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Premium Assistance: What Works? What Doesn't?

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This paper, which represents the final product of this series of grant-funded projects, highlights what have been found to be the most critical issues for the effective functioning of premium assistance programs. In it, we attempt to distill the key lessons we have learned and key insights we have gained from working with States over the past five-and-a-half years.

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“Premium Assistance” means helping low-income working families to pay the employee contribution necessary to enroll (or remain enrolled) in employer-sponsored coverage that is available to them.¹

As they search for efficient and effective ways to provide health insurance coverage for working uninsured families, policy makers at both the state and the federal level have increasingly expressed interest in premium assistance approaches to subsidizing the purchase of private employment-based coverage by such families.

States began to gain limited experience with premium assistance even before a specific requirement for “health insurance premium payment (HIPP)” was added to the Medicaid statute in 1990.² Interest in premium assistance increased with the enactment of the State Children’s Health Insurance Program (SCHIP) in 1997, which expanded public coverage to children in working families above poverty, who were presumed to be more likely to have access to employment-based coverage than children on Medicaid were, and which specifically authorized payment of premiums for private health care insurance coverage.³ While a growing number of States are now pursuing premium assistance, only a handful have achieved significant enrollment under Medicaid, and none have under SCHIP, without a §1115 demonstration waiver and funding for parents as well as children.

This paper draws upon and attempts to distill State experience to date with premium assistance. It seeks to highlight the most critical issues for the effective functioning of premium assistance programs, as well as areas where additional flexibility under Health Insurance Flexibility and Accountability (HIFA) waivers could make a real difference in the feasibility of such programs. More specifically, the paper addresses the following questions:

- What policy and program elements are critical to making premium assistance really *work*?
- How is the design of these critical elements related to key environmental and program variables, such as target population, employers, etc.?

¹ The term “premium assistance” is used regularly in the context of State Children’s Health Insurance Programs (SCHIP). Under Medicaid, premium assistance usually is referred to as “Health Insurance Premium Payment” or “HIPP”. Other terms States use include “premium support” and “purchasing credits.” Under SCHIP, because children who already have employer coverage are ineligible for the program, SCHIP-funded premium assistance cannot be used to help them remain enrolled in that coverage. Medicaid, however, does not require that applicants be uninsured in order to qualify. Therefore, HIPP is used not infrequently to encourage (or require) Medicaid recipients to remain enrolled in their employer coverage.

² Section 1906 of the Social Security Act, as added by Pub.L. 101-508, title IV, Sec. 4402(a)(2), Nov. 5, 1990, and amended by Pub.L. 105-33, title IV, Sec. 4741(b), Aug. 5, 1997. The original provision was theoretically mandatory on the States, but the 1997 amendment recognized reality and made HIPP optional.

³ Section 2110(a)(25) of the Social Security Act specifies that “child health assistance” includes “premiums for private health care insurance coverage.”

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- What new approaches are being pursued under HIFA waivers that could make ideas work that could not work before?

A schematic outline giving key features of currently operating State premium assistance programs appears as Appendix B.

I. Policy Goals: Alternative “Mindsets”

There are a variety of reasons for States’ growing interest in subsidizing the purchase of private employer coverage by uninsured working families.

- By taking advantage of employer contributions, premium assistance allows States to serve more uninsured children and families with the public funds available.
 - » Nationwide in 1998-99, 22% of children and 11% of parents on Medicaid had access to employment-based coverage but were not enrolled. For children on SCHIP or other public coverage, the access rate was almost 40%.⁴
- Because it builds on enrollment in mainstream, employment-based health coverage, premium assistance may be able to reach uninsured children whose parents are loath to enroll them directly in a separate public program.
 - » Again in 1998-99, 30% of uninsured children and 26% of uninsured parents had access to employment-based coverage but were not enrolled. For families with incomes between 133% and 200% of poverty, the access rate was even higher—36% for both uninsured children and parents.⁵
- Allowing families to enroll together in a single health plan, easily and conveniently, makes it more likely that children will be covered and will actually use preventive services and other necessary medical care.
- When eligibility for public programs expands above the poverty level, making premium assistance available may help to discourage workers from dropping employment-based coverage.
- 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, and will remain available if they become ineligible for public subsidies due to increased earnings.

⁴ Unpublished Institute for Health Policy Solutions analysis of public-use data from the Community Tracking Survey, Round Two Household Survey, sponsored by the Center for Studying Health Systems Change (www.hschange.org).

⁵ Ibid. The 36% access rate for children in the 133%-200% FPL range consists of 16.2% with a parent who had employer coverage and 19.4% with a parent who had declined employer coverage. In analyzing the March 2000 Current Population Survey (which measured coverage status during 1999), IHPS found a similar result: Of uninsured children in the 133%-200% FPL income range, 18.3% had a parent who was covered by employment-based insurance. (The number of uninsured children whose parent declined employer coverage cannot be determined in the March CPS.)

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While states' interest in premium assistance is generally motivated by some combination of these objectives, there can be important and substantial differences of perspective about broader goals. For example, some state officials view premium assistance as an important tool in a broader strategy of encouraging private employment-based coverage, while others view it more as a way to extend the reach of public program dollars and approaches.

As a result, there are differences in what premium assistance program structures are deemed desirable or applicable (although changes in the fiscal and political environment can substantially alter such perspectives in a given state over time). These often unstated policy goal "mindsets" influence program design as well as views regarding public budget efficiency measures. Understanding such differences in policy context can facilitate a constructive appreciation of "effective" program design. To assist such an understanding, this section identifies three major alternative "mindsets" and discusses how they differ with respect to their primary goal, their views about "benefit equity" and how they measure "efficiency" in the use of public funds.

Note that these "mindsets" apply primarily in discussing coverage for working families with incomes above the poverty level. Families below poverty are much less likely to have a permanent full-time worker and, therefore, will have to rely primarily on public coverage because employment-based coverage is much less likely to be available to them.

A. Maximize Private Employment-Based Coverage

Policy makers with this perspective believe that coverage expansions should, to the degree possible, reinforce the mainstream system under which people who work regularly, and their families, get health coverage through their workplace. Therefore, in this mindset, the *primary goal*, for those above the poverty level, is to maximize the number of persons covered through private employment-based coverage, using premium assistance where needed to do so. Public program coverage is seen as intended primarily for the poor and for those for whom adequate private coverage is not affordable or accessible.

Since workplace coverage is primary in this mindset, *benefit equity* means equity within the employer group, i.e., all those in a given employer group should receive the same benefits, regardless of their subsidy status. Where public subsidies are restricted to people who are uninsured when they apply (as, e.g., under SCHIP), the question from this perspective is why workers who initially declined employer coverage should receive both public subsidies toward their premium share and better benefits than their low-income coworkers who accepted (and paid for) employer benefits in the first place and therefore would not qualify for subsidies. (Whether the employer plan meets adequate benefit standards may or may not be additional criteria.)

In this mindset, *efficiency* is thought of in terms of public outlays per covered person in the target income group, system-wide (i.e., without regard to how they are covered or who pays).

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B. Reduce the Cost of Providing Public-Program-Equivalent Benefits

Policy makers with this perspective accord very high priority to the *benefit equity* concern that all those receiving publicly subsidized coverage should receive equivalent benefits. Their *primary goal* is to extend the equivalent of public program coverage to all uninsured, income-eligible persons, whether or not they have access to employer coverage. But they are willing to make use of employment-based coverage (and employers' contributions) to stretch public funds further and make that goal financially attainable, wherever it is cost-effective to do so and the employer plan's benefits are, or can be supplemented to be, equivalent to public program benefits. They think of *efficiency* in terms of public outlays per subsidized person. (That is, people not receiving public subsidies are not taken into account, even if they belong to the target income group.)

C. Maximize Public Coverage

In this mindset, the *primary goal* is to extend public program coverage to the maximum number of low-income working families. The *benefit equity* concern is that all those receiving publicly subsidized coverage have access to the same (public program) benefits, and this concern is given very high priority. Employer coverage tends to be viewed as inadequate to meet the needs of low-income people and, therefore, it is seen primarily as a third-party financing source rather than as standalone coverage. Premium assistance is not a priority and is acceptable only in instances where public costs for an individual are dramatically reduced (e.g., because it is a high-cost individual), and premium assistance recipients must continue to have access to all public program benefits with at most nominal cost sharing. *Efficiency* is measured in terms of cost per public program enrollee.

