Real Rough - can't get off the phone.

CROWD OUT IN GROUP HEALTH PLANS

The Balanced Budget Act requires that states submitting applications to the Department under the Child Health Insurance Program include a description of procedures that the state will use to ensure that coverage provided under the state's plan does not substitute for coverage under group health plans (See section 2102 (b)(3)).

The potential for some substitution exists anytime a public subsidy is provided for goods or services that people currently purchase with their own funds. However, when a state chooses to use a portion of its CHIP funding to subsidize coverage through employer-sponsored health insurance arrangements, the potential for substitution would appear to be enhanced without appropriate safeguards.

employers would be more likely to lower their contributions for dependent coverage if they knew that their employees could get access to a subsidy without having to change their coverage or leave the employer plan. Similarly, families would be more likely to drop existing coverage to get access to a subsidy if they could resume coverage in their existing plans.

The following are provisions that HHS would view as minimum standards to reduce substitution when a state subsidized coverage through existing employer-sponsored group health plans. The first group of provisions would be viewed as mandatory by HHS, and states would be expected to incorporate provisions in their state plans that are substatially equivalent to each of the provisions in this group. The second group of provisions would be viewed as additional provisions that could assist in the reduction of crowd out. HHS would expect states to incorporate at least one of these options in its state plan, or to develop other provisions that would have a similar effect.

Mandatory Provisions.

1. To discourage employers and families from dropping current coverage, children would not be eligible for the program unless they had been without coverage for at least six months. Exceptions could be made if prior coverage was involuntarily terminated (by other than a current employer).

2. To ensure that the provision of child health assistance through employer-sponsored group health plans is cost effective, a state's payment for the children in a family enrolled in an employer-sponsored group health plan could be no greater than the payment that the state would make for that family if it enrolled in a separate CHIP plan offered by the state (or in Medicaid if appropriate). (What if there is a significant difference in benefits?)

3. To promote cost effectiveness, families electing to receive child health assistance through an employer-sponsored group health plan would be required to apply for and apply toward the plan any premium contribution available from the employer.

4. To demonstrate cost effectiveness, the state would be required to incorporate an evaluation that examines the amount of substitution (if any) that has occurred under the program.

Optional Additonal Provisions.

1. To discourage employers from lowering their existing contributions for dependent coverage, states only would be permitted to make subsidies available for the purchase of dependent coverage through employer-sponsored group health plans in cases where the employer pays at least 50 percent of the cost of family coverage (calculated including the cost of insuring the employee). For ease of administration, the state could establish a minimum dollar employer contribution (approximating 50 percent of the cost of an average family plan) instead of a minimum percentage. To further prevent families from dropping employer coverage and to preserve existing employer contributions, states could require families that have an option of selecting coverage through an employer-sponsored group health plan to do so, provided that it resulted in no greater cost to the family.

2. To discourage employers from reducing contributions or coverage, states would provide less generous subsidies toward the purchase of dependent coverage through employer-sponsored group health plans than they provide for enrollment in a separate CHIP plan offered by the state (or in Medicaid if appropriate). (Cannot think of the right test).

3. To ensure cost effectiveness and discourage employers from reducing contributions or coverage, states only would be permitted to make subsidies available for the purchase of dependent coverage through employer-sponsored group health plans in cases where the cost of subsidizing the group health coverage was substantially less than the cost of providing coverage through a separate CHIP plan offered by the state (or in Medicaid if appropriate).

~~More cost effective~~

Gary -

That was an interesting conversation yesterday. I would like to follow up with you to get your reactions. I am swamped this morning, but am free after lunch. Can we plan to talk at 1? I'll have my secretary try to set it up.

In anticipation of our conversation, I just wanted to write down my thoughts coming out of the phone call today. I will try to fairly summarize the consensus of the group. It would be great if you could fold this stuff into a revision of your memo:

1) There is no doubt that, without some type of hurdle, substitution is a much bigger problem with the group health option (GHO)

2) Combatting this with a waiting period is sensible, but it requires a waiting period that is longer than 3 months, due to pre-existing conditions rollovers in K-K. Longer waiting periods can be readily justified as well by the length of pre-existing conditions in standard health plans.

