

Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?

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OVERVIEW — *This issue brief explores the use of premium assistance in publicly financed health insurance coverage programs. In the context of Medicaid and the State Children’s Health Insurance Program (SCHIP), premium assistance entails using federal and state funds to subsidize the premiums for the purchase of private insurance coverage for eligible individuals. This paper considers the evolution of premium assistance and some of the statutory and administrative limitations, as well as private market factors, that have prevented widespread enrollment in Medicaid or SCHIP premium assistance programs. Finally, this issue brief offers some ideas for potential legislative and/or programmatic changes that could facilitate the use of premium assistance as a mechanism for health coverage expansion.*

Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?

In times of ongoing budgetary pressures and rapidly rising health care costs, states and the federal government must continuously search for ways to deliver health care services to low-income individuals and families at as low a cost to the government as possible. Driven by this need to stretch resources, as well as by the ever-changing political and ideological climate, terms like “personal responsibility” and “consumer choice” have migrated from the world of welfare reform into the Medicaid and SCHIP vocabulary.

In the absence of national solutions to address the growing number of Americans without health insurance, states have been motivated to find, develop, and finance coverage strategies on their own. One result is an increasing interest in looking to the employer-based group health insurance market—the backbone of the health insurance system—as a mechanism for financing and delivering health coverage in cooperation with public funding. About 25 states are currently considering expanding coverage through employer mandates, and 13 states are considering legislation that would establish or study the feasibility of a universal health care plan.¹ Policymakers have theorized, for several years, that one way to more effectively reach the uninsured is to coordinate public and private sources of health financing. States and the federal government have increasingly pursued the use of Medicaid- and/or SCHIP-financed premium assistance for the purchase of private health coverage, both as a source of program savings and to reach individuals who would not otherwise enroll in public programs. In theory, this practice saves government dollars by utilizing an employer contribution toward the cost of health coverage. In addition, many premium assistance (PA) programs require individual contributions via premiums and other cost-sharing requirements.

Some analysts object to the context in which PA programs are moving forward, noting that the shift toward the private market could result in more limited benefit packages and reduced access to care compared with traditional public programs. They further note that it is unclear whether premium assistance truly saves government dollars because private coverage usually is more costly than Medicaid or SCHIP coverage and provides less comprehensive benefits with higher out-of-pocket costs for families. Proponents, on the other hand, have argued that premium assistance holds

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promise in that it can serve as a mechanism to expand access to comprehensive employer-sponsored insurance (ESI) coverage for families who would not otherwise be able to afford it.

Indeed, PA programs may have a number of advantages in addition to the potential cost savings for state and federal governments. Over time, PA programs could strengthen the private insurance market and prevent Medicaid and SCHIP from substituting for private coverage by enrolling beneficiaries in the health coverage plans that are offered by their employers. Families who are unwilling to apply for Medicaid or SCHIP may be more likely to participate in PA programs that utilize private coverage available through their employers, and employers could even potentially benefit from healthier employees who miss work less often and may be less likely to change jobs.

The effectiveness of premium assistance as a mechanism for expanding coverage has been limited to date. There are at least 15 states operating some form of Medicaid or SCHIP premium assistance program, with enrollment numbers ranging from 61 individuals in the smallest program to over 30,000 in the largest (Table 1, next page). Overall, premium assistance enrollees constitute less than 1 percent of total enrollment in Medicaid and SCHIP and an even smaller portion of program spending.² This limited utilization is in part due to a number of factors (which will be discussed later) that have hindered the use of PA programs, not the least of which is the availability of ESI coverage among low-income populations.

