

DOH Response to HCFA's June 25, 1998 Questions

On April 2, 1998, the Governor and the Utah Department of Health submitted the plan for the Children's Health Insurance Program (CHIP) for the State of Utah to the U.S. Health Care Financing Administration (HCFA). The information contained herein provides the response of the Utah Department of Health (DOH) to the three (3) questions submitted by HCFA in their June 25, 1998 letter.

Question 1

Please confirm that the income **group** for cost sharing are 100% through 150% and 151% through 200%.

Response

Section 6.2.1, page 38, line 18 is revised to read:

"For enrollees **at 151% through 200%** of the federal poverty level.

Section 8.2.3, page 64, line 19 is revised to read:

"Co-Payment Requirements for CHIP clients/enrollees **at 100% through 150%** of the federal poverty level."

Section 8.2.3, page 65, line 12 is revised to read:

"Co-Insurance and Co-Payment Requirements for CHIP clients/enrollees **at 151% through 200%** of the federal poverty level."

Attachment B: Benefit Plan, page 93, line 3 is revised to read:

"for CHIP enrollees **at 100% through 150%** of the federal poverty level."

Attachment B: Benefit Plan, page 93, line 19 is revised to read:

"For CHIP enrollees **at 151% through 200%** of the federal poverty level."

Question 2

The Department of Health and Human Services is planning to propose a regulation which will place a limit on the amount of cost sharing for families at or below 150% of FPL. For families at or below 150% of FPL, would Utah at this time be willing to decrease the percentage of family income which cost sharing may not exceed?

Response

Utah and many other states are attempting to develop programs that parallel private sector plans. As part of this approval process, we think it is essential that even lower income recipients understand the value of the medical services that receive. The best way to ensure this is through a reasonable copayment structure that we think we have constructed for those families with incomes below 151% of poverty.

Utah's current cost sharing structure is, on average, far below the 5% maximum allowed under

federal statute. In fact, the **\$500** limit for enrollees from 100% through **150%** FPL represents an average of only 2.04% (based on a family size from 2 through 8) and the **\$800** limit for enrollees from 150% through 200% FPL represents an average of only 2.38% (based on a family size from 2 through 8). As we **are** not **imposing** premiums, it is unlikely that families below **151%** FPL will reach the maximum **we** have proposed.

A reduction in the overall **cost** sharing percentage is unnecessary. Therefore, Utah views this proposed change as unnecessary, unwise, and detrimental to CHIP enrollees **and** the stability of the Program. While **we** would comply with a final federal regulation, we would strongly oppose a change in this provision of **the** law.

Question 3

Please provide additional clarification on the State's mechanism to ensure that a family ceases payment once a family has reached their maximum out-of-pocket expenses. Will the **family** be allowed to cease the payment of copays once the out-of-pocket limit has been reached or is Utah planning to continue reimbursing families for incurred expenses? In addition, please clarify our understanding that the family maximum out-of-pocket expenses will be either the allowable percentage of income or the dollar amount set by the State, whichever is less. Will any families reach the maximum allowable percentage prior to reaching the **\$500** or **\$800** limit? **If so, how** will Utah provide the appropriate cost sharing relief to these families?

Response

Enrollees will be notified of their out-of-pocket limit upon enrollment. The Department of Health will act as a clearinghouse for all out-of-pocket expenses. When **an** enrollee reaches their respective **\$500** or **\$800** maximum out-of-pocket limit, the Department will notify the health plan that the limit has been reached. **CHIP** health plans will notify providers and enrollees once the respective limit **is** reached. If **an** enrollee happens to pay any amount in excess of their limit, a reimbursement will be provided to the enrollee for that amount.