Coordinating State Children's Health Insurance Programs with Employer-Based Coverage:

Design and Implementation of Premium Assistance Programs

Sponsored by the Institute for Health Policy Solutions
and
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Conference Highlights and Related Information

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I. Introduction: Why Get it Together?

On October 5, 1999, the Institute for Health Policy Solutions (IHPS) and the National Governors' Association (NGA) held a conference entitled "Coordinating Children's Health Insurance Programs with Employer-Based Coverage: Design and Implementation of Premium Assistance Programs."[1] This conference, held in Washington, D.C., brought together state and federal officials, employer representatives, researchers, children's advocates, and others to discuss coordination of employer-based coverage with the State Children's Health Insurance Program (S-CHIP).

The meeting was made possible by a grant from the David and Lucile Packard Foundation, under which IHPS provides technical assistance, largely to states, towards development of programs to supplement parents' payments toward available employment-based coverage of uninsured children. More generally, these efforts are helping to develop promising approaches to coordinate public and private funds to cost-effectively reach and cover uninsured working families.

This report provides highlights of the conference and synthesizes key presentations. Additional data and information, not presented at the conference, are included where appropriate. A conference agenda is included as Attachment A.

A. Overview

IHPS President Rick Curtis opened the session by describing the purposes of the conference. The primary motivation for this meeting is that, by and large, policy makers at both the state and the federal level are facing a steep learning curve. Premium Assistance is new. Except for some limited experience under Medicaid, it has not been done before. Policy makers need facts about the target population, facts about available employer coverage, and the opportunity to talk together about significant issues and learn from one another's insights and experiences.

Rationale for Premium Assistance Programs

There are several reasons for the growing interest in alternative approaches to subsidizing the purchase of private coverage by uninsured working families:

- Because it builds on enrollment in mainstream, employment-based health coverage, Premium Assistance may be able to reach uninsured children whose parents are loathe to enroll them directly in a separate public program.
- By taking advantage of employer contributions, Premium Assistance allows States to serve more uninsured children with the public funds available.

[1] A conference agenda book, including a detailed agenda, speaker biographical information, a list of participants, and background materials, is available. Please contact the Institute for Health Policy Solutions at (202) 789-1491 or e-mail S-CHIP@ihps.org.

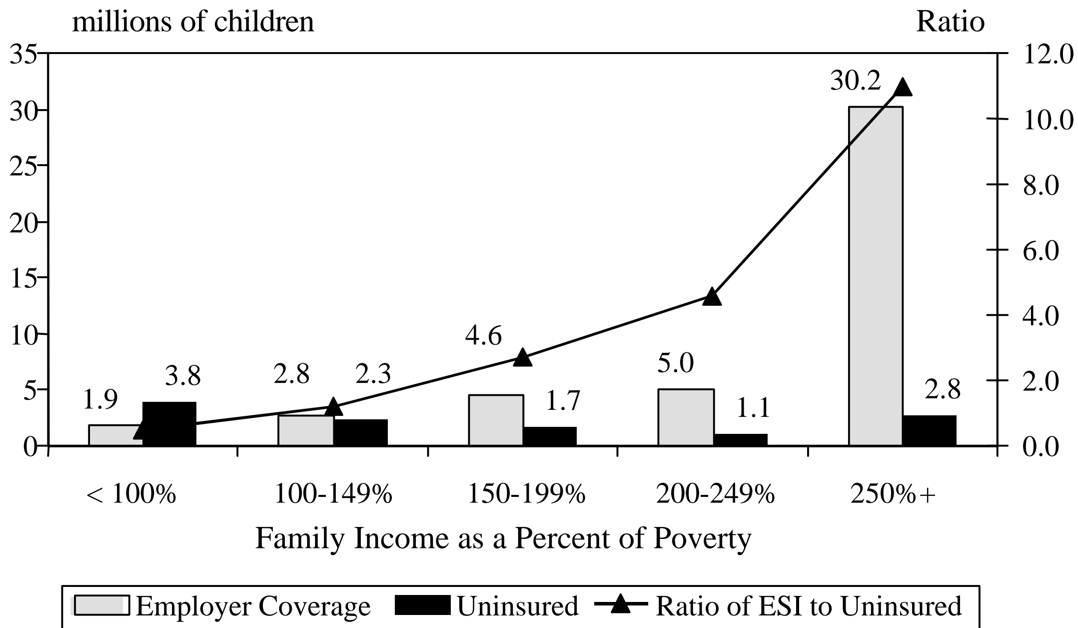
- As discussed later, keeping families together under a single health plan may make it more likely that children will actually use preventive services and other necessary medical care.
- Many states believe Premium Assistance is consistent with the welfare reform goal of encouraging self-sufficiency through employment. Employment-based health benefits can help to strengthen modest-income parents' attachment to the labor force.

Concerns About "Crowd-Out"

Some, however, are concerned that Premium Assistance could increase the likelihood that S-CHIP funds will "crowd-out" current employee contributions by making it possible for families to "refinance" coverage they already have and pay for. In this view, parents would be less likely to drop existing private coverage to qualify their children for S-CHIP if enrollment in the public S-CHIP program were the only option available. (As a result, federal guidelines now require children to have been without employer coverage for a minimum of 6 months before they can qualify for Premium Assistance, while there is no federal minimum period of uninsurance for enrollment in S-CHIP generally.)

The importance and complexity of the relationship between S-CHIP and employer coverage is highlighted by the fact that, even in families barely above the poverty line (with incomes between 100% and 149% of the federal poverty level), more children have employer-sponsored health insurance than are uninsured. Between 200% and 249% of poverty, 4.6 times more children have employer coverage than are uninsured. [See Figure I-1.]

Figure I-1: Primary Insurance Status of Children Under Age 19 by Family Income, 1997



Source: IHPS Analysis of March 1998 Current Population Survey.

The fact that many "near-poor" children in working families already have coverage through a parent's employer is the reason behind many of the most confounding features of the S-CHIP statute (Title XXI). Given limited public funds, policy makers obviously want to maximize the number of uninsured children they reach. Congress did not want to spend scarce public dollars subsidizing coverage for which private dollars are already paying.

But trying to cover only uninsured children creates a huge set of complex counter-incentives for both families and employers. For example, many low-income working parents have been and are making the financial sacrifices necessary to enroll their children in employer-sponsored coverage. Thus, there are difficult issues of equity across working families as well.

Premium Assistance and "Crowd-Out"

Moreover, in the long term, "crowd-out" may be much greater in the absence of Premium Assistance. Longitudinal survey data show that more than one-quarter of children typically become uninsured for at least one month over a 2-year period.[2] Each "spell" without insurance provides low-income parents with the opportunity to enroll their children in S-CHIP**.** Once they do so, they may decide to keep their children there, even after they again have a job that offers health insurance. (In survey data, more than half of new children's spells without insurance lasted for 6 months or less.) In the absence of Premium Assistance, their alternative (to free or heavily subsidized public coverage for their children) would be to pay the necessary employee contribution out of their own pocket to enroll their children in the new employer plan. Thus, over time, many children who would have been enrolled in employer-financed coverage could continue to be enrolled in S-CHIP, with the full cost (other than modest family premiums) paid by the state and federal governments. States would not access employer contributions available to these children, and children would forego the access improvements expected from having insured parents in the same health plan.

On the other hand, if Premium Assistance were available, parents would be able to enroll their S-CHIP-eligible children in their employer-sponsored plan and pay only an amount comparable to the state's S-CHIP premium. For families that prefer this approach, the state would be able to take advantage of the available employer contribution to either reduce the state's costs for the children alone or, alternatively, subsidize coverage for the entire family at a cost no greater than serving the children along through the public S-CHIP program.

Thus, in the long run, well-designed Premium Assistance programs should be able to reduce substitution of public subsidies for private contributions.

There is also the very real possibility that employers with a large share of low-wage workers[3] will decide that the availability of a public insurance program for children of low-income workers means that they no longer have to offer dependent coverage. If they don't come up with that idea

[2] See section IV.D of this report.

[3] Note that many of these employers are not "small." Office cleaning firms, for example, may be quite sizable, but the vast majority of their workers earn low wages.

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themselves, clever consultants may well bring it to their attention. (Mississippi has already uncovered an example of this kind of advice.) Employers who choose that course will gain a cost advantage over their competitors who continue to offer and contribute towards dependent coverage. Unfortunately, children of workers with slightly higher incomes (above the S-CHIP threshold) would be left without coverage. If low-wage workers tend to be concentrated in certain firms (as not-yet-published research shows), and if this dynamic were to take hold, states could easily spend their entire federal allotment, and more, without reducing the number of uninsured children.

Again, such incentives are created where states have only a public S-CHIP program. By making it equally affordable for low-wage workers to enroll their children in an employment-based plan, a well-designed Premium Assistance program might help encourage employers to continue to sponsor and contribute toward dependent coverage.

Perhaps most importantly, more uninsured children are likely to be covered where parents have the option of enrolling them in "one-stop-shopping" family coverage through their place of employment.

For these reasons, the Institute for Health Policy Solutions believes it is important to find ways to make S-CHIP and employer coverage work together. That is the goal of this conference.

Where Are the Uninsured Children with Access to Employer-Sponsored Insurance?

Discussions about uninsured children often focus on those whose parents work for small employers, because it is known that small employers are less likely to offer health coverage. A majority (57.7%) of uninsured children of private-sector wage and salary workers have parents who work for firms with fewer than 100 workers. [See Figure IV-19 in section IV-C below.]

But, because small employers are less likely to offer health coverage at all, many of these children do not now have access to employment-based coverage.

If we look instead at uninsured children who currently have access to (but are not enrolled in) employment-based insurance, we estimate that almost two out of three have parents who work for medium and large firms (100 or more employees). Only about one out of six have parents who work for firms with fewer than 25 employees. [See Figure IV-20 in section IV-C below.] These parents, half of whom have also declined coverage for themselves, have chosen not to enroll their children in the coverage that is available to them, presumably due to the cost of the required employee contribution.

Therefore, if a state wants to use Premium Assistance to reach uninsured children who already have access to employment-based coverage, its focus should include large employer plans. If, on the other hand, a state wants to use Premium Assistance as part of a strategy to reach uninsured working families by extending coverage through previously uninsured employers, an initiative targeting small-firm workers would be appropriate. A broad state strategy to reach uninsured children in working families might include both approaches.

B. Federal Policy Perspectives

This section is based on a presentation by:

- Jeanne Lambrew, Senior Health Policy Analyst, Office of Policy and Development, Executive Office of the President.

The federal government is concerned with following through on the potential of the Children's Health Insurance Program to provide health insurance coverage for children. Despite the facts that each of the fifty states has an approved State Plan and that there are currently 1.3 million children covered under S-CHIP, there is much work still to be done. In addition to partnering with private corporations to publicize S-CHIP, the federal government has organized an interagency task force to pool the resources of various federal agencies. By using existing federal programs that have contact with potential S-CHIP recipients, such as school lunch programs and crime prevention programs, more children can be reached and covered.

However, there are ways to continue to do more to get children enrolled in the Children's Health Insurance Program. The federal government recognizes the value of obtaining coverage for families. When covered by the same health plan, families are able to more effectively managed the care of all family members. Utilizing the family coverage waiver option is one way states cover more children under S-CHIP.

C. State Policy Perspectives

This section is based on presentations by:

- Robert S. Diprete, Director, Oregon Health Council
- Mark Reynolds, Acting Commissioner, Massachusetts Division of Medical Assistance
- Anna Marie Barnes, Mississippi Medicaid Director
- Joyce Raichelson, Administrator, Florida MediKids Program

Currently, three states - Massachusetts, Mississippi, and Wisconsin - have been approved by the Health Care Financing Administration (HCFA) to implement Premium Assistance programs under S-CHIP. The State of Oregon has a Premium Assistance proposal pending with the federal agency. Florida's Premium Assistance proposal was denied by HCFA on November 5, 1999, due to concerns about employer contribution policies. However, Florida officials will revisit the employer-sponsored piece and may re-submit a Premium Assistance State Plan amendment to HCFA in the future.

While the rationale for implementing Premium Assistance programs varies among these states, the overall goal is clear: states want to cover more children under programs that are accessible to low-income working families.

Massachusetts

Massachusetts has developed a Premium Assistance program for uninsured families under S-CHIP that parallels an 1115 Research and Demonstration Waiver project that provides family coverage to both the uninsured and underinsured. Under the Massachusetts program, CHIPfunds are only used for uninsured families, while Medicaid funds can be used to cover the currently insured.

Massachusetts implemented S-CHIP as a mixed model, creating both a Medicaid expansion and a stand-alone program. Both programs are run by the same agency, use one application, and are known by the umbrella name of "MassHealth." Program applicants generally are not aware that there are multiple programs.

For children with incomes between 150% and 200% of the federal poverty level (FPL), there are two ways of receiving S-CHIP coverage: directly, or through the Premium Assistance program, called the MassHealth Family Assistance Program. If families do have access to appropriate employer-based coverage, they are required to take it (i.e., they do not have the option of enrolling in the direct coverage program).

Massachusetts policy-makers decided to develop a Premium Assistance portion of MassHealth for a number of reasons:

- Officials believed that many families in the targeted income range (150%-200% FPL) had access to employer-based coverage, and they wanted to take advantage of private dollars that were "on the table" or available for coverage.

- Officials also wanted to give families that couldn't currently afford their private insurance the option of taking that coverage, rather than requiring them to enroll in a completely separate, public program to receive assistance. Officials believed that families might be more likely to enroll in MassHealth if it resembled a private insurance program rather than a welfare program.

- The State also hoped to slow the long-term decline in the private insurance market. Officials feared that as private insurance became more expensive, and more and more employees declined it when offered, employers would stop offering coverage. This dynamic could cause a long-term shift (population-wide) from private to public sources of coverage. By making it possible for employees to accept private coverage when it is offered, the State hoped to encourage employers to continue to make such coverage available.

- Finally, the State believes that although S-CHIP is for covering children, children cannot be best served in an environment that is fully separate from their families. It is important for many families to have the same source of care and the same insurance package for all family members. In addition, by buying into employer-based family coverage, the State can often give insurance to parents at no cost to the program (beyond what would have been spent to cover only the child under direct coverage). This is possible because of the employer contributions that are available. In many cases, it can be less expensive for the State to assist the family in buying family coverage through an employer than to buy separate insurance for children through a public program.

Massachusetts officials believe the MassHealth Family Assistance Program will continue to attract enrollees. However, this program is just one of an overall set of approaches designed to insure children. It is not expected that the majority of MassHealth children will be enrolled in the Family Assistance Program, but it is an important option for many families.

Oregon

In 1989, Oregon law-makers passed legislation requiring the State to apply for a Medicaid Section 1115 Research and Demonstration waiver. The waiver program was to be used to expand access to Medicaid and to modify the benefit package based on a prioritized list of services. The same legislation included a "pay or play" mandate that employers provide insurance to their workers. In 1995, the employer mandate portion of the legislation was repealed. In response to this repeal, in 1996, the legislature created the Family Health Insurance Assistance Program (FHIAP), a voluntary effort to expand employer-based insurance.

Under the FHIAP, families with incomes under 170% FPL can obtain a subsidy to help them buy employer-based or individual insurance policies. FHIAP was implemented in 1998 with state-only funding. This Fall, the State submitted a Title XXI State Plan amendment to the Health Care Financing Administration (HCFA), seeking permission to access S-CHIP funds for qualified children enrolled in FHIAP. This State Plan amendment request is still under review. (The current S-CHIP program in Oregon is a Medicaid look-alike).

The State is interested in using the S-CHIP and FHIAP programs to buy into employer-based coverage for a number of reasons:

- Officials believe that to make the expansion of coverage as sustainable as possible, they have to focus on both public and private coverage sources. Oregon policy-makers have expanded eligibility for public programs up the income scale, while at the same time making subsidies for private coverage available down the income scale. The hope is that at some point, these two strategies would meet, making health insurance affordable to nearly everyone in the state.

- Policy-makers also believe it is important to let families obtain health coverage as a unit; rather than requiring children to enroll in a program that is separate from their parents' insurance coverage.

- As in Massachusetts, officials in Oregon are also interested in maintaining the long-term viability of the private insurance market by making it more affordable. If employees continually decline available coverage because it is too expensive, employers may stop offering it. As a result, when children enrolled in public programs lost eligibility, employer-based insurance would no longer even be offered. The State views a Premium Assistance program as a means of both supporting the private insurance market and covering additional children.

Mississippi

The State of Mississippi received federal approval for implementation of a S-CHIP Premium Assistance program on February 10, 1999. The S-CHIP program, which became operational on January 1, 2000, serves children in families with incomes between 100% and 200% FPL. The program is a separate, non-Medicaid health insurance plan administered by the same agency that manages the health insurance program for state employees. The Premium Assistance portion of the program is projected to be operational by January 2, 2001. At that point, program participants will either enroll in the "regular" S-CHIP (through a fully-insured plan purchased by the State) or will participate in the Premium Assistance component.

While state policy-makers recognize the challenges of implementing a Premium Assistance program in a state with many small employers and many non-standardized plans, they believe such a program is necessary to prevent further erosion of private sector coverage. Other reasons for designing a Premium Assistance program include the following:

- A Premium Assistance program is consistent with the State's overall welfare policy of encouraging self-sufficiency through employment. Covering children through employer-based plans is a logical part of transitioning parents into the workforce.

- Officials also hope a Premium Assistance program will strengthen employees' ties to their employers and to their private coverage so that they may be informed consumers of private health insurance even when they are no longer eligible for S-CHIP.

- Policy-makers believe the Premium Assistance program may help prevent crowd-out of private insurance. By making it possible for families to receive assistance in obtaining health insurance while at the same time remaining in employer-based coverage, officials hope they will make it less attractive for families to drop such private coverage in favor of low-cost public programs.

- Mississippi officials also want to make it possible for entire families to be enrolled under one insurance plan, rather than having the parents enrolled through the employer-based plan and the children enrolled through a separate S-CHIP.

- Finally, officials hope the Premium Assistance program will allow them to reach children whose parents would not otherwise participate, due to the stigma that may be associated with Medicaid and other public programs.