Reliance on the employer-based system has been more challenging in some states and communities than in others. Many employers, particularly those operating small businesses with predominantly lower-wage employees, do not currently offer health coverage as a benefit to employees. In addition, ESI coverage is eroding across the board, albeit slowly, as premiums continue to rise. Between 2001 and 2004, the percentage of workers covered by employer health plans fell from 65 percent to 61 percent. During that same period, premiums increased 51 percent and employee contributions for family coverage grew by 49 percent.³

These rising premiums disproportionately affect individuals in lower-wage occupations. One-third of the uninsured are in families with incomes below \$20,000 per year, compared with 5.6 percent of workers earning \$50,000 or more. In one study, only 15 percent of uninsured workers said they were eligible for health benefits through their employer in 2004, and 19 percent reported they were working for a firm that offered coverage to some individuals but that they did not personally qualify. The remaining 66 percent of the uninsured reported that they did not have access to health insurance coverage.⁴ This lack of access to coverage has hindered some state efforts to get premium assistance off the ground and has important implications for program design. Iowa, for example, targets

TABLE 1: Premium Assistance Programs in Medicaid and SCHIP, by Type

	State	Date Started	Enrollment [†]	Eligibility
Section 1906 (HIPP)*	Iowa	1991	9,211	All Medicaid eligibles
	Pennsylvania	1995	23,657	All Medicaid eligibles
	Rhode Island	2002	5,300	Parents to 185% FPL, children to 250% FPL
	Texas	1995	8,197 [‡]	All Medicaid eligibles
Section 1115 (HIFA)	Idaho	2005	Not reported	Adults [§] and children to 185% FPL
	Illinois	2002 [¶]	2,409	Children and parents to 185% FPL
	Oklahoma	2005	712	Adults [§] to 185% FPL
	Oregon	2002**	15,776	Adults [§] and children to 185% FPL
	New Mexico	2005	4,509	Uninsured employed adults to 200% FPL
	Utah ^{††}	2003	61	Uninsured adults to 150% FPL
Section 1115 <u>and</u> Section 1906^{‡‡}	Maine (HIFA)	2005	297	Childless adults to 100% FPL
	Massachusetts	1998	33,318	Children to 200% FPL, parents to 133% FPL, adults [§] to 200% FPL
	New Jersey (HIFA)	2001	770	Families to 200% FPL, children to 350% FPL
	Virginia ^{§§} (HIFA)	2005	1,629	Children to 200% FPL
	Wisconsin	1999	1,691	Children to 200% FPL, families to 185% FPL

* Only the largest Health Insurance Premium Payment (HIPP) programs are included in this chart. Several other states operate small HIPP programs directed only at high cost cases.

† As of May 2006, unless otherwise indicated.

‡ As of March 2004.

§ Adults include those working for small employers and their spouses.

¶ Prior to federal approval of its Health Insurance Flexibility and Accountability (HIFA) waiver, Illinois operated a premium assistance program with state-only funds that began in 1998.

** Prior to federal approval of its HIFA waiver, Oregon operated a premium assistance program with state-only funds that began in 1998.

†† Utah's premium assistance program, Covered at Work, was approved under section 1115 after the start of HIFA but is not technically considered a HIFA waiver.

‡‡ Massachusetts, New Jersey and Wisconsin section 1115 demonstrations were approved by CMS prior to the HIFA initiative. New Jersey later amended its demonstration under HIFA. Start dates for all states in this category reflect implementation of premium assistance under section 1115 demonstrations. States in this category cover all regular Medicaid eligibles, in addition to the expansion populations under section 1115 identified in this chart.

§§ Virginia operated a premium assistance program under its SCHIP state plan prior to approval of its HIFA waiver.

its efforts primarily at large employers because they have found that small employers do not have the same ability to offer coverage. Oklahoma, on the other hand, provides subsidies to small employers to encourage more offers of coverage in that market.

