SCHIP Funding for Employer-Sponsored Insurance: Federal Issues and Barriers Encountered

A Briefing Paper

Oregon, among many other states, has been active in implementing children's health coverage in order to reduce the number of uninsured children in the state. Experience with trying to enroll children without also covering parents/families for health insurance has shown that adults are hesitant to enroll in health care plans that do not include the entire family. This paper will explore the barriers and issues in seeking to use the State Children's Health Insurance Program (SCHIP) funds for health insurance coverage for children of families who are uninsured even though employer coverage is available.

Family Coverage via Employer Sponsored Insurance

Family Health Insurance Assistance Program (FHIAP)

Oregon's FHIAP is a unique, public-private partnership program that subsidizes health insurance coverage for families and individuals who are currently uninsured. FHIAP provides direct subsidies to purchase health insurance for low-income (up to 170% FPL) working people who cannot afford to buy health insurance through either their employer or the individual insurance market, and who are not receiving benefits from the Medicaid program. Families who meet income limits are eligible to receive premium subsidies of 70%, 90% or 95%, based on a sliding scale. As of January 2001, there were nearly 4800 approved and enrolled members with 1200 approved to be enrolled. FHIAP maintains a reservation list of approximately 15,000.[1] FHIAP emphasizes coverage for children, as parents cannot use the subsidy strictly for themselves if the eligible child is uninsured. It is funded totally by state funds because it does not qualify for federal matching funds, limiting the capacity to expand coverage.

In 1999, Oregon submitted a SCHIP amendment application to HCFA requesting approval to use SCHIP funds to subsidize employer sponsored insurance (ESI) coverage through its Family Health Insurance Assistance Program. This amendment application did not prove workable and Oregon withdrew it. However, there is continued interest in developing successful and effective approaches in a state ESI program using federal funding to increase support for FHIAP. Three concepts in the application will be included in the framework for any new initiatives, as follows:

1. Increase opportunity for covering non-Medicaid eligible children by subsidizing low income working uninsured parents.
2. Build on Oregon's success with the public-private partnership in financing health care coverage.
3. Increase federal match to support funding the FHIAP program, since it currently is funded by state funds entirely.

There are barriers in federal policies/regulations that must be addressed to pursue ESI for family coverage. The Office of Oregon Health Plan, Policy and Research (OHPPR) responded to the

[1] Kelly Harms, Family Health Assistance Program, Oregon Insurance Pool Governing Board, Personal Communication (January 18, 2001)

Proposed Rule for SCHIP program (Federal Register, November 8, 1999) in a letter to HCFA.[2] Several features are identified in the following paragraphs to demonstrate some of the more difficult issues for Oregon's implementation of its proposed ESI model. However, HCFA has recently (January 8, 2000) announced the new rules for SCHIP and where applicable, they are noted.

Administrative burden/Oregon's role

One of the main concerns for the state in trying to work with employers and insurance carriers is the apparent expectation on the part of HCFA (under the proposed rules) that states can dictate certain reporting and other requirements to these parties. For employer-sponsored insurance coverage there is no contractual mechanism for enforcing these requirements, as the state is not the contracting entity. In the ESI model, the state is only the provider of the premium subsidy and has no legal role in directing payments and other procedures for insurance carriers. Regulatory rules could act as disincentives for partnerships between the state and the commercial insurance market for SCHIP children.

Cost sharing requirements

There are two primary issues related to the proposed requirement: 1) Medicaid cost sharing limits are too low for OHP-SCHIP income eligibility (170% FPL) and 2) the requirement does not reflect the principles of cost containment inherent in the managed care environment. For instance, the Medicaid schedule does not consider the substantial inflation in health care premium rates that have occurred in the last 20 years, and maxes out at income levels of over $1,000 per month. Under the OHP Medicaid schedule a family of 1 or 2 persons with a monthly income over $1,000 would pay $19 for their monthly premium. With current SCHIP income eligibility, a family of four with an income of 150% FPL ($2,088 per month) would be required to pay $16 per month under the proposed rule (or less than 0.8% of income). There is also a cumulative cost-sharing maximum of 2.5% of income that applies under another section, making this proposed income-to-premium ratio seem very low.

Minimum benefits

For family coverage through the ESI model, the health plans must meet the minimum benefit standards required under Title XXI; states must provide wrap-around coverage where the benefits offered do not meet the standard; and cost sharing under the private plan must not exceed the caps identified in Title XXI (5% of family annual incomes greater than 150% FPL). The new rules recognize that there is not a direct relationship between the state and ESI carriers/plans through which premium assistance is provided. Children covered through the ESI program must be assured the minimum benefits and cost-sharing protections in the SCHIP statute, through either the employer plan or supplement to the employer plan.

