



Premium Assistance: An Update

BACKGROUND
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OVERVIEW — This background paper explores the use of premium assistance in publicly financed health insurance coverage programs. In Medicaid and the Children's Health Insurance Program, premium assistance involves using federal and state funds to subsidize premiums for the purchase of private insurance coverage for eligible individuals. This paper reviews the statutory authority for premium assistance, including two new options made available under the Children's Health Insurance Program Reauthorization Act of 2009. It examines the status of premium assistance programs in the states and offers some insights into how premium assistance programs may fare under the Patient Protection and Affordable Care Act.

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Premium assistance programs, in which states subsidize the purchase of private health insurance, have existed in Medicaid and the Children's Health Insurance Program (CHIP) for many years. Their popularity at both the state and federal level has waxed and waned, sometimes in response to budgetary pressures and the prevailing political philosophy of the times. During the administration of President George W. Bush, states were strongly encouraged, through section 1115 demonstration waiver policy, to develop premium assistance programs in order to promote use of the private insurance market to provide coverage for low-income individuals.¹ This paper examines the background and progress of premium assistance programs in order to offer insights into how they may fare in the future. Some policymakers theorize that premium assistance expands coverage and access, saves government money by utilizing employer contributions to help offset the cost of health coverage, and reaches individuals who might not otherwise enroll in a public program because of the welfare stigma sometimes associated with Medicaid. Other policymakers point out the potential disparities between the benefit and cost-sharing protections for enrollees in premium assistance programs and those afforded enrollees in direct Medicaid or CHIP state plan coverage.

The effectiveness of premium assistance as a mechanism for expanding coverage has been limited to date. While at least 39 states are operating some form of Medicaid or CHIP premium assistance program, premium assistance enrollees constitute less than 1 percent of total enrollment in Medicaid and CHIP and account for an even smaller portion of program spending.² This limited utilization is due to a number of factors that have hindered the use of premium assistance programs, including the lack of available employer-sponsored coverage for low-income workers, rising premiums that

limit cost effectiveness, and the challenges inherent in the coordination of public programs and private markets.³

Nonetheless, many states continue to pursue premium assistance as an approach to expanding coverage and stretching scarce state dollars. For example, several states are exploring these programs, using federal (non-Medicaid) grant money made available through the State Health Access Program (SHAP).⁴ In addition, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3) made available new options for states to offer premium assistance in Medicaid and CHIP and included provisions to ease administration. Finally, there is speculation about the potential role for premium assistance or similar programs under the new health reform law.

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BACKGROUND

Premium assistance was first authorized in Medicaid by the Omnibus Budget Reconciliation Act of 1990. As originally enacted, section 1906 of the Social Security Act required states to identify cases in which enrollment in an employer group health plan would be cost-effective for Medicaid-eligible individuals. It was believed that Medicaid spending would be reduced under this arrangement, as some Medicaid costs would be offset by the employer contribution. However, a variety of administrative barriers, as well as the low number of eligible individuals with coverage available through an employer, prevented most states from utilizing premium assistance on a broad scale. As a result, providing premium assistance to Medicaid-eligible individuals with access to employer-sponsored coverage was changed from a requirement to a state option in the Balanced Budget Act of 1997. The Medicaid premium assistance program, also known as the Health Insurance Premium Payment (HIPP) program, can be used for anyone eligible for Medicaid, and states have the option to make enrollment mandatory as a condition of Medicaid eligibility.⁵ Through the use of "wrap-around" coverage that supplements the employer health plan benefits and cost sharing, HIPP program enrollees receive the same benefit package and cost-sharing protections as any other Medicaid beneficiary.