As will be seen in the following sections, these policy "mindsets" have an important impact on pragmatic policy design questions for premium assistance.

II. Relationship to Direct Public Coverage

Premium assistance is usually (but not always) offered as an alternative to enrollment in direct public coverage. Where this is the case, and low-income working parents and children have access to direct public direct coverage, the design of the underlying public program can have a significant impact on the feasibility, effectiveness and efficiency of a premium assistance program. (As used here, "design" includes both stated policy goals and operational processes.)

Public program design theoretically should, but may or may not, reflect a consensus among policy maker's regarding the State's broad policy goals. For example, it can give effect to a policy that applicants are expected to make use of employer coverage that is available to them (with assistance where appropriate). Or it can emphasize primarily getting people enrolled promptly in public coverage, in effect leaving the possibility that employer coverage is available as a lower priority concern. Wisconsin's experience provides a case in point.

In designing the BadgerCare family-coverage program, **Wisconsin** policy makers intended that families should make use of employer coverage that was available to

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them. Families whose employers offered family coverage and paid 80% or more of its cost were made ineligible for public coverage. If employer family coverage was available but the employer contributed less than 80%, families were required to enroll in that coverage at their next opportunity, with premium assistance to pay their share of the employer-coverage premium (when cost-effective). In short, a general policy that apparently supported use of available employer coverage.

However, other public program (BadgerCare) policies and objectives have caused premium assistance enrollment in Wisconsin to remain meager, even more than three years after BadgerCare was implemented. Primarily, a decision was made to enroll people in the public program first and try to check on the availability of employer coverage later. That is, applicants found eligible for BadgerCare are enrolled immediately, and checking on the availability of employer coverage takes place only afterwards. A few applicants do have their coverage terminated, two or three months later, when their employers report that family coverage with an 80%+ employer contribution had been offered to them within the past 18 months. But the applicants themselves are not required to obtain insurance verification information from their employer and, while employers are asked (primarily by mail) to supply that information, they also are not required to and often do not supply it. Moreover, the actual current employer often cannot be located. As a result, as of June 2001, no employer verification had been obtained for about 4 out of 9 employed BadgerCare applicants.

(In the context of the Wisconsin's severe revenue shortfall, the newly elected Governor's budget recommends that applicants be required to obtain verification of insurance status from their employer as a condition for initial eligibility for, and renewal of, BadgerCare coverage.)

Two aspects of public-program design that can be particularly critical for the success of premium assistance programs are (a) verification of employer insurance as part of the eligibility process and (b) the premium contributions that are required to enroll in the public program. The different approaches being used by States on these issues, which are discussed at some length in the following sections, reflect their differing policy perspectives. Some additional related issues are also discussed briefly, and the section concludes by noting that several States provide premium assistance to people who are not eligible for direct public coverage.

A. Eligibility Rules and Verification Requirements

As the Wisconsin example makes clear, the public program eligibility determination process is a critical juncture for the success of a premium assistance program. Whether the State's goal is to enforce an employer-coverage-first policy or simply to tap into available employer contributions, it cannot be achieved unless the fact that employer coverage is available can be identified and the necessary information about it obtained.

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1. "Public Program Enrollment First"

Like Wisconsin, some States emphasize making the application process for public coverage as easy as possible and avoiding delays in public-program enrollment. While this approach enables the public program to reach more uninsured people more quickly, it makes it much harder to obtain information about employer coverage the applicant may have access to and therefore reduces the potential reach of premium assistance. Specific operational policies that create obstacles for premium assistance include:

- a. Not verifying the identity of the applicant's employer or obtaining contact information for the person most knowledgeable about the employer's health coverage.
- b. Granting public-program eligibility before investigating whether employer coverage is available to the applicant.

From a premium assistance perspective, such policies can create problems such as:

- c. Inability to identify the actual employer due to inaccurate or incomplete information on the application.
- d. Inability to obtain information from the employer (if identified), because the State cannot compel the employer to cooperate (per ERISA)⁶, and the applicant has already been granted eligibility.

2. Insisting on Employer Coverage Information and/or Enrollment First

States that want to maximize reliance on private employment-based coverage could consider policies such as:

- a. Requiring adults to accept qualifying employer coverage, if available, as a condition of eligibility for receiving public subsidies. (I.e., premium assistance is available toward the cost of their employer coverage but refusal to enroll in that coverage results in loss of eligibility.)
- b. Denying public program eligibility to applicants who turned down an employer's offer of affordable coverage. (E.g., **Wisconsin** terminates eligibility if a recipient's employer reports coverage is available and the employer pays 80% or more of the premium.)

⁶ The Employee Retirement Income Security Act of 1974 (ERISA) does not allow States to regulate employee benefit plans. Thus, States cannot directly demand that employers provide them with plan information. However, ERISA rules do require employer plans to develop and give to plan participants a Summary Plan Description. Workers could simply ask their employer for a copy of that same Summary Plan Description (or some other existing benefit coverage documents) along with employee contribution requirements. See Rick Curtis and Ann Page, *Extending Health Care Coverage for Modest-Income Children and Pregnant Women: Public & Employer-Financed Coverage Lessons*, Institute for Health Policy Solutions, December 1996.

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However, the success of such policies and of premium assistance itself depends on the State's ability to identify promptly and accurately when employer coverage is available to an applicant. States could consider:

- c. Requiring that (verified) basic information about whether employer coverage is available be provided before eligibility for the underlying public program will be granted.

For example, until very recently, **Iowa**, which has a relatively large Health Insurance Premium Payment (HIPP) component of its Medicaid program, required employer verification of both wages paid and whether or not employer health coverage was available to the applicant before granting Medicaid eligibility.

By requiring the applicant to obtain information directly from their employer, the State avoids (or at least significantly reduces) the potential for fraud, as well as operational problems due to inaccurate or incomplete employer identification information.

As policy makers strove to reduce barriers to coverage, particularly of uninsured children, requiring verification during the eligibility determination process has fallen out of favor in the past five years or so. From this perspective, the obvious disadvantages of requiring verification about employer coverage are that some eligible people will be discouraged from applying and that eligibility will be delayed for some period of time for applicants who are in fact eligible. Additionally, if applied to families who are already enrolled in public coverage (e.g., as part of a transition to premium assistance or at redetermination), a verification requirement could increase caseload churning.

When budget shortfalls might otherwise force reductions in income-eligibility standards, however, States may prefer a policy of stricter verification so that those who need and want coverage can still obtain it.

- An important limitation of required verification is that, under federal rules, Medicaid eligibility for children cannot be denied based on their parent's failure to enroll them in employment-based health insurance.⁷

Note also that, due to a work overload situation in its local eligibility offices, Iowa recently decided to revise its employer-verification process. Effective April 2003, verification of employer coverage availability will be done by the central HIPP unit rather than by local eligibility workers and will take place after eligibility has been determined rather than before, although sanctions will still be applied if a client fails to cooperate.

⁷ Section 1906(b)(2) of the Social Security Act.

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B. Premium Contributions

Free or virtually free health coverage for families below poverty seems entirely appropriate to most policy makers. Relatively few of them have a full-time worker in the family who might be eligible for employer coverage. But, as income eligibility levels increase beyond the poverty level, free or very low-cost public coverage may be very attractive alternative to the cost of private employer coverage for a number of low-income working families and their employers. It may encourage these families not to enroll in, or perhaps even to drop (or encourage their employer to drop), employer coverage that would otherwise be available to them. One recent study estimated that, among children in families with incomes between 100% and 200% of poverty, about 39% of the increase in SCHIP and Medicaid coverage between 1997 and 2001 involved substitution for private coverage.⁸

On the other hand, higher recipient contribution requirements are known to discourage public program participation, even among those who do not have access to employer coverage. (The same study found that the proportion of low-income children who were uninsured dropped from 20.1% in 1997 to 16.1% in 2001, as a result of significant increases in public program coverage.⁹) So, as always, there are difficult trade-offs to be evaluated. Ideally, the right combination of eligibility, contribution and premium assistance policies would maximize the number of children and parents covered, overall.