3) There is uncertainty about whether substitution would remain differentially problematic under the GHO with a serious waiting period. But I would still argue that, even with a 6 month waiting period, there is still a differential substitution problem, since I think that the stigma of public insurance is very large. A simple fact to keep in mind when thinking about this: even by the large Cutler-Gruber numbers, 85% of eligible kids with private insurance kept that insurance rather than dropping to join Medicaid. This implies enormous stigma around leaving group plans for public plans. Even a six month waiting period may not be enough to combat this (although I will admit I can't prove that statement).

4) There was little support for differential family income requirements or other "punitive" approaches to limiting substitution under the GHO option.

5) But there was support for the notion of setting minimum employer premium shares. Indeed, Linda was concerned that 50% was too low, since (she claimed) the vast majority of firms were far about that level today. The key advantage of this is that we are guaranteed that, even if substitution is larger with the GHO option, we don't lose too many dollars since each kid is cheaper. Indeed, if we can set this at 50%, then so long as substitution is less than twice as bad with the GHO option (unlikely with a serious waiting period), then we can ensure overall (not just kid-by-kid) cost effectiveness.

Conclusion: It seems to me that we have a strong case for a waiver here. There is consensus (that we could undoubtably build more widely) that substitution is a significantly more important problem with the GHO option. This requires much more careful evaluation of this option before we can approve states to use it.

I would further argue that we should move the minimum employer premium share requirement into the "mandatory" from the "optional" category. This is critical to ensuring overall cost-effectiveness.

Finally, I think that we need to find some way to deal with the family, versus kid only, premium issue. Even if we get the 50% employer share minimum requirement, on a per kid basis this is a lot less effective if we are paying half of the entire family's premium. At a minimum, we should only be paying based on the differential between family and individual coverage. Can we go further and make some estimate of kid-only costs?

IMPORTANT PROBLEM WITH CHILDREN'S HEALTH INTIATIVE:

Paying Employee Share of Contributions Has Little Effect on Coverage

Subtitle J - Children's Health Insurance Initiatives - of the Senate Finance mark provides for several State options for the purchase or provision of children's health insurance. One option allows States to "subsidize payment of employee contributions for health insurance coverage for a dependent low-income child that is available through group health insurance coverage offered by an employer in the State"

This provision would be *very expensive*, would have *little effect on children's health insurance coverage*, and would *likely lead to higher premium shares for employees*

- The motivation for this approach is to avoid employer substitution by paying individuals to maintain their employer coverage. But this is a "scattershot" approach which pays costs for all low income privately insured, when only a small share of this population will substitute out of private insurance.

  -- The key is that even if crowdout is large as a share of program enrollees, it is very small as a share of the privately insured population.

  -- As a result, it is wasteful to pay the private insurance premiums of the entire low income population, when only a small share of that population will consider dropping insurance.

- Moreover, this approach will lead to a different kind of substitution: because employees' premium shares will be subsidized, employers with many low income workers will likely cut back on the employer share of the premium, while increasing the employee share.

  -- Indeed, higher income employees may be adversely affected as some employers increase employees' premium shares across the board. Some employees ineligible for a subsidy may not be able to afford the higher employee premium share and may therefore drop dependent coverage for children.

  -- Thus, this proposal may have the unintended consequence of causing some higher income insured children to become uninsured.

- The proposal raises problems of administration related to the difficulty of providing subsidies in a timely manner and verifying the employee portion of the premium.

  -- If the subsidy is not available until the end of the year, families may be unable to afford the monthly payments on the employee share of premiums, and therefore may not maintain employer coverage in response to this subsidy.

ATTACHMENT B - PROBLEMS WITH PREMIUM SUBSIDIES

Paying Employee Share of Contributions Has Little Effect on Coverage

Subtitle J - Children's Health Insurance Initiatives - of the Senate Finance mark provides for several State options for the purchase or provision of children's health insurance. One option allows States to "subsidize payment of employee contributions for health insurance coverage for a dependent low-income child that is available through group health insurance coverage offered by an employer in the State"

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- The proposal raises problems of administration related to the difficulty of providing subsidies in a timely manner and verifying the employee portion of the premium.

  -- If the subsidy is not available until the end of the year, families may be unable to afford the monthly payments on the employee share of premiums, and therefore may not maintain employer coverage in response to this subsidy.