CHIPRA provides states with an additional premium assistance option in Medicaid by adding section 1906A to the Social Security

Act. This option is similar to the existing HIPP program in many respects, but with a few key differences. While the HIPP program applies to all those eligible for Medicaid and can be mandatory if the state so chooses, 1906A applies only to children under age 19 and their parents, enrollment must be voluntary, and individuals must be able to opt out in any month. In HIPP, some nominal cost sharing is permitted, and noneligible family members pay for any cost sharing incurred other than premiums; however, under 1906A, the state must pay all premiums and other cost sharing for children and parents. While there is no required minimum employer contribution in the HIPP program, employers must contribute at least 40 percent of the premium costs under 1906A.

Premium assistance has been an option under CHIP since its enactment in 1997.

Premium assistance has been an option under CHIP since its enactment in 1997. The CHIP statute permits states to provide coverage to children eligible for CHIP and, under certain circumstances, to their family members by subsidizing group health plan premiums. The rules on premium assistance for separate (non-Medicaid) child health programs require that children enrolled in premium assistance programs receive the same benefits and cost-sharing protections as other CHIP-eligible children, and states may supplement, or wrap around, the benefits offered by the group health plans when those plans do not meet the CHIP benefit and cost-sharing requirements. Like HIPP, CHIP premium assistance programs must be determined to be cost-effective, meaning the cost of covering the children through employer-sponsored insurance (ESI) must not exceed the amount it would cost to cover eligible children through the state's direct-coverage CHIP program. When families are covered, CHIP as originally enacted required the cost-effectiveness test to compare the cost of covering the families in the premium assistance program to the cost of covering only the children in the direct coverage program: a test that virtually excluded premium assistance as an option. CHIPRA modified this cost-effectiveness test so that now the cost of covering the family in premium assistance, including administrative costs, is compared to the cost of direct CHIP coverage for the entire family, rather than just the low-income child.

CHIPRA also provides states with an additional premium assistance option under CHIP. This option is similar to the existing CHIP premium assistance requirements, with some notable exceptions.

It is unclear that the changes made by CHIPRA will be significant enough to spur more robust enrollment in premium assistance programs.

The new option is available only for children: families can be covered only on an incidental basis. (For example, when an employee with a CHIP-eligible child elects dependent coverage in an employer health plan, a spouse or the employee's non-eligible children could potentially gain coverage as well.) While CHIP premium assistance has been either mandatory or voluntary, the new option must be voluntary and the child must be able to opt out on a monthly basis. The new option also includes a requirement that the employer contribute at least 40 percent of premium costs. (See Table 1, page 8, for a summary of selected requirements for Medicaid and CHIP premium assistance.)

It is unclear, however, that the changes made by CHIPRA will be significant enough to spur more robust enrollment in premium assistance programs. Although the CHIP cost-effectiveness test has been modified to permit inclusion of family members, it now requires that administrative costs are included in the test. These administrative costs can be significant and may limit states' ability to show cost-effectiveness. It is also uncertain that states will take up the two new CHIPRA options for premium assistance programs in any great numbers: thus far, only Oklahoma (under title XXI) and Washington and Wisconsin (under title XIX) have done so. The requirement for states to pay full cost sharing in the Medicaid 1906A option may deter states from pursuing the program. In the past, states have also expressed concern about minimum employer premium contribution levels of 40 percent. Although recent data show that employers, on average, contribute 73 percent of premiums for family coverage, there is wide variation in contribution levels that could prevent some employers and their workers from participation.⁶ Further, the monthly opt-out provisions in both new options may be difficult to implement, as many employer-sponsored health plans permit coverage to be dropped only during open enrollment periods or are required to maintain a minimum number of enrollees during a 12-month period.

At least 16 states have also used the flexibility available through section 1115 demonstration projects to implement premium assistance programs. Premium assistance programs that operate under section 1115 waiver authority are not required to meet some of the Medicaid and CHIP requirements that have discouraged the use of premium assistance programs. For example, Oregon is not required to provide

wrap-around benefits to enrollees in its premium assistance program. Section 1115 authority is also desirable for states that want to provide coverage to people (such as parents or childless adults) who are not otherwise permitted to be covered under the Medicaid and CHIP statutes. For example, New Jersey used section 1115 demonstration authority to implement its premium assistance program that expanded coverage to whole families rather than only those individuals who meet the Medicaid or CHIP eligibility criteria. Following the enactment of CHIP in 1997, when enrollment was low and federal allotment funds were plentiful, states were permitted to receive the CHIP enhanced federal matching rate for some adult expansion populations.