A related issue for premium assistance program design is whether employer's contributions (toward private coverage) will reduce their workers' costs compared to enrollment in the public program. If working families can receive premium assistance to help them enroll in their employer's plan, but have to make the same contribution from their own funds that they would have to make to enroll in the public program, then they are no better off despite their employer's contribution. In this situation, employers with many income-eligible workers have no incentive to maintain or increase their contributions over time.

States that want to maximize reliance on private employment-based coverage could consider policies such as:

1. *Increasing the charge for public-program enrollment as income increases, on a sliding scale.*
 - a. For example, **Rhode Island**'s monthly premium per family (for both public coverage and premium assistance) now ranges from \$61 just above 150% FPL to \$92 at the maximum income.
 - b. For families above 150% FPL, **Wisconsin** charges approximately 3% of countable family income, yielding a range from \$30 to \$165 per month. (Only large families, whose size makes them eligible despite higher incomes in dollar terms, would pay more than about \$90 per month.)

⁸ Peter J. Cunningham, James D Reschovsky and Jack Hadley, "SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage," *Issue Brief No. 59*, Center for Studying Health System Change, December 2002.

⁹ *Ibid.*

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- c. But, in these and most States with operating premium assistance programs, premium assistance recipients pay the same amount as people enrolled in direct public coverage. So, even if an employer pays a greater share of the premium, the worker still has to pay the same amount.
2. *Alternatively, charging an increasing percentage of the total premium or capitation payment.*
 - a. Under its HIFA waiver, **Oregon** charges modest enrollment fees, ranging from \$6 to \$20 per month, for “OHP Standard” (public) coverage of adults below poverty. Above poverty, Oregon charges an increasing share of the actual premium, beginning at 9.2% and increasing to 50%.
 - b. Under premium assistance, Oregon also pays a decreasing percentage of the worker’s cost to enroll in employer coverage as the worker’s income increase, so greater employer contributions do reduce the workers’ cost for coverage.

C. *Related Issues*

1. *Benefits Offered Under Public Coverage*

The content of the benefit package for public coverage is also an important consideration. If a State wants to emphasize and encourage use of employment-based coverage, making public coverage much richer than typical employment-based coverage (for working families above the poverty level) makes no sense. At least in part for this reason, **Oregon** (for example) designed its “Oregon Health Plan (OHP) Standard” coverage for non-“mandatory” adults to be much more like typical employer coverage than like the more comprehensive “OHP Plus” coverage provided to children and “mandatory” groups.

2. *“Qualifying Event” for Employer-Plan Enrollment*

Typically, a worker can enroll in his or her employer plan, or switch from worker-only to family coverage, only once per year or when certain specified events occur. If a worker does not enroll at his or her first opportunity, there may be a considerable wait for the next “open enrollment” period. Obviously, this reality creates potential problems for State premium assistance programs. Workers in families found eligible for Medicaid or SCHIP will often not be permitted to enroll in their employer plan immediately. Thus, their premium assistance status must be “pending” until they can actually enroll, and they must be granted public coverage while they wait.

States can directly address this problem for employer plans provided by licensed health insurance carriers. State insurance law (or perhaps regulations) can be changed to require that licensed carriers and health plans recognize becoming eligible for Medicaid or SCHIP as a “qualifying event” that triggers a special enrollment period. Families found eligible for premium assistance would then be able to enroll in their employer’s plan immediately. **Maryland** is one State that has changed its insurance law in this way.

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However, because the Employee Retirement Income Security Act of 1974 (ERISA) does not allow States to regulate employee benefit plans, States cannot directly tell employer plans they must let workers enroll immediately upon being found eligible for Medicaid or SCHIP premium assistance. If the employer plan is self-insured, there is nothing the State can do except ask for the employer's voluntary cooperation and, if it is not granted, tell the worker to enroll during the next open enrollment period.

The President's Budget for Fiscal Year 2004 includes a legislative proposal to correct this situation. For all employer plans, the proposal would make eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside the plan's open enrollment period. This proposal is specifically intended to help states implement premium assistance programs in Medicaid and SCHIP.

- States should be aware that many uninsured workers who have access to employer coverage work for larger employers who often offer a self-insured plan that is beyond the reach of State insurance regulation. But such employers often also offer an HMO or POS plan that is subject to State insurance rules.

D. Premium Assistance as a Standalone Program

Premium assistance can be offered as a standalone program (i.e., with no option for direct public coverage) for working families. That is, at least for some groups, subsidies can be made available only for private coverage. Recent examples of the standalone approach include:

- **Oregon's** Family Health Insurance Assistance Program (FHIAP), which originally was a solely state-funded program completely separate from Medicaid that provided the only health insurance subsidies available to people above the poverty level. Under Oregon's HIFA waiver, approved in October 2002, FHIAP will now be a federally matched program. But for adults above 100% of poverty, FHIAP will only subsidize private coverage (including individual as well as employment-based coverage). Initially, no direct public coverage will be available for this group.¹⁰
- For adults under 200% FPL, **New Mexico** is developing an employment-based system under a HIFA waiver. By paying \$75 per (income-eligible, covered) worker per month, employers can buy into a system of health-plan offerings arranged by the State for their workers. (Workers pay \$0-\$35 per month, depending on income.) The program is targeted on, but not strictly limited to, uninsured employers.
- In **Massachusetts**, subsidized coverage for childless adults is available only through the Insurance Partnership program, under which the State provides subsidies toward the cost of employment-based coverage for both low-income workers and their small employers.

¹⁰ Public coverage may be made available up to 185% of poverty at a later date.

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Deciding to provide subsidies only for private coverage obviously represents the epitome of the “Maximize Private Coverage” mindset. Most often, however, premium assistance is offered as an alternative to enrollment in direct public coverage.

III. Broadening the Reach of Premium Assistance

If premium assistance programs are to achieve their objectives (as each State defines them) and operate efficiently, they need to reach more than a handful of recipients. This section discusses several “do and don’ts” with respect to maximizing the population served by premium assistance.

A. Keep It Simple for Employers

Successful premium-assistance programs minimize the administrative burden on employers, particularly with respect to subsidy administration.

When they first begin to consider developing a premium assistance program, States sometimes expect that employers will do much of the administrative work for them. For example, they envision employers submitting their benefit plans to the State for pre-certification, even before any of the employer’s workers have applied for assistance. States may also expect to be able to pay the premium assistance subsidy to the employer, who would then eliminate (or reduce) the worker’s payroll deduction for health insurance.

These expectations are for the most part unrealistic. Businesses are not charitable institutions, and an employer’s primary focus is, appropriately, the business and its bottom line. States should not expect employers to be eager to increase their benefit costs by enrolling more workers in the employer’s health plan. Moreover, payroll processing is already complicated enough, without attempting to build in special treatment for premium assistance recipients. And businesses may also be concerned about aspects of premium assistance that may seem unfair to them or to their workers (e.g., providing assistance only for uninsured workers who previously turned down employer coverage, and not for otherwise-identical workers who have been paying out of their own paycheck to be in the employer’s plan).

- Pioneering States like **Massachusetts** and **Oregon** explored whether employers would be willing to receive subsidy funds on behalf of their employees. The answer has generally been “No.” Both these States, as well as **Iowa**, are willing to pay the subsidy to the employer, but they find that employers only rarely are willing to handle subsidy funds, so subsidy payments usually go directly to workers. (But see further discussion of **Massachusetts** below.) Both **Iowa** and **Oregon** will pay the subsidy directly to the health plan when premium assistance is being provided for individual (non-group) coverage.¹¹

¹¹ Iowa notes that direct payment to the health plan may also apply when premium assistance is provided for COBRA continuation coverage.

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- Recently, **Rhode Island** had little success with its initial approach to premium assistance, under which it asked employers to receive subsidy payments from the State and reduce eligible workers' health insurance payroll deduction. In the first year of operation, only about 275 individuals were enrolled in premium assistance. After the State decided early in 2002 to make subsidy payments directly to families, rather than through their employers, 1,700 individuals were enrolled within six months.¹²

There are, however, some situations in which an employer or some other intermediary may be willing to handle subsidy payment on behalf of the State.