[2] The Office for Oregon Health Plan, Policy and Research (OHPPR). Letter to Health Care Financing Administration, Department of Health and Human Services. (January 4, 2000). Robert DiPrete, Acting Administrator, OHPPR, Salem, Oregon. E-mail address: Bob.DiPrete@state.or.us.

Medicaid screen-enroll requirement

The proposed rule requires that states screen for Medicaid eligibility and compel Medicaid enrollment, rather than SCHIP ESI, if eligible. There appears to be ample evidence from states that many citizens prefer a non-Medicaid type of program because of the stigma of welfare health care, even though the benefits are better under Medicaid and they are required to contribute toward their premiums. Oregon supports *freedom of choice* for people to make informed decisions about where they get their health care coverage. Excluding people who are eligible for Medicaid from Title XXI may result in uninsured people remaining so because of their values about public assistance or Welfare. Oregon suggests that in lieu of the Medicaid screen-enroll requirement, states be given the option of accepting the lower Medicaid match rate. This strategy may reduce the numbers of uninsured who are eligible for Medicaid but who elect to remain uninsured rather than enroll in the Medicaid program.

The new rules retain the screen-enroll requirement. The revisions include HCFA's continuing requirement that states make sure that Medicaid and SCHIP programs coordinate and transmit information in a timely manner for efficient screen and enroll procedures between the two programs. All states are required to monitor and evaluate the effectiveness of the process they devise to improve the coordination, flexibility and determination processes.

Employer contribution

Another barrier has been the required 60% employer contribution toward the family coverage premium. The new rule allows states to establish a reasonable minimum employer contribution based on data that represent the state's commercial insurance market for employer-sponsored insurance. In the comments to HCFA on the proposed rules, Oregon recommended a rate of 35% for family coverage, based on its experience with the Health Insurance Purchasing Cooperative (HIPC) businesses.[3] Currently, 75% of employers in the HIPC are covering all of the employee-only premium cost, resulting in an employer contribution toward the family premium cost of 35%. Oregon believes that any higher employer contribution requirement would lead to such low participation that it would erode any ESI-SCHIP efforts. Oregon's recommendation should meet the requirements of the new rule.

Cost-effectiveness

To qualify for a family coverage waiver under section 2105 (c)(3), states must demonstrate that the cost of covering the entire family will be less than or equal to the cost of covering only the children. This requirement is burdensome in the general insurance market, as it must be done on a case-by-case basis. As noted earlier, Oregon's experience with the HIPC model demonstrates that it is more administratively feasible because the HIPC carriers and benefit plans are known and limited in number, and the benefits are uniform and comprehensive. Oregon, therefore, would have the advantage of assuring cost-effectiveness and compliance with Title XXI benchmark benefit plans and of cost sharing requirements *before* implementation.

[3] Associated Oregon Industries HealthChoice is a health insurance program with multiple options offered by leading health plans in Oregon. Businesses with two to 50 employees may belong to this purchasing cooperative to provide health coverage for their employees.

Crowd-out features

The state must show that public funds are not substituting for private family coverage. HCFA requires the state to show that applicants for the SCHIP premium subsidies have not been covered under an employer-sponsored insurance plan in the previous six months. However, the new rule provides for "reasonable exceptions" that the state may incorporate in its regulations. Moreover, the state should be cognizant of possible negative consequences on children's access to services with undue waiting periods. In addition, for families with incomes over 200% FPL, states are responsible for monitoring for substitution and must have a "trigger point" at which a substitution prevention mechanism would be instituted. At income levels above 250% FPL, the state is responsible to have substitution prevention strategies in place in addition to regular monitoring.

Outreach requirements

As SCHIP is not an entitlement program, the state should not be required to conduct outreach that would exceed the state's ability to provide services. Oregon recommended that states be allowed to limit and target their outreach efforts. The provision specifies that a State must describe in its state plan the procedures to implement outreach strategies intended to inform families of the availability of the programs and to assist them in enrolling if eligible. The provision also provides examples of outreach strategies such as public education and awareness campaigns, enrollment simplification activities, and application assistance strategies such as working with community-based organizations and in collaboration with other programs to reach children.[4]

Other important topics can be found in the attachment, such as: use of managed care network providers; procedures around planning, reporting and evaluation of the SCHIP plan and demonstration projects; program integrity and beneficiary protections; fraud and program abuse protections and legal processes; privacy protections; consumer rights and responsibilities; and waiver procedures.