The use of CHIP funds for adult populations was controversial, particularly as states began to use their full allotments for eligible children, and was even viewed as illegal by some observers. As a result, these types of waivers have been limited in recent years. The Deficit Reduction Act of 2005 prohibited the Secretary of Health and Human Services from granting any new waivers for coverage of nonpregnant childless adults at the CHIP enhanced matching rate. CHIPRA further prohibits the Secretary from granting any new waivers for the use of CHIP funds to cover parents and phases out existing waivers that provide coverage to childless adults and parents. However, states may still submit section 1115 demonstration proposals for premium assistance programs in Medicaid without the CHIP enhanced match.

CHALLENGES FOR PREMIUM ASSISTANCE PROGRAMS

Several common barriers to the success of premium assistance programs have emerged over the years.

Many low-income workers do not have coverage available on the job.

Workers with incomes below 200 percent of the federal poverty level (FPL) are significantly less likely than higher-income workers to have health insurance coverage available as an employment benefit.⁷ In 2007, about 42 percent of workers with incomes below 200 percent of the FPL did not have an offer of health insurance in the family, compared to only about 19 percent of employees with incomes between 200 percent and 400 percent of the FPL and 14 percent of employees above 400 percent of the FPL. In addition, the number of employers offering health insurance coverage has declined in recent years, and this decline is more pronounced for low-income workers.

TABLE 1 | Selected Requirements for Medicaid and CHIP Premium Assistance

	MEDICAID		CHIP	
	SECTION 1906 (HIPP)	SECTION 1906A	SECTION 2105(c)(3)	SECTION 2105 (c)(10)
Eligibility	All Medicaid-eligible individuals, including CHIP Medicaid expansion eligibles.	Medicaid-eligible individuals under age 19 and their parents.	Children above Medicaid levels to state-specified income limit (generally 200 percent of FPL).	Children above Medicaid levels to state-specified income limit (generally 200 percent of FPL).
Insurance Status	Eligible, regardless of current insurance status.	Eligible, regardless of current insurance status.	Not eligible if already enrolled in group health coverage.	Not eligible if already enrolled in group health coverage.
Noneligible Family Members	May provide coverage to noneligible family members when that enrollment is necessary to achieve coverage for eligible family members.	May provide coverage to noneligible family members when that enrollment is necessary to achieve coverage for eligible family members.	May provide coverage to noneligible family members through a family coverage waiver.	Incidental coverage only.
Mandatory Enrollment	Can be mandatory at state option.	Must be voluntary and individual can opt out at the end of each month.	Can be mandatory at state option.	Must be voluntary and individual can opt out at the end of each month.
Benefits	Enrollees must have access to all services covered under the Medicaid state plan, either through ESI or through wrap-around coverage. Noneligible family members do not receive wraparound benefits.	Individuals under age 19 and their parents must have access to all services covered under the Medicaid state plan, either through ESI or through wraparound coverage.	Enrollees must receive benefits meeting one of the CHIP benchmarks or Secretary-approved coverage, either through ESI or through wrap-around coverage.* <i>(*See Table 1-Notes, sidebar, p. 9)</i>	Enrollees must receive benefits meeting one of the CHIP benchmarks or Secretary-approved coverage, either through ESI or through wrap-around coverage. An actuary may certify that ESI meets the benchmark or benchmark-equivalent standards.
Cost Sharing** <i>**See Table 1-Notes, sidebar, p. 9</i>	Children are excluded from cost sharing. Only premiums are paid for noneligible family members.	Cost sharing must be nominal. The state must pay all premiums and other cost sharing for individuals under age 19 and their parents.	Cost sharing must meet the same requirements as CHIP direct coverage.	Cost sharing must meet the same requirements as CHIP direct coverage. If ESI is certified by an actuary as benchmark or benchmark-equivalent, the plan meets CHIP cost-sharing standards.
Employer Contribution	No minimum requirement.	Employer must contribute at least 40 percent toward the cost of the premium.	States must identify a minimum contribution level; there is no federal minimum.	Employer must contribute at least 40 percent toward the cost of the premium.
Cost-Effectiveness	The cost of covering eligible and noneligible family members in ESI cannot be greater than the cost of direct coverage for these same family members.	The cost of covering the child and his/her parents in ESI cannot be greater than the cost of covering the child and his/her parents in Medicaid direct coverage.	The cost of covering the child or family in ESI cannot be greater than the cost of covering the child or family in CHIP direct coverage.	The cost of covering the children in ESI cannot be greater than the cost of covering the children in CHIP direct coverage.