- For example, **Massachusetts'** Insurance Partnership program subsidizes both low-income workers and their small employers. Some employers go through a "billing and enrollment intermediary (BEI)" to obtain their health insurance. In this case, the State pays the subsidy to the BEI, which adjusts its billing to the employer appropriately. Other employers receive a check directly from the State through an Insurance Partnership contractor. These employers adjust the health insurance payroll deduction for the employee to reflect the subsidy payment.
- Small employer purchasing pools, where they have certain characteristics, may present States with a real opportunity to reach workers at many small employers easily and efficiently. Such pools generally offer a few standardized benefit plans, which could be pre-certified in advance as meeting State requirements for premium assistance. (In fact, they could even be designed to do so.) And, where they are truly *purchasing* pools, they regularly bill employers for premiums due on behalf of workers who have selected different health plans charging different premium rates. Thus, they would be able to adjust their billings to reflect State subsidies payable on behalf of particular workers. Also, they could routinely collect employer-contribution information at application and renewal, making it easy to determine cost-effectiveness on an ongoing basis. The process would remain simple for the employer, because the pool would handle all of the hard work. The motivation for the pool to participate would be increased enrollment over which to spread its fixed costs.

There may also be rare cases in which a large employer with a significant number of low-wage workers not participating in its health plan would be willing to work actively with the State to make premium assistance work for its eligible employees. The motivation for the employer would be reduced worker turnover—workers who have coverage through their employer are less likely to look elsewhere for a job with better benefits. But this sort of situation is likely to be the exception, rather than the rule. In general, States interested in promoting premium assistance should not ask employers to do more than supply basic information about what their health plan covers and how much workers have to pay to enroll.

¹² Leddy, P. Premium assistance: Opportunities and challenges: Implementing Rhode Island's RItShare program. Philadelphia, PA: 15th Annual State Health Policy Conference of the National Academy for State Health Policy, August 5, 2002. Slide presentation.

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B. Program Exclusions and Narrow Income Ranges Arbitrarily Limit the Population Eligible for Premium Assistance

Because Medicaid and SCHIP are different programs subject to different federal regulatory requirements (see Appendix A) and are often administratively separate at the State level, States often offer premium assistance under one program but not the other. For example:

- Despite its large Medicaid premium assistance (HIPP) program, **Iowa** has not attempted premium assistance under SCHIP, even though, given the higher incomes involved, a much higher percentage of SCHIP children are likely to be eligible for employer coverage.
- **Maryland** has implemented a premium-assistance initiative only for children between 200% and 300% of poverty (eligible for its separate SCHIP program), and not for lower-income children under its much larger Medicaid and Medicaid-model SCHIP programs.
- **Wisconsin** will not provide premium assistance to a family if the children in the family are eligible for regular Medicaid, rather than for BadgerCare (SCHIP). From October 2000 through June 2001, about 60% of cases that would otherwise have qualified for premium assistance were denied because the children in the family were Medicaid-eligible.

In addition to directly limiting the population eligible for premium assistance, such an approach is too fragmented to work well in the world of employer coverage.

- Narrow income-eligibility ranges make only a very small fraction of workers eligible for premium assistance for themselves and their children.
 - » For example, almost three-quarters (73%) of uninsured children with access to employer coverage are in families with incomes below 250% of poverty, but only one in eight (12.6%) are in the income range from 200% to 249% of poverty.¹³
 - » Even employers with a mostly low-wage workforce would have very few of their workers qualify for premium assistance under a program with a narrow income range. Among low-wage full-time workers—those who earn less than \$20,000 per year or about \$10 per hour—27% are parents with family incomes below 250% of poverty, but only 5% are parents in the income range from 200% to 249% of poverty.¹⁴
- Narrow eligibility ranges can also mean that higher-income workers qualify for premium assistance while lower-income workers in the same firm do not. Where lower-income

¹³ Unpublished Institute for Health Policy Solutions analysis of the 1996 Medical Expenditure Panel Survey (full-year panel).

¹⁴ Unpublished Institute for Health Policy Solutions analysis of the March 2000 Current Population Survey. This percentage is low for several reasons: Many workers are childless (i.e., do not have minor children at home). Some low-wage parents have working spouses, and their combined earnings bring family income above 250% of poverty. Conversely, low-wage parents without a working spouse most likely will have family income below 200% of poverty. (Even with only one dependent, a single worker would have to earn \$11.65 per hour, 40 hours per week, to reach 200% of poverty in 2003.)

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families are excluded from premium assistance, the program may seem disjointed and unfair to parents whose larger family size lowers their income relative to poverty and thereby precludes them from receiving assistance for an employer family plan covering their colleagues.

- » For example, consider the situation of two single parents, both working full time and earning \$8.25 per hour (or \$17,160 per year), in a State that offers premium assistance for SCHIP-eligible children (above 133% FPL) but not for Medicaid-eligible children (below 133% FPL).
- » The single parent with one child has income at 148% FPL, and her child qualifies for premium assistance under SCHIP.
- » The single parent with two children has the same dollar income but is at 117% FPL, so her child qualifies for Medicaid and cannot receive premium assistance.
- A less fragmented approach that incorporates a broader income range for premium assistance (incorporating both SCHIP and Medicaid income ranges) would be more equitable and broaden the eligible population considerably.

For example, **Rhode Island**'s RItShare (premium assistance) program is available to all parents and children who are eligible for public coverage through RItCare, the State's combined Medicaid-SCHIP managed care program for families and children. Enrollment in RItShare grew rapidly during 2002.

New Jersey also makes premium assistance available to all parents and children who are eligible for public coverage through its FamilyCare or KidCare programs. For other reasons, however, premium assistance is growing slowly in New Jersey.

C. "Parental Choice" Can Cover More Entire Families When Public Funding Is Only Available for Children

Under normal program rules, premium assistance is typically offered (or required) only when it is cost-effective, i.e., when the total cost to the State of covering the family through their employer's coverage is less than the total cost of covering the eligible family members through direct public coverage. If the worker's share of the premium for employment-based family coverage is too high, this cost-effectiveness test will not be met, and premium assistance will not be offered.

When public coverage is available only for children, as under SCHIP or where a State has not expanded family coverage under Medicaid, the worker's premium share for employment-based family coverage will often exceed the State's cost of covering (only) the worker's children under Medicaid or SCHIP, and premium assistance will not be cost-effective under a narrow interpretation of program rules. (This will be the case especially in States that have obtained very favorable capitation rates for coverage of children.)

- For example, **Rhode Island** reports that, among families with access to employer coverage, premium assistance is found to be cost-effective much more frequently for

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families below 185% FPL (where both parents and children are eligible) than above 185% FPL (where only the children are eligible).

Thus, a narrow interpretation of cost-effectiveness limits the population that could benefit from premium assistance. But an alternative approach is possible, on a voluntary basis for families.

- The State could offer to pay the family a premium subsidy equal to the cost of enrolling the eligible children in direct public coverage.¹⁵ If the family accepted the State's offer, the worker would pay the difference between the amount of the State subsidy and his or her full cost to enroll in the employer plan. In effect, the parent is opting to pay the extra amount—beyond the State's cost for children's coverage—in order to cover themselves as well as their children under a single health plan.

Such an approach apparently would be in compliance with federal requirements for premium assistance under SCHIP, because the additional premium the worker has to pay to enroll all family members in their employer's plan would not be considered to be cost-sharing applicable to the children and therefore would not count toward the 5%-of-income cumulative limit on cost-sharing on behalf of the children.¹⁶

- In **Virginia**, participation in HIPP is mandatory for Medicaid recipients when enrollment in employer coverage with premium assistance is found to be cost-effective. When paying the entire worker's share of the premium for employer coverage is not found to be cost-effective, the State offers the family the option to enroll in their employer's plan with the family paying the employee costs beyond those covered by premium assistance. Much recent enrollment in HIPP has come through this route.¹⁷

A major benefit of this approach is that it provides coverage to an entire family, including the parents, but costs the State no more than covering only the recipient in public coverage.

¹⁵ To comply with cost-effectiveness requirements, the premium assistance subsidy would equal the normal capitation amount the State would pay for direct public coverage of the children, less the cost of any coverage that would be provided to supplement the employer plan and an administrative charge to cover the marginal costs of the premium assistance operation.