Florida

Florida's S-CHIP program, KidCare, was implemented on October 1, 1998. The State is currently planning what it calls "Phase 3" of the program, the Premium Assistance portion. Florida's State Plan amendment describing the Premium Assistance program was recently denied by HCFA, due to concerns regarding employer contribution policies. Florida officials will revisit the State Plan amendment at some point in the future and may re-submit it to the federal agency.

Florida officials believe it is important to develop a Premium Assistance program as part of the state's overall S-CHIP strategy because they believe employers should remain involved in providing insurance to workers and their families. One of the State's biggest concerns in program design is structuring the program such that employers will be encouraged to participate. Officials recognize that businesses, especially small businesses, are concerned about their "bottom line" and will not wish to contribute toward children's coverage under a Premium Assistance program if they believe this expense will harm their competitiveness in the marketplace. Current HCFA guidance suggests that a state can buy into employer-based coverage under a S-CHIP Premium Assistance program only if the employer contributed at least 60% of the cost of family coverage.[4] Florida officials are particularly concerned about this contribution requirement and had proposed an alternate arrangement, in which an employer's minimum contribution requirement would depend on the size of the business and whether or not the employer had ever contributed toward coverage before. This specific proposal was not acceptable to HCFA.

[4] For more information about this and other HCFA guidelines, see the section "The Strings that are Attached."

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II. The Strings that are Attached: Key Program Requirements for Premium Assistance Under S-CHIP

This section is based on a presentation by:

- Cheryl Austein Casnoff, Acting Director, Division of Benefits, Coverage and Payment, Center for Medicaid and State Operations, Health Care Financing Administration

In February, 1998, the Health Care Financing Administration issued a letter to State Health officials, outlining requirements for S-CHIP Premium Assistance programs.[5] In November of this year, the agency released proposed rules regarding all aspects of S-CHIP, including Premium Assistance programs.[6] The proposed rules largely reflect and clarify the guidelines issued in the February 1998 letter.

To date, three states have been approved to implement Premium Assistance programs under S-CHIP– Massachusetts, Mississippi, and Wisconsin. Each state's program is unique in its design and funding. Federal officials believe it is important for states to design programs that fit their own employer-based insurance market.

In developing guidelines and rules around Premium Assistance programs, HCFA officials have placed a great deal of emphasis on the prevention of crowd-out of private coverage. Officials believe that crowd-out may occur under regular (non Premium Assistance) S-CHIP programs, but that the risk of crowd-out is greater under Premium Assistance. Federal policy-makers believe the risk of crowd-out is heightened under Premium Assistance because such programs may be more attractive to families, who would be able to retain their current private coverage while receiving a subsidy, rather than enrolling in a completely separate public program. The sense is that families who have the chance to keep children and adults together under a single, private insurance plan are more likely to accept public funds to substitute for private funds they were using for coverage.

From the federal perspective, there are a number of reasons why a state should consider a S-CHIP Premium Assistance program. First, by accessing employer contributions, a Premium Assistance program can help a state cover more children than it would have otherwise covered with existing state and federal dollars. Second, Premium Assistance programs allow families to remain together under a single insurance plan. Data suggest that children are more likely to use the insurance they have purchased if their parents also use services.[7] It is therefore important for both children and parents to be able to access health care in the same manner and through the same insurance plan. Finally, although some policy-makers believe Premium Assistance programs may lead to crowd-

[5] This letter is available on-line at: http://www.hcfa.gov/init/chsub213.htm.

[6] The proposed rule can be found on-line at : http://www.hcfa.gov/init/chnprm.htm.

[7] Hanson, K., 1998, "Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Revisited." *Inquiry* 35:294-302, (Fall 1998).

out of employer contributions, other believe just as strongly that such programs are a means of strengthening the employer-based insurance market.

One of states' biggest concerns in implementing Premium Assistance programs is the cost associated with program administration. Federal officials caution states that they should weigh the costs against the number of children likely to gain coverage as a result of the program.

If states decide to pursue Premium Assistance programs under S-CHIP, they must meet a number of federal requirements:

- Benefits and Benchmarks. Premium Assistance programs must provide benefits that meet the S-CHIP "benchmarks." The S-CHIP statute permits states to choose one or more benchmark plans from among three options: a) the commercial HMO plan in the state with the largest enrollment; b) the state employee plan; or, c) the Federal Employees Health Benefit Plan standard option PPO. Premium Assistance programs can provide the benchmark plan itself, or they can offer coverage that has been deemed "benchmark-equivalent."
- Cost-Sharing. Coverage provided under a Premium Assistance program must meet the same cost-sharing requirements as coverage provided under regular S-CHIP programs. First, there may be no cost-sharing for well-baby, well-child, and immunization visits. Second, families with incomes under 150% of the federal poverty level (FPL) may pay no more than the Medicaid-level of copays, which includes $3 office visits. Finally, families with incomes over 150% FPL may pay no more than 5% of their total income for cost-sharing in a given year (including both premium contributions and cost-sharing at the point of service). States are responsible for meeting these requirements and, in most cases, must do so through a cost-sharing "fill-in" plan that supplements the employer-based coverage. The Health Care Financing Administration has determined that reimbursement of families is not an acceptable means of ensuring that cost-sharing stays within allowable limits.
- Crowd-Out Prevention Policies. As outlined in the proposed rules and the February 13, 1998 letter to State Health Officials, states implementing Premium Assistance programs must comply with all of the following requirements designed to prevent substitution of public for private dollars:
  - ✓ Children receiving a subsidy toward employer-based insurance may not have been covered by an employer-based plan for at least six months.
  - ✓ For a child to receive a subsidy toward employer-based insurance, the employer must contribute at least 60% of the cost of family coverage. (However, HCFA will consider a lower level of employer contribution if state officials have data indicating that a lower level is prevalent in the state.).
  - ✓ A state's payment for a child enrolled in an employer-based plan may be no greater than the payment the State would make for the child if he/she were enrolled in a separate S-CHIP plan offered by the State.

- ✓ Families receiving a S-CHIP subsidy toward employer-based coverage must apply for and receive the full premium contribution available from the employer.
- ✓ States implementing a Premium Assistance program under S-CHIP must collect information to quantify the amount of substitution of private funds that takes place under the program.

Section 2105(c)3 of Title XXI allows states to apply for a "waiver" to provide coverage to whole families (including the adults as well as the S-CHIP-eligible children) if they can show that it is cost effective to do so. The cost of providing coverage to a family must be no more than the cost of providing coverage only to the S-CHIP-eligible child(ren). At this time, Premium Assistance seems to be the most logical means of providing family coverage because the presence of an employer contribution makes it possible to meet the cost-effectiveness test. However, HCFA does not preclude an application from a state wishing to provide family coverage in some other way.

Although the rules regarding when a family coverage variance is required are complicated, in general, states should assume they need a variance if they intend to cover any adults. Since most states designing Premium Assistance programs do intend to use such programs to cover whole families (not just children), they must apply for a family coverage variance.

III. Program Operations: How States are Making it Work

This section provides information regarding states' different approaches to implementing Premium Assistance programs under S-CHIP. As described throughout this paper, officials wishing to establish a S-CHIP Premium Assistance program must address requirements contained in the federal law and regulations. State officials have therefore developed a number of innovative program features designed to reduce administrative and technical difficulties associated with implementing program requirements. Specifically, states have developed or are developing mechanisms to: disburse subsidies to families; gather detailed information about employer contributions, benefits, and cost-sharing provisions of employer-based plans; perform cost-effectiveness calculations; and provide any wrap-around benefits or cost-sharing fill-ins. These functions can be administratively burdensome. This section explores innovative ways that states are addressing these new administrative requirements.

A. Who Pays Whom How? Subsidy Payment Approaches

This section is based on presentations by:

- Anita Smith, Manager, Health Insurance Purchasing Program, Iowa Department of Human Services
- Deborah Bradley, Chief of Staff, New Jersey Division of Medical Assistance and Health Services
- Patricia Canney, Director of Program Implementation, Massachusetts Division of Medical Assistance
- Robert DiPrete, Director, Oregon Health Council
- Therese Hanna, Mississippi State Insurance Administrator

For states to use S-CHIP funds to buy into employer-based insurance, they must develop mechanisms to actually pay these funds to enrollees, a task that is not required under regular S-CHIP programs. Most states do not, therefore, have mechanisms already in place to carry out this administrative function. There are essentially four ways a state can pay out the subsidy under a Premium Assistance program. States can make subsidy payments to: employees; employers; insurance carriers (or TPAs for self-insured employers); or, intermediaries, such as purchasing groups or brokers.

In thinking about subsidy administration, state officials should consider the extent to which the program must depend on the voluntary cooperation of employers, carriers, and others who do not directly benefit from the buy-in program. Officials should also consider issues such as participant confidentiality and the potential for misuse of subsidies, or fraud.

Iowa

Iowa does not have a Premium Assistance program under Title XXI but does operate one of the country's most well-developed Medicaid Health Insurance Premium Payment (HIPP) Programs. In operation since 1991, the program pays for employer-related and other private health insurance for Medicaid-eligible persons when it is cost effective to do so. The program has approximately 8,000 participants, and the State employs 14 people to administer it.

From its inception, the Iowa HIPP program has made subsidy payment directly to families. While employers are asked if they would be willing to accept premium payments from the State, approximately 98% of employers choose not to do so. As a result, most HIPP program participants receive subsidy checks directly from the State. The State pays subsidies on the same schedule as deductions are made from enrollees' paychecks (e.g., monthly, bi-weekly, etc.). It is of great concern to the State that participants need not wait for reimbursement, so subsidy checks are cut five to seven days before payroll deductions are made. In addition, the State advises employers of program participants not to take employee's premium deductions from their paychecks on a pre-tax basis.[8]

Although families are paid directly in the vast majority of instances, there are certain circumstances under which the State prefers to make other arrangements. If a HIPP program participant is a part-time employee and does not earn enough per pay period to cover the cost of the premium payment, the state is more likely to pay the employer directly. Similarly, if a program participant is receiving coverage through COBRA or an individual plan, the State makes payments directly to the carrier.

New Jersey

New Jersey is developing two programs that coordinate public and employer-sponsored insurance. The first is a Premium Assistance program for uninsured children with access to employer-based coverage. This program will be funded under S-CHIP. The State is also developing a state-funded program, the Equity Program, which will provide subsidies to low-income families who are already purchasing coverage.[9] A statutory change is required to authorize the Equity Program. Legislation has been introduced and is currently pending further action.

State officials originally thought that subsidy payments under both programs would be made directly to employers. However, after holding a series of outreach meetings with representatives of employer organizations, certain common concerns with this approach became apparent.

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[8] Although Iowa does not do this yet, Ms. Smith advised other state officials that if subsidy program participants do have premium deductions made on a pre-tax basis, the State should issue a Form 1099 to the participant for tax purposes.

[9] Policy-makers developed the Equity Program because they believed it was "inequitable" that S-CHIP assistance was available only to currently uninsured families, while low-income families who had been purchasing insurance are ineligible for assistance. Because the Equity Program will provide assistance to currently insured children, it will not receive a federal match.

Employers were concerned about the administrative tasks they might be required to perform if they were to receive the subsidies. Specifically, they were apprehensive about implementing separate enrollment and accounting processes for program participants and the need to address federal requirements related to cost sharing and benefit packages. In addition, employers were concerned that by accepting payment directly from the State, they would be held liable for any funds that might be misused by program participants.

As a result of these meetings with employers, New Jersey officials decided that subsidies would be paid directly to families under both S-CHIP and the Equity Program. A proposed amendment to the authorizing legislation includes "hold harmless" language to address employers' liability concerns.

Massachusetts

The MassHealth Family Assistance Program employs two methods of paying subsidies: payments can be made directly to families, or they can be made through Billing and Enrollment Intermediaries.

When subsidy payments are made directly to families, the State requires that the participant sign up for health insurance with his or her employer, using the same procedures as other employees in the firm. The employer then fills out an Enrollment Verification Form for the State. Next, a check is generated in a timely manner to ensure that payment is received prior to the premium deduction being taken from participant's paycheck. To date, the program has not experienced any problems with payment and has been able to generate checks easily. An advantage to this payment approach is that the employer's involvement in the process is minimal. In addition, because participants are paid directly, they appear to receive services much as any other employee in the firm, and stigma surrounding the use of a public subsidy is reduced.

It has been Massachusetts' experience that it is administratively simple to pay families directly. However, there is some concern that families might receive funds intended for the purchase of health coverage and then fail to enroll in such coverage, using the money for other purposes. To date, Massachusetts officials have seen no evidence to suggest that this type of behavior is taking place.[10] In addition, the State requires that a participant report any changes in income, employment status, or insurance status.

MassHealth also has mechanisms in place to remit subsidies to the appropriate carrier without involving the family. Two factors, which may not be present in other states, make this arrangement possible. First, many small employers in Massachusetts buy health insurance through entities called Billing and Enrollment Intermediaries (BEIs). These entities, similar to insurance agents, not only sell coverage to small employers but also provide ongoing administrative

[10] To monitor this kind of behavior, program officials perform a monthly audit in which they match program eligibility files against the enrollment files of several of the state's largest commercial carriers. This audit allows program officials to determine whether subsidy recipients continue to enroll in employer-based coverage. However, not all carriers participate in this process. As a result, MassHealth officials are continuing to develop additional auditing procedures.

functions, such as premium billing, enrollment, and disenrollment. Second, Massachusetts has obtained a Medicaid Section 1115 waiver, which allowed the State to establish the Insurance Partnership program. Under this program, the State makes incentive payments to small employers to offset the employer's cost of offering insurance to low-income employees.

MassHealth partners with BEIs to administer both subsidies for Family Assistance Program participants employed by small employer and subsidies for the small employers themselves, through the Insurance Partnership program. The system works as follows:

- The BEIs have access to a bank account established by the State, from which they withdraw funds to cover both family premium subsidies and Partnership payments.
- The BEIs also collect the remaining employer contributions from small employers, along with any employee contributions that are still required.
- Because premium subsidies and Partnership payments are collected by the BEIs and remitted directly to insurance carriers, employers and employees owe less for their insurance than they would if they were being paid directly by the State. In other words, the state subsidy amounts collected by the BEIs off-set what the employer and employee would otherwise owe the insurance carrier. As a result, BEIs need to calculate the reduced premium owed by the employer and employee and bill them accordingly.
- In situations where employers take employee premium contributions directly out of employees' paychecks, they must modify this deduction (by the amount of the family's state subsidy) to account for the reduced amount owed by program participants.

By partnering with BEIs, MassHealth officials can use a single mechanism to administer both participants' subsidies and small employer Insurance Partnership payments. In addition, this system does not require participants to provide ongoing proof of health plan enrollment. The BEIs are responsible for verifying enrollment with the carrier.

Program participants who are employed by non-small employers or by small employer who do not contract with BEIs will continue to receive subsidies directly from the State.

The largest drawback to the BEI approach is that participant confidentiality cannot be maintained. The employer must be aware that the employee is receiving a subsidy so that the payroll deduction can be modified accordingly. The State has yet to receive any complaints from employers about this additional work, but a relatively small number of employers are participating in the program. In addition, small employers receive an incentive payment for offering coverage. This may be seen as compensation by employers for the additional work involved in participating in this program.

Oregon

From the outset, Oregon officials decided that subsidies would be paid directly to families under the Family Health Insurance Assistance Program (FHIAP). Not only was the State concerned about maintaining the privacy of its program participants, but it also wanted to avoid placing an

administrative burden on employers. Moreover, the State did not want to involve employers in any way that might give them a reason to opt out of the program, thereby making the subsidies unavailable to participants.

Officials also explored whether it would be feasible to pay subsidies directly to health plans. The program eventually abandoned this payment option due to a reluctance on the part of insurance carriers to receive payments from two separate sources (the employer and the State) for the same policy.

Oregon officials did have some concerns about paying families directly, but most of those concerns have not materialized. For instance, officials feared that generating hundreds of subsidy checks would be burdensome and prone to error. The program has been in operation for over a year, and the State has not experienced any problems with the generation of checks. Program officials also feared that subsidy checks would not arrive in a timely manner, causing families to wait for reimbursement. During the early period of FHIAP's operation, there were some problems in this area. However, it now appears that the program's administrator has made the necessary corrections to the system to ensure timely payment of subsidies.

The State also had concerns that some premium payments to families would be made in error and that the funds would be irretrievable. Currently, to prevent payments being made to families who are not enrolled in an employer health plan, the program requires monthly verification of enrollment. Each month, the participant is required to mail to the State a copy of his/her paycheck stub, indicating that the premium payment has been deducted from the paycheck. However, this verification system is cumbersome, and the State would prefer to develop some other method of verifying enrollment. Fortunately, it does not appear that erroneous payment or intentional misuse of subsidies have been significant problems. The State had set aside five percent of FHIAP's budget as a contingency fund to account for any misused or misdirected funds. Almost none of this fund has been used during the more than one year that FHIAP has been in operation. Officials estimate that only a handful of payments have been made in error.

It is possible for employers to receive premium payments directly under FHIAP if they wish to do so. However, no employers have yet volunteered to perform this function. Employers have indicated that they prefer not to be in the middle of the administration of subsidy payments.

Oregon officials hope to continue to make subsidy payments directly to families under the S-CHIP component of FHIAP. The Health Care Financing Administration has not yet determined whether this payment system will be acceptable.

Mississippi

When Mississippi officials first conceptualized the S-CHIP Premium Assistance program, they assumed it would make the most sense to make subsidy payments to employers. However, as the State began discussing the program with employer groups, it became clear that employers were hesitant to take on this new role. The employers indicated that their accounting systems were not set up to handle these types of payments. Furthermore, employers were concerned about being

placed in the middle of a program that has inherent inequities. (The inequity is related to the S-CHIP requirement that children receiving assistance must be currently uninsured. This means that low-income families who had previously been purchasing coverage for their children would be ineligible for assistance, while those who had not covered their children could receive a subsidy. An employer might have two employees of similar income levels, only one of whom is able to participate in the program because of this requirement. Employers who thought this policy was unfair did not want to appear to be associated with the program.)

The State also feared that by making subsidy payments directly to employers, they might increase employers' incentives to reduce their own premium contributions. Because of this and other concerns, the State has begun to explore ways of paying subsidies directly to program participants. Mississippi officials have not yet submitted a Title XXI State Plan amendment to HCFA requesting this change.

B. Obtaining Information about Applicants' Employer-Based Coverage: Benefits and Cost-Effectiveness

This section is based on presentations by:

- Anita Smith, Manager, Health Insurance Purchasing Program, Iowa Department of Human Services
- Patricia Canney, Director of Program Implementation, Massachusetts Division of Medical Assistance

To administer a Premium Assistance program, states need certain information regarding the coverage available to participants. Specifically, states need information regarding covered benefits, cost-sharing requirements, total premiums, and employer and employee contributions toward premiums. States need this information to determine whether available private coverage meets the program's benefits and cost-sharing standards. They will also use this information to determine whether the purchase of employer-based coverage meets the cost-effectiveness test required by S-CHIP and Medicaid law (if applicable).

Iowa

As described previously, Iowa operates one of the country's most well-developed Medicaid Health Insurance Premium Payment (HIPP) programs. Every Medicaid applicant is screened for HIPP eligibility, and there are extensive systems in place to gather and assess information about private coverage that may be available to Medicaid recipients.

The information-gathering process begins with a form that asks each Medicaid applicant's employer to verify earnings. This is required as part of normal Medicaid eligibility determination. The form also includes questions about the availability of employer-based insurance. If the employer indicates that coverage is available, a copy of the form is sent to the HIPP unit, which is responsible for gathering further information regarding the benefits and cost of the employer-based plan. The HIPP program maintains a library of the plan information they have gathered

from employers. They can refer to this information when they have more than one applicant working for the same employer, rather than gathering the same information multiple times. The information gathered about an applicant's employer-based coverage includes specific benefits covered, patient cost-sharing and required (employee) premium contribution.

Once gathered, the information is entered into an automated cost-effectiveness determination system. This system performs a benefit-by-benefit comparison of the cost of buying into the employer-based plan versus providing the same services through the direct fee-for-service Medicaid program. The cost of the premium and deductible of the employer-based plan are included in this calculation.

Next, the computer system performs a cost-effectiveness assessment. In making this assessment, the system takes into account five factors: the Medicaid aid category, institutional status, age, sex, and Medicare status for every Medicaid-eligible person in the family If, based on these factors, it is likely to be less expensive to cover an individual under an employer-based plan than under the fee-for-service Medicaid program, the system delivers a "buy" recommendation.[11]

However, when the automated system indicates that the purchase of private coverage is not cost effective for a given person, the State sends the individual a health status survey. The survey is designed to elicit information about any high-cost health conditions an individual may have. If such conditions exist, the individual is likely to be more expensive than the average person in his category (based on age, sex, institutional status, Medicare status, and aid category). It may therefore be less expensive for the State to buy into the employer-based plan than to cover the individual's expenses on a fee-for-service basis under the Medicaid program. This type of decision must be made on a case-by-case basis.

Once it is determined to be cost-effective to buy into private coverage on behalf of a Medicaid recipient, the program mails the recipient a letter, instructing him to enroll in the employer-based plan. The person is told to enroll in whichever tier of coverage (e.g., employee-only, family, etc.) is necessary to cover all the Medicaid-eligible individuals in the family. (In many cases, when the state buys into a family coverage tier, it is also possible to cover individuals who are not Medicaid-eligible at no additional cost.) If an individual is unable to enroll in the employer-based plan due to open enrollment period restrictions, he is identified in a "tickler" system until the next open enrollment period.

The state asks the employer to verify that enrollment has taken place and to provide information regarding the timing of paychecks and the amount of premium deducted from each check. Premium subsidy payments can be sent to either the employee or the employer (see the preceding section of this paper, "Who Pays Whom How: Subsidy Payment Approaches"). Each subsidy check includes a "change report form," which asks the recipient to report any changes in

[11] In addition, a "buy" decision is automatically delivered in two situations: 1) when an applicant has access to a major medical plan that costs him or her less than $50 per month; and, 2) when a pregnant woman can be insured, even if the pregnancy itself is not covered. This is because if the mother is covered under the employer-based policy when the baby is born, the baby is automatically covered for thirty days. (If the mother is Medicaid-eligible, so is the baby.)

employment status, benefit package, etc. In the early stages of the HIPP program, officials reviewed each recipient's case every six months to look for such changes. However, there were so few changes that program officials determined it would be acceptable to review each case only once per year. At renewal time, employees are asked to have their employers fill out a form stating whether there have been any changes to the plan or the contribution policy since the previous year.

There have been a few instances in which individuals have dropped employer-based coverage, failed to inform the State, and continued to collect subsidy checks for a few months. This happens infrequently and is referred to the Medicaid fraud unit.

Massachusetts

As part of its eligibility determination process, the MassHealth program screens all applicants with incomes between 150% and 200% FPL for the availability of employer-based coverage. The State contracts with a third party vendor to conduct this "insurance investigation." The vendor contacts applicants' employers by phone and by mail to collect information about the plans that are offered, the total cost, the employer contribution, and a summary of benefits. After making an initial call to the employer, the vendor mails the employer a MassHealth Family Assistance Program fact sheet. This informational piece explains the program and informs the employer that the employee has signed a release allowing the employer to provide the requested information. As is the case in Iowa, the pertinent information is entered into a database, where it can be referenced if another applicant is employed by the same employer.

Once the State gathers the necessary information about the available employer-based coverage, the vendor determines whether the coverage meets the following program requirements:

- The employer must contribute at least 50% of the cost of family coverage;
- It must be no more costly to buy into the employer-based plan than it would be to cover the eligible individual(s) under the regular MassHealth program; and,
- The plan must meet the S-CHIP benchmark benefit requirements.

The benchmark in Massachusetts is the largest commercial HMO in state. The State compares an applicant's private coverage to this benchmark using a benefit-by-benefit comparison. Analysts have developed a check-off form or matrix to assist them in this process. The private coverage must meet or exceed benchmark coverage for every benefit in order to qualify for the S-CHIP program.

If the employer-based coverage meets S-CHIP requirements, the applicant is told to enroll. For the most part, MassHealth officials have found that employers are cooperative in providing information in a timely manner. In the few instances in which the employer is not cooperative, the employee may be asked to gather the required information herself. Currently, the State requires that the vendor complete the insurance investigation within sixty days. (During this period, children are presumptively eligible and can receive care on a fee-for-service basis.) Officials

would like to reduce the insurance investigation period but recognize that the manual review of employer-based benefit plans is time-consuming and labor-intensive.

C. Coordinating with a Health Insurance Purchasing Cooperative

This section is based on presentations by:

- Robert DiPrete, Director, Oregon Health Council
- Mark Hogan, Vice President, Gallagher Byerly, Inc.
- Peggy Anet, Consultant, Associated Oregon Industries HealthChoice

One way to simplify the administration of a Premium Assistance program is to make use of an existing health insurance purchasing cooperative (HIPC).[12] Such purchasing groups exist in a number of states, although their structures vary considerably.[13] In general, HIPCs negotiate for and buy a limited number of standardized benefit plans from competing carriers on behalf of a large number of different employers. They also allow workers and their families to choose and enroll in any of the plans they offer (within given rules). As a result, they have administrative structures that facilitate contracting with a number of insurance carriers, collecting premiums from multiple sources, enrolling families in their choice of health plans, and making premium payments to the appropriate carriers for the duration of enrollment.

The State of Oregon is hoping to link its current state-funded Family Health Insurance Assistance Program (FHIAP) with its S-CHIP program using the administrative mechanism of a private, non-profit health insurance purchasing cooperative – Associated Oregon Industries "HealthChoice."

During this conference session, three parties involved with the HealthChoice pilot project discussed their rationale for participating and their understanding of major issues and challenges. The three parties were: the State of Oregon, the third-party administrator responsible for operation of the HealthChoice cooperative, and the cooperative itself.

The State's Perspective

State officials favor the HIPC approach because they believe the purchasing group can offer the program established administrative capacity and expertise. Specifically, HealthChoice can assist the State in performing the following tasks:

- Enrolling individuals in group coverage;
- Handling relationships with employers;

[12] These entities are also referred to as "Consumer-Choice Health Purchasing Groups," or "CHPGs."

[13] For more information about such groups, see the Institute for Health Policy Solutions web site at www.ihps.org/CHPGs.html.

- Notifying the State when enrollment (or disenrollment) of Premium Assistance program participants has taken place (so that participants no longer have to send the State copies of pay stubs, as required under the current FHIAP); and,
- Administering a standardized benefit and/or cost-sharing upgrade to bring the purchasing group's standardized plans into compliance with S-CHIP requirements.

The Health Care Financing Administration is currently reviewing Oregon's request to implement a FHIAP/S-CHIP Premium Assistance program using the cooperative HealthChoice. In the meantime, Oregon officials and representatives of HealthChoice are developing a workplan for pilot program implementation. Officials have identified a number of major issues that will need to be resolved during the planning process, including establishment of rules regarding minimum employer contribution levels (HCFA requires a 60% contribution toward family coverage, but officials believe the average in the HealthChoice cooperative is lower) and development of streamlined eligibility and enrollment processes.

The Third Party Administrator's Perspective

The HealthChoice cooperative is administered by the employee benefit consulting firm Gallagher Byerly, Inc. Founded forty years ago, Gallagher Byerly began administering Multiple Employer Welfare Associations (MEWAs) approximately twenty years ago and began providing services to purchasing cooperatives in 1996. Today, Gallagher Byerly serves 6,000 employer groups with over 100,000 lives. The customer base includes purchasing cooperatives in Colorado, Montana, Washington, and Oregon. In most cases, these cooperatives serve employers with one to fifty employees.

Representatives of Gallagher Byerly see the HealthChoice FHIAP/S-CHIP pilot project as an opportunity to participate in public/private collaboration. They also see this program as a potential growth opportunity. In general, approximately 15 to 20% of employers participating in a health insurance purchasing cooperative have never purchased insurance before. The FHIAP/S-CHIP pilot project may provide an additional incentive to previously non-covered employers to join the cooperative and/or for previously uninsured families to take up available coverage. As do State officials, representatives of Gallagher Byerly believe that the HealthChoice cooperative has an ideal infrastructure for administering the FHIAP/S-CHIP program. Specifically, the cooperative has expertise in:

- Collecting information from employers regarding their contributions toward coverage;
- Maintaining a distribution network of agents who educate employees and employers and carry out open enrollment;
- Managing eligibility data;
- Billing and distributing premium to appropriate parties; and,
- Staffing a customer service center for agents, employers, and employees.

While the pilot project presents some opportunities, the firm is aware that administering a public (or quasi-public) program is a new endeavor and must be approached carefully. The following are specific concerns:

- Cooperatives provide a service to their enrolled employer groups in exchange for a monthly administration fee. For the cooperative to be successful, administrative costs must be kept to a reasonable level or employers will find it more cost effective to purchase health insurance on their own. It is therefore extremely important the HealthChoice FHIAP/S-CHIP pilot project be administered in a cost-effective manner that does not jeopardize the cooperative's existing business. An important factor in developing a cost-effective administrative structure is enrolling a minimum volume of covered lives.
- Success of a cooperative is also based on its ability to simplify health insurance purchasing for employers. It will therefore be important to integrate the FHIAP/S-CHIP pilot program with the cooperative's existing business in a manner that is not confusing to employers and employees.

The Cooperative's Perspective

The HealthChoice cooperative is sponsored by Associated Oregon Industries (AOI), the state's largest business association. Founded over fifty years ago, AOI performs legislative advocacy and provides member employers with workers' compensation insurance, employee assistance, and technical assistance. The association created the HealthChoice cooperative four years ago to meet the health insurance needs of its member small employers. Today, HealthChoice covers approximately 5,000 lives.

HealthChoice is interested in participating in the FHIAP/S-CHIP pilot project as an additional means of providing a valuable service to employers and employees. In recent years, the small employer insurance market has become more volatile. In Oregon, rate increases of 30 to 40% are common. Employers are changing their contribution strategies as a result of these increases, and many more employees are finding that they can no longer pay their share to provide insurance to their children. At the same time, Oregon law-makers have recently increased the minimum wage, which may have had the unintended effect of making certain low-income families ineligible for Medicaid (due to changes in income). Together, these factors have increased the likelihood that low-income employees will be unable to purchase insurance for their children. HealthChoice officials believe that FHIAP/S-CHIP pilot project will benefit small employers and their employees by helping to maintain the affordability of private coverage.

HealthChoice officials believe the pilot program will be a success if it is cost effective for the cooperative and its employers and if it is administratively simply for employers. The program must also provide stable rates over time and offer choice to employees.

D. Working with a Supplemental Carrier

This section is based on presentations by:

- Therese Hanna, Mississippi State Insurance Administrator
- Robert Stampfly, Director, Managed Care Support Division, Michigan Department of Community Health
- Catherine Schmitt, Director of PPO Programs, Blue Cross Blue Shield of Michigan

As described previously, states seeking to develop S-CHIP Premium Assistance programs must comply with a number of federal requirements regarding benefits and cost-sharing. In cases where an applicant's private employer coverage does not meet program requirements, states can either disqualify the health plan from the subsidy program, or they can develop a rider or "wrap-around" plan to supplement the applicant's coverage.

This section focuses on one approach to administering a cost-sharing and/or benefit "wrap-around" - that of contracting with a single supplemental carrier. This approach is probably most attractive for states with fairly fragmented employer-based insurance markets (i.e., where many plans have relatively moderate market shares or where there is great variation in the types of coverage offered by employers).

States could contract with a single supplemental carrier to administer a wrap-around to employer-based plans that do not meet the S-CHIP benefit and/or cost-sharing standards. To a private carrier, this function might be similar to traditional coordination of benefits (COB) administration. This approach is similar to the approach used under many states' (Medicaid) Health Insurance Premium Payment (HIPP) Programs, in which providers bill the State for benefits or cost-sharing fill-ins that are not provided under the employer's plan. However, there are important potential differences. For example, some states' Medicaid programs treat such employer-based plans as a third-party liability recovery source, rather than as the primary source of coverage. Many states have a limited capacity to administer a HIPP program and only do so for a relatively few high-cost cases. Further, under the supplemental carrier approach, providers would bill a State-contracted carrier for cost-sharing, rather than billing the State (as they do under HIPP programs).[14]

Both Mississippi and Michigan officials are considering the use of the supplemental carrier approach for their S-CHIP Premium Assistance programs.

[14] This approach could be preferable in situations where a large number of providers contracting with employer-based plans generally do not also participate in the state's S-CHIP program directly. In such situations, providers might balk at contracting, billing, and payment through the Medicaid or public program. In contrast, a supplemental carrier or intermediary with established relationships with private, mainstream providers may already have contracts and systems in place to pay such providers.

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Mississippi

The State of Mississippi has contracted with Blue Cross Blue Shield of Mississippi to administer its S-CHIP program, which is a stand-alone (non-Medicaid) program. In addition to administering the regular S-CHIP, the carrier has also agreed to develop the capacity to administer the Premium Assistance portion of the program by January 1, 2001.. Under the Premium Assistance program, the carrier will perform the following functions:

- Provide supplemental cost-sharing coverage to Premium Assistance enrollees whose employer-based plans do not include the S-CHIP cost-sharing provisions;
- Cover certain required services, such as immunizations, which may not be covered by the employer-based plan;
- Provide coverage for any pre-existing conditions which may be subject to a waiting period (or not covered at all) under an employer-based plan; and,
- Track families' out-of-pocket expenses to ensure that total spending does not exceed 5% of family income (as required by federal law).

When providers treat children enrolled in the Premium Assistance program, they will be required to bill the employer's carrier first and then to bill Blue Cross Blue Shield for any allowable unpaid amount. Providers will not be permitted to balance-bill patients.

Initially, the State intended to contract with an insurance carrier to administer the Premium Assistance Program on an at-risk basis. However, state officials recognized that it would be difficult to develop a premium for both the benefits and the cost-sharing upgrades. The supplemental carrier would know the level of coverage employer-based plans need to be upgraded "to," but it would not know what level all employers' plans were starting "from." Because of the difficulty associated with developing a premium, the State assumed that any at-risk bids would be extremely high (due to the unknowns). Instead, State officials solicited a carrier on an administration-only basis.

One drawback to contracting with a supplemental carrier on an administration-only basis is that the cost of such a contract counts towards the state's overall limit on administrative expenses. Under federal law, states can only receive federal match on administrative expenses that do not exceed 10% of program expenditures. However, Mississippi officials believe that during the early stages of the Premium Assistance program, enrollment will be low enough that the administrative cost will not be a concern. Later, as enrollment grows and Blue Cross Blue Shield and the State are better able to predict program costs, it may be possible to establish an at-risk contracting relationship.

Michigan - The State's Perspective

The State of Michigan received federal approval to implement its S-CHIP program, MIChild, on April 11, 1998. MIChild is a stand-alone (non-Medicaid) S-CHIP. The program covers children under the age of one at incomes between 186% and 200% FPL and children between one and eighteen at incomes between 150% to 200% FPL.

All enrollees are guaranteed twelve months of eligibility and are locked into their choice of HMO for that period. Currently, the program covers 13,000 children and has reached 45% of its target population of uninsured children.[15]

Although MIChild does not currently include a Premium Assistance component, program officials are extremely interested in this approach. In particular, officials hope to use a Premium Assistance program to cover uninsured family members, in addition to children, when it is cost effective to do so. Because officials are concerned about the administrative complexity and cost associated with a Premium Assistance program, they are hoping to contract with a supplemental carrier to administer this portion of MIChild.

State officials have already begun discussions with Blue Cross Blue Shield of Michigan (BCBSM). Currently, BCBSM covers nearly 80% of MIChild enrollees. It is also the largest carrier in the state, covering over 50% of the insured population and an even greater percentage of employer groups. Because a single carrier has such a strong presence in both the private and public markets, it presents a unique opportunity for collaboration. State officials would like to partner with BCBSM to develop a program that allows MIChild-eligible children to enroll in their parents' employer-based coverage, when such coverage is with BCBSM.

Michigan officials asked Blue Cross Blue Shield to develop a proposal for administering the MIChild Premium Assistance program. The following is an overview of the carrier's informal, initial response.

Michigan – The Carrier's Perspective

Blue Cross Blue Shield of Michigan (BCBSM) covers 53% of the insured lives in the state of Michigan. Its PPO is its fastest growing product with over 1.5 million members. The PPO network includes 14,000 physicians, 1,700 other health care professionals, and nearly every hospital in the state, making it a truly state-wide product. In addition, BCBSM covers 78% of MIChild enrollees for health care and 55% of MIChild enrollees for dental care. Given this major market penetration, representatives of the carrier believe it is ideally suited to administer a program designed to coordinate MIChild and private employer-based coverage.

In developing a proposal for administering the Premium Assistance program, BCBSM officials made several design assumptions:

- The program will be limited to Community Blue, the carrier's largest PPO product. Under this product, there are a number of options. The carrier will have to compare the Community Blue variations to the state's S-CHIP benchmark to determine which ones can be easily brought up to benchmark standards through supplementation.
- The carrier will develop a benefit and/or cost-sharing supplement for MIChild-eligible children enrolled in qualified Community Blue plans.

[15] Program officials also report that MIChild outreach efforts have resulted in an additional 45,000 children being found eligible for and enrolling in Medicaid.

- The third-party administrator that performs eligibility determination for MIChild will continue to perform this function for the Premium Assistance portion (i.e., BCBSM does not intend to perform eligibility determination itself). The administrator will be responsible for screening MIChild applicants to determine whether their parents have access to employer-based benefits under a Community Blue plan. The program application will include a section for the employer to confirm coverage type and employer contribution. Employees will be responsible for having employers provide this information.

- The carrier will hold two contracts: one with the State for the supplemental benefits, and one with each employer for the regular Community Blue coverage. The employer need not be aware of the carrier's contract with the State and will be billed as usual for the regular coverage.

- In developing renewal rates for group coverage, the carrier normally accounts for a group's experience. Experience associated with any supplemental coverage provided to MIChild enrollees will be excluded from this re-rating analysis.

The carrier has identified a concern associated with the current tier rating structure of the Community Blue plan. Currently, the two-person rate is 2.1 times higher than the single-person rate. Most of the enrollees in this tier are young couples (with high maternity costs) or older couplers with grown children (with high costs associated with aging). This two-person rate is fairly expensive for a single-adult/single-child unit, which may result in many employer-based plans failing to meet the S-CHIP cost-effectiveness requirements. As a result, BCBSM will develop a new two-person rate specifically for the single-adult/single-child unit.

Blue Cross Blue Shield officials have also identified a number of unresolved issues, such as:

- How will identification cards be handled? Will Premium Assistance program enrollees carry both a MIChild and regular Community Blue card?
- How will providers be informed of the benefits available to MIChild children enrolled in employer-based plans?
- How will subsidies be paid?
- What will marketing and outreach look like? Will agents be involved? What will agent commissions look like?
- What will happen to a child when the parent loses eligibility for the employer-based plan? How can such a child be transitioned back to the regular MIChild program?
- Will MIChild eligibility be considered a "qualifying event," allowing children to enroll in employer-based plans at times other than during open enrollment?
- How will the out-of-pocket maximum (5% of family income) be administered?

Blue Cross Blue Shield officials continue to develop their proposal for administering a MIChild Premium Assistance program. At this time, they have not developed a cost estimate for providing these services to the State.

E. Other Approaches to Filling in Cost-Sharing

This section is based on a presentation by:

- Patricia Canney, Director of Program Implementation, Massachusetts Division of Medical Assistance

Under the MassHealth Family Assistance program, if a participant's employer-based insurance does not measure up to S-CHIP benefit standards, the child may not be enrolled in the S-CHIP Premium Assistance program (but may be eligible for the Medicaid Premium Assistance program or the regular S-CHIP). As a result, the State has not developed a mechanism for filling in benefits of employer-based plans. However, the State does fill in cost-sharing provisions of employer-based plans if doing so would qualify such coverage for the S-CHIP Premium Assistance program.

As described previously, for a state to buy into employer-based insurance for a S-CHIP-eligible child, the State must ensure that the federal cost-sharing requirements are met. Specifically, there may be no cost-sharing for well-baby and well-child visits, and there is an out-of-pocket cost-sharing maximum for 5% of family income for children in families with incomes above 150% FPL. Because employer-based plans rarely, if ever, include such cost-sharing provisions, MassHealth officials have developed a cost-sharing wrap-around for program participants. This wrap-around is provided to families in the form of a "kit" called Children's Allowable Receipts and Expenses (C.A.R.E.).

All children enrolled in the S-CHIP portion of the MassHealth Family Assistance program receive a C.A.R.E. kit, which provides information about the importance of well-child and well-baby care. The kit also explains that families are not required to pay cost-sharing amounts for well-baby or well-child care or for any services after the out-of-pocket maximum has been reached. Each family's out-of-pocket amount is calculated separately, and the family is provided with this information. The kit also includes a place where families can keep and record cost-sharing receipts so they will know when they have reached their out-of-pocket maximum. Once cost-sharing reaches this dollar amount, the families is instructed to send all receipts to the State. The MassHealth Family Assistance Program has been in operation since August of 1998, and, to date, no family has yet reached its out-of-pocket spending maximum.

The C.A.R.E. kit also includes a supply of forms for providers to bill the State for any cost-sharing amounts for which the family cannot be billed. When a child receives services from a provider, he presents the employer-based insurance ID card, which tells the provider what the cost-sharing amount is for the employer's plan. For well-child or well-baby visits (or for any visits after the out-of-pocket maximum has been reached), rather than paying this cost-sharing

amount, the child's parent can give the provider the billing form, with instructions to bill the State. As a fail-safe, if a provider will not accept the State's billing form, or if the parent fails to give the form to the provider, individuals can submit cost-sharing receipts to the State for reimbursement, using the same form as is used by providers.

In addition to providing families with C.A.R.E. kits, the State conducts training for providers to educate them about cost-sharing under the Mass Health Family Assistance Program. Providers are also able to access an automatic recipient eligibility verification system by calling the MassHealth program. Through this system, the provider can receive a message indicating whether a given child is in fact eligible for MassHealth Family Assistance and what his or her cost-sharing requirements are.

In the approximately sixteen months that the program has been in operation, MassHealth has received only a few claims from providers for cost-sharing. Officials assume that most providers have simply decided to take a loss for the small cost-sharing amounts that families are not required to pay. An alternate theory is that providers are in fact billing families, and families are, in turn, failing to request reimbursement from the State. Program officials would like to develop a means of determining which of these two scenarios is actually taking place.

The C.A.R.E. kit was developed in conjunction with consumer and patient advocates in the state. In general, the kit has been well received by families.[16]

[16] For a copy of the C.A.R.E. kit, please contact the Institute for Health Policy Solutions at (202) 789-1491 or e-mail S-CHIP@ihps.org.

IV. As a Matter of Facts

This section is based on presentations by:

- Karla Hanson, Ph.D., Assistant Professor, New School University
- Linda Bilheimer, Ph.D., Deputy Assistant Director for Health, Congressional Budget Office
- Paul Fronstin, Ph.D., Senior Research Associate, Employee Benefit Research Institute
- Stephen Long, Ph.D., Senior Economist, RAND
- Susan Marquis, Ph.D., Senior Economist, RAND

States considering buying in to employer-based insurance have many questions about low-income children and the extent to which such insurance is available to them. This sections presents researchers' findings on a range of these questions. Issues addressed include:

- The relationship between parents' and children's coverage and services use
- Overall trends in employer-based health insurance, including:
  - ✓ Trends in health insurance coverage of children
  - ✓ Trends in availability and acceptance of employer-based insurance
  - ✓ Trends in availability and cost of family coverage
  - ✓ Take-up Rates and Employer Contributions
- Targeting issues: Where are the uninsured children with access to employer-based insurance?
- Turnover and crowd-out
  - ✓ Implications for crowd-out and the efficiency of public subsidies
- Trends in benefit packages for employer-based health insurance

A. The Relationship Between Parents' and Children's Coverage and Service Use

Once children have financial access to medical care, does the nature of that access (the kind of insurance) affect how readily they will actually use needed care? Put another way, does it matter whether children have coverage through the same plan as their parents or a different plan?

Karla Hanson, Ph.D., Assistant Professor in the Health Program at the Milano Graduate School of Management and Urban Policy of the New School University, spoke to this question. Her research was published last year in *Inquiry*.[17]

Dr. Hanson noted that it is well known that uninsured children use less care than insured children do. Prior research has also clearly established that parents' (mothers') own use of physicians' services is a strong predictor of their children's use of services. Specific findings from prior research include:

- Mother's use of physician services is strongly associated with children's use of physician services.[18,19]

- Mother's receipt of adequate prenatal care is related to her child's receipt of well-child care including recommended immunizations.[20,21]

- Mother's receipt of adequate prenatal care is associated with higher continuity of pediatric care, among a cohort of universally insured children.[22]

It makes sense to expect that, in deciding whether her children need care, a parent will bring to bear the same cultural factors, health beliefs, symptom recognition skills, and experience with the health care system she would use in deciding whether to seek care for herself.

Dr. Hanson wondered whether the presence of insurance altered in any way the connection between the health care use of parents and that of their children. Using the 1990 National Health Interview Survey, she studied utilization by uninsured and privately insured children. The expected association between parent's and children's use of physician services is clear from the basic utilization rates for both uninsured and privately insured children, as Table IV-1 shows.

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[17] Hanson, K.L. Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Revisited. *Inquiry* 35:294-302 (Fall 1998).

[18] Newacheck, P.W., and N. Halfon. 1986. The Association Between Mother's and Children's Use of Physician Services. *Medical Care* 24(1): 30-38.

[19] Newacheck, P.W. 1992. Characteristics of Children with High and Low Usage of Physician Services. *Medical Care* 30: 30-42.

[20] Bates, A.S., et al. 1994. Risk Factors for Underimmunization in Poor Infants. *Journal of the American Medical Association* 272(14): 1105-1110.

[21] Kogan et al. 1998.

[22] Mustard et al. 1996.

Table IV-1: Utilization of Any Physician Services for Uninsured and Privately Insured Children, by Primary Parent's Own Utilization

	Percentage of Children with One or More Physician Visits	
	Uninsured Children (n= 2,181)	Privately Insured Children (n= 10,802)
Total	71.0	83.4
Primary Parent Had One or More Physician Visits		
No	56.3	65.7
Yes	76.8	87.0

Source: Hanson, K.L. Is Insurance for Children Enough? The Link Between Parents' and Children's Health Care Revisited. *Inquiry* 35:294-302 (Fall 1998).

In fact, the association is even stronger than the raw utilization rates suggest. After controlling for other individual and family attributes known to affect use of health services, Dr. Hanson found that the primary parent's (usually the mother's) use of any physician services was a strong predictor of whether the child would use physician services, for both insurance statuses.

- Uninsured children were twice (2.07 times) as likely to have any physician visits if their parents had at least one visit. Privately insured children were almost three (2.94) times as likely. (Again, these "odds ratios" are adjusted for other individual and family attributes known to affect the use of health services.)

- The effect is even more striking if stated in the reverse: A privately insured child whose parent did not visit a physician even once during the year was only one-third as likely to have seen a physician as a child whose parent had one or more physician visits.

- The presence of private insurance appeared to amplify the relationship between parents' and children's use of any physician services. (The difference in the effect between uninsured and privately insured children was statistically significant.)

Parental use also affected the volume of physician services used by children. For example, children whose parents had relatively high physician use (6 visits within one year) made one-third more physician visits than children whose parents had low physician use (1 visit). The same increase was observed for both insurance statuses.

In summary, Dr. Hanson found that children fared best (i.e., were most likely to have at least one physician visit during the year, as recommended by the American Academy of Pediatrics) if they were privately insured and their parent used physician services during the year. Parental use of services may reflect both the parents' knowledge of when it is appropriate to seek care and their experience in using the health care system. Clearly, it is important to consider care for children

within the context of care for the family. If parents do not have access to care, that fact alone may diminish the children's access, whether or not the children have coverage. To quote from Dr. Hanson's *Inquiry* article:

> "While child health insurance initiatives … represent an important step toward securing access to care for children, neglecting insurance for adults may have the unintended effect of reducing the potential impact of such policies. Further, policies to support targeted insurance for children may undermine our ability to develop more integrated delivery systems for families."

Dr. Hanson also suggests that the shift to managed care may accentuate the link between health services for children and parents. As she notes, "[l]earning to navigate a managed care system can be complex. … Children who received care from the same managed care organization as a parent may be advantaged by their parents' cumulative knowledge of that system." On the other hand, children who are enrolled in plans other than their parents' plan may not benefit from their parents' knowledge.

Using the 1996 Medical Expenditure Panel Survey (MEPS), Dr. Hanson is now exploring questions such as these in families with "mixed" insurance status (i.e., where family members have different types of insurance or a mix of insurance and uninsurance).

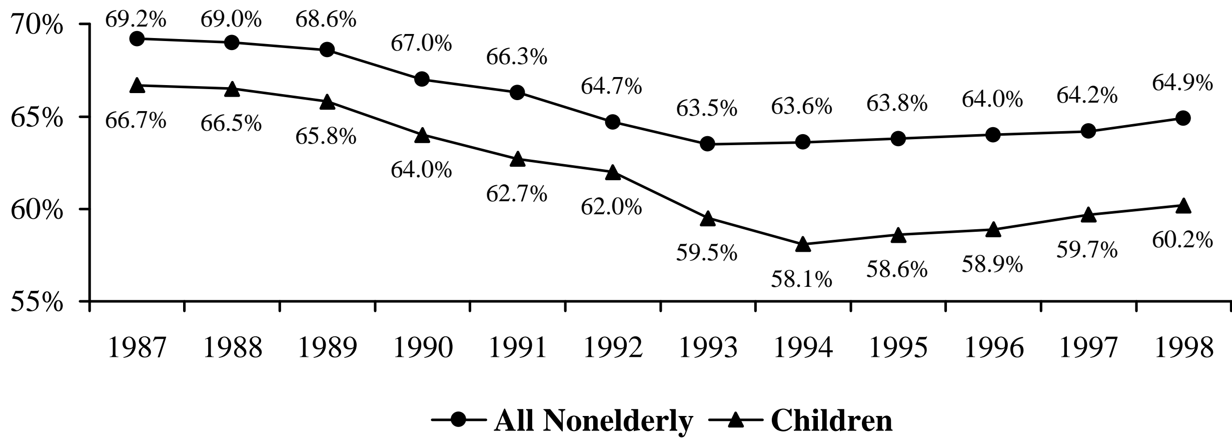
B. Overall Trends in Employer Based Health Insurance

<u>Trends in Health Insurance Coverage of Children</u>

Paul Fronstin, Ph.D., Senior Research Associate with the Employee Benefit Research Institute (EBRI), discussed recent trends in health insurance coverage of Americans in general and children in particular, based on his analysis of the U.S. Census Bureau's Current Population Survey (CPS).

The proportion of nonelderly Americans covered by employer-sponsored health insurance declined consistently from 69.2% in 1987 to 63.5% in 1993. [See top line in Figure IV-2.] This decline resulted from rising health care costs, declining real income, and structural changes in the economy, which included a shift from manufacturing to service industries, an increase in part-time workers, and a decrease in unionization. Firm size was not a factor in the decline. Since 1993, health care costs have increased less rapidly, the economy has gotten stronger, and the proportion of the population covered by employer-based insurance has risen slightly, reaching 64.9% in the latest figures from the Current Population Survey. The most recent annual increase (+0.7% for 1997-98) was the largest single-year increase, equaling the total increase from 1993 through 1997.

Figure IV-2: Employment-Based Coverage 1987-1998



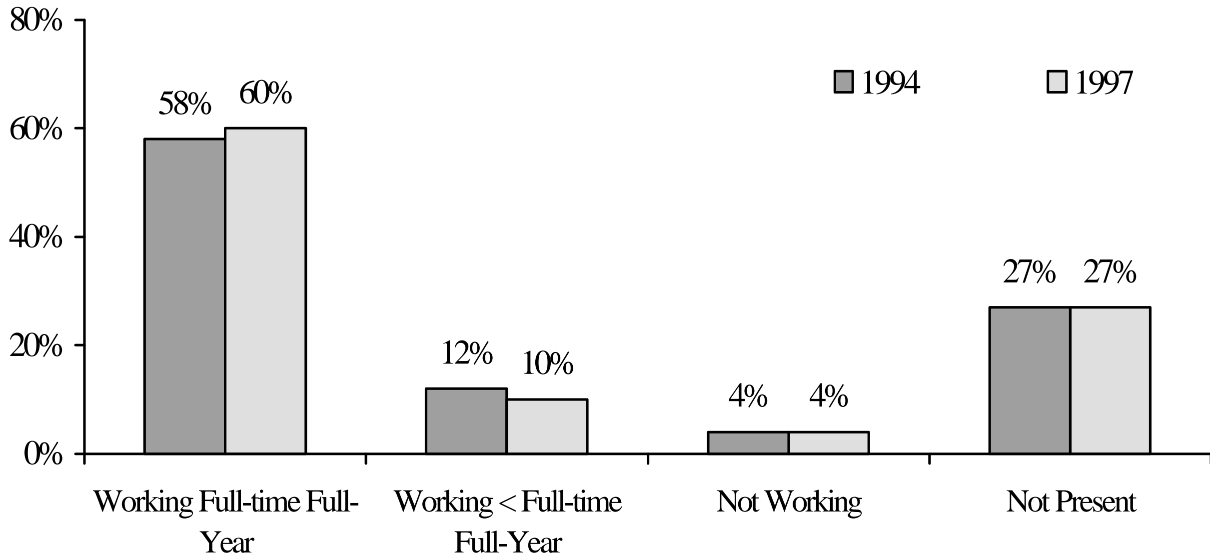
Source: Employee Benefit Research Institute analysis of March supplements to the Current Population Survey, various years.

The proportion of children under 18 covered by employer-based insurance has followed a similar pattern, falling from 66.7% in 1987 to a low of 58.1% in 1994, then rising again to 60.2% in 1998. [See bottom line in Figure IV-2.]