Questions about the Group Coverage Waiver

Major design questions

- **Choice or requirement**: Must a family with access to employer-sponsored insurance (ESI) purchase it, or is there a choice between ESI and the public plan?

- **Which employer plans**: Employer plans would have to meet the minimums in statute for benefits and cost sharing. Would the state assess plans employer-by-employer or would there be some process that would select acceptable employer plans (e.g, a certification process or an arrangement directly with a set of employers).

- **Subsidy amount**: How is the subsidy amount determined? Is it the same amount as for a child in a public plan or is it increased or decreased with respect to the family contribution to the employer plan?

Issues

- **Plan-by-plan benefits and cost sharing determinations**: Since Federal funds may only be used for qualifying plans, each families' employer's plan will have to be reviewed to see if it qualifies.

- **Different benefits for families receiving assistance**: The cost sharing protections and the prohibition on covering abortion make it likely that employers' plans will need to be modified to qualify. This could create problems for the employers' benefits managers as well as equity concerns from other employees not receiving the same benefits.

- **Lower employer contribution**: New employers in a state in which low-wage workers have access to premium assistance may set up plans with contributions that are lower than they would otherwise have been. In a state decides to work with employers to determine eligibility, there is a risk that the employer will only agree to modify its benefits if it can change its contribution (e.g., go from 80% / 20% to 60% / 40% with an understanding that the premium assistance of 30% will allow the employee pay less).

- **Higher costs for family than children-only coverage**: If families with access to ESI were required to accept it to receive assistance, they would have to pay more than a family with the same income but no access to ESI. This is because only the cost of the children's part of the premium is subsidized; the parents would have to pay the rest of the premium which could be substantial.

- **Dropping of coverage by co-workers and new employees**: Most states will probably adopt "fire walls" or requirements that children must be uninsured for a certain time period (e.g., 6 months) in order to be eligible. This means that if there are two families in a firm with the same income, one of which purchases ESI and the other doesn't, the family that purchased ESI cannot be eligible for assistance unless they drop that coverage and their children remain uninsured for the required period of time. Will families who currently pay their full share think it worth it to expose their children to being uninsured for the time period so that they can get the exact same coverage at a lower price? What happens if a family changes jobs?

- **If the families has a choice between the public plan and ESI, the state would have same administrative work.** The state will have to make the determination for employers even if the family chooses the public plan.

CRITERION

① TYPE OF EMPLOYER

② AMOUNT OF SUBSIDY = Total Premium − Employer SHARE − Allowable Premium

③ TIME LIMITED.

Using State Funds to Pay Employee Share of Contributions

One option that may be available to states for using their CHIP funds is to pay the employee share of employer premiums for dependent coverage. The motivation for this approach is to avoid the substitution of public health insurance for private, employer-provided, health insurance, by paying individuals to maintain their employer coverage. But, in fact, this approach will be *inneffective in reducing the number of uninsured children, and will as a result undercut the premise of the CHIP program.*

This conclusion derives from four considerations:

- **"Needle in a Haystack"**. Although one-half of all uninsured children have a parent who is offered health insurance at work, these children represent the vast minority in their employment settings. About 90 percent of children whose parents are offered health insurance participate in those plans. Even among those children with family income between 100 and 200% of poverty, this figure is about 80 percent. That is, *for every five children made eligible under this option, only one would benefit from public coverage.*

- **Risk is Greater than Possible Benefit**. Even by the CBO estimate that 40% of new enrollees in CHIP had dropped employer coverage, this represents only 17% of privately insured children between 100 and 200% of poverty. Thus, once again, *we are subsidizing four children who would not have dropped to prevent one child from dropping.* Simply put, it is wasteful to pay the private insurance premiums of the entire low income population, when only a small share of that population will consider dropping insurance.

- **Decreased Employer Shares**. When the government offers to pay the premiums for low-income children covered by private insurance, it induces employers to lower the share of premiums that they pay. This once again reduces the effectiveness of the government program, since these additional costs are not buying more insurance coverage; they are simply paying costs that would otherwise have been paid by employers. This employer response is not necessarily tempered by existing anti-discrimination laws, since there are many firms where the majority of workers are in the eligible income range. For example, one-quarter of workers are in industries where the majority of workers are below 200% of poverty line, and these firms will have huge incentive to increase employee premium sharing. Indeed, past research on the Medicaid expansions found that employees becoming eligible saw a reduction in the employer share of premium payments.