THE EVOLUTION OF PREMIUM ASSISTANCE

The concept of premium assistance is not new to Medicaid. States have been operating Health Insurance Premium Payment (HIPP) programs as authorized under section 1906 of the Medicaid statute for 15 years. Premium assistance was also included in the SCHIP statute in 1997, a result of bipartisan legislation designed to ensure that the new program reflected many of the elements found in the commercial insurance market. States and the Centers for Medicare & Medicaid Services (CMS) have also used the flexibility available through section 1115 waiver authority to facilitate the development of PA programs. Since the announcement of the Health Insurance Flexibility and Accountability (HIFA) initiative in 2001, CMS has been proactively requiring states to include a premium assistance component in all HIFA section 1115 waiver programs. CMS has relaxed certain benefit, cost-sharing, and cost-effectiveness requirements in an attempt to stimulate greater utilization of premium assistance. Table 2 compares the key requirements for each program type (see next page).

Medicaid Section 1906

Premium assistance was first authorized in Medicaid by the Omnibus Budget Reconciliation Act (OBRA) of 1990 as a mechanism to reduce Medicaid spending. As originally enacted, section 1906 of the Social Security Act required states to identify cases in which enrollment in a group health plan would be cost effective for Medicaid-eligible individuals and also required such enrollment as a condition of Medicaid eligibility. 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 this mechanism on a broad scale. As a result, the requirement was changed to a state option in the Balanced Budget Act (BBA) of 1997.

Medicaid-eligible individuals enrolled in premium assistance (HIPP) must receive the same benefit package and cost-sharing protections as any other Medicaid beneficiary. This is accomplished by providing “wrap-around” coverage that supplements the employer health plan benefits and cost sharing. The coverage offered through HIPP must be cost effective—that is, the Medicaid program’s contribution toward employer coverage, including any wrap-around costs, must be no greater than

TABLE 2
Comparison of Premium Assistance Program Statutory Requirements

	Medicaid HIPP	SCHIP	HIFA Demonstration Projects
Eligibility	All Medicaid eligibles.	Children above Medicaid levels up to state-specified income limit (<i>generally 200% FPL</i>).	As specified in project terms and conditions.
Insurance Status	Insurance status does not affect eligibility.	Not eligible if already enrolled in group health coverage.	No specific standard.
Mandatory Enrollment	Can be mandatory at state option.	Can be mandatory at state option.	Can be mandatory at state option. Optional populations may be required to have choice of public coverage or premium assistance if no of supplementation of benefits.
Benefits	Enrollees must have access to the full range of Medicaid benefits provided either through ESI or wrap-around coverage.	Children covered through premium assistance programs must receive benefits meeting one of the SCHIP benchmarks or Secretary-approved coverage,* either through ESI or wrap-around coverage.	No specific standard for optional and expansion populations. States may not have to provide any wrap-around coverage beyond ESI.
Cost Sharing[†]	Must be “nominal.” Children are excluded from cost sharing.	Cannot exceed 5% of family income. Only cost sharing for children in the family must be counted toward the cumulative cost-sharing maximum. Specific limits on premiums and co-payments for families below 150% FPL. No cost sharing for preventive care.	No specific standard. CMS has not generally permitted higher than nominal cost sharing for mandatory Medicaid eligibles and has retained the 5% cap on children’s costs.
Cost Effectiveness	States may enroll eligibles in ESI as long as the cost is not greater than the cost of coverage in the public program. Cost effectiveness can be measured on an individual or aggregate basis.	States may enroll noneligible family members in ESI if cost effective and needed to obtain coverage for the Medicaid-eligible family members. Federal matching funds are available only for premium payments for non-eligibles.	No specific test required. Aggregate costs must not be significantly higher than costs in the public program.
Covering Non-Eligibles	No minimum contribution.	States can purchase coverage in ESI for noneligible family members by obtaining a family coverage waiver under Section 2105(c)(3). Coverage must be cost effective (<i>i.e., cost no more than to cover only eligible children</i>) and cannot substitute for private coverage.	States may cover “optional” and “expansion” populations, including childless adults. [‡] Coverage generally not permitted above 200% FPL unless state has achieved significant coverage below that level.
Employer Contribution	No requirement.	States must identify a minimum contribution and evaluate whether substitution is occurring.	None specified.
Substitution (Crowd-Out)	No requirement.	Eligible children must not have been covered by group health insurance for the six months before enrollment in the premium assistance program; reasonable exceptions permitted.	None specified.