(continued on sidebar, page 9)

The cost of coverage may be prohibitive for low-income workers, even when a state subsidy is provided. Private insurance premiums have been rising rapidly over the last few years, and employers have shifted more costs to employees, imposing higher deductibles and other out-of-pocket expenses in an attempt to contain premium increases. While a high proportion (81 percent) of workers overall who are offered coverage take it, the take-up rate is much lower for low-income workers (62 percent).⁸ Among people who do not enroll in coverage offered by their employer, cost has been found to be the primary factor.⁹ In premium assistance programs that limit premium subsidies to a specific dollar amount, the subsidy may not cover the entire employee contribution and, as a result, the cost of health insurance may remain out of reach for the worker.

Federal rules and complex administration create barriers to growth for premium assistance programs. Federal rules have limited the number of health plans that can qualify for the federal-state premium subsidy. Coverage in premium assistance programs must meet the cost-effectiveness requirement, which includes the cost of premium subsidies for the employer group health insurance, the cost of any wrap-around benefits that the state must provide to meet the Medicaid or CHIP benefit and cost-sharing standards, and costs for administration. Group health plans that do not meet these requirements cannot qualify for the federal-state premium subsidy. Cost effectiveness becomes more difficult to attain as group health insurance premiums paid by employees and their out-of-pocket costs (deductibles, coinsurance, and co-payments) continue to rise.

The administrative procedures states must set up to operate premium assistance programs are complex. In order to determine whether a health plan qualifies for a premium assistance subsidy, states may have to collect detailed information from employers about what health plans are available to workers, whether workers and their dependents are eligible to participate, what benefits are covered, the amount of premiums and other cost-sharing required by those plans, and the frequency of premium payments. This information is needed to assure that federal rules are met, as well as to make accurate and timely subsidy payments. The information also must be updated periodically as plan benefits and costs change. Even in most programs set up using the greater flexibility of section 1115, states must still, at a minimum, determine whether eligible individuals have coverage available on the job and the amount of premiums for

TABLE 1 (cont.)**Notes**

* As outlined in the January 2001 CHIP regulations, these benchmarks are: (i) the standard Blue Cross/Blue Shield preferred provider option offered under the Federal Employees Health Benefits Program, (ii) a health benefits plan offered to state employees, and (iii) health benefits coverage offered by the HMO with the largest commercial enrollment in the state. Children must be provided benefits meeting one of these benchmarks or benefits that are "benchmark-equivalent" (that is, benefits with the same or higher actuarial value). Secretary-approved coverage can include (but is not limited to) comprehensive coverage for children offered by the state under a Medicaid 1115 demonstration, coverage that is the same as the coverage provided to children under the Medicaid state plan, and coverage the state demonstrates to be substantially equivalent to or greater than coverage under a benchmark health benefits plan.

** Premium and copayment requirements for Medicaid are found at Code of Federal Regulations, 42 CFR, sections 447.50 through 447.58; available at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=229eae61fd4d2a27edb4aa44fba0a2c1&rgn=div5&view=text&node=42:4.0.1.1.12&idno=42>. The requirements for CHIP are found at 42 CFR, section 457.540 and 42 CFR, section 457.555; available at <http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?type=simple;c=ecfr;cc=ecfr;sid=1ff566d30ccde5e42d3df217f5317104;idno=42;region=DIV1;q1=457.540;rgn=div5;view=text;node=42%3A4.0.1.2.15>.

which workers are responsible. The procedures needed to accomplish these tasks can involve costly changes to computer systems and require additional staff resources.

While some employers are enthusiastic about providing health insurance coverage to more of their workers because it enhances their ability to attract and retain workers and is “the right thing to do,” others are reluctant to cooperate with public premium assistance programs. These employers express concern about the increased administrative burden associated with providing health plan information to the state and, depending on how the program is set up, receiving and administering the state-federal premium subsidies. Some employers also fear the increased costs that they incur when more workers are enrolled in their health plans. State officials have often cited lack of employer cooperation as one of the greatest barriers to the success of premium assistance programs.

State administrative efforts have been aided by CHIPRA through changes that require greater employer cooperation with premium assistance programs. Before the enactment of CHIPRA, the Employee Retirement Income and Security Act of 1974 (ERISA)¹⁰ prohibited states from requiring many employer-sponsored health plans to provide the information needed to determine whether a health plan qualifies for premium subsidy. In many cases, states were also prevented from immediately enrolling Medicaid- and CHIP-eligible individuals into an employer-sponsored health plan outside of an open enrollment period.¹¹ To address these problems, CHIPRA includes a provision that requires all employers to provide states with information about benefits and other features of their coverage so that states can determine whether the employer-sponsored insurance qualifies for subsidies. It also requires group health plans to permit an employee or dependent to enroll when gaining or losing eligibility for Medicaid or CHIP, making such an eligibility change a “qualifying event” for enrollment at any time during a year.

STATE PARTICIPATION

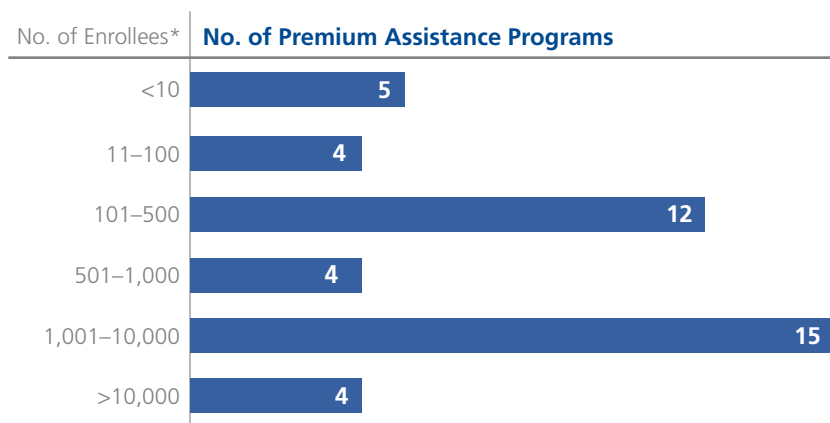
The majority of states are operating some type of premium assistance program. A study by the Government Accountability Office (GAO) found that at least 39 states were operating 47 programs in 2009.¹² (Eight states had two programs.) The majority (29) of these programs were operated under Medicaid section 1906 authority,

while 16 operated under section 1115 authority and only 1 operated under CHIP section 2105(c)(3).¹³ Twenty of these programs subsidized both employer-sponsored insurance and coverage purchased in the individual market.

Although many states operate premium assistance programs, the enrollment in these programs constitutes only a small portion of these states' total Medicaid/CHIP populations: less than 1 percent overall. Only seven states (Iowa, Massachusetts, Oklahoma, Oregon, Pennsylvania, Rhode Island, and Vermont) had premium assistance enrollment that exceeded 1 percent of their total Medicaid/CHIP enrollment as of June 2009, and none had enrollment that exceeded 5 percent.¹⁴ Moreover, the absolute numbers of individuals enrolled in many states tends to be extremely low. Nine state premium assistance programs in the GAO study reported fewer than 100 enrollees as of June 2009 and five of those programs had fewer than 10 enrollees (Figure 1).¹⁵ In light of the challenges associated with implementing a premium assistance program, some states have chosen to use their HIPP programs primarily to target Medicaid-eligible individuals with high medical expenses, such as individuals with HIV/AIDS.

FIGURE 1

Distribution of Enrollees in Premium Assistance Programs, by Number of Enrollees, June 30, 2009



*Enrollment number includes both Medicaid/CHIP eligibles and noneligible family members.

Source: Government Accountability Office (GAO), "Medicaid and CHIP: Enrollment, Benefits, Expenditures and other Characteristics of State Premium Assistance Programs"; available at www.gao.gov/new.items/d10258r.pdf. The GAO study included information from 45 premium assistance programs in 37 states; however, one state did not report enrollment numbers.

However, states that operate the largest HIPP programs, such as Iowa, Pennsylvania, and Rhode Island, do not limit their programs to these high-cost individuals. In fact, the majority of enrollees in states with higher enrollment are families and children. Enrollment tends to increase when eligibility is extended to broader categories of individuals and when whole families can be covered under the same health plan.

As might be expected, given the low enrollment numbers, expenditures for premium assistance constitute only a small portion of states' total Medicaid and CHIP budgets. With total Medicaid and CHIP expenditures topping \$366 billion in 2008, premium assistance expenditures of over \$222.7 million are only a fraction of 1 percent.¹⁶ It also appears that, as a share of total program costs, ad-

ministrative costs for premium assistance programs can be significantly higher than administrative costs for the Medicaid program in general. While Medicaid costs for administration overall are reported to be about 5 percent of total Medicaid spending, administrative costs for premium as-

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sistance among the 21 programs that reported these costs in the GAO study ranged anywhere from 3.6 percent of total premium assistance expenditures to over 90 percent in one state. The greatest number of programs (14) reported administrative costs of 15 percent or less. These numbers should be viewed with caution because not all states reported costs in all categories of applicable expenditures, and costs were not reported in a consistent manner. However, they do point out the need for states and policymakers designing a premium assistance program to carefully consider administrative costs, in addition to benefit costs, in order to assure cost effectiveness.

MOVING FORWARD UNDER HEALTH REFORM

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) reshapes Medicaid in fundamental ways that are likely to affect premium assistance programs. In 2014, states will be required to cover all nonelderly individuals with incomes up to 138 percent of the FPL in Medicaid. Because many states currently cover only those parents with very low incomes (the median income level was 64 percent of

the FPL in 2009) and have been generally prohibited from covering childless adults with federal Medicaid funds, many more working individuals will qualify for Medicaid and may be eligible for premium assistance if their employers offer health insurance coverage for which they are eligible.

PPACA also standardizes the way eligibility is determined in order to permit coordination with the health insurance exchanges in the new system. Exchanges for individuals who do not have access to affordable employer-sponsored insurance (called American Health Benefit Exchanges) and for small businesses and their employees (operated under the Small Business Health Options Program, or SHOP) must be operational by January 1, 2014. SHOP exchanges are initially for businesses with up to either 50 or 100 employees, at a state's choosing, with the option to allow businesses with more than 100 employees to purchase coverage from the exchange, beginning in 2017.

Federal guidance on how exchanges, federal subsidies for lower-income families, and tax credits for employers might work is pending.

Federal guidance on how these exchanges, federal subsidies for lower-income families, and tax credits for employers might work is pending; therefore it is unclear how the subsidies made available through health reform would be coordinated with premium assistance program subsidies. However, to the extent that small businesses opt to offer health insurance purchased on an exchange, it appears that some Medicaid-eligible individuals and some higher-income (non-Medicaid-eligible) individuals with CHIP-eligible children could gain access to employer-sponsored insurance purchased on the exchange and receive Medicaid or CHIP premium assistance. Higher-income individuals who do not have access to affordable employer coverage could obtain coverage through the individual exchanges and receive premium assistance for their CHIP-eligible children, although cost-effectiveness might prove more difficult in this situation, since there would be no employer contribution for coverage purchased individually. Additional federal guidance on the interaction of Medicaid and CHIP with the exchange and subsidy programs established under PPACA will help to clarify how all these programs can interface after full implementation of the new law.

Subsidizing coverage purchased on an exchange could potentially simplify administrative procedures for premium assistance

programs. PPACA requires states to establish screening and enrollment systems that allow application for Medicaid, CHIP, or an exchange through a state-run website. It also allows states to enter into an agreement with exchanges to determine eligibility for premium subsidies to purchase coverage through the exchange. If carefully constructed, these features would permit states to (i) more easily identify individuals who are eligible for Medicaid or have CHIP-eligible children and work for small employers that offer coverage on the exchange and (ii) set up premium assistance payments for those Medicaid/CHIP-eligible individuals. Because PPACA requires standardization of benefit packages offered through the exchanges, evaluation of the benefit packages that qualify for premium assistance could also be simplified because information about the plans would be more readily available and there would be less variation among plans. Theoretically, benefit plans could even be structured to accommodate Medicaid- and CHIP-eligible individuals for the purposes of premium assistance. Additional simplifications related to eligibility determination for public programs under PPACA could also enhance states' use of premium assistance programs.

While these appear to be promising directions for premium assistance programs under health reform, it is uncertain whether these programs will ever attain a large percentage of Medicaid and CHIP enrollees. The Congressional Budget Office has estimated that in 2019 approximately 5 million additional people will gain coverage through employers that allow all their workers to choose among the plans on the exchange; however, only a portion of those individuals would be Medicaid-eligible or have CHIP-eligible children. In addition, many low-income individuals will continue to work for employers who do not offer coverage, choose to drop coverage in the future, or do not purchase their coverage through an exchange, leaving premium assistance programs to struggle with many of the same challenges they face today.

Still, premium assistance captures the imagination of many legislators and policymakers with its promise of cost savings and appeal for individuals who prefer employment-based health insurance. It remains to be seen whether innovative approaches and incentives under health reform will spur greater growth of premium assistance programs in the future.