- **Daunting Administrative Difficulties.** Carrying out this type of policy runs into two severe administrative difficulties. First, the state must ensure that the benefits offered under each and every employer plan that applies for this subsidy meet the Title XXI standards. Second, the state must endeavor to separate out the portion of employee premiums that is due to coverage of qualifying children. Otherwise, the targetting of these payments are even worse than described above, since the state will be paying for the entire family simply to ensure the coverage of qualifying children.

Options For Designing Group Health Premium Payment Policy for CHIP

If there is a waiver granted for paying group health premiums under CHIP, we can design a set of safeguards to maximize the efficiency of this spending.

Waiting Period: Mandate that, to be eligible for government payment of group premiums, the child must have been uncovered for some period of time. In this way, we can target the costs of children who would otherwise have been uninsured, and minimize payments of the costs of children who would otherwise retain their private insurance. The waiting period must be at least six months to deter families from dropping coverage temporarily in order to qualify.

Restrict to Employees Whose Costs Exceed Public Premiums: Another option is to restrict eligibility for assistance only to those families whose share of income paid for employer coverage exceeded the share paid under the public program. For example, for a family that would pay 3% of income for coverage under CHIP, the government would pay a portion of their employee premiums if those premiums exceeded 5% of income. The portion paid would only be the amount by which the premiums exceeded 5% of income. The differential between the expected family contribution under this option and the expected family contribution under direct coverage by Title XXI (2% of income in this example) reduces the inefficiency of the program by limiting the government buyout of premiums for families who were not planning to drop private coverage; but it still provides real benefits to those families who would otherwise drop, since maintaining group coverage is more valuable to them than moving to a public program.

Restrict to Firms That Do Not Substantially Discriminate Against Family Coverage: One potential problem noted earlier is that firms may lower their premium share in response to the availability of this option. This problem could be combatted by requiring firms that avail themselves of this option to not substantially discriminate against family coverage, relative to individual coverage; that is, to impose another form of "non-discrimination" test. This test could be of the form, for example, that the employee premium share for family coverage be no more than 30% greater than the individual premium share. Alternatively, it could be cast in dollar terms; the employee premium share for family coverage should be no more than $500 more than for individual coverage.

Set a Target "Hit Rate": As noted above, the key disadvantage of this approach is the very low "hit rate"; the government pays the premiums of four children for every one child who does not drop insurance. This compares very unfavorably to the "hit rate" of pure eligibility expansions, estimated to be 60% by the CBO. This 60% figure (or some other) could be set as a target for a waiver application, with the state required to demonstrate at least 60% cost-effectiveness before such a premium-payment plan would be approved.

Include an Ex-Post Evaluation Component: Waiver approval for a group health premium payment option could be only temporary (e.g. 2 years), with a requirement that the waiver be evaluated before it could be renewed. States would have to demonstrate at the end of this period that the waiver was cost effective, perhaps drawing on the "hit rate" concept noted above.

Gary -

Just to clarify what I sent yesterday, I was much too weak on the family premium issue, as per our conversation. We should include language along the lines of what I handed you at the tobacco meeting. This language will allow us to limit what the government pays to only a share of the total cost of the child, without explicitly sounding mean spirited.

I look forward to seeing the next draft. Thanks for taking the pen on this. Please let me know if I can help in any other way.

Jon

Gary -

Thanks for sending over your very nice exposition of the group health premium issue. I think that your writeup lays out the problems and possible solutions quite eloquently. I have a few minor comments:

1) Most importantly, I think that if we apply the 50% rule to the total family premium, it really loses a lot of its bite. For a typical family with two small (2-10 year old) kids and 30-39 year old parents, the kids will account for only about 25-30% of the total family premium (calculated using data on expenditures by age). So even if we pay one-half of the total family premium, we are paying more than 100% of the cost of the insurance for the children! This doesn't seem to offer much protection.