* As outlined in the June 2001 SCHIP regulations, Secretary-approved coverage can include (but is not limited to) comprehensive coverage for children offered by the state under a Medicaid section 1115 waiver, 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 42 CFR 447.50 through 447.58. The requirements for SCHIP are found at 42 CFR 457.540 and 42 CFR 457.555.

‡ HIFA defines optional populations as individuals who could be covered under a Medicaid or SCHIP state plan at state option and expansion populations as those who could not otherwise be covered under Medicaid or SCHIP. It should be noted that the DRA of 2005 includes a prohibition on the use of SCHIP funds for coverage of childless adults. The provision is applied prospectively, so states with existing approval to do so may continue claiming federal matching funds for this population.

what the state would have otherwise spent through the direct coverage program. States may also enroll family members who are not eligible for Medicaid in employer coverage when that enrollment is necessary to achieve coverage of Medicaid-eligible family members.⁵ For example, Medicaid can pay premiums for a noneligible parent to enroll in an employer health plan so that a Medicaid-eligible child can be enrolled in that plan. However, noneligible family members do not receive any wrap-around benefits.

In most states, HIPP has been used primarily to target Medicaid-eligible individuals with high medical expenses, such as individuals with HIV/AIDS. However, the four states that operate the largest premium assistance programs under the HIPP authority—Iowa, Pennsylvania, Rhode Island and Texas—do not limit their programs to high-cost eligibles. In fact, the majority of enrollees in these states are families and children, which may be a major contributor to the programs' relative success. Several other states' PA programs began as HIPP programs but have since used the section 1115 waiver authority to utilize the increased flexibility and expand program enrollment.

Rhode Island was one of the first states to design and implement a premium assistance program that utilized the Medicaid HIPP authority

within its section 1115 waiver program, better known as RIte Care. The premium assistance component, called RIte Share, provides an example of a small state's ability and willingness to be nimble by recognizing problems and making program improvements quickly and effectively. Rhode Island learned from other states' attempts at obtaining employer participation and corresponding employee enrollment and has realized a substantial amount of program savings as a result.

The RIte Share program is mandatory for all Medicaid enrollees with access to employer-sponsored health coverage. The state provides "wrap-around" benefits to cover those that are not included under the employer health plan, up to the level of benefits provided in RIte Care, and reimburses individuals for any premiums required by the employer plan that exceed Medicaid levels. The state reimburses providers for co-payments on behalf of RIte Share enrollees. Rhode

Premium Assistance Snapshot: Rhode Island's RIte Share

Island's Department of Health Services targeted marketing efforts at employers who were already offering employer-sponsored coverage. (The rate

of employer coverage in Rhode Island is high—77 percent—and many of those employees who work for small or low-wage firms that do not offer coverage are eligible for RIte Care.)

The state has made several mid-course adjustments to RIte Share that have dramatically increased its success. Like many other states with PA programs, Rhode Island initially paid the enrollee's premium directly to his or her employer, who then paid the premium to the health plan. While this process avoided the need for employee payroll deduction, employers perceived it as administratively challenging. In late 2001, the state began to reimburse employees directly for the family's share of cost of the coverage, taking the burden off the employer. As a result, employer participation increased dramatically and, between January and June 2002, enrollment jumped from 275 to over 2,000. Enrollment has since reached more than 5,000 individuals.

Premium Assistance and SCHIP

The enactment of the bipartisan legislation authorizing the SCHIP program in the BBA of 1997 included provisions designed to encourage increased public-private interaction. The legislation permits states to provide coverage to children and families eligible for SCHIP by subsidizing group health plan premiums. The rules on premium assistance for separate (non-Medicaid) child health programs under SCHIP require that eligible children receive one of the benchmark benefit packages, an actuarially-equivalent benefit package, or a “secretary-approved” benefit package as identified in federal statute.⁶ States also have the option to supplement, or wrap around, the benefits offered by the group health plans when those plans do not meet the SCHIP benchmark requirements. Cost sharing must be “nominal” as defined in the SCHIP regulations for children with family incomes at or below 150 percent of the federal poverty level (FPL), and charges may not exceed 5 percent of the family’s income for children of all income levels.