States and Experience with Waivers and Expansion of Programs

According to the State Coverage Initiatives,[5] thirty-three states provide coverage to children in families with incomes up to 200% FPL. As noted earlier, Oregon's SCHIP program covers children in families with incomes under 170% FPL. New Jersey's KidCare program has extended coverage to 350% FPL, and Connecticut, Missouri, and Vermont have raised eligibility as high as 300% FPL. Since New Jersey and Connecticut did not have Medicaid expansions in place before SCHIP, they have used income disregards to increase SCHIP eligibility above the 200% FPL limit. Vermont expanded eligibility above 250% to 300% FPL under its Medicaid 1115 demonstration waiver to use enhanced federal funds provided by SCHIP. According to a

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[4] The State Children's Health Insurance Program (SSCHIP), Final Regulation Summary – HCFA 2006-F. Implementing the Balanced Budget Act of 1997. Informational Transmittal #2-0101.
[5] Academy for Health Services Research and Health Policy. State Coverage Initiatives: SCI State of the States (January 2001). Available: www.statecoverage.net (retrieved November, 2000).

Commonwealth Fund report[6] both Medicaid and SCHIP programs provide assistance with employee premium contributions, and they share two key provisions:

- Assistance must be cost-effective
- If the employer plan does not provide all of the benefits available under the public program, the state must provide some form of wraparound coverage. In addition, it must assure that cost-sharing amounts paid by the family do not exceed allowable cost sharing under the public programs.

Three states have received federal approval under the SCHIP Family Coverage and Employer Buy-In waivers: Massachusetts, Mississippi and Wisconsin. Under this program, parents are not counted as enrollees as their coverage is considered an ancillary benefit of providing coverage to children through employers. In order to qualify for a SCHIP waiver, states need to have already expanded coverage to all children with family incomes up to at least 200% FPL; must be enrolling children on a state-wide basis and cannot have a waiting list; and must have adopted at least three of the list of policies/procedures set out by HCFA (SCI, 2001). The following table demonstrates the variation among these states' coverage approaches.

Table 1 States' SCHIP Family Coverage Waivers for ESI

ESI under SCHIP Family Coverage Waivers	State Coverage Options
MassHealth (Massachusetts)	State argued persuasively to HCFA to include ESI subsidies using SCHIP funds under its 1115 Medicaid waiver to cover children in families w/incomes <200% FPL. Using Medicaid and SCHIP funds provides a seamless application-enrollment process between these programs. Only 9,000 people are covered under ESI subsidies, compared to 900,000 Medicaid enrollees.
Mississippi	SCHIP subsidizes cost of children's coverage in ESI, covers parents. Employer pays at least 50% cost of family coverage. Implementation has been delayed due to federally required minimum employer contribution.
Wisconsin BadgerCare	Uses HIPP program to provide ESI subsidy for children and parents. Employer covers between 60%–80% cost of family coverage. Only 7 families have been enrolled in the HIPP program (10/00).

[6] The Commonwealth Fund. (October 2000). Mark Merlis, Public Subsidies for Required Employee Contributions toward Employer-Sponsored Insurance: Strategies to Expand Health Insurance for Working Families. Institute for Health Policy Solutions. Available: www.cmwf.org

The table below shows the states that have combined various funding sources in order to support ESI for expanded coverage for families and children.

Table 2 **States' Use of Combined Funding for Employer-Sponsored Insurance**

State/Federal Programs	Programs Combined to Fund ESI Coverage
Maryland	Raises the income eligibility level to cover families between 200%–300% FPL. State introduced cost sharing and established premium assistance program for ESI. Families w/incomes 200%–250% pay $38/mo premium; families w/incomes above 250%–300% pay $47/mo premium. Used Section 1931 (SSA); Employer Buy-In.
Rhode Island RiteShare	Used Section 1931 (SSA) in developing original expansion for parents of children eligible for Medicaid program (RiteCare). Under new program, state task force has recommended strategies to contain crowd-out and to create ESI subsidy for low-wage workers, combining Title XXI funding for parents. In August 2000, submitted 1115 demonstration waiver but discouraged by HCFA response. In September 2000, submitted SCHIP waiver for moving all parents enrolled in RiteCare through 1931 into SCHIP family coverage.
Iowa	Uses 1931 (SSA); has operated a HIPP program since 1991, pays premiums, deductibles and coinsurance, when cost effective for any Medicaid recipients who have access to employer-based or private plans. This has allowed the state to lower the cost of operating the Medicaid program. As of 11/99, 8,441 people were participating in HIPP with 5,574 being Medicaid eligible (3% of total Medicaid population in Iowa). Received approval for 9/2000 amendment expanding coverage to families with income eligibility up to 200% FPL under Medicaid expansion program for infants up to 1 year and under Iowa's HAWK-I program for children up to age 19.
Minnesota MinnesotaCare	Receives funding from several sources: Medicaid waiver for pregnant women and children (6.5%); premium payments by enrollees (8.1%); *provider tax of 2% (82.7%)*; and other (2.7%). (Percentages represent total revenue share). 1115 demonstration waiver proposal to provide additional coverage for children. MN SCHIP currently covers children up to age 2 w/incomes between 275%–280% FPL.

Conclusion

Oregon is interested in trying to increase access and coverage to health care for uninsured children in the state through the use of Employer-Sponsored Insurance (ESI) strategies and with funding from Title XXI (SCHIP) and Title XIX (Medicaid). There are currently three states that have received approval for Family Coverage and Employer Buy-Ins. Massachusetts is the only state that has implemented its waiver and is covering only 9,000 people, compared to their Medicaid enrollees of 900,000. Wisconsin has implemented an ESI program by using the HIPP program approach, but has only enrolled seven people (November 2000).

Other states have successfully used a hybrid, or combination approach to fund ESI coverage in their states (Table 2). Oregon also has taken advantage of various federal programs, such as the Medicaid 1115 demonstration waiver that funds the Oregon Health Plan, and use of tobacco tax money to help fund the SCHIP program, developing the FHIAP program, and support from the State general fund. The FHIAP program is funded by state revenue only, so to be cost-effective, the state must find other sources to help it expand to a larger population.

With the new regulations just published, there may be some additional incentives for states and private insurance and employer groups to develop effective partnerships toward increasing access to health coverage for the working uninsured and their families. The increased flexibility indicates that Medicaid may be as viable an option for ESI as SCHIP. Oregon may consider these new opportunities offered by the Medicaid and SCHIP programs as possible avenues for expansion waivers for family coverage through ESI. According to the Health Policy Studies Division of the National Governors' Association (NGA,1998)[7], an innovation might be that when families reach the limits of their cost sharing obligations, they would no longer be responsible for any additional premium charges. However, HCFA may not allow states to use SCHIP for plans that have large payments even if the ceiling is capped at 5 percent.

Another federal barrier identified in this briefing paper was the issue of burdensome Medicaid-SCHIP screen and enroll procedures, and how these represent an administrative burden on employers and insurance carriers. Oregon must continue to refine its policies so that there is no disincentive for employers and insurance carriers to cover the eligible but uninsured population. A procedure for making SCHIP eligibility a "qualifying event" (NGA, 1998) could be helpful for both the state and employer. Essentially, this means that as soon as a child becomes SCHIP income eligible, the child is enrolled in the ESI plan and not required to wait for an open enrollment period. Having to wait is counter-productive to administrative efficiencies for state and employer/insurance groups and for continuity of care for these vulnerable children. If the child's eligibility/enrollment experience were not considered a qualifying event, the child's health care might occur under a different source and funding category until an open enrollment period, at which time it is conceivable that the child would need to change providers and plan procedures.

The use of tax credits for employers who provide health coverage for low-wage workers is a useful incentive, and could be explored in Oregon to increase participation from the private

[7] National Governors' Association On Line. (1998). Using SSCHIP Funds for Health Insurance Premium Contributions: Policy Issues and Operational Challenges. Health Policy Studies Division. www.nga.org/Pubs/IssuesBriefs/1998/981015SSCHIP.asp

market. The previous amendment application submitted by Oregon to use SCHIP funds for subsidizing ESI health coverage may now have more credence with HCFA. Consumer Choice Health Purchasing Groups seem to be increasing around the country, including in Oregon with its Associated Oregon Industries HealthChoice, and in other Western states, such as Utah, Colorado, Washington, Montana and California. Perhaps these states could cooperate in a regional plan for a purchasing coalition to provide appropriate benefits to meet SCHIP match rates while spreading the risk among employers, consumers and insurance carriers.

Undoubtedly, other options might be considered, especially those that can maximize the federal match rates with no increase on the state's fiscal burden. Reducing administrative burdens for all stakeholders in processing claims and eligibility is a high priority as the state attempts to reorganize its departments for a more customer-oriented environment. The ESI concepts identified in Oregon's proposal, however, are strategies worth considering in meeting the goal of increasing access to coverage for the uninsured working families of the state.

This is one of a series of papers discussing issues related to universal health coverage for low-income uninsured Oregonians. This work is supported by a grant from the Health Resources and Services Administration. As more information is gathered, the papers will change. Views and ideas expressed within these papers are not intended to reflect those of any particular group, unless so noted, but are intended to inform and stimulate discussion and debate on critical health care coverage strategies. For the most recent revision, please visit the grant team's Web site: http://www.ohppr.org/hrsa/index_hrsa.htm, or call 503/418-1067 to request the paper in an alternate format.