute. Presumably, the current implementing regulation (42 CFR 447.52) would apply; this rule sets out maximum monthly enrollment fees by gross family income and family size (see Appendix B). Deductibles and cost-sharing would have to be "nominal" as defined in the implementing regulation for Medicaid section 1916(a)(3), subject to updating for inflation or other adjustments. The rule (42 CFR 447.54) limits deductibles for non-institutional services to \$2 per month, coinsurance to 5 percent, and copayments to \$3.³⁴ For institutional services, cost-sharing may not exceed 50 percent of the cost of the first day of care.

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

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

Preexisting condition exclusions

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

Compliance with other requirements

Section 2103(f)(2) reads:

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

³⁴ Copayments may be doubled for nonemergent use of an emergency room.

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

2105. Payments to States

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

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

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

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

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

- (A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and
- (B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

There are at least two possible interpretations of this language. One is that secretarial approval is required if the state assists family members other than the targeted children (for example, by contributing towards the premium for a parent who has previously declined coverage and must cover herself in order to cover her children). This provision

would then be similar to the provision of Medicaid law requiring that a state show that it is cost-effective to buy into employer coverage for non-Medicaid eligible family members in order to cover Medicaid-eligible family members. A second, and broader, possible reading is that secretarial approval is required in order for the state to furnish any assistance with the purchase of employer coverage.

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

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

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

Finally, section (c)(7) prohibits payment “for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion... [except] if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.” This provision appears to preclude any contribution to an employer plan coverage of these services. As such coverage is quite common since employer plans might often include such coverage in their scope of benefits, this could be a major barrier to any buy-in initiative. Possibly it could be argued that premiums for coverage of a child below child-bearing age do not include any amount for abortion even if abortion is nominally included in the benefit package. This argument could not be raised if the state chose to contribute towards family coverage.

2107. Strategic Objectives and Performance Goals; Plan Administration

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

2109. Miscellaneous Provisions

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

APPENDIX B - Medicaid Enrollment Fee Limits Referenced in the Children's Health Insurance Program Legislation

For children below 150 percent of poverty, premiums imposed under CHIP may not exceed those allowable under section 1916(b)(1) of the Medicaid statute. The following is the currently effective implementing regulation. The monthly maximums specified generally equal from 1 to 2 percent of family income.

42 CFR 447.52 Minimum and maximum income-related charges.

For the purpose of relating the amount of an enrollment fee, premium, or similar charge to total gross family income, as required under sec. 447.51(d), the following rules apply:

- (a) **Minimum charge.** A charge of at least \$1.00 per month is imposed on each--
 - (1) One- or two-person family with monthly gross income of \$150 or less;
 - (2) Three- or four-person family with monthly gross income of \$300 or less; and
 - (3) Five- or more-person family with monthly gross income of \$350 or less.
- (b) **Maximum charge.** Any charge related to gross family income that is above the minimum listed in paragraph (a) of this section may not exceed the standards shown in the following table:

Maximum Monthly Charge

Gross family income (per month)	Family Size		
	1 or 2	3 or 4	5 or more
\$150 or less	\$1	\$1	\$1
\$151 or \$200	2	1	1
\$201 to \$250	3	1	1
\$251 to \$300	4	1	1
\$301 to \$350	5	2	1
\$351 to \$400	6	3	2
\$401 to \$450	7	4	3
\$451 to \$500	8	5	4
\$501 to \$550	9	6	5
\$551 to \$600	10	7	6
\$601 to \$650	11	8	7
\$651 to \$700	12	9	8
\$701 to \$750	13	10	9
\$751 to \$800	14	11	10
\$801 to \$850	15	12	11
\$851 to \$900	16	13	12
\$901 to \$950	17	14	13
\$951 to \$1,000	18	15	14
More than \$1,000	19	16	15

(c) Income-related charges. The agency must impose an appropriately higher charge for each higher level of family income, within the maximum amounts specified in paragraph (b) of this section.

[43 FR 45253, Sept. 29, 1978, as amended at 45 FR 24889, Apr. 11, 1980]

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**DRAFT MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

Preamble

This draft model application template outlines the types of information that are likely to be included in the state child health plan required under Title XXI. It has been designed to reflect many of the requirements that will be necessary for state plans under Title XXI. It is not intended to be comprehensive or final. We provide it for preliminary guidance as well as to solicit additional information from states and other interested parties on the appropriate content.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like benefits definitions, maintenance of effort provisions, collection of baseline data, and methods for preventing substitution of new Federal funds for existing state and private funds. As such guidance becomes available, the model application template will be revised and finalized. We will work to distribute it in a timely fashion to provide assistance as states submit their state plans.