Like Medicaid, SCHIP premium assistance programs must be determined to be cost effective, meaning the cost of covering the children through ESI must not exceed the amount it would cost to cover eligible children through the state’s direct-coverage SCHIP program. However, in a significant departure from Medicaid, states with separate SCHIP programs must apply for a special waiver when noneligible family members are to be covered and meet a stricter cost-effectiveness test. Under this “family coverage waiver,” the cost of covering both eligible and noneligible family members must not exceed the cost of covering only the SCHIP-eligible children. This test has proven to be virtually impossible to meet because of high premium costs in the private market. The theory that the employer contribution would be sufficient to reduce the family premium below the cost of covering the children alone has not proven to be valid.

The SCHIP regulations also require that PA programs have procedures in place that are designed to prevent SCHIP from substituting for private coverage, commonly known as “crowd out.” Children must not have had coverage under a group health plan during the six months prior to enrollment; this six-month waiting period is intended to discourage parents from dropping existing coverage in favor of SCHIP.⁷ However, reasonable exceptions are permitted, including cases of economic hardship.

Programs operating under SCHIP authority have been extremely limited. Maryland and Virginia are the only two states that have operated PA programs under an approved SCHIP state plan.⁸ Maryland’s legislature terminated the program as of July 1, 2003, because of low enrollment and high administrative costs. Virginia’s program operated for a number of years with very low enrollment. In 2005, Virginia made changes to its program under a HIFA waiver and, although enrollment has grown, SCHIP children continue to make up only 14 percent of the total population receiving premium assistance in the state.⁹ Covering only children (as opposed to whole families) within a narrow band of eligibility appears to be a contributing factor to low enrollment for both states.

Premium Assistance Through Section 1115 Waivers

States have more successfully used the flexibility available through section 1115 demonstration projects, including HIFA waivers, to implement PA programs.¹⁰ Premium assistance programs that operate under section 1115 authority are not required to meet some of the Medicaid and SCHIP requirements that have impeded enrollment. Waiver authority is also desirable because section 1115 allows states to provide coverage to people (such as parents or childless adults) who are not otherwise permitted to be covered under the Medicaid and SCHIP statutes.¹¹

Beginning in the mid-1990s, a few states sought the flexibility available through section 1115 demonstration projects to implement PA programs.¹² These states generally wanted to expand coverage to whole families rather than only those individuals who met the Medicaid eligibility criteria and also wanted to include the newly eligible SCHIP children in their expanded Medicaid populations. The Health Care Financing Administration (HCFA, now CMS) required the premium assistance components of these Medicaid demonstrations to follow the SCHIP statute and related guidance, which provided somewhat more flexibility than Medicaid in terms of benefit package and permissible cost sharing for children in the expansion groups. The demonstrations also followed SCHIP guidance for crowd out prevention procedures. Despite these small increases in flexibility, program growth has remained slow and states have struggled to balance the need and desire to pursue this source of potential savings with the programmatic and administrative challenges created by the governing statute, regulations, and policy.

Under the HIFA initiative, CMS goes one step further by requiring states to include premium assistance as part of their project proposals. HIFA offers greater flexibility in implementing PA programs than had been approved in previous demonstrations. States are no longer required to comply with all of the benefits, cost-sharing, and cost-effectiveness requirements that had previously deterred some states from pursuing PA programs. For example, in the Illinois HIFA waiver program, group health plans do not have to meet the specific benefit or cost-sharing requirements for either Medicaid or SCHIP, and the state is not required to provide wrap-around benefits.¹³ Enrollees receive the benefits covered by the employer plan and pay the applicable cost sharing. However, CMS required as part of the demonstration approval that families have a choice of whether to enroll in their employer's group health plan or the state's public program. Similarly, Massachusetts and New Jersey have modified some features of their existing section 1115 demonstration projects in order to utilize the increased flexibility under HIFA. In fact, Massachusetts will use the coverage expansion included in its Medicaid section 1115 waiver as a building block for its recently enacted universal coverage plan. The expansion will help

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low-income individuals meet the individual mandate, which requires all Massachusetts residents to obtain health insurance coverage. For those with higher incomes, the plan includes several insurance market reforms and broad-based state subsidies designed to make it easier for individuals to afford private coverage.