It seems to me that there are two types of solutions here:

a) One alternative is to at least price out the individual portion of the insurance policy. That is, you could say that the state will pay no more than one-half of the cost of the difference between individual and family coverage. This has two disadvantages, however: it is hard to explain, and it still doesn't solve the entire problem, since you still subsidize the spouse.

b) A cruder alternative would be to adjust upward the minimum employer share from 50%, to say 75%. But this starts to appear extreme.

My vote would be that we combine these, somehow figuring a politically acceptable way to price the family only, and then raising the minimum employer share to something like 60%. This still isn't perfect, but its a lot better.

2) I think that we need to make the employer option takeup mandatory (your language in bullet 2 implies that it is a state option), else you will lose the families who are most inclined to join the public program (when your motivation, after all, is to keep these very families in employer coverage).

3) Your third requirement needs to be reworded, I think:

To ensure that the provision of child health assistance through employer-sponsored group health plans is cost effective, a state's payment for the children in a family enrolled in an employer-sponsored group health plan could be no greater than the payment that the state would make for *those children* [my italics] if they enrolled in a separate CHIP plan offered by the state.

This helps with point (1) - at least it guarantees that we pay no more per child from the fact that we are paying the entire family's premiums. This is a critical point, especially if we go with just paying family premiums in point (1).

4) Can we make your fifth point stronger, in the context of a waiver, by time limiting the waiver and conditioning renewal on demonstration of cost effectiveness? This was Jeanne's idea, and I

think that it is an important one. This way, if the thing turns out to be as much of a disaster as I fear, at least we have only wasted two years of money and not much more.

5) It seems to me that, if you agree with point (4), there is a compelling case for a waiver over a state plan, right? My reading is that you could only do your this, and your cost-effectiveness evaluation, if it is a waiver, and these are critical points.

6) Comments on the text:

Third paragraph: The first two sentences are a bit redundant, and there is a typo. I would suggest the following:

Although providing subsidies through employer-sponsored group health plans allows states to take advantage of the premium contributions offered by employers, it also substantially increases the potential for substituting public for private spending on insurance. Two particular additional substitution problems arise. One is that, without speical protections, subsidizing coverage in employer-sponsored group health plans will increase the likelihood that families currently covered by such plans seek subsidized coverage, since families will value maintaining their group coverage over joining the public plan. Another is that, under such schemes, employers with low wage workers have incentives to reduce their .... [continue with your language]

Fourth paragraph: I only have old (1992) data, but in that year the number would be almost two-thirds of children in the target income levels are covered by ESI.

Fifth paragraph: Add a new final sentence:

Moreover, withough sufficient safeguards, under this plan we would subsidize the employee share of the entire family premium, rather than paying for the children only. Paying just a share of the total costs of the family could still cost more than paying the entire costs of the children in that family.

DRAFT 4/21/98
CROWD OUT POLICY
TALKING POINTS WITH NGA/CONGRESS – NOT FOR DISTRIBUTION

I. BACKGROUND: SUMMARY OF PROPOSED HHS POLICY

Note: Crowd out policy only applies to targeted low-income children and optional targeted low-income children.

For New plans or Old Plans that do not have good data on Crowd out:

If the expansion is below 150 percent of poverty, there only is a requirement to study crowd out. After two years, the State must conduct a study to see if there was enough substitution to warrant stronger crowd out provisions as was mentioned in the crowd out letter. The cutoff of 150 percent was chosen as it is the same cutoff used in the cost-sharing provisions in Title XXI.

If the expansion is between 150 and 200 percent of poverty, the State will have to conduct a study on the prevalence of crowd out in the initial period of implementation. Based on the results of that study, the State would agree to implement some type of crowd out provisions if the data show a problem with crowd out. It is up to the Secretary and OMB to decide if there is a problem with crowd out.

For States with expansions above 200 percent of poverty, the State will be required to undertake some type of crowd out provision. We would not prescribe what States should do but rather each State would be judged separately. For example, we could require that a State use provisions that already have been approved in other States including a 3 month waiting period for either people who had insurance or who had access to insurance, a limited open enrollment period or any other idea that the Secretary approved. The State would be required to study the effectiveness of their approach.