ENDNOTES

1. For more background on section 1115 demonstration policy, see Cynthia Shirk, “Shaping Medicaid and SCHIP Through Waivers: The Fundamentals,” National Health Policy Forum, Background Paper No. 64, July 22, 2008; available at www.nhpf.org/library/background-papers/BP64_MedicaidSCHIP.Waivers_07-22-08.pdf.
2. For premium assistance enrollment, see U.S. Government Accountability Office (GAO), “Medicaid and CHIP: Enrollment, Benefits, Expenditures and other Characteristics of State Premium Assistance Programs,” GAO-10-258R, January 19, 2010, available at www.gao.gov/new.items/d10258r.pdf; total Medicaid enrollment, Kaiser Commission on Medicaid and the Uninsured, “Medicaid Enrollment: June 2009 Data Snapshot,” February 2010, available at www.kff.org/medicaid/upload/8050.pdf; and total CHIP enrollment, Vernon Smith *et al.*, “CHIP Enrollment June 2009: An Update on Enrollment and Policy Directions,” Kaiser Commission on Medicaid and the Uninsured, April 2010, available at www.kff.org/medicaid/upload/7642-04.pdf.
3. For more information on challenges in premium assistance programs, see Cynthia Shirk and Jennifer Ryan, “Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?” National Health Policy Forum, Issue Brief No. 182, July 17, 2006; available at www.nhpf.org/library/issue-briefs/IB812_PremiumAssist_07-17-06.pdf.
4. The State Health Access Program (SHAP) is a federal grant program administered by the Health Resources and Services Administration. The program awards grants to states help them expand access to affordable healthcare coverage for people who are uninsured. SHAP was authorized by the Omnibus Appropriations Act, P.L. 111-8, signed by the President on March 11, 2009.
5. Mandatory enrollment does not apply to children. An eligible child cannot be denied Medicaid coverage if the parent fails to enroll him in a group health plan.
6. Gary Claxton *et al.*, “Employer Health Benefits Survey 2009,” Kaiser Family Foundation and Health Research and Educational Trust, September 15, 2009, p. 1; available at <http://ehbs.kff.org/pdf/2009/7936.pdf>. In the Children’s Health Insurance Program (CHIP), the federal government initially required that states could subsidize only those plans in which employers contributed a minimum of 60 percent toward premium costs. However, because states found that employer recruitment proved difficult at that level, the Centers for Medicare & Medicaid Services (CMS) modified its position, and final regulations did not mandate a minimum employer contribution level.
7. Peter Cunningham, Samantha Artiga, and Karen Schwartz, “The Fraying Link Between Work and Health Insurance: Trends in Employer-Sponsored Insurance for Employees, 2000–2007,” Kaiser Commission on Medicaid and the Uninsured, November 2008; available at www.kff.org/uninsured/upload/7840.pdf.
8. Cunningham, Artiga, and Schwartz, “The Fraying Link.”

9. Bowen Garrett, "Employer-Sponsored Health Insurance: Coverage, Sponsorship, Eligibility, and Participation Patterns in 2001," Kaiser Commission on Medicaid and the Uninsured, July 2004; available at www.kff.org/uninsured/upload/Employer-Sponsored-Health-Insurance-Coverage-Sponsorship-Eligibility-and-Participation-Patterns-in-2001-Full-Report.pdf.
10. The Employee Retirement Income and Security Act of 1974 (ERISA) is a federal law that governs employee pension and other benefit plans sponsored by private-sector employers and unions (known as ERISA plans), including health benefit plans. For a fuller description of ERISA's effect on premium assistance programs, see Shirk and Ryan, "Premium Assistance."
11. Typical benefits rules permit employees to enroll in group health plans or change their election (for example, to add dependents or select a different plan) only during an annual open enrollment period or when there is a "qualifying event," such as a birth, adoption, marriage, or divorce. Consequently, workers and/or their family members may be eligible for premium assistance but unable to join the group health plan until the next open enrollment period.
12. GAO, "Medicaid and CHIP." GAO did not include information on Medicaid or CHIP-funded programs in which states subsidize only insurance packages they created as opposed to private health insurance packages created by employers or insurance companies. Arkansas, Massachusetts, and New Mexico have such programs that are not reflected in the GAO data. Programs in North Carolina and West Virginia are also not reflected in the data, because these states did not complete the GAO survey.
13. Oklahoma received approval from CMS to operate a portion of its premium assistance program under the new CHIP 2105(c)(10) authority after the GAO study was completed.
14. Author's analysis of data contained in GAO, "Medicaid and CHIP"; Kaiser Commission, "Medicaid Enrollment"; and Smith *et al.*, "CHIP Enrollment."
15. The number of enrolled individuals is likely undercounted because some states were not able to report the number of noneligible family members covered in their premium assistance programs.
16. Premium assistance expenditures from GAO, "Medicaid and CHIP." Premium assistance expenditures are likely to be higher than \$222.7 million because not all states reported expenditures in all categories. Total Medicaid and CHIP expenditures from Barbara S. Klees, Christian J. Wolfe, and Catherine A. Curtis, "Brief Summaries of Medicare and Medicaid: Title XVIII and Title XIX of the Social Security Act," CMS, November 1, 2009; available at www.cms.gov/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2009.pdf.