¹⁶ The preamble to the revision of the final SCHIP regulations, published June 25, 2001, specifically says that "States need not count an adult family member's cost sharing toward the cumulative family maximum when providing family coverage." *Federal Register*, vol. 66, no. 122, p. 33815. The guidance for the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative specifically states, "In cases where an entire family is covered, this guideline [the 5%-of-income limit] does not need to apply to cost sharing not attributable to individual family members, such as a family premium." While this statement was made in the HIFA waiver guidance, it seems fairly clear from the context that it expresses the federal Administration's general intent on this matter.

¹⁷ Virginia has not expanded coverage of parents under Medicaid. Therefore, families using this option are most likely families in which the children but not the parents are eligible for Medicaid. Enrolling in employer coverage allows the whole family to be covered.

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D. Broader Perspectives on Cost-Effectiveness

Cost-effectiveness is often applied on a case-by-case basis. That is, the specific makeup of the applicant family (number, gender and age of members, etc.) is considered in determining whether premium assistance will be more cost-effective for the State than direct public coverage.

This approach is appropriate if the State's goal is to assure that providing premium assistance does not cost the State more than providing direct public coverage in each particular instance. If the State wants to use premium assistance to encourage use of, and avoid shifts from, employment-based coverage on a broader basis, however, this approach is too narrow. In particular, worker premiums for employment-based family coverage generally do not vary with family size (and may or may not vary based on whether the worker's spouse is or is not included), while public program costs do vary with family size. Thus, smaller families will be much less likely to qualify for premium assistance than larger families if a case-by-case approach to cost-effectiveness is used. In this situation, among workers with the same income working for the same employer, some will qualify for premium assistance and some will not qualify, based on the size of their family, even where all would qualify for direct public coverage. Such a result will seem unfair to the workers and may create morale problems for the employer, making them less willing to participate in premium assistance. Moreover, such confusing mixed signals undermine the State's desire to promote employment-based coverage for low-income working families.

The alternative is to assess cost-effectiveness in a more aggregate way (as permitted, for example, under the SCHIP regulations).¹⁸

- For example, **Rhode Island** performs its cost-effectiveness test for premium assistance on what it calls an "employer-by-employer" basis. The State compares the cost of providing premium assistance for family coverage under a particular employer's plan with the State's average cost of providing coverage to a family under its public RItCare program. If the employer plan is found to be cost-effective using this test, any income-eligible parent working for that employer qualifies for premium assistance. [Separate tests are applied for full family coverage (under 185% FPL) and children-only coverage (over 185% FPL).]

As noted earlier, some States may wish to take an even broader approach to cost-effectiveness by focusing on public outlays per covered person in the target income group, system-wide (i.e., without regard to how they are covered or who pays). Some of the premium-assistance-only strategies recently approved under HIFA waivers (Oregon, New Mexico) move in this direction. They can do so because the HIFA waiver guidance does not require a traditional cost-effectiveness test:

"States will not be required to meet a specific cost effectiveness test for premium assistance programs as part of comprehensive approaches that promise to decrease

¹⁸ 42 CFR 457.810(c)(2).

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the number of uninsured under 200 percent of the FPL. States should monitor that aggregate costs for those enrolled in premium assistance programs are not significantly higher than costs would be if under a direct coverage program, for the purpose of controlling both State and Federal costs under the demonstration.”

IV. To Supplement, or Not to Supplement? Benchmark Issues.

Few, if any, employer plans provide everything that direct public coverage provides. And many don't provide everything included in any one of the SCHIP “benchmark” plans. Some categories of service will not be covered (e.g., dental, mental health), or will be covered less comprehensively under employer plans. And cost sharing at the time of service will almost certainly be higher than under Medicaid or SCHIP.

Dealing with this issue has been among the most vexing problems facing States interested in premium assistance under separate (non-Medicaid) SCHIP programs.

Two salient facts energize a difficult policy debate about the “benefit equity” issue:

- First, direct public coverage is not now available to all low-income children (or adults), because under programs like SCHIP applicants who already have health coverage elsewhere are not eligible for public coverage or subsidies, even when they meet the income standards. (And, of course, relatively few States cover parents above the poverty level, and coverage for low-income childless adults is even rarer.)
- Second, roughly half of people under age 65 (including children) between 100% and 200% of poverty have employment-based health coverage.¹⁹

There are different policy perspectives on what to do about the equity issues raised by the coverage discrepancy between employer plans and direct public coverage (with respect to working families above the poverty level).

- One school of thought holds that all people receiving subsidized coverage should have the same benefits, no matter how they are covered. This view often places overriding priority on the importance of the SCHIP and Medicaid benefit packages.
- The other school of thought holds that low-income people covered by a particular employer plan should receive the same benefits, whether or not their premium costs are publicly subsidized, and that low-income workers whose premiums are subsidized should not be doubly advantaged, compared to their low-income but non-subsidized co-workers, by also

¹⁹ In 1999, 48.1% of U.S. residents under age 65 in the 100%-199% of poverty range had employment-based coverage (with employment-based coverage considered primary to Medicaid). Unpublished Institute for Health Policy Solutions analysis of the March 2000 Current Population Survey. In 2000, 46.6% of U.S. residents under age 65 in the 100%-199% of poverty range had employment-based coverage (with Medicaid considered primary to employment-based coverage). Kaiser Commission on Medicaid and the Uninsured, *Health Insurance Coverage in America: 2002 Data Update*, February 2002. Table 1. (Based on analysis of data from the March 2001 Current Population Survey by the Urban Institute.)

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receiving better benefits. This view often places overriding priority on maximizing the number of low-income people covered by at least a basic package of benefits.

This paper does not attempt to resolve this debate but rather lays out alternative approaches a State might use, depending on its policy perspective. The paper does assume, however, that the issue in debate is the appropriate benefits for children and adults above poverty, i.e., in working families. That benefits equivalent in all respects to those provided by public coverage are appropriate for the poor is not in question.

This section also highlights how federal rules regarding benefit supplementation differ under Medicaid, SCHIP, and Health Insurance Flexibility and Accountability (HIFA) waivers. For a concise matrix highlighting the major differences, see Appendix A.

A. Full Supplementation—for Both Services and Cost-Sharing

Full supplementation aims to assure that premium assistance recipients have access to the same services, subject to the same cost-sharing limitations, that children and parents with direct public coverage have access to. Under regular (non-waivered) Medicaid, full supplementation is required for premium assistance (HIPP) recipients. Under regular (non-waivered) SCHIP, service supplementation is required unless the employer plan meets SCHIP's "benchmark" requirement. Also required is cost-sharing supplementation, which is discussed further in the next section.

1. Fee-for-service (FFS) card for supplemental public coverage.

The typical approach to full supplementation, used by essentially all non-waivered Medicaid HIPP programs (and by some that operate under waivers as well) is to give each premium assistance recipient a fee-for-service (FFS) Medicaid card in addition to their employer coverage. Recipients are expected to use their employer plan primarily. If they need to access a service not covered by their employer plan, they can visit a Medicaid-participating provider of that service and present their Medicaid card. If they want assurance that they will not have to pay more than the Medicaid-allowed nominal copayment for services covered by their employer plan, they can use a provider who participates both with the employer plan and with Medicaid, and present both plans' cards, or they can use a Medicaid provider who does not participate in the employer plan, and Medicaid will seek reimbursement from the employer plan through coordination of benefits.

a. Advantages

This approach solves the problem relatively simply, if the State still has FFS claims payment capability. It requires no new administrative systems, and works with the State's usual third-party liability (TPL) / coordination of benefits system. (That is, if the recipient for some reason does not present their employer plan card to the provider, the Medicaid claims processing system will reject the claim and direct the provider to bill the employer plan first.)

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The availability of full supplementation using a FFS card also simplifies the process of evaluating whether an employer plan qualifies for participation in premium assistance (compared to a formal “benchmark” determination) and thus increases the number of employer plans that will qualify.

This approach is also likely to be low cost. In most cases, recipients will use their employer benefits and not the Medicaid card. [Anecdotal evidence from several States suggests that recipients usually choose not to use the Medicaid card for copayment relief. They are more likely to use it for services (provider types) not covered by their employer plan at all.]