Proposed Effective Date _____

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**MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: _____
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions; search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

Proposed Effective Date _____

Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); **OR**
- 1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); **OR**
- 1.3. A combination of both of the above.

Section 2. General Background and Description of State Approach to Child Health Coverage
(Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

- 2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).
- 2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)
 - 2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

 - 2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

- 2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:
(Section 2102)(a)(3)

Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

Section 4. Eligibility Standards and Methodology (Section 2102(b))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

- 4.1.1. Geographic area served by the Plan: _____
- 4.1.2. Age: _____
- 4.1.3. Income: _____
- 4.1.4. Resources (including any standards relating to spend downs and disposition of resources): _____
- 4.1.5. Residency: _____
- 4.1.6. Disability Status (so long as any standard relating to disability status does not restrict eligibility): _____
- 4.1.7. Access to or coverage under other health coverage: _____
- 4.1.8. Duration of eligibility _____
- 4.1.9. Other standards (identify and describe): _____

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))

- 4.2.1. These standards do not discriminate on the basis of diagnosis.
- 4.2.2. Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3. These standards do not deny eligibility based on a child having a pre-existing medical condition.

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4.3. Describe the methods of establishing eligibility and continuing enrollment.
(Section 2102)(b)(2))

4.4. Describe the procedures that assure:

4.4.1. Through intake and followup screening, that only targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))

4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))

4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))

4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

5.2. Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children:
(Check all that apply.)

6.1.1. Benchmark coverage; (Section 2103(a)(1))

6.1.1.1. FEHBP-equivalent coverage; (Section 2103(b)(1))
(If checked, attach copy of the plan.)

6.1.1.2. State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. HMO with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.) _____

6.1.2. Benchmark-equivalent coverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.

6.1.3. Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage." _____

6.1.4. Secretary-Approved Coverage. (Section 2103(a)(4))

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6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

- 6.2.1. Inpatient services (Section 2110(a)(1))
- 6.2.2. Outpatient services (Section 2110(a)(2))
- 6.2.3. Physician services (Section 2110(a)(3))
- 6.2.4. Surgical services (Section 2110(a)(4))
- 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5))
- 6.2.6. Prescription drugs (Section 2110(a)(6))
- 6.2.7. Over-the-counter medications (Section 2110(a)(7))
- 6.2.8. Laboratory and radiological services (Section 2110(a)(8))
- 6.2.9. Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9))
- 6.2.10. Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10))
- 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11))
- 6.2.12. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12))
- 6.2.13. Disposable medical supplies (Section 2110(a)(13))
- 6.2.14. Home and community-based health care services (See instructions) (Section 2110(a)(14))
- 6.2.15. Nursing care services (See instructions) (Section 2110(a)(15))
- 6.2.16. Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest (Section 2110(a)(16))
- 6.2.17. Dental services (Section 2110(a)(17))
- 6.2.18. Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))

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- 6.2.19. Outpatient substance abuse treatment services (Section 2110(a)(19))
- 6.2.20. Case management services (Section 2110(a)(20))
- 6.2.21. Care coordination services (Section 2110(a)(21))
- 6.2.22. Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders (Section 2110(a)(22))
- 6.2.23. Hospice care (Section 2110(a)(23))
- 6.2.24. Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- 6.2.26. Medical transportation (Section 2110(a)(26))
- 6.2.27. Enabling services (such as transportation, translation, and outreach services) (See instructions) (Section 2110(a)(27))
- 6.2.28. Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))

6.3. **Waivers - Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))

6.3.1. **Cost Effective Alternatives.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following:

6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 - 6.2.28.** (Section 2105(c)(2)(B)(i))

6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and **Describe the cost of such coverage on an average per child basis.** (Section 2105(c)(2)(B)(ii))

6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** (Section 2105(c)(2)(B)(iii))

6.3.2. **Purchase of Family Coverage.** Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: (Section 2105(c)(3))

6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** (Section 2105(c)(3)(A))

6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

Section 7. Quality and Appropriateness of Care

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

- 7.1.1. Quality standards
- 7.1.2. Performance measurement
- 7.1.3. Information strategies
- 7.1.4. Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

Section 8. Cost Sharing and Payment (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan?

8.1.1. YES

8.1.2. NO, skip to question 8.5.

8.2. Describe the amount of cost-sharing and any sliding scale based on income: (Section 2103(e)(1)(A))

8.2.1. Premiums: _____

8.2.2. Deductibles: _____

8.2.3. Coinsurance: _____

8.2.4. Other: _____

8.3. Describe how the public will be notified of this cost-sharing and any differences based on income: _____

8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))

8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))

8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))

8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).

8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))

8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5))

8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.

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(Section 2105(c)(6)(A))

8.4.7. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))

8.4.8. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))

8.4.9. No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). (Section 2105)(c)(7)(A))

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))

8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:

8.6.1. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); **OR**

8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA (Section 2109(a)(1),(2)). Please describe:

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops: (Section 2107(a)(4)(A),(B))

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

9.3.1. The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. The reduction in the percentage of uninsured children.

9.3.3. The increase in the percentage of children with a usual source of care.

9.3.4. The extent to which outcome measures show progress on one or more of the health problems identified by the state.

9.3.5. HEDIS Measurement Set relevant to children and adolescents younger than 19.

9.3.6. Other child appropriate measurement set. List or describe the set used.

9.3.7. If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:

9.3.7.1. Immunizations

9.3.7.2. Well child care

9.3.7.3. Adolescent well visits

9.3.7.4. Satisfaction with care

9.3.7.5. Mental health

9.3.7.6. Dental care

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9.3.7.7. Other, please list: _____

9.3.8. Performance measures for special targeted populations.

9.4. The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. (Section 2107(b)(1))

9.5. The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports. (Section 2107(b)(2))

9.6. The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. (Section 2107(b)(3))

9.7. The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.

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9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX:

(Section 2107(e))

- 9.8.1. Section 1902(a)(4)(C) (relating to conflict of interest standards)
- 9.8.2. Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
- 9.8.3. Section 1903(w) (relating to limitations on provider donations and taxes)
- 9.8.4. Section 1115 (relating to waiver authority)
- 9.8.5. Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI
- 9.8.6. Section 1124 (relating to disclosure of ownership and related information)
- 9.8.7. Section 1126 (relating to disclosure of information about certain convicted individuals)
- 9.8.8. Section 1128A (relating to civil monetary penalties)
- 9.8.9. Section 1128B(d) (relating to criminal penalties for certain additional charges)
- 9.8.10. Section 1132 (relating to periods within which claims must be filed)

9.9. Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. (Section 2107(c))

9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

A financial form for the budget is being developed, with input from all interested parties, for states to utilize.

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))

10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.1.2. Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

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Below is a chart listing the types of information that the state's annual report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

<u>Attributes of Population</u>	<u>Number of Children with Creditable Coverage</u>		TOTAL
	<u>XIX</u>	<u>OTHER CHIP</u>	
Income Level:			
< 100%			
≤ 133%			
≤ 185%			
≤ 200%			
> 200%			
Age			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
Race and Ethnicity			
American Indian or Alaskan Native			
Asian or Pacific Islander			
Black, not of Hispanic origin			
Hispanic			
White, not of Hispanic origin			
Location			
MSA			
Non-MSA			

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- 10.2. **State Evaluations.** The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: **(Section 2108(b)(A)-(H))**
- 10.2.1. An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
- 10.2.2. A description and analysis of the effectiveness of elements of the state plan, including:
- 10.2.2.1. The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
- 10.2.2.2. The quality of health coverage provided including the types of benefits provided;
- 10.2.2.3. The amount and level (including payment of part or all of any premium) of assistance provided by the state;
- 10.2.2.4. The service area of the state plan;
- 10.2.2.5. The time limits for coverage of a child under the state plan;
- 10.2.2.6. The state's choice of health benefits coverage and other methods used for providing child health assistance, and
- 10.2.2.7. The sources of non-Federal funding used in the state plan.
- 10.2.3. An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.

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- 10.2.4. A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.
- 10.2.5. An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- 10.2.6. A description of any plans the state has for improving the availability of health insurance and health care for children.
- 10.2.7. Recommendations for improving the program under this Title.
- 10.2.8. Any other matters the state and the Secretary consider appropriate.
- 10.3. The state assures it will comply with future reporting requirements as they are developed.
- 10.4. The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.