For States with experience:

For States with prior State-only plans and good data related to crowd out, HHS would judge they had a problem with crowd out and determine if they needed additional crowd out procedures. For example, in Florida, the data showed some level of crowd out, and the State instituted a limited open enrollment period to address that issue. The Administration further required the State to conduct a survey within the first six months to see if crowd out has increased. If so, the State must institute additional crowd out prevention policies, such as three months of uninsurance prior to enrollment.

II. DISCUSSION ISSUES FOR NGA/CONGRESS

Issue A. We believe that crowd out concerns increase at higher income levels. Should we apply stricter standards on CHIP plans that expand coverage to higher levels of income?

Option 1: Apply a different set of standards for expansions: (1) below 150 percent of poverty; (2) between 150 and 200 percent of poverty; and (3) above 200 percent of poverty.

Option 2: Apply one set of standards for expansions up to 200 percent of poverty and another set for those expansions above 200 percent of poverty.

Option 3: Apply uniform standards regardless of the income level of the expansion.

Issue B. In the 2/13/98 letter, HHS has said that it will review States' procedures to limit substitution. Should HHS develop a standard set of questions on crowd out that would be incorporated by all States or should States have flexibility to design their own studies?

Option 1: Develop a standard set of questions on crowd out for all States.

Pro:

- It would provide consistent data for State-by-State comparisons. This would help ensure that all States are evaluated fairly and in the same manner.

Con:

- States will oppose as too prescriptive.

Option 2: Let States develop their own set of questions to analyze the extent of crowd out in their State. DHHS could recommend a standard set of questions, but States would not be required to use this set of questions.

Pro:

- Provides States flexibility.

Con:

- It would not provide consistent data for State-by-State analysis of provisions to prevent crowd out.
- States could create definitions and methodologies that bias the data.

Issue C. Should questions related to crowd out be asked on the application for enrollment or as part of a survey conducted by States?

Option 1: Application

Pro:

- It would provide reliable data on the entire population.

Con:

- Burdensome on States.
- States may argue that this policy is inconsistent with Administration policy encouraging States to shorten and simplify their eligibility applications.

Option 2: Survey

Pro:

- Some States may find a survey less burdensome than asking questions of all applicants.

Con

- May not be as reliable as asking all enrollees.
- Would make process more complex due to methodological concerns (e.g., sample size, confidence intervals)
- Burdensome on States

Issue D. What are the questions that should be included in the study? The following are some potential questions that could be asked by enrollees. (We would have survey experts review questions before guidance is issued.)

(1) When did you last have insurance? ___ Never ___ less than 3 months ago ____ 3-6 months ago ____ 6-12 months ago ____ more than 12 months ago

(2) What type of insurance did you have most recently? ___Medicaid ____Employer-sponsored insurance ___Individual ___Other (e.g., CHAMPUS, Medicare , VA) [Note: More than one may apply.]

(3) What reason best characterizes why you don't have insurance today? ___ No longer working for the employer who offered the insurance ___ Can't afford insurance ___Employer dropped coverage ____ Public benefits are better ____ No longer need insurance

Issue E. In the 2/13/98 letter, DHHS said that we may require States to alter their plans if the review shows that they have not adequately addressed substitution. What is the threshold for determining if crowd out is a problem?

What is the level of crowd out that triggers additional action?

- 5 percent crowd out
- 10 percent crowd out
- 15 percent crowd out

Should we have one threshold level for all States?

Issue F. What is the definition of crowd out? (Please note that the following are just suggestions for discussion.)

(1) How recently did the person have insurance?

- 3 months ago
- 6 months ago
- 12 months ago

(2) What type of previous coverage did the person have?

- If the person responds that they most recently had "employer-sponsored insurance" it is crowd out.
- If the person responds that they most recently had " individual, Medicaid, Medicare, CHAMPUS, or VA coverage," it is not considered crowd out.

(3) Why is the person uninsured today?

- If the person doesn't have insurance today because "insurance not affordable"or "employer dropped coverage," it is considered crowd out.
- If the person doesn't have insurance today because they are "no longer working for the employer who offered the insurance," it is not considered crowd out.

Issue G. What type of provision must be adopted if crowd out is determined to be a problem?

Several options include:

- 3- 6 month period of uninsurance required for CHIP eligibility;
- Open enrollment period(s); or
- Access to employer-sponsored insurance precludes eligibility for CHIP.