In the early years of the HIFA initiative, despite CMS's keen interest in premium assistance, only four states—Illinois, Oregon, New Mexico, and Utah—included premium assistance components as a central part of the demonstration design. Oregon and Illinois refinanced and expanded existing state-funded PA programs. Oregon has had the most success with its program, where enrollment has recently grown to almost 16,000 people. New Mexico delayed implementation of its program until 2005, largely due to a change of administrations in the state. Utah has implemented its PA program, but it has enrolled only 61 individuals thus far.

In order to meet the PA component requirement, several other states negotiated plans to conduct feasibility studies rather than actually pursuing PA programs. Interestingly, the results of the feasibility studies in Arizona, Colorado, and California indicated several implementation barriers, including limited availability of ESI for low-wage workers, rapidly rising premium and cost-sharing requirements, along with a variety of administrative challenges for the states.¹⁴ Consequently, those three states have not yet moved forward in implementing PA programs.

More recently, several states have expressed interest in pursuing PA programs under HIFA and have voluntarily included implementation plans as part of their waiver proposals. Oklahoma's recently implemented PA program, O-EPIC, helps small business owners with 25 or fewer employees purchase health insurance in the private market for employees who earn less than 185 percent of the FPL. Thus far, 369 businesses and over 700 people have been enrolled. Arkansas has received approval for a demonstration centered around a public-private partnership that relies heavily on the ESI market. Eligible employers (those with 2 to 500 employees) will voluntarily participate in the program but will be required to provide coverage to 100 percent of their employees, regardless of income. In order to reduce the effect of crowd out, the program will be limited to employers who have not offered health insurance coverage to their employees as a group benefit for the 12 months prior to their decision to participate in the program. The state is also exploring the feasibility of extending eligibility to individuals who are not affiliated with participating employers for phase II of the demonstration. The state estimates potential coverage of up to 80,000 enrollees through the demonstration.¹⁵

But Does It Save Money?

Limited information is available to show conclusively that premium assistance saves state and federal dollars. Any estimates of cost effectiveness must be viewed with caution because each state calculates cost

effectiveness differently, particularly with regard to the amount of administrative costs included. However, there is evidence to suggest that PA programs produce cost savings in at least some states. Iowa estimates that its HIPP costs are roughly 30 percent below the standard Medicaid program, and Rhode Island estimates savings of approximately \$1 million annually for each 1,000 people enrolled for a full year.¹⁶ Pennsylvania—one of the largest PA programs with over 23,000 enrollees—estimates that savings for fiscal year 2003 reached \$76.3 million.¹⁷ A recent study of five states (Illinois, New Jersey, Oregon, Rhode Island, and Utah) found that Rhode Island and New Jersey appear to be saving money on a per-enrollee basis; however, sufficient data were not available for the other states.¹⁸ Further, some analysts speculate that any savings are merely a cost shift to the employer and, ultimately, to low-income workers who pay for premium increases in the form of lower wages. However, no research is available that has examined the impact of PA programs on the wages of low-income workers.

LEARNING FROM EXPERIENCE

Premium assistance offers a number of potential advantages for states, employers and workers. However, PA programs have made limited progress in covering significant numbers of low-income, uninsured workers and their families. The largest programs have enrolled only about 4 percent of the Medicaid population.¹⁹ The PA programs that have had the most success with enrollment have several features in common which appear to contribute to their effectiveness. States have also faced several common barriers that have inhibited the full potential for program savings and coverage expansion.