- Note, however, that where the employer plan will not pay for “out-of-network” providers (as in an HMO with no point-of-service option, for example), or requires pre-authorization for certain services, premium assistance recipients could potentially use a FFS Medicaid card to obtain “out of network” or non-pre-authorized services. In either instance, the employer plan has no obligation to pay, and Medicaid could be faced with considerable costs. Just as with Medicaid-contracted managed care plans, States can adopt policies and procedures to avoid such costs. One possible approach would be to annotate the Medicaid card to indicate that the recipient has an employer plan and must follow that plan’s procedures and requirements. This approach would be analogous to annotating the Medicaid card to indicate the recipient is enrolled in a Medicaid-contracted managed care plan.

b. Disadvantages

The major drawback of the supplemental-FFS-card approach is that recipients would usually get cost-sharing protection only if they use an employer-plan provider who is also a Medicaid provider (because Medicaid cost-sharing protections cannot be imposed on non-participating providers). One advantage of employer coverage is access to a broader set of providers, including many who do not participate in the State’s Medicaid program. But using a Medicaid card for supplementation may mean that the recipient is unintentionally exposed to cost-sharing requirements. (However, see discussion of Rhode Island’s approach below.)

Another drawback is that non-Medicaid-based SCHIP programs often do not have FFS capability. No federal rule prohibits them from arranging to use their Medicaid FFS capability for this purpose so long as it is treated as a separate program (i.e., SCHIP-related expenditures are separately accounted for), but there may be potential budget and political issues due to the open-ended scope of Medicaid benefits. There may also be issues with providers who are not enrolled as Medicaid providers, difficulties with enrollment systems (e.g. lack of a Social Security number under SCHIP), or other operational problems. Nevertheless, these problems are not insurmountable, and in fact Virginia’s separate SCHIP program does handle supplementation by giving premium assistance enrollees a FFS card.

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c. Example States

As noted, FFS cards are used to provide supplementation in all non-waivered Medicaid HIPP (premium assistance) programs, including several States with large Medicaid-only HIPP programs, such as **Iowa, Pennsylvania, and Texas**. **Virginia** uses the FFS card approach to supplementation both for Medicaid HIPP and for SCHIP premium assistance. **Massachusetts**, which has a §1115 waiver, uses FFS supplementation only for its non-expansion population under 150% FPL. Waiver programs in **Wisconsin** and **Rhode Island** also use FFS supplementation approaches.

Rhode Island, whose SCHIP program is a Medicaid expansion, has enrolled many physicians as “copayment-only” providers to assure that recipients are protected and employer-plan providers are fully paid.

2. *No other approach to full supplementation has yet worked in practice.*

The search for other possible approaches to full supplementation has taken place largely in the context of SCHIP because, as noted, many separate SCHIP programs do not have their own FFS claims payment capability.

States have explored hiring a claims processing intermediary just to handle SCHIP supplemental claims. Theoretically, if that intermediary was a carrier that had a large share of the employer market in a State—so that processing of the primary and supplemental claims often could be carried out in one operation—the cost would be reasonable. However, one State that explored this approach fairly extensively (Mississippi) received cost estimates that were prohibitively expensive.

Another approach that was discussed was the concept of purchasing “riders” for supplemental coverage. That is, the State would contract directly with health plans that provider employer coverage to supplement (or “wraparound”) that coverage so that it meets federal/State standards. This idea was raised in at least one State (Maryland), but health plans have not been interested.

B. *Partial Supplementation—for Cost-Sharing Only*

A mid-range approach is to subsidize worker premiums only for employer plans that provide all required benefits (or benefits equivalent in actuarial value), and set up a separate system to handle only “filling in” of cost-sharing requirements. This approach aims to meet federal SCHIP requirements without a waiver.

1. *Advantages:*

Judicious use of alternative “benchmarks” and “benchmark equivalence” (as allowed under SCHIP) can make this a realistic alternative for some employer plans, even without a HIFA waiver.

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Moreover, if clients in fact feel little need for assistance with copayments (as seems to be the case—see Massachusetts example below), then a sophisticated computerized payment system will probably not be necessary. A manual system may well be sufficient to handle the low volume of expected claims.

2. *Disadvantages:*

Evaluating employer plans against a benchmark is labor-intensive. If using a benchmark-equivalence approach, an actuarial model needs to be developed and applied. Fewer employer plans will qualify for subsidies than if a full supplementation system is available (or if, under a waiver, no or only minimal supplementation is required).

This approach does require States to develop some payment system to deal with cost-sharing fill-in. Because federal regulations do not allow recipients to be reimbursed after the fact for excess cost-sharing paid, this system will have to be capable of paying providers, including providers that do not now contract with Medicaid. (The Rhode Island approach of having providers participate as “co-payment only” providers may or may not work in larger States.) And, to the extent clients feel they do need assistance with cost sharing, or are encouraged to seek it, this approach could be more costly.

3. *States using this approach:*

Massachusetts provides cost-sharing fill-in only for its expansion population over 150% FPL. In addition, under a relatively recent modification of their waiver, the benchmark used for premium assistance is less stringent than the SCHIP benchmark plan. (The State asked for and was granted authority to use its §1115 Medicaid-expansion benefit package as the benchmark for premium assistance, under the “Secretary-approved coverage” authority at 42 CFR 457.450.²⁰)

New Jersey, whose premium-assistance enrollment is still very small, requires large-employer plans to meet the SCHIP benchmark and does not provide “wrap” services for those plans. (Small employer plans in New Jersey are standardized, and the State does provide wrap services for those plans.)

Both Massachusetts and New Jersey have built in-house, separate (manual or largely manual) payment systems for cost-sharing fill-in. Massachusetts reports very limited use of this system either by providers or by clients.

Maryland hired a single vendor to handle cost-sharing fill-in for all qualifying employer plans, which must meet the State’s benchmark. (Small employer plans are also standardized in Maryland.)

²⁰ More specifically, 42 CFR 457.450(b) states that “Secretary-approved coverage” include “comprehensive coverage for children offered by the State under a Medicaid demonstration project approved by the Secretary under section 1115 of the Act.”

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Despite apparently limited use so far, with the degree of patient cost sharing in employer plans rising, “filling in” cost sharing may become a more important issue.

C. No Supplementation—Waiver Approaches

Before HHS Secretary Tommy Thompson announced the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative in August 2001, States that wanted to provide premium assistance to help working families pay for employer coverage, but found it was not feasible (or acceptable) to provide supplemental coverage to those families, had few good alternatives available to them. Limiting premium assistance to employer plans that fully meet federal Medicaid or SCHIP requirements was not a good option, because so few employer plans can meet those requirements without supplementation. Thus, while several States developed sizeable premium assistance programs under Medicaid (with supplementation) or under section 1115 waivers, no State had achieved significant enrollment under a (non-Medicaid) SCHIP premium assistance program.

In the HIFA waiver guidance, however, the Administration indicated its strong support for State initiatives aimed at expanding coverage for low-income working families by coordinating with private health insurance. In addition to allowing greater flexibility with respect to benefits for State coverage expansions beyond those allowable under current law, the guidance from the federal Centers for Medicare and Medicaid Services (CMS) strongly encouraged coordination with private health insurance by giving States flexibility needed to pursue private health insurance coverage options. Since the formal guidance was issued, State interest in “coordination with private health insurance” has focused primarily on employment-based coverage approaches.

The precise extent of benefit flexibility with respect to premium assistance and other approaches to coordinating with employer coverage was not specified in the waiver guidance. Therefore, federal limits on this flexibility were not fully specified in advance, but are becoming more apparent as CMS negotiates with States over the terms and conditions of specific waiver requests.

This section presents what is known so far about the conditions under which premium assistance without supplementation will be permitted as part of a HIFA waiver. The discussion is based on HIFA waivers that have been approved to date.