The post-1994 increase in children covered by employer-based insurance is due to two main factors:

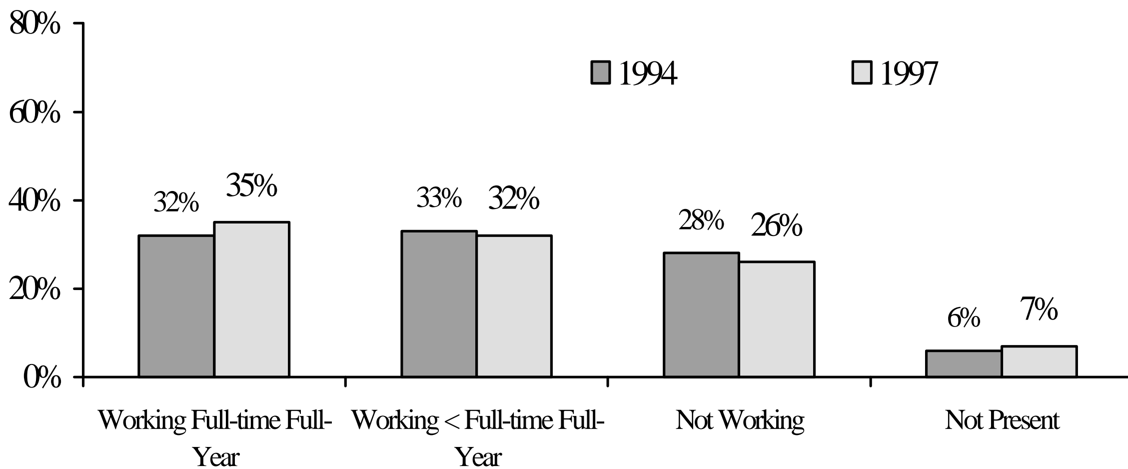
- First, more parents worked full-time for a full year (FTFY) in 1997 than in 1994. Though the increases appear modest—2% more fathers (60%) and 3% more mothers (35%) were FTFY workers in 1997 than in 1994 (58%, 32%)—the probability of a child having employer-based insurance is much higher if their parent is a FTFY worker. [See Figures IV-3 and IV-4.]

Figure IV-3: Work Status of Children's Father, 1994 & 1997



Source: Employee Benefit Research Institute analysis of March supplements to the Current Population Survey, various years.

Figure IV-4: Work Status of Children's Mother, 1994 & 1997



Source: Employee Benefit Research Institute analysis of March supplements to the Current Population Survey, various years.

- Second, parents were more likely to be employed by large firms (1,000 or more employees) in 1997 than in 1994. Again, the increases appear modest — +1.4% for both fathers and mothers — but employer-based insurance coverage rates of children are higher for large firms than for smaller ones. [See Table IV-5.]

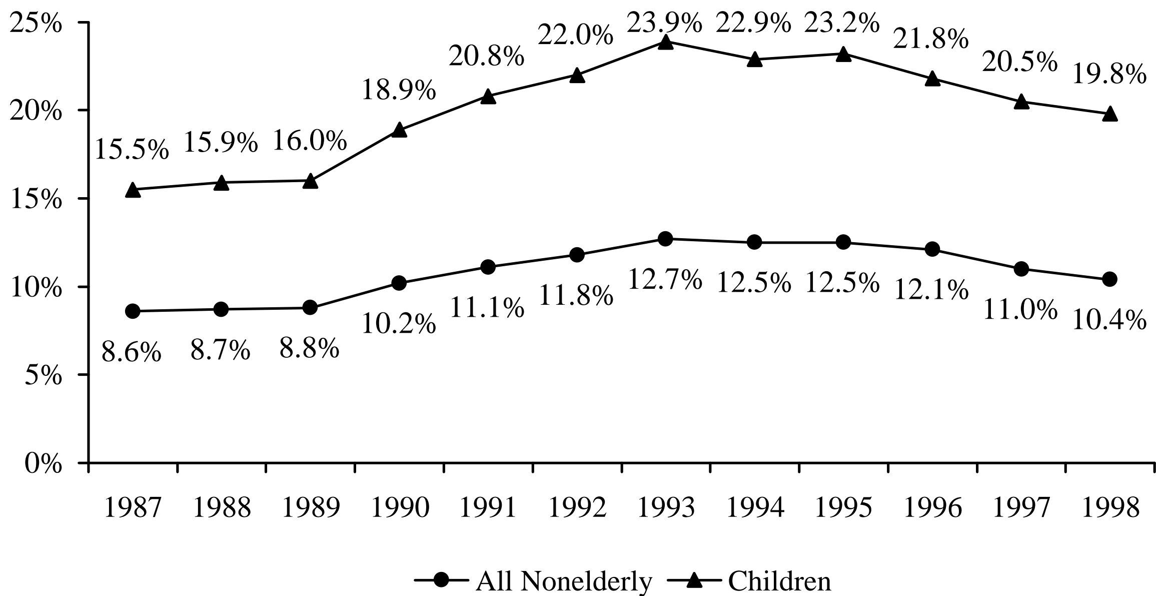
Table IV-5: Percent of Working Parents Employed in Large Firms, 1994 & 1997

	1994	1997
Father	37%	38%
Mother	38%	40%

Source: Employee Benefit Research Institute analysis of March supplements to the Current Population Survey, various years.

The trend for Medicaid seems to be the inverse of the trend for employer-based insurance. Medicaid coverage peaked in 1993 at 12.7% of the nonelderly population and 23.9% of children under 18 and, due to a combination of welfare reform and a strong economy, has since fallen to 10.4% of the nonelderly and 19.8% of children in 1998.[23] [See figure IV-6.]

Figure IV-6: Medicaid Coverage: 1987-1998



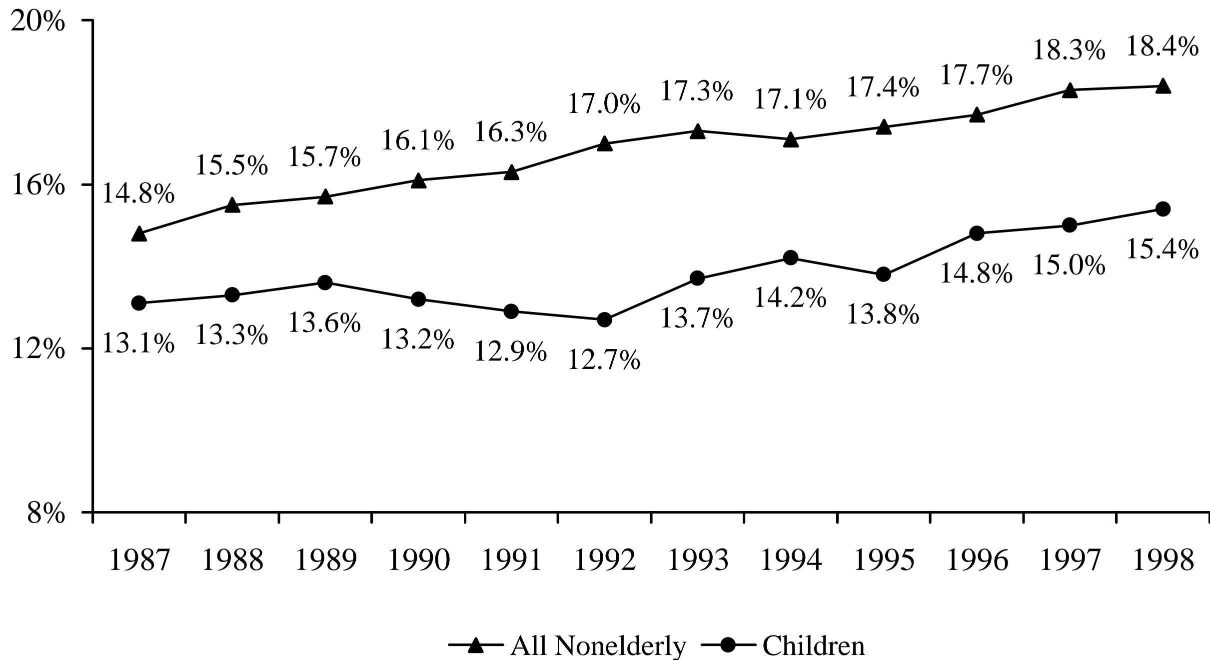
Source: Employee Benefit Research Institute analysis of March supplements to the Current Population Survey, various years.

Unfortunately, the percentage of nonelderly Americans who are uninsured has risen almost without interruption from 14.8% in 1987 to 18.4% in 1998. The proportion of children who are

[23] The Current Population Survey chronically underreports Medicaid coverage; however, the undercount in the absolute figures should not affect the accuracy of the year-to-year trend.

uninsured reached a low of 12.7% in 1992 but has since risen to 15.4% in 1998. [See Figure IV-7.]

Figure IV-7: Uninsured: 1987 - 1998



Source: Employee Benefit Research Institute analysis of March supplements to the Current Population Survey, various years.

For children, prior to 1993, the increase in Medicaid coverage was larger than the decline in employer-based insurance, so the uninsured rate for children fell. The Medicaid increase for children, however, was not sufficient to offset the loss of employer-based insurance for the entire nonelderly population. Since 1993, as employer-based insurance has stabilized and grown slightly, the increase in the uninsured population has been driven primarily by loss of Medicaid coverage.

Trends in Availability and Acceptance of Employer-Based Health Insurance

Overall, employers continue to offer health insurance coverage much as they have in the past. The decline in employment-based coverage between 1987 and 1993 seems to have been primarily the result of a lower "take-up rate," i.e., fewer employees elected to enroll in coverage that was available to them. Since 1993, employer coverage has generally stabilized.

Take-up rates are important to this discussion because, very simply, the goal of Premium Assistance is to increase low-income workers' take-up rate for family coverage.

The trend data presented here come from analyses of three different sets of surveys:

- Paul Fronstin of EBRI analyzed data from special supplements to the Current Population Survey conducted in May 1988, April 1993 and February 1997, focusing on wage and salary workers aged 18-64.

- Philip Cooper and Barbara Schone, economists with the U.S. Agency for Healthcare Research and Quality (formerly the Agency for Health Care Policy and Research), compared household survey data from the 1996 Medical Expenditure Panel Survey (MEPS) with similar data from the 1987 National Medical Expenditure Survey (NMES) for employed adults aged 21-64 who were not self-employed.[24]

- Stephen Long and Susan Marquis, both Senior Economists with RAND, analyzed data from two surveys of private-sector employers—the National Employer Health Insurance Survey (which collected data pertaining to 1993) and the 1997 Robert Wood Johnson Foundation Employer Health Insurance Survey.[25]

These surveys clearly show that fewer workers were covered through health insurance offered by their own employer in 1997 than in 1987, but most of the drop seems to have occurred before 1993. Changes since 1993 differ between sources but are small, leading to the general conclusion of rough stability since then. [See Table IV-8.] (As noted earlier, the overall proportion of the nonelderly covered by employer-based insurance, whether through their own employer or as a dependent, is up modestly since 1993.)

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[24] Philip F. Cooper and Barbara Steinberg Schone, "Trends: More Offers, Fewer Takers for Employment-Based Health insurance: 1987 and 1996," *Health Affairs* 16:6 (November/December 1997).

[25] Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999).

Table IV-8: Percent of Adult Workers Covered Through Their Own Employer, 1987-1997

Source	1987/1998	1993	1996/1997
CPS (88,93,97)[a]	68%	63%	62%
NMES/MEPS (87,96)[b]	63.9%		60.4%
NEHIS/RWJF (93,97)[c]		58%	60%

Sources and Notes:

a: Employee Benefit Research Institute analysis of special supplements to the Current Population Survey, May 1988, April 1993 and February 1997. Data pertain to wage and salary workers aged 18-64.

b: Philip F. Cooper and Barbara Steinberg Schone, "Trends: More Offers, Fewer Takers for Employment-Based Health insurance: 1987 and 1996," *Health Affairs* 16:6 (November/December 1997), Exhibit 1, p. 144. Data pertain to workers aged 21-64.

c: Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999), Exhibit 2, p. 136. Data pertain to all employees of private-sector firms.

The analysis by Cooper and Schone clearly shows that access to employment-related health insurance did not decline between 1987 and 1996, but take-up rates fell. [See Table IV-9.]

Table IV-9: Employment-Related Health Insurance, 1987 and 1996

Percent of workers aged 21-64	**1987**	**1996**	**Change**
Workers offered insurance by own Er	72.4%	75.4%	+3.0%
Take-up rate	88.3%	80.1%	-8.2%
Workers holding coverage from own Er	63.9%	60.4%	-3.5%
Workers with access to ESI (through own or spouse's Er)	81.8%	82.2%	+0.4%
"Family" Take-up Rate	93.2%	89.1%	-4.1%
Workers with ESI	76.2%	73.2%	-3.0%

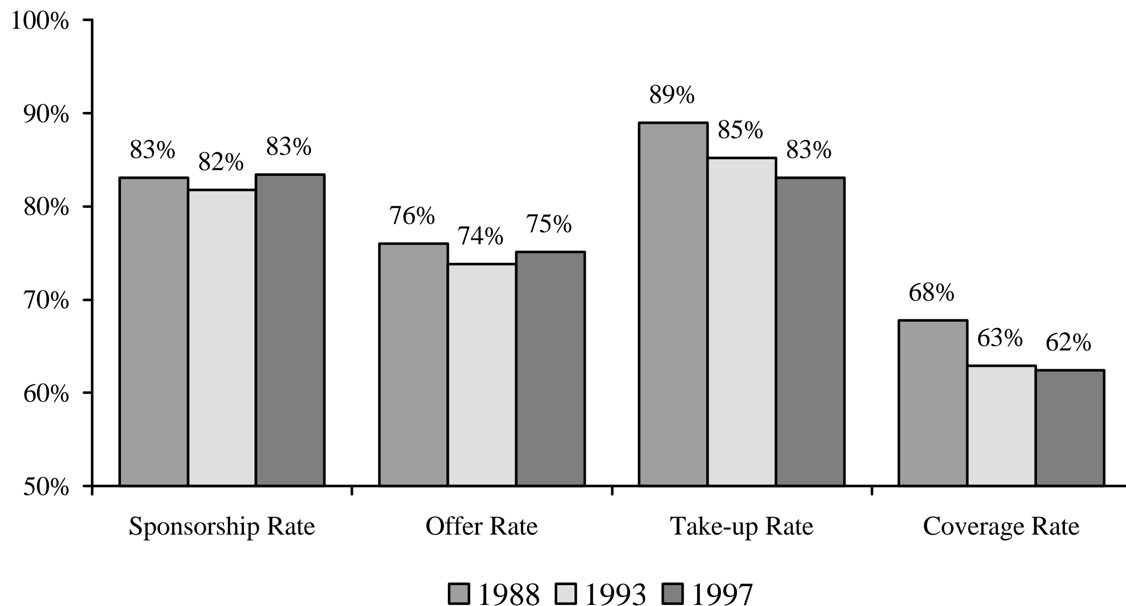
Source: Philip F. Cooper and Barbara Steinberg Schone, "Trends: More Offers, Fewer Takers for Employment-Based Health insurance: 1987 and 1996," *Health Affairs* 16:6 (November/December 1997), Exhibit 1, p. 144.

The proportion of workers holding employer-based insurance from their main job fell from 63.9% in 1987 to 60.4% in 1996. The decline was due primarily to a drop in the take-up rate. The

proportion of workers offered coverage by their own employer actually grew by 3 percentage points, from 72.4% in 1987 to 75.4% in 1996. The proportion of workers who had access to employer-based insurance, through either their own or their spouse's employer, also increased, from 81.8% in 1987 to 82.2% in 1996. But take-up rates fell dramatically: in 1987, 88.3% of workers accepted their own employer's offer of health insurance coverage; in 1996, only 80.1% did so. When considering coverage available from either spouse's employer, the combined ("family") take-up rate dropped from 93.2% in 1987 to 89.1% in 1996.

Using the CPS, Dr. Fronstin also found a significant decline in the take-up rate between 1988 and 1997. [See Figure IV-10.] Overall, the percent of wage and salary workers who work for employers that sponsor a health insurance plan essentially did not change between 1988 and 1997, nor did the percent of wage and salary workers who were actually offered health insurance coverage by their employer. However, the proportion of eligible wage and salary workers who chose to enroll in their employer's health plan—the take-up rate—declined from 89% in 1988 to 83% in 1997. As a result, the percent of wage and salary workers covered through their own employer dropped from 68% in 1988 to 63% in 1993, then remained essentially unchanged at 62% in 1997. (Workers who decline their employer's offer are not necessarily uninsured; they may have coverage through a spouse or from other sources.)

Figure IV-10: Employment-Based Health Insurance Sponsorship, Offer, Take-up and Coverage Rates Among Wage and Salary Workers Ages 18-64, 1988-1997

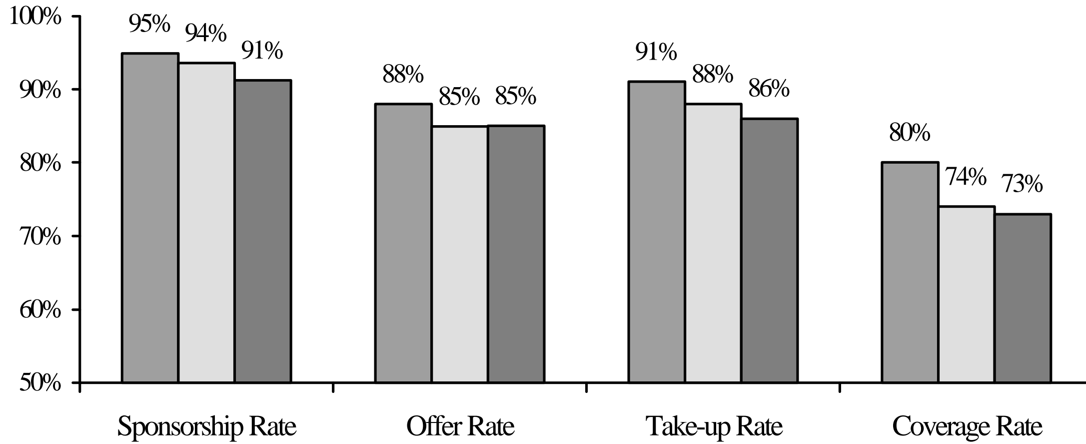


Source: Employee Benefit Research Institute analysis of special supplements to the Current Population Survey, May 1988, April 1993 and February 1997. Data pertains to wage and salary workers aged 18-64.

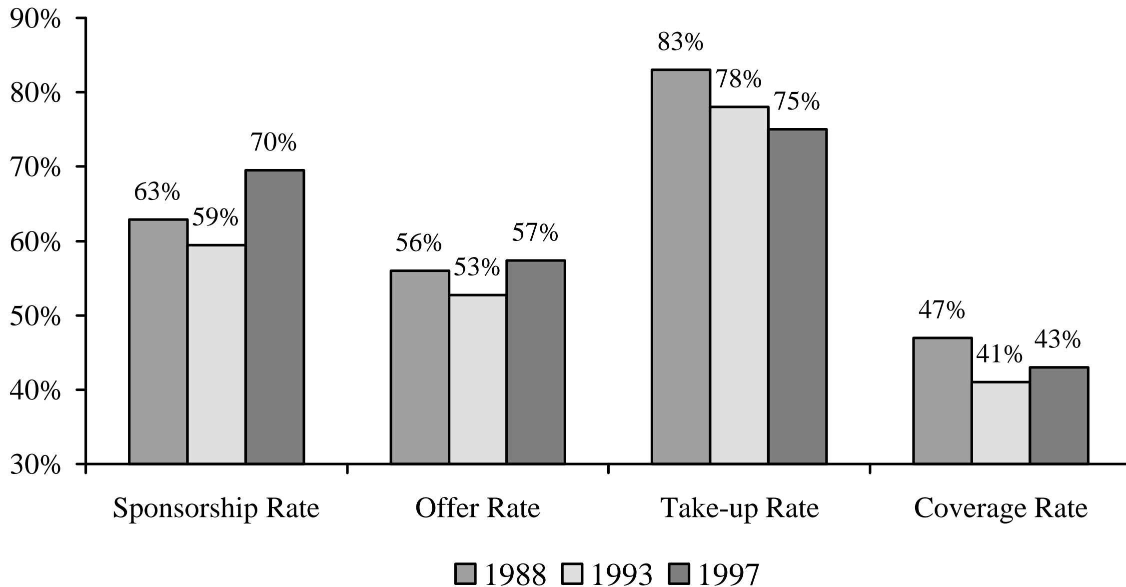
But Dr. Fronstin also found that changes in sponsorship and offer rates did vary by firm size. [See Figure IV-11.] Both sponsorship and offer rates dropped slightly for firms with 100 or more workers, while the sponsorship rate rose for firms with fewer than 100 workers. The offer rate for smaller firms also rose from 1993 to 1997, but only slightly exceeded the 1988 level. Take-up rates fell slightly more for employees in smaller firms.

Figure IV-11: Employment-Based Health Insurance Sponsorship, Offer, Take-up and Coverage Rates Among Wage and Salary Workers Ages 18-64

A: in Firms with 100 or More Employees, 1988 - 1997



B: in Firms with Fewer than 100 Employees, 1988 - 1997



Source: Employee Benefit Research Institute analysis of special supplements to the Current Population Survey, May 1988, April 1993 and February 1997. Data pertains to wage and salary workers aged 18-64.

Using employer surveys providing data for 1993 and 1997, rather than population surveys, RAND researchers Long and Marquis found that the proportion of employees covered through their own employer was essentially stable, rising slightly from 58% in 1993 to 60% in 1997. [See the last line of Table IV-12.] (Recall that Dr. Fronstin's analysis of CPS data showed a slight decrease

from 63% to 62% over the same period. The small size and differing directions of these changes argues for the conclusion of "no significant change.")

By firm size, the increase in coverage rates varied from 1% to 3%. Dr. Marquis noted that, although coverage rates varied significantly by firm size (from 38% for smaller firms to 76% for larger firms in 1997), the difference was due largely to sponsorship rates; both eligibility rates and take-up rates were similar across firm sizes (although slightly lower for smaller firms). Also, these data show a slight increase, rather than a decrease in take-up rates between 1993 and 1997. (Note that the CPS data showed a larger decline in take-up rates between 1988 and 1993 than between 1993 and 1997.)

Table IV-12: Employer-sponsored Health Insurance Coverage, 1993 and 1997: Sponsorship, Eligibility and Participation

	Year	Firm Size (Number of Employees)			
		Fewer than 50	50-499	500 or More	All
Sponsorship Rate[a]	1993	57%	92%	99%	84%
	1997	55%	93%	99%	83%
Eligibility Rate[b]	1993	81%	80%	84%	82%
	1997	82%	80%	86%	84%
Take-up Rate[c]	1993	80%	82%	88%	85%
	1997	83%	86%	89%	87%
Coverage Rate[d]	1993	37%	60%	73%	58%
	1997	38%	63%	76%	60%

Source: Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999), Exhibit 2, p. 136.

a: Percent of employees in firms that offer (sponsor) insurance (for at least some workers).

b: In firms that sponsor insurance, percent of employees eligible for coverage.

c: Among employees eligible for coverage, percent who enroll.

d: Percent of employees enrolled in their own employer's plan.

One reason for the stability of employer coverage since 1993, noted Dr. Marquis, is the fact that, on average, the premium increases faced by employers has been low, averaging only 2.1% per year between 1993 and 1997.[26]

Taken together, these three studies demonstrate that the drop in employer-based coverage between 1987 and 1993 occurred because fewer workers elected to enroll in coverage that was available to them. By lesser percentages, employer sponsorship and offer rates also declined prior to 1993, particularly for small employers. Since 1993, there is no clear trend in coverage of workers through their own employer. The small changes in offer and take-up rates noted in the research are for the most part not statistically significant.

Data from employer surveys conducted over the years by the Health Insurance Association of America, KPMG Peat Marwick and, now, the Kaiser Family Foundation / Health Research and Educational Trust suggest one possible reason for these trends in take-up rates for employer-sponsored coverage: the average employee contribution required for single coverage rose significantly in dollar terms from $8 per month in 1988 and to $34 per month 1993, then leveled off again. The average contribution in 1999 was $35 per month.[27]

Trends in Availability and Cost of Family Coverage

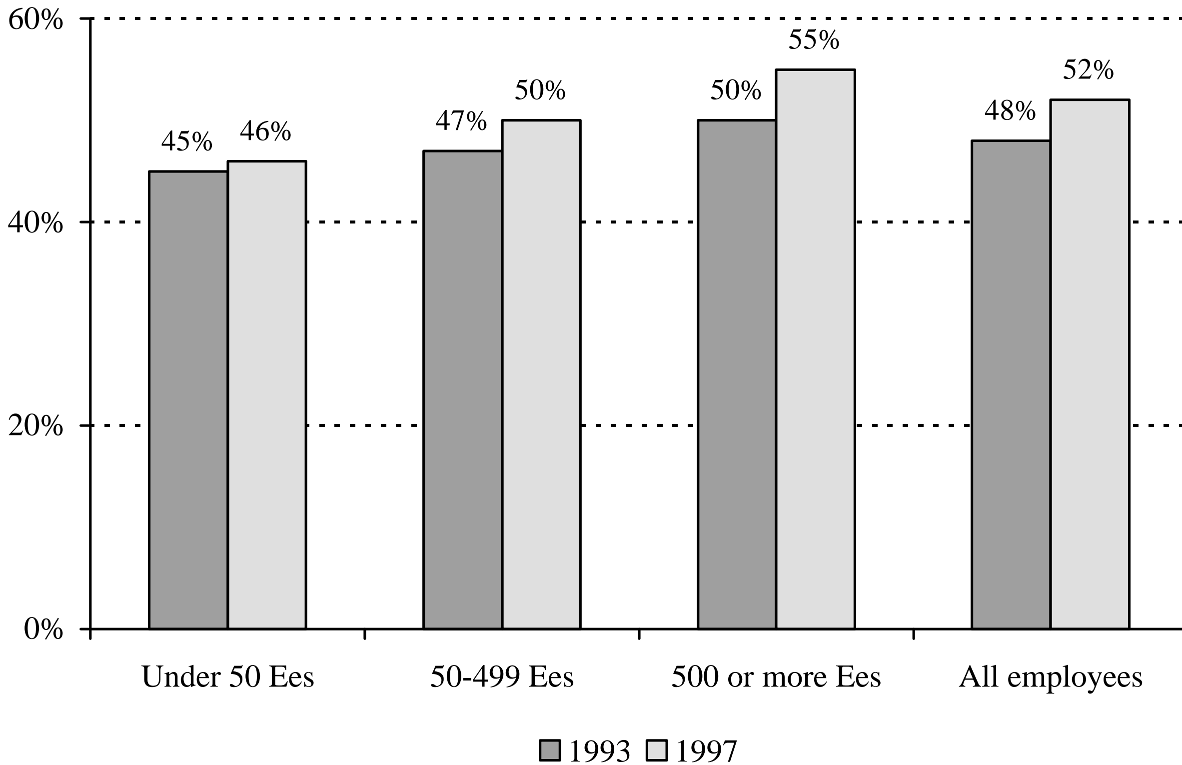
Virtually all employers who offer health insurance offer family coverage.[28] Although take-up rates have been dropping, there is no evidence that access to family coverage has been reduced. Analysis of two employer surveys by Long and Marquis shows that eligible workers signed up for dependent coverage at somewhat higher rates in 1997 than in 1993. [See Figure IV-13.] Note that no information was presented regarding whether the proportion of workers who have dependents grew or remained stable over this period.

[26] Long and Marquis, *op.cit.*, p. 136.

[27] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 1999 Annual Survey*, Exhibit 7.1, p.62.

[28] In both 1993 and 1997, 100 percent of enrollees in firms with 50 or more employees were offered family coverage. In 1997, 98 percent of enrollees in firms with fewer than 50 employees were offered family coverage. Long and Marquis, *op.cit.*, Exhibit 2, p. 136.

Figure IV-13: Percent of Enrollees Taking Dependent Coverage, by Firm Size, 1993 and 1997



Source: Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999), Exhibit 2, p. 136.

The more important issue is how much employees are required to contribute to the cost of family coverage, versus how much their employer contributes. Long and Marquis reported that employer contribution rates to family coverage have been essentially stable for the last few years, falling only a few percentage points on average (from 73% in 1993 to 70% in 1997), with no striking differences in this pattern across firm sizes.

Estimates for large firms from the William M. Mercer benefits consulting firm, cited by Paul Fronstin, found average employer contributions for family coverage varying from 64% to 69% across plan types in 1997, and from 62% to 71% in 1998. Moreover, the Mercer data show no clear upward or downward trend in how health insurance premiums are split between employers and employees in large firms over the past few years (1993 – 1998). For single coverage, the average employer share ranges from 81% to 75% across years and plan types. For family coverage, the range is a bit wider, from 75% to 59% (again, across years and plan types), with no clear trend for most plan types. The exception is PPO plans, for which the average employer contribution (toward family coverage) is clearly lower after 1995 than before.

With respect to actual employee contribution amounts, the U.S. Bureau of Labor Statistics (BLS) reports that, in 1997, 80% of employees with medical care coverage in medium and large private sector establishments were required to contribute toward the cost of family coverage. For those required to contribute, the average monthly contribution was $130.07, or about $1,561 per year. The distribution of contribution amounts is shown in Table IV-14.

Table IV-14: Percent Distribution of Employee Contribution for Family Coverage, Full-Time Employees in Private Sector Establishments

Establishment Size and Year	<100 Ees (1996)	100+ Ees (1997)
No contribution required	25%	20%
Less than $100 per month	15%	29%
$100 - $199 per month	23%	21%
$200 - $299 per month	17%	5%
$300 or more per month	8%	3%
Through flexible spending account	2%	9%
Other and unknown	10%	11%
Average contribution (when one is required)	$181.53	$130.07

Source: IHPS interpolations from U.S. Bureau of Labor Statistics, *Employee Benefits in Small Private Establishments, 1996*, Table 43, and *Employee Benefits in Medium and Large Private Establishments, 1997*, Table 52. Percentages are approximate (+/- 1%).

The comparable BLS figures for small private sector establishments are from 1996. (Note that "establishment" is a single work site and does not have the same meaning as "firm," which may consist of multiple establishments. A small establishment could be part of a much larger firm. Also, in BLS parlance, small establishments have fewer than 100 workers.)

In 1996, 75% of employees with medical care coverage in small private sector establishments were required to contribute toward the cost of family coverage. For those required to contribute, the average monthly contribution was $181.53, or about $2,178 per year. Again, the distribution of contribution amounts is shown in Table IV-14.

Since the October 5th conference, more recent data on employer contributions has become available from the Kaiser Family Foundation / Health Research and Educational Trust Survey of

Employer-Sponsored Health Benefits, 1999. Typically, employers contribute 68% of the cost of family coverage, and the worker is required to contribute $145 per month.[29]

But there is considerable variation across plan types (HMO, PPO, POS, conventional), size of firm, industry and geographic region.[30] For example, workers in the smallest firms (3-9 workers) paid the lowest amount for family coverage in 1999—$99 per month—while workers in firms with 50-199 workers paid the most—$172 per month averaged across all plan types, and $205 per month for HMO plans.[31]

Across regions, worker contributions for family coverage ranged from $104 per month in the Northeast (where employers contributed 80%) to $170 in the West (where employers contributed 57%). Workers paid the least for conventional plans in the Northeast ($71) and the most for Point-of-Service plans in the West ($208).[32]

The 1999 Kaiser/HRET survey also found that employers with 3-199 workers pay the entire premium for family coverage for 26% of their covered workers, while larger employers (200 or more workers) pay the entire premium for only 8% of covered workers (down from 14% in 1996). Employers are more likely to pay the entire cost of a conventional plan than an HMO, PPO or POS plan.[33]

Take-up Rates and Employer Contributions

The amount of the employer's contribution does make a difference in whether or not workers elect to enroll themselves and their dependents in the employer's plan. By firm size, Figure IV-15 shows the distribution of workers who faced employer contributions of varying percentages for family coverage in 1997 (based on the 1997 Robert Wood Johnson Foundation survey of employer-sponsored health benefits, analyzed by Long and Marquis). Figure IV-16 then shows the percent of employees who elect family coverage at each of those contribution levels. It can be see that:

- Where the employer pays less than 60% of the cost of family coverage, only 42% of enrollees elect family coverage (38% in small firms, 43% in other firms).
- Where the employer pays 60% or more, about half of small-firm enrollees and five out of nine enrollees in larger firms elect family coverage. (The survey cannot determine what proportion of enrollees have dependents who could be enrolled. Nor do these figures include eligible employees who failed to enroll even for single coverage.)

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[29] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 1999 Annual Survey*, Exhibits 7.7, p.66, and 7.4, p.64. The entire report can be obtained online at www.kff.org.

[30] *Ibid*. Exhibits 7.3 through 7.15, pp. 63-71.

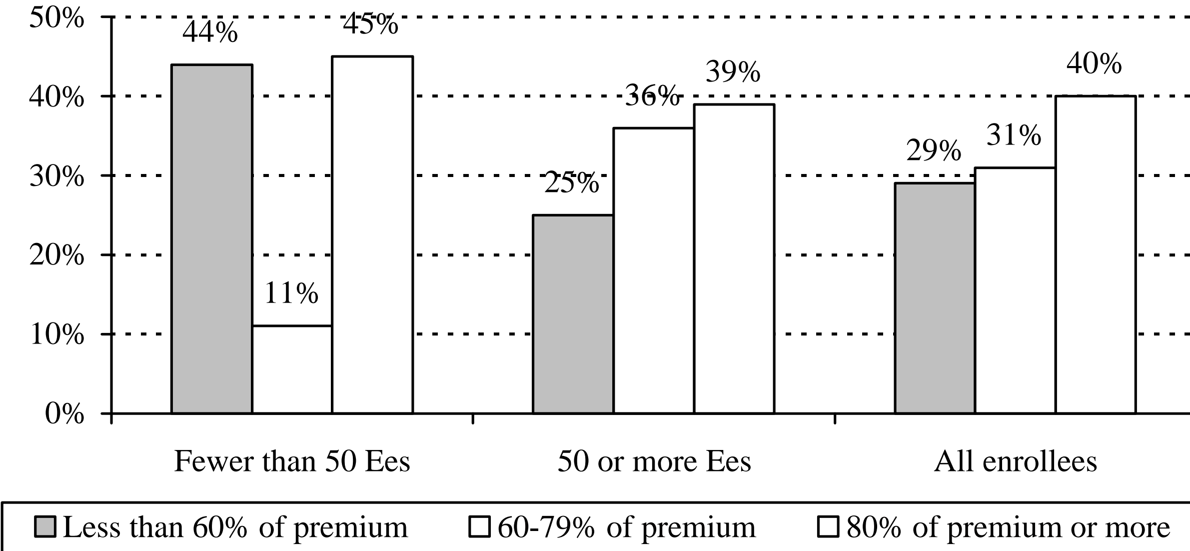
[31] *Ibid*. Exhibit 7.3, p. 63.

[32] *Ibid*. Exhibits 7.4, p. 64, and 7.14, p.70. (Note, however, that due to sample size constraints, many of the regional averages are not statistically different from the "All Regions" estimate.)

[33] *Ibid*. Exhibits 7.12 and 7.13, p. 69.

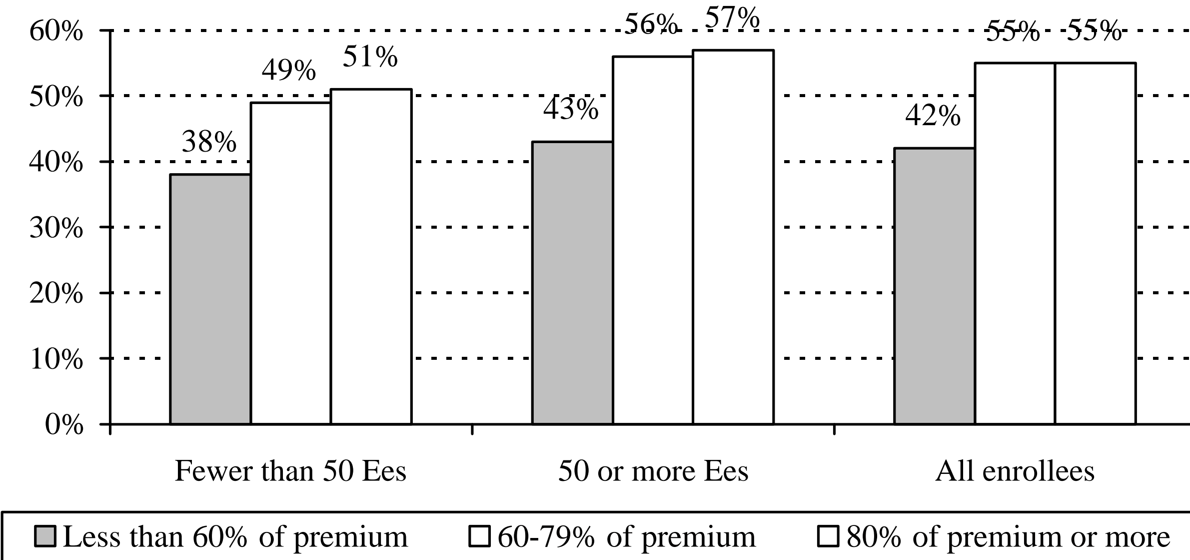
- Overall, slightly fewer enrollees in small firms elect family coverage (46%) than do enrollees in larger firms (50% for firms with 50-499 employees, 55% for larger firms).

Figure IV-15: Percent of Enrolled Employees Facing Various Rates of Employer Contributions for Family Coverage, by Firm Size, 1997



Source: Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999), Exhibit 4, p. 138.

Figure IV-16: Percent of Employees Facing Various Rates of Employer Contributions Who Elect Family Coverage, by Firm Size, 1997

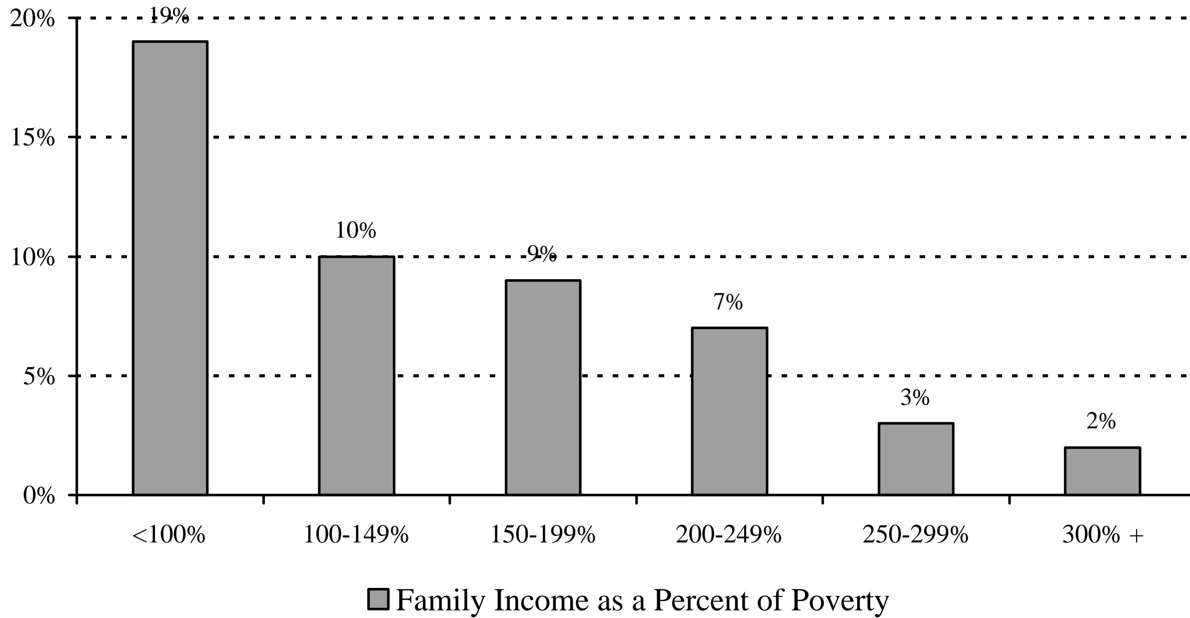


Source: Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999), Exhibit 4, p. 138.

Another recent study shows that low-income persons who have access to employer-sponsored coverage are more likely to remain uninsured than higher income persons.[34] [See Figure IV-17.]

[34] Peter J. Cunningham, Elizabeth Schaefer and Christopher Hogan, "Who Declines Employer-Sponsored Health Insurance and Is Uninsured?" Center for Studying Health System Change *Issue Brief* No. 22 (October 1999).

Figure IV-17: Uninsurance Rates for Persons with Access to Employer-Sponsored Coverage, by Income, 1996-1997



Source: Peter J. Cunningham, Elizabeth Schaefer and Christopher Hogan, "Who Declines Employer-Sponsored Health Insurance and Is Uninsured?" Center for Studying Health System Change *Issue Brief* No. 22 (October 1999), Figure 2. (Data from the HSC Community Tracking Study, Household Survey, 1996-1997.)

Even the same required dollar contribution would be a larger barrier to enrollment for lower income workers, but this study goes on to show that low-income workers typically face higher premium contributions than other workers. Data from the RWJF employer survey show that employee contributions tend to be higher in firms that employ primarily low-wage workers. The result of these higher contribution requirements is clearly shown in lower take-up rates in firms with lower-wage work forces. [See Table IV-18.]

Table IV-18: Employee Cost of Health Insurance and Take-up Rate, by Typical Wage in Firm, 1997

		Average Monthly Contribution for Lowest-Cost Option		
Typical Hourly Wage in Firm	Percent of All Workers	Self-Only	Family Option	Average Take-up Rate
Less than $7	16%	$27*	$130*	78%*
$7 - $10	19%	$20	$112	86%
$11 - $15	27%	$20	$120	89%
More than $15	39%	$17*	$84*	89%*
Total	100%	$20	$106	87%

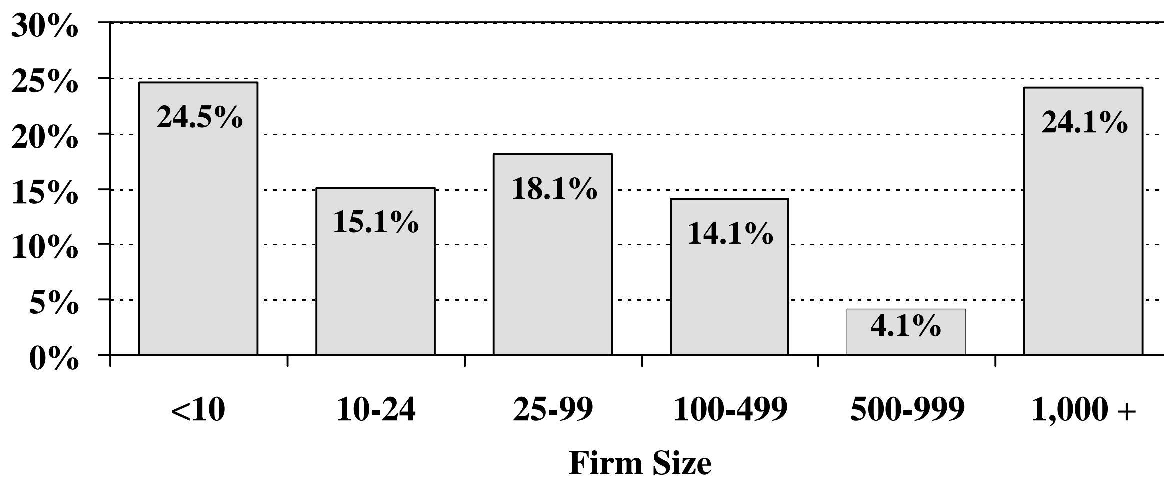
* Difference from average for all firms is statistically significant at the $p<0.05$ level.

Source: Peter J. Cunningham, Elizabeth Schaefer and Christopher Hogan, "Who Declines Employer-Sponsored Health Insurance and Is Uninsured?" Center for Studying Health System Change *Issue Brief* No. 22 (October 1999), Figure 3. (Data from the RWJF Health Insurance Survey, 1997.)

C. Targeting Issues: Where are the Uninsured Children with Access to Employer-Sponsored Insurance?

It is well known that the parents of uninsured children primarily work for small firms. As shown in Figure IV-19, below, almost one-quarter of uninsured children (of wage and salary workers) have parents who work for firms with fewer than 10 employees. Almost 40% have parents who work for firms with fewer than 25 employees.

Figure IV-19: Distribution of Uninsured Children (Under Age 18) of Private Sector Wage and Salary Workers, by Size of Employer, 1997



Source: EBRI Analysis of March 1998 Current Population Survey.

Most of these children do not have access to employer-based insurance; their parent's employer does not even offer coverage. If we focus instead on children who currently have access to employer-based insurance we find a very different picture.

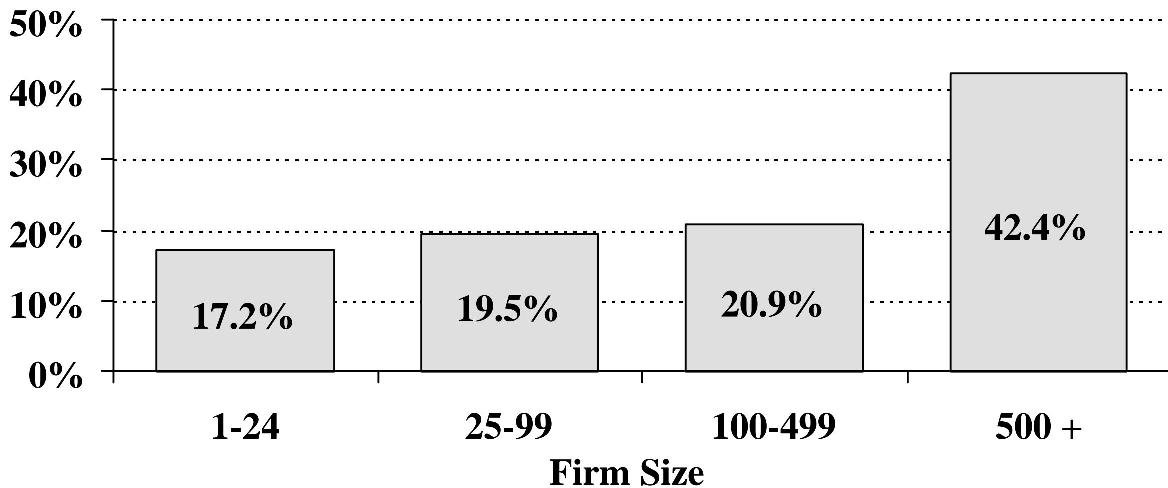
In 1996, about 4.3 million uninsured children (37% of all uninsured children) had parents who either were insured through their own employment or were offered employment-based coverage and declined it.[35] Of these, about 3.4 million uninsured children had parents who worked for private firms. (The remaining parents worked for government or their type of employer was not reported.)

As shown in Figure IV-20, almost two-thirds (63.3%) of these children had parents who worked for medium and large firms (100 or more employees); over 40% had parents worked who worked for large firms. Only one-sixth (17.2%) had parents who worked for firms with fewer than 25 employees. (The distribution differs only slightly between parents who have employer-based

[35] Institute for Health Policy Solutions analysis of 1996 Medical Expenditure Panel Survey data.

insurance and parents who were offered such insurance but declined it. Somewhat more of the parents who have employer-based insurance work for large firms.)

Figure IV-20: Distribution of Uninsured Children Under Age 19 with a Parent Who Has Access to Employment-Based Coverage from a Private Firm, by Size of Employer



Source: IHPS Analysis of March 1998 Current Population Survey and Round 1 of 1996 MEPS.

What these data tells us is that if a state is primarily interested in accessing currently available employer contributions so that it can cover more children, then it should broaden its focus beyond small firms. Most of the uninsured children who currently have access to employer-based insurance have parents who work for medium or large firms. On the other hand, if a state wishes to use a state subsidy for the employee share of dependent coverage as an incentive to try to induce more employers to offer health insurance, then small firms are the appropriate target group.

D. Turnover and Crowd-Out

A critical fact about health insurance coverage, both for children and for adults, is that it is not static. People lose jobs and, after a period of being unemployed, find a new job. While unemployed, they may (or may not) receive welfare and Medicaid. People change jobs. In all of these transitions, people may gain or lose health insurance or change their type or source of health insurance. Moreover, a business's decision to offer health insurance to its workers is not a once-and-for-all decision, particularly for small businesses. Each year, some businesses decide to start offering health coverage, and others decide to stop offering it.

Thus, "the uninsured" are not a fixed group of people; the composition of the group changes constantly. In economists' terms, said Linda Bilheimer, Deputy Assistant Director for Health at the Congressional Budget Office, the uninsured are a "flow," not a "stock." She noted that this insight has profound implications for the size and cost of a subsidized public insurance program

over time. The long-term implications and costs are potentially much different from the short-term.

Because the Current Population Survey (CPS), the survey most frequently used to report on the number and characteristics of the uninsured, is cross-sectional, it is not a good tool for studying the dynamics of insurance status. A different Census Bureau survey, the Survey of Income and Program Participation (SIPP), does track individual households for more than two years and thus allows a better understanding of how people's health insurance status changes over time. Unfortunately, it is not as timely as the CPS.

Using the panel of households that entered SIPP in 1992, Mathematica Policy Research, Inc., analyzed patterns of health insurance coverage for children for the HHS Assistant Secretary for Planning and Evaluation. Significant findings from this study, as presented to the October 5th conference by Linda Bilheimer, include:

- About twice as many children experienced a period of uninsurance some time over a 2-year-period (October 1992 through September 1994) as were uninsured at any particular point in time during that period:
  - ✓ 12-13% of children were uninsured at a point-in-time.
  - ✓ More than one quarter were uninsured at some time during the 2-year period.
- "Spells of uninsurance" experienced by children varied significantly in length, and there seemed to be two different groups of children: The majority were uninsured for only a short time, but some were uninsured for more than a year.
  - ✓ Half of uninsured spells lasted less than 6 months.
  - ✓ One-quarter of uninsured spells lasted a year (12 months) or more.
- Turnover and churning were very high:
  - ✓ Each month, almost 800,000 children gained coverage, and slightly more than 800,000 lost coverage.
  - ✓ Of the specific children who were uninsured in October 1992 (9.2 million children), half were uninsured in September 1994. (This does not mean that they were uninsured for the entire period in between. Many of them had coverage during some of the intervening months.)
  - ✓ Over the 2-year period, 12 million children had 19 million uninsured episodes.

- Even during this pre-welfare-reform period, Medicaid coverage was volatile also, and many children eligible for Medicaid were not enrolled:
  - ✓ One-third of uninsured kids were Medicaid-eligible. Some were in transition, either to employer-based insurance or to Medicaid.
  - ✓ But almost one-half of the children who remained uninsured and eligible for Medicaid for longer periods <u>had previously been enrolled in Medicaid</u> (thus suggesting that lack of knowledge about the program was not the reason they remained uninsured and that further investigation is needed to understand why eligible children drop off the program.)

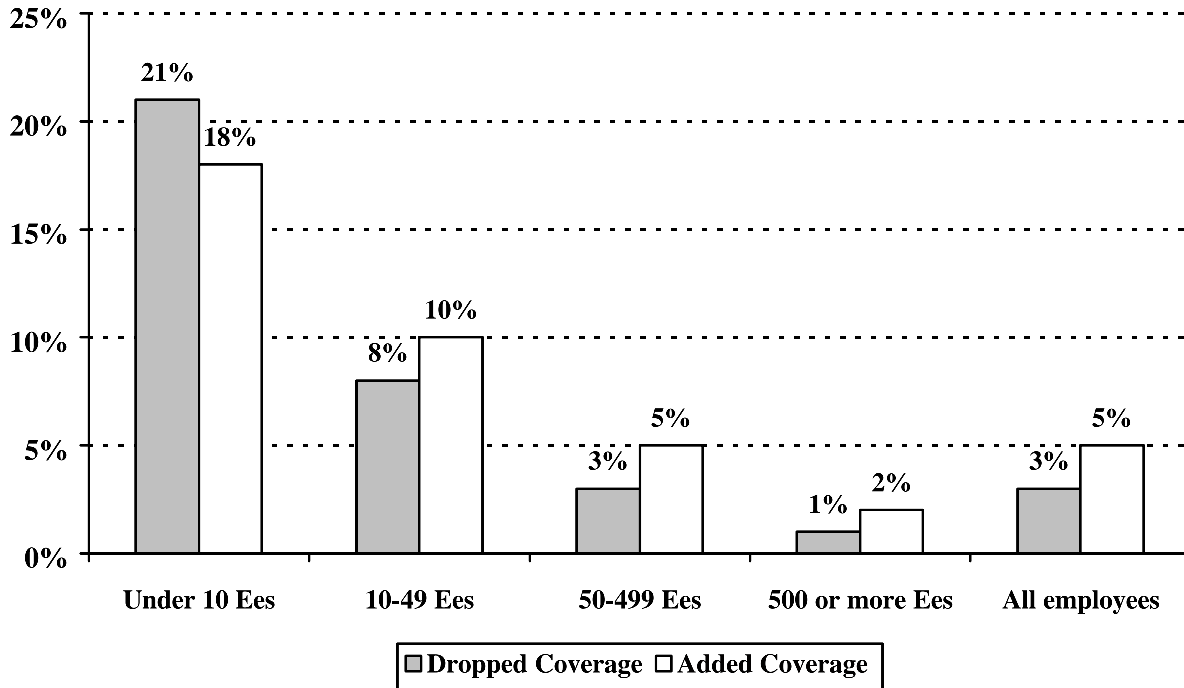
The difference between the "stock" and "flow" concepts of the uninsured is nicely captured in a scenario suggested by Dr. Bilheimer at the October 5th conference, based on Mathematica's findings for the 1992-to-1994 period.

> Suppose we could find every child who is uninsured today, wave a magic wand and give each of them a health insurance card valid until their 21st birthday. Assume that would mean issuing 11 million or so "permanent" health insurance cards. We then do nothing more for a full year. Because of the dynamism of children's insurance status, one year from now there would be about 5.5 million uninsured children—half as many as there are today. (Of course, they would be different children.) Also, we would project that another 3.7 to 5.5 million (one-third to one-half) would have experienced a period of uninsurance at some time during the year.
>
> (Note that those projections of newly uninsured children may be conservative because of the effects of welfare reform on Medicaid enrollment. Welfare reform occurred after the period on which the Mathematica study was based. Thus, in the current environment, the number of children losing coverage might be larger.)

It is also worth noting that businesses, especially small businesses, go in and out of existence quite readily and that businesses do change their minds about offering health insurance coverage to their workers. Using data from the Small Business Administration, Dr. Bilheimer noted that in 1995 there were 4,176,000 establishments in firms with fewer than 20 employers. In 1996, there were 4,256,000, a growth rate of slightly less than 2%. However, during that year, 574,000 new businesses were established (an increase of 14% of the 1995 base) and 494,000 establishments went out of business (a loss of 12%).

RAND researchers Long and Marquis reported that businesses, particularly small businesses, also change their minds about whether to offer health insurance coverage to their workers. [See Figure IV-21.] While coverage is quite stable in larger firms (large firms that dropped coverage between 1995 and 1997 represented only 1% of all workers in large firms), volatility is particularly high for firms with fewer than 10 employees. Of all workers in these micro-businesses, 21% worked for firms that dropped coverage between 1995 and 1997, while 18% worked for firms that added coverage.

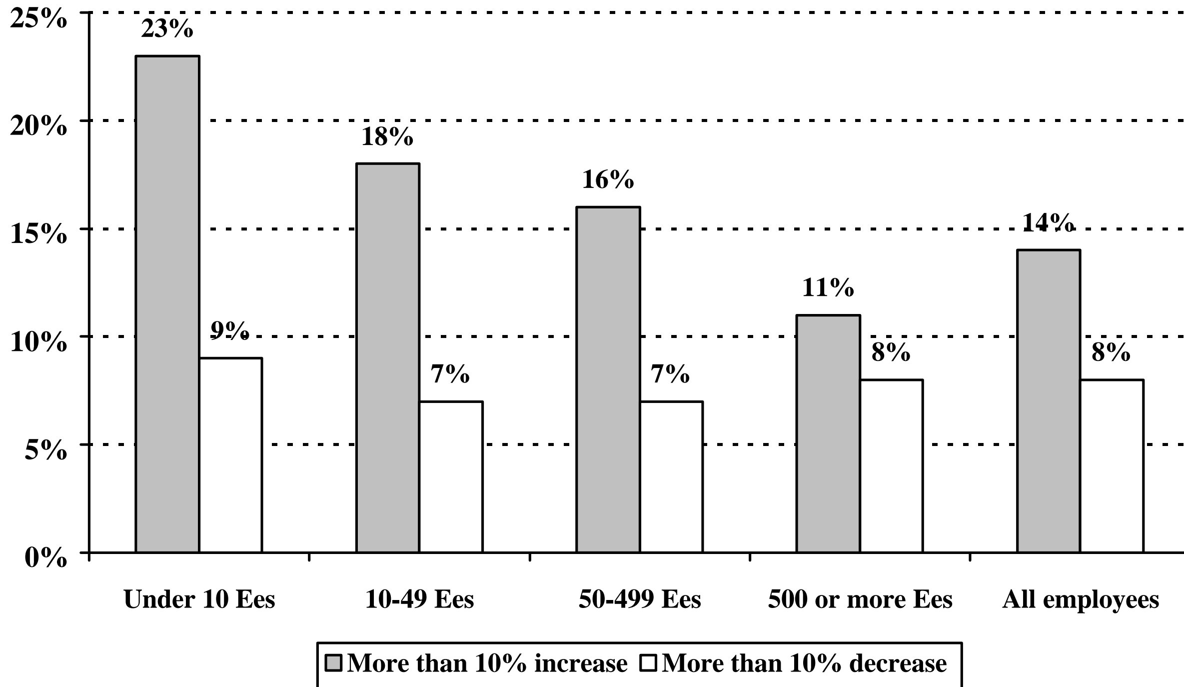
Figure IV-21: Percent of Employees in Firms Which Added or Dropped Coverage Between 1995 and 1997, by Firm Size



Source: Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999), Exhibit 3, p. 137.

Business's decisions to drop health insurance coverage may well be driven by the premium increases they face. Despite the recent stability in average employer-based insurance premiums, many firms report that their premiums increased more than 10% between 1996 and 1997, while about half as many reported premium decreases of more than 10%. [See Figure IV-22.] As might be expected, a greater proportion of the smallest firms faced large premium increases.

Figure IV-22: Percent of Employees in Firms Experiencing Large Changes in Premium Costs Between 1996 and 1997, by Firm Size



Source: Stephen H. Long and M. Susan Marquis, "Stability and Variation in Employment-Based Health insurance Coverage, 1993-1997," *Health Affairs* 18:6 (November/December 1999), Exhibit 3, p. 137.

Implications for Crowd-Out and Efficiency of Public Subsidies

The dynamism in children's health insurance status has important implications for policymakers interested in assuring that public subsidies for children's health insurance do not replace ("crowd-out") private funds currently being used for this purpose. The key fact is that many children who become uninsured and potentially eligible for S-CHIP would be likely, even in the absence of S-CHIP, to obtain coverage again within a matter of months (rather than years) in most cases.

Some percentage of these children will actually enroll in S-CHIP while they are uninsured. At issue is what happens if employer-based insurance subsequently becomes available to them. If no Premium Assistance is available through S-CHIP, parents who are faced with any significant contribution requirement for dependent coverage through their employer may forego the employer-based insurance available to their children and simply leave them enrolled in S-CHIP, at full cost to the State (except for any S-CHIP premium the State may require). If, on the other hand, the State has established a Premium Assistance program to subsidize employer-based insurance for S-CHIP-eligible children, parents may be more likely to enroll their children in the employer's plan, potentially reducing the State's expected cost.

However, while a Premium Assistance program may reduce public costs compared to a regular S-CHIP, Linda Bilheimer believes that displacement of private spending on health insurance (by individual families) is inevitable if the program is successful. Costs will rise over time as new children become eligible for subsidies and those enrolled in the program do not return to unsubsidized private coverage. It may be tempting to try to avoid this scenario by targeting only the long-term uninsured, but the Mathematica study was unable to identify significant differences in characteristics between long-term and short-term uninsured children, making such targeting difficult. Dr. Bilheimer also believes that "firewalls" do not accomplish much. As the previous discussion suggests, requirements that children be uninsured for some period of months before enrolling in S-CHIP may prevent parents from dropping private coverage to enroll them in S-CHIP in the short term, but will not preclude them from enrolling in S-CHIP over the longer term.

Over time, labor markets will also adjust to the presence of subsidies. Low-wage workers with employer-sponsored coverage, for example, may transfer to firms offering higher wages and no insurance coverage, and then apply for subsidies for their children. Moreover, state attempts to establish different participation requirements for employers, based on whether or not they currently offer insurance, are not likely to be effective. A program such as S-CHIP, affecting low-income workers, is not likely to change the behavior of large, established firms with heterogeneous work forces. But, for the many new firms established each year, whatever parameters the state establishes will become reality for those firms if enough of their workers are eligible for the program.

A conference participant, noting the "churning" of children's insurance status, suggested that low-income children might have more stable coverage and care in a public S-CHIP program than in ESI. Because low-wage workers change jobs and, therefore, health plans frequently, it might seem that the children's coverage and care arrangements would be more stable if they were continuously enrolled in the public S-CHIP program.

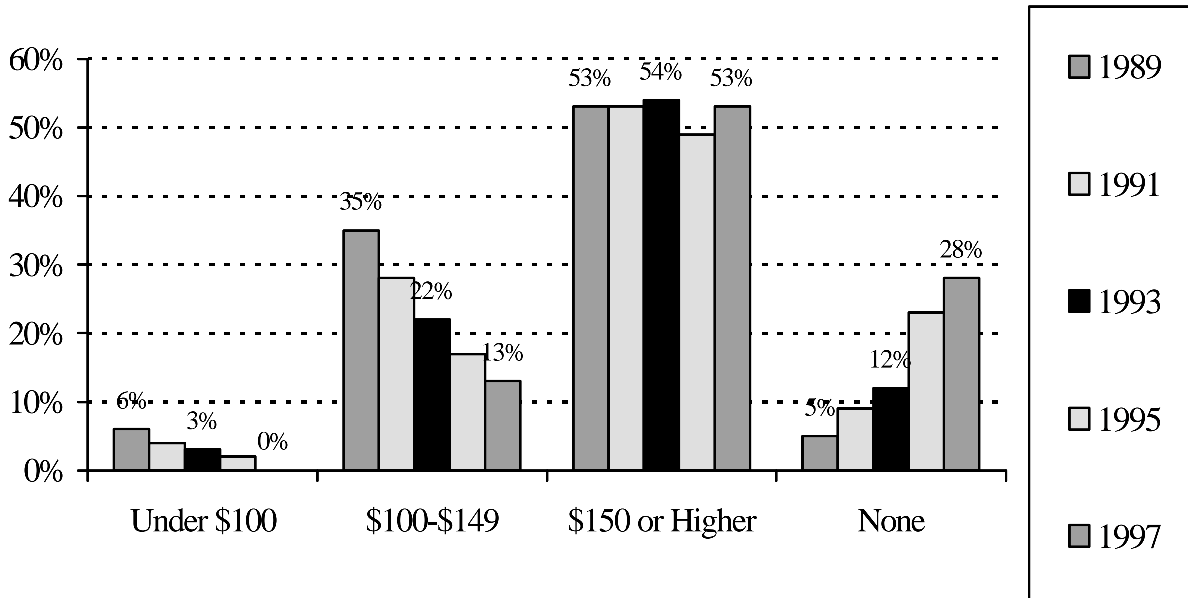
On the other hand, job changes also affect workers' incomes and could lead to frequent changes in whether the worker's children were eligible for S-CHIP. In this case, employer-based insurance might be the more stable environment. If Premium Assistance were available under S-CHIP, the children's coverage and care arrangements could remain stable whether or not a subsidy was available to the family at a particular time. (And, by leveraging the employer's contribution, the premium subsidy would cost less than enrollment in the public program.) Moreover, as Karla Hanson's research indicates, having the child enrolled in the same employer plan as the parent facilitates the child's access to needed services. However, as Linda Bilheimer suggested, not enough is known about why children go in and out of employer-based insurance to answer this question definitively.

E. Trends in Benefit Packages for Employer-Sponsored Health Insurance

With respect to benefits offered, it does not appear that covered employees are being asked to pay more out of pocket for deductibles and co-insurance. Dr. Fronstin reported that, between 1989 and 1997, there was a considerable increase in the percentage of workers in medium and large

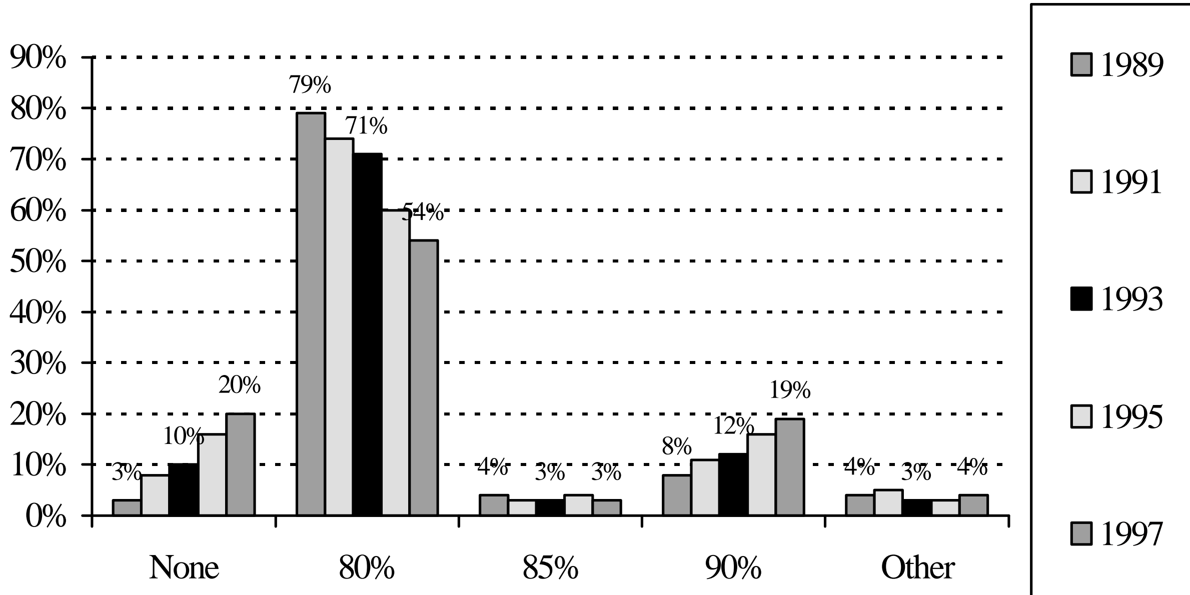
private establishments who faced no deductible (for their non-HMO plans). [See Figure IV-23.] Similarly, the percentage of such workers required to pay the once-standard 20% of medical bills also fell sharply, while the percentage required to pay 10% or no coinsurance at all rose. [See Figure IV-24.] Presumably, these trends reflect the shift of workers out of traditional indemnity plans into PPO-style plans, which may not impose deductibles for in-network services and may charge flat-dollar copayments instead of percentage coinsurance.

Figure IV-23: Percent of Full-Time Employees Participating in non-HMO Plans Facing Deductibles of Various Amounts, Medium and Large Private Establishments, 1989-1997



Source: U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments,* various years, as presented by Paul Fronstin, Employee Benefit Research Institute.

Figure IV-24: Percent of Full-Time Employees Participating in non-HMO Plans Facing Varying Coinsurance Rates, Medium and Large Private Establishments, 1989-1997



Source: U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Private Establishments,* various years, as presented by Paul Fronstin, Employee Benefit Research Institute.

In 1997, according to the Bureau of Labor Statistics, 66% of full-time workers with health coverage through medium and large private sector establishments had coverage for well-baby care (96% of those enrolled in HMOs and 51% of those enrolled in other plans). For immunizations and inoculations, 52% had coverage (90% of those in HMOs and 34% of those in other plans).

Attachment A: Conference Agenda

9:00 a.m.	**Registration-** *Washington Room Foyer*
9:30	**Welcome and Introductions** • **Ray Sheppach**, Executive Director, National Governor's Association • **Rick Curtis**, President, Institute for Health Policy Solutions
9:40	**The View from Pennsylvania Avenue** Administration Policy Perspectives • **Jeanne Lambrew**, Senior Health Policy Analyst, Office of Policy Development, Executive Office of the President
9:45	**Why Get it Together?** Why pursue kids' coverage through parents' employer-based plans: State and federal policy perspectives • **Robert. S. Diprete**, Director, Oregon Health Council • **Mark Reynolds**, Acting Commissioner, Massachusetts Division of Medical Assistance • **Therese Hanna**, Mississippi State Insurance Administrator • **Joyce Raichelson**, Administrator, Florida MediKids Program • *Moderator:* Rick Curtis, Institute for Health Policy Solutions
10:45	**As a Matter of Facts** Analytic insights into: the relationships between parents' and children's coverage and service use; the dynamic nature of health insurance status and longer term public and private cost; trends in children's coverage and employment-based health insurance • **Karla Hanson**, Ph.D., Assistant Professor, New School University • **Linda Bilheimer**, Ph.D., Deputy Assistant Director for Health, Congressional Budget Office • **Paul Fronstin, Ph.D.,** Senior Research Associate, Employee Benefit Research Institute • *Moderator:* Rick Curtis, Institute for Health Policy Solutions

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12:00	**Lunch –** *Two Continents- Lobby Level*
1:00	**Say What?** Employer-based health insurance trends, benefit packages, employer contributions, and differences for modest wage workers • **Stephen Long**, Ph.D., Senior Economist, RAND • **Susan Marquis**, Ph.D., Senior Economist, RAND • *Moderator:* Ed Neuschler, Senior Program Officer, Institute for Health Policy Solutions
2:00	**Who Pays Whom How?** Subsidy payment approaches and implications for what will work • **Anita Smith**, Mananger, Insurance Purchasing Unit, Division of Medical Services, Iowa Department of Human Services • **Deborah Bradley**, Chief of Staff, New Jersey Division of Medical Assistance and Health Services • **Mark Reynolds**, Acting Commissioner, Massachusetts Division of Medical Assistance • **Robert. S. Diprete**, Director, Oregon Health Council • **Therese Hanna**, Mississippi State Insurance Administrator
3:00	**Break-** *Washington Room Foyer*
3:15	**The Strings that are Attached** Overview of Key Program Requirements for Premium Assistance under CHIP • Cheryl Austein Casnoff**, Acting Director, Division of Benefits, Coverage and Payment, Center for Medicaid and State Operations, Health Care Financing Administration**

<table>
<tr><td>3:30</td><td>How's That?
Pioneering states present design and implementation approaches

Obtaining information and assessing applicants' employer-based coverage: benefits and cost-effectiveness
Anita Smith, Mananger, Insurance Purchasing Unit, Division of Medical Services, Iowa Department of Human Services
Patricia Canney, Director of Program Implementation, Massachusetts Division of Medical Assistance
Getting benefits up to snuff:

Coordinating with employer groups
Robert. S. DiPrete, Director, Oregon Health Council
Mark Hogan, Executive Vice President, Gallagher Byerly, Inc.
Peggy Anet, Consultant, AOI Oregon HealthChoice
Contracting with a supplemental carrier
Robert Stampfly, Director, Managed Care Support Division, Michigan Department of Community Health
Catherine Schmitt, Director of PPO Programs, Blue Cross Blue Shield of Michigan
Therese Hanna, Mississippi State Insurance Administrator
Other approaches
Patricia Canney, Director of Program Implementation, Massachusetts Division of Medical Assistance
Moderator: Laura Tollen, Senior Analyst, Institute for Health Policy Solutions</td></tr>
<tr><td>4:50</td><td>What Next?
Concluding Remarks
Rick Curtis, Institute for Health Policy Solutions
Joan Henneberry, Deputy Director, Health Policy Studies Division, National Governors' Association</td></tr>
</table>