Effective Strategies

Several programmatic features appear to contribute to PA programs' success.

- **Programs with larger enrollment tend to have wider bands of eligibility and target whole families rather than just children.** States' efforts to streamline and expand eligibility categories—for example, by covering all children under age 19 with incomes up to 200 percent of the FPL and by tying eligibility for adults and children exclusively to income instead of to eligibility for welfare programs or disability status—have made the Medicaid and SCHIP programs less complicated administratively and have helped increase the pool of potential premium assistance eligibles. Streamlining eligibility categories can help prevent “fragmentation” of families, where some members are eligible for premium assistance while others are not. Making whole families eligible makes the cost-effectiveness test easier to meet.

For example, both Massachusetts and Rhode Island cover parents and children in their Medicaid programs and make premium assistance

available to mandatory Medicaid populations, as well as to expansion populations under their section 1115 demonstrations. Massachusetts has enrolled over 33,000 people in its PA program, and Rhode Island has enrolled more than 5,000. Rhode Island has reported that premium assistance is found to be cost effective much more frequently for families with incomes below 185 percent of the FPL, where both parents and children are eligible, than for families with incomes above 185 percent of the FPL, where only children are eligible.²⁰ Conversely, Maryland's program, which covered only children between 200 and 300 percent of the FPL, enrolled slightly less than 200 children. Similarly, Virginia's program limits eligibility to children with family incomes between 100 and 200 percent of the FPL and has enrolled 229 children in premium assistance to date.

- **Mandatory enrollment appears to make a difference.** Not surprisingly, states find that participation in PA programs improves when eligible individuals are required to enroll in available group health coverage as a condition of Medicaid or SCHIP eligibility. However, there may be important trade-offs to mandatory enrollment. Illinois, for example, operated a PA program with mandatory enrollment for a number of years with state-only funds. When the state later obtained approval to receive federal matching payments under a section 1115 waiver, CMS required Illinois to allow families to choose between ESI and SCHIP. Premium assistance enrollment decreased as a result. At the same time, premiums in the private market were rising, so the value of the state subsidy (\$75 per eligible family member) eroded over time.

Families reported that group health insurance was either too expensive, even with a subsidy, or did not include certain benefits (for example, prescription drug coverage) that were needed by the family. Therefore, states must consider the economic and health factors that may lead families to choose enrollment in Medicaid or SCHIP rather than group health coverage, even when ESI enrollment may be more advantageous for the state in terms of cost.

- **Employer relationships and communication efforts are critical.** States that devote significant resources to employer education, recruitment, and relationship building have had more success with PA programs over time. As employers become more familiar and comfortable working with states, their cooperation and participation increases. Pennsylvania, for example, has staff located in regional offices throughout the state. Cases are assigned to these staff on an employer-by-employer basis so that one state staff member routinely works with the same company representative. This helps eliminate duplicate phone calls and minimizes the burden on employers. As employers have come to understand the program, they have become more cooperative, and

Participation in PA programs improves when eligible individuals are required to enroll in available group health coverage.

some voluntarily contact the state on a quarterly basis to submit a list of new employees.²¹

- **States with better enrollment have committed significant resources to program development and operation.** These states devote staffing to the program and often contract with outside resources to perform major functions such as tracking down information about available coverage and determining cost effectiveness. Several states have redesigned their eligibility systems to capture information about employment and to link with other systems within the state. These systems help identify eligible individuals who have coverage available on the job and verify continuing enrollment in that coverage. States have established data banks or libraries containing information about employers and group health plans so that information can be more readily available when determining eligibility for new applicants.

Enrollment is important to the success of PA programs, but not only because more people are insured. The admittedly high administrative costs associated with operating PA programs are mitigated as enrollment increases; the costs are spread across more individuals, thereby increasing the likelihood that the program will achieve savings for both states and the federal government.