1. Summary of HIFA Waiver Parameters for Premium Assistance

CMS has recently approved two State HIFA waiver requests that include premium assistance with no supplementation of employer coverage. Reviewing those waiver approvals suggests that:

- a. In the case of employer-sponsored coverage, CMS appears to be prepared to waive most benefit and cost-sharing requirements with respect to “optional”

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populations and basically all requirements with respect to “expansion” populations.²¹

But a few things are still required:

- b. States must assure that all SCHIP-eligible children have access to age-appropriate immunizations, regardless of how they are covered.
- c. “Mandatory” and “optional” populations cannot be forced to take lesser benefits than are available to them under direct public coverage (which in turn may be more limited for “optional populations” under a HIFA waiver).
 - “Optional” populations can be given the option of enrolling in employer coverage with premium assistance but without supplementation (except for immunizations, as noted), but cannot be forced to do so.
 - What may be allowable with respect to “mandatory” populations in this regard is somewhat less clear. Oregon (see below) was permitted to offer “mandatory” populations a choice of premium assistance without supplementation, but Illinois was not.²² This apparently relates to Oregon’s pre-existing §1115 waiver that already affected benefits for the “mandatory” population. Premium assistance for “mandatory” populations can always be done (with supplementation), even on a mandatory basis, under HIPP (§1906).

2. *Illinois*

Illinois has a multi-faceted HIFA waiver using Medicaid and SCHIP funds—the KidCare Parent Coverage Demonstration. Premium assistance is one component of this waiver, which was approved by CMS on September 13, 2002. Key premium assistance provisions are:

- a. Premium assistance will be an option for “optional categories” of parents and children (i.e., enrollment in premium assistance v. public plan will be strictly voluntary). Premium assistance will not be available to “mandatory” populations.
- b. To qualify, employer coverage must cover at least physician visits and inpatient hospital services. There will be no requirements with respect to cost sharing, and no minimum employer contribution.
- c. “Already insured” parents and children with employer coverage who meet the income guidelines can qualify for premium assistance. Federal financial

²¹ “Optional” populations are those that could be covered under a State’s Medicaid or SCHIP plan without a waiver, if a State wished to do so under the normal terms of those plans. Optional groups include all SCHIP children and some Medicaid children (those above poverty if age 6 or older and above 133% of poverty if under age 6) and most parents. “Expansion” populations are those that cannot be covered under Medicaid or SCHIP without a waiver. “Mandatory” populations are those that under federal law must be covered under the State’s Medicaid plan. “Expansion” populations cannot be covered under Medicaid or SCHIP except through a §1115 waiver.

²² See below for a discussion of the “access to immunizations” requirement under the Oregon and Illinois waivers.

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participation (FFP) for this group will be at the regular Medicaid matching rate (50%). FFP for spending on those enrollees who are uninsured when they apply but arrange for private insurance and choose premium assistance will be matched at the SCHIP rate (65%).

- d. Anyone who chooses premium assistance can switch over to direct public coverage at any time, whether or not they remain insured (but individuals cannot receive premium assistance and direct State coverage in the same month).²³
- e. With one exception, no supplemental coverage will be provided for parents and children that elect premium assistance. The exception is immunizations.
 - Illinois will provide information as to where children receiving premium assistance (“KidCare Rebate”) can receive well-baby and well-child visits, including immunizations.
 - In addition, in the case of previously uninsured (i.e., title-XXI-eligible) children, Illinois will inform families that all age-appropriate immunizations are covered and, in cases where the employer or other private plan does not cover immunizations, will establish a mechanism to reimburse providers for the cost of immunizations.

3. Oregon Waiver

On October 15, 2002, HHS approved §1115 waivers for Oregon’s restructured Medicaid and SCHIP demonstration, called “Oregon Health Plan 2.” Under the demonstration, which has multiple components, Oregon will receive federal matching funds for the first time to expand its premium assistance program, the Family Health Insurance Assistance Program (FHIAP). Specifics are as follows:

- a. Premium assistance will be an option for “mandatory” categories of recipients and for all eligible children and pregnant women (i.e., enrollment in premium assistance will be strictly voluntary for these groups).
- b. Premium assistance will be mandatory for “optional” adults and “expansion” eligibles (including parents and childless adults), if qualifying employer coverage is available and “slots” are open in the premium assistance program. In the near term, only premium assistance (FHIAP) will be available to adults (other than pregnant women) over 100% FPL, due to budgetary limitations.
 - I.e., although the waiver authorizes both public coverage and premium assistance up to 185% FPL, for the time being public coverage under “OHP Standard” will not be provided to non-pregnant adults above 100% FPL, due to State budget limitations. Premium assistance through FHIAP will be available up to 185% FPL, but the overall number of FHIAP “slots” is limited as well.

²³ Adults seeking to switch to direct State coverage from premium assistance will be required to provide verification that their income continues to fall within the eligibility standard for adults.

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- c. To qualify, employer coverage must cover 21 specified services (e.g., cover well-baby and well-child care and immunizations, not impose an annual deductible in excess of \$500, and meet several other requirements.)
 - This benefit standard may be adjusted over time but must always equal or exceed the actuarial value of federally mandated Medicaid benefits.
- d. No supplemental coverage will be provided for recipients that elect premium assistance, provided, however, that—
 - Immunizations for children must be provided. If they are not available under the employer or other private plan, they must be provided through some other means, and the State must reimburse providers for them. (This provision would only become operational if the FHIAP benefit standard were to be adjusted sometime in the future so as not to require coverage of immunizations.)

V. Conclusion

Premium assistance for employment-based family coverage could provide a sensible coverage source for many low-income working families, while helping to assure that public coverage complements, rather than undermines, the employment-based coverage system.

Nonetheless, premium assistance presents many challenges. State experiences to date indicate that there is potential to overcome these obstacles, and premium assistance can be successful. But it is also clear that incremental improvements to highly fragmented and administratively burdensome conventional approaches are unlikely to cover many more low-income children or families.

Alternatively, creative and responsible use of the kind of flexibility offered by the HIFA waiver initiative has the potential to work as a cost-effective coverage vehicle for many low-income working families. While balancing competing policy objectives will be difficult, increased use of premium assistance can constructively link public and employer benefits and help maximize the number of low-income working families covered by health insurance, especially in an environment of severe budgetary constraints.

Premium Assistance: What Works? What Doesn't?

Appendix A: IHPS Interpretation of Standards Related to Premium Assistance for Employer Coverage under Medicaid and SCHIP

Issue	Medicaid Health Insurance Premium Payment (HIPP)	SCHIP Premium Assistance (PA)	Waiver Possibilities under New Federal Guidance (HIFA)*
Are applicants eligible for premium assistance if they already have employer coverage?	Yes	No. For SCHIP, applicants must be uninsured. For SCHIP premium assistance, applicants must have been without employer coverage for six months.	States could ask to use federal matching funds to subsidize some applicants who are already insured (within budget limits).
What is the minimum employer contribution required to qualify for premium assistance?	None	State must specify one. No minimum percentage is specified in federal regulations, but in practice the federal government seems to require no less than 30%-40%.	Federal requirement to specify some minimum can be waived.
Must states provide supplemental coverage for services not covered by the employer plan?	Yes. Recipient must have access to all Medicaid-covered services. (Recipient can use traditional Medicaid fee-for-service card.)	Yes, unless the employer plan meets one of the SCHIP benchmarks. (Harder to handle. Most separate SCHIP programs have no fee-for-service claims-payment capability.)	Waiver guidance allows greater flexibility on benefit requirements for "optional" groups, so supplemental coverage is less likely to be required. Children's immunizations must be provided for in some way.
Must states "fill in" employer-plan cost-sharing amounts that exceed program rules?	Yes. Essentially no cost sharing is allowed for Medicaid recipients. (Issuing traditional Medicaid fee-for-service card suffices.)	Yes. Must meet statutory SCHIP limitations prohibiting any cost sharing for well-child care and limiting other cost sharing to 5% of family income.	Allows greater flexibility. Only the 5-percent-of-income limit on cost sharing for children remains.

Premium Assistance: What Works? What Doesn't?

Issue	Medicaid Health Insurance Premium Payment (HIPP)	SCHIP Premium Assistance (PA)	Waiver Possibilities under New Federal Guidance (HIFA)*
Must premium assistance be cost effective (that is, cost less than direct public coverage)?	Yes. (Most states use HIPP only for obviously high-cost cases. A few, such as Iowa, screen all recipients with access to employer coverage.)	Yes. Costs can be compared on a case-by-case basis or on an aggregate basis for the total premium-assistance population.	Requirement is less strict. Aggregate costs for all those covered under premium assistance must not be "significantly higher" than they would be under a public program.

Source: IHPS' understanding of federal rules and regulations governing Medicaid, HIPP, and SCHIP premium-assistance programs (based on rules published through June 25, 2001) and the HIFA waiver guidance (August 2001).

* HIFA refers to the Health Insurance Flexibility and Accountability Demonstration Initiative, announced by the federal Centers for Medicare and Medicaid Services in August 2001.

Premium Assistance: What Works? What Doesn't?

Appendix B: Characteristics of Currently Operating State Premium Assistance (PA) Programs for Families

State	Number of Lives Covered under PA	Programs Included	Public Program Kids Eligibility Level (%FPL) [age]	Parents (above 75% FPL) Covered by Underlying Public Program? If so, %FPL	"Already privately insured" eligible?	Is use of PA Mandatory or Optional?	Enrollee Premium for Public Program and PA	Does Benchmark Used for PA Differ from SCHIP benchmark for public coverage?	Supplementation Method for Services, Cost-Sharing
Illinois (pre-waiver)	5,700+	State-only (related to SCHIP)	133%-185%	NO	YES (No FFP)	Optional	>150% FPL: \$15-\$30 (for public coverage only)	Physician and inpatient hospital. Differs significantly from SCHIP.	No supplementation
(HIFA waiver)	NA	Medicaid+ SCHIP	<185%	<185% (initially, up to 65% authorized by legislature)	YES (50% FFP. 65% FFP only if uninsured at application.)	Optional	>150% FPL: \$15-\$40 (for public coverage only)	Physician and inpatient hospital. Differs significantly from SCHIP.	Services: Immunizations only (when uninsured at application). No supp for cost sharing.
Iowa	8,600	Medicaid only	<100% [6+] <133% [1-6] <200% [<1]	<@87% (including value of earned income disregards)	YES	Mandatory if cost-effective.	NO	NA	Medicaid FFS card
Missouri (limited, unverified info)	4,000	Medicaid + MA-expansion SCHIP	<300% ?	Uncertain.	Old MA YES. SCHIP NO.	Mandatory if cost-effective.	>225% FPL: \$65	Uncertain. Believed NA (Medicaid-style).	Believed to be Medicaid FFS card

Premium Assistance: What Works? What Doesn't?

State	Number of Lives Covered under PA	Programs Included	Public Program Kids Eligibility Level (%FPL) [age]	Parents (above 75% FPL) Covered by Underlying Public Program? If so, %FPL	"Already privately insured" eligible?	Is use of PA Mandatory or Optional?	Enrollee Premium for Public Program and PA	Does Benchmark Used for PA Differ from SCHIP benchmark for public coverage?	Supplement-ation Method for Services, Cost-Sharing
Massachusetts (Regular Medicaid HIPP)	5,000	MassHealth Standard (pre-expansion Medicaid)	<150%	<133%	YES	Mandatory if cost-effective.	NO	NA	Medicaid FFS card
(Prem Ass't expansion)	16,000	Medicaid 1115 expansion and SCHIP	150%-200%	<133%	Yes. (50% FFP if insured, 65% if uninsured)	Mandatory if cost-effective.	>150% FPL: Kids \$10-\$30 Adults \$25-\$50.	PA+1115 basic benefit package differs from SCHIP benchmark (largest HMO).	Kids below 150% FPL, Medicaid FFS card. Above 150%, none for services. SCHIP kids: Manual system for copays + shoe-box for >5%.
Insurance Partnership (IP) expansion (employer subsidy)	4,500 small employers	Medicaid 1115 expansion and SCHIP	N/A	No direct public coverage. Prem Ass't for any adult <200% thru IP only.	Yes (50% FFP if uninsured. No FFP if previously insured.)	Mandatory	N/A	N/A	N/A

Premium Assistance: What Works? What Doesn't?

State	Number of Lives Covered under PA	Programs Included	Public Program Kids Eligibility Level (%FPL) [age]	Parents (above 75% FPL) Covered by Underlying Public Program? If so, %FPL	"Already privately insured" eligible?	Is use of PA Mandatory or Optional?	Enrollee Premium for Public Program and PA	Does Benchmark Used for PA Differ from SCHIP benchmark for public coverage?	Supplementation Method for Services, Cost-Sharing
Maryland	174	Non-Medicaid SCHIP only	200%-300%	NO	NO	Mandatory if cost-effective.	\$40-\$50	= Comprehensive Standard Health Benefit Plan (State-required small employer Plan)	No supp for services. Supplemental carrier for cost sharing.
New Jersey	500+	Medicaid+ SCHIP, 1115	<350%	<200%	NO	Mandatory if cost-effective.	>150%FPL: \$15-\$100	Same as SCHIP.	Medicaid FFS card for services. Separate, non-MMIS system for cost sharing.
Pennsylvania (limited, unverified info)	21,000	Medicaid only	<100% [6+] <133% [1-6] <185% [<1]	NO	NO	Mandatory if cost-effective.	NO	NA	Medicaid FFS card

Premium Assistance: What Works? What Doesn't?

State	Number of Lives Covered under PA	Programs Included	Public Program Kids Eligibility Level (%FPL) [age]	Parents (above 75% FPL) Covered by Underlying Public Program? If so, %FPL	"Already privately insured" eligible?	Is use of PA Mandatory or Optional?	Enrollee Premium for Public Program and PA	Does Benchmark Used for PA Differ from SCHIP benchmark for public coverage?	Supplementation Method for Services, Cost-Sharing
Oregon (pre-waiver)	4,000	State-only	<170%	<100% (but to 170% for premium assistance only).	NO			FHIAP minimum differs significantly from kids' benefits (OHP+).	No supplementation.
(HIFA waiver)	25,000 new FHIAP (Prem Ass't) slots expected	Medicaid+ SCHIP per HIFA 1115 waiver.	<185%	<185% (but initially only to 100% for non-PA enrollees).	Yes, for federally mandated groups. No, for other groups.	Optional for children, pregnant women, and cash recipients; mandatory for other adults.	\$6 to 50% of premium (minimum 5% of premium for PA)	FHIAP minimum differs significantly from kids' benefits (OHP+).	Immunizations. No supp for cost sharing.
Rhode Island	3,500	Medicaid+ SCHIP, 1115	<250%	<185%	YES	Mandatory if cost-effective.	>150% FPL: \$61-\$92	SCHIP = Medicaid. Employer coverage must be comprehensive and not use co-insurance.	Medicaid FFS card for services and copays. Augmented system pays actual copayment. Allows non-Medicaid co-pay-only providers.

Premium Assistance: What Works? What Doesn't?

State	Number of Lives Covered under PA	Programs Included	Public Program Kids Eligibility Level (%FPL) [age]	Parents (above 75% FPL) Covered by Underlying Public Program? If so, %FPL	"Already privately insured" eligible?	Is use of PA Mandatory or Optional?	Enrollee Premium for Public Program and PA	Does Benchmark Used for PA Differ from SCHIP benchmark for public coverage?	Supplementation Method for Services, Cost-Sharing
Texas	23,000	Medicaid only	<100% [6+] <133% [1-6] <185% [<1]	NO	YES		NO	NA	Medicaid FFS card
Virginia (Medicaid)	2,000	Medicaid	<100% [6+] <133% [<6]	NO	YES	Mandatory if cost-effective	NO	NA	Medicaid FFS card
(SCHIP)	<100	SCHIP	100%-200%	NO	NO	Optional	No	Same as SCHIP.	SCHIP FFS card
Wisconsin	<200	SCHIP, 1115	<185% (initial) <200% (cont'g)	<185% (initial) <200% (cont'g)	NO	Mandatory if cost-effective.	>150% FPL: \$30-\$165	NA (Medicaid-style)	Medicaid FFS card
Washington	4,400 (3/4s ABD)	Medicaid	<200%	<90%	YES	Optional	NO	NA (Medicaid-style)	Medicaid FFS card
New Mexico (HIFA waiver—not traditional premium assistance. Unverified info.)	Up to 40,000 in Phase I	New program: Adults only <200%	<235% (NA) (Kids not eligible for new plan)	<85% (NA)	NO	State-developed plan for employment-based only.	>100% FPL: \$20-\$35	State-specified basic package. Differs significantly from SCHIP (SCHIP = Medicaid)	NA. Only State-specified plan will be offered.