Operational Challenges

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

- **Many low-income workers do not have coverage available on the job.** Sixty-five percent of uninsured workers have family incomes of less than 200 percent of the FPL,²² and these workers are significantly less likely to have health insurance coverage available as an employment benefit. One study found that only about 41 percent of workers below 100 percent of the FPL and 61 percent of workers with incomes between 100 and 199 percent of the FPL were offered health insurance through their employers.²³ Low-income workers also tend to lose or change jobs more frequently than higher-income workers, and such changes in employment often result in loss of, or interruptions in, coverage. These individuals are among the target populations for Medicaid and SCHIP programs, so establishing PA programs can be especially difficult if the employer is not already offering coverage.
- **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, in the form of higher deductibles and other out-of-pocket expenses, to employees in an attempt to reduce premium increases. While a high proportion (85 percent) of workers overall who are offered coverage take it, the take-up rate is lower for low-income workers (71 percent for workers with incomes below the poverty level).

Among people who do not enroll in coverage offered by their employer, cost has been found to be the primary factor.²⁴ For example, Utah provides a fixed subsidy of \$50 to uninsured adults with incomes up to 150 percent of the FPL in their program called Covered at Work. The program's low enrollment (61 people) is attributed to the low subsidy amount. As private market costs rise, PA programs must provide ever-larger subsidies so that coverage remains affordable.

- **Federal rules and complex administration create barriers to growth for PA programs.** Federal rules limit the number of health plans that can qualify for the federal subsidy. For Medicaid, coverage must meet the cost-effectiveness requirement, which includes both the cost of the employer group health insurance and the cost of any wrap-around benefits that the state must provide to meet the Medicaid benefit and cost-sharing standards. Group health plans that do not meet the cost-effectiveness test cannot qualify for subsidy. The cost-effectiveness requirement becomes more difficult to meet as group health insurance premiums and workers' out-of-pocket costs (deductibles, coinsurance, and co-payments) continue to rise.

States with separate SCHIP programs must also evaluate cost effectiveness, as well as whether group health plans meet or are actuarially equivalent to one of the benchmark benefit package options. Group health plans that do not meet SCHIP benefit package requirements cannot be subsidized. Alternatively, separate SCHIP programs may establish a mechanism to provide wrap-around coverage, but doing so increases the costs of the program.

SCHIP requirements for crowd-out prevention in premium assistance also limit the number of people who qualify. Children must be uninsured and may not have been covered by group health insurance within the past six months.²⁵ The federal government also initially required that states could only subsidize plans in which employers contributed a minimum of 60 percent toward premium costs as another way to prevent crowd out. However, because employer recruitment proved difficult at that level, CMS gradually modified its position regarding employer participation. As a result, the final regulations do not mandate a minimum employer contribution level. But it is important to note that employer contribution levels generally have to be substantial in order for the plan to meet the cost-effectiveness test.

Despite some additional flexibility that the federal government has allowed for PA programs, the evaluation of benefit packages, calculation of cost effectiveness, and provision of wrap-around coverage require states to set up complex procedures to administer PA programs. Even in many programs set up under section 1115 waivers, states must still, at a minimum, determine whether eligible individuals have coverage available on the job and the amount of premiums for which workers are responsible. The procedures needed to do so can involve costly changes to computer

systems and require additional staff resources. State administrative efforts in these areas are further complicated by federal rules under ERISA (the Employee Retirement Income and Security Act of 1974).

THE ERISA EFFECT

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. ERISA contains broad language, known as “the preemption provision,” stating that federal ERISA law supersedes state law relative to employee benefit plans.

Therefore, states cannot directly regulate employer-sponsored health plans, nor can they regulate employer behavior in their role as health plan administrators.

However, ERISA does permit states to regulate the insurers with which employers contract. As a result, states

can indirectly regulate employer-sponsored, commercially insured health plans, through laws that apply to insurers, but cannot regulate plans that are self-insured by employers.²⁶

Employer recruitment and participation have been key challenges in establishing and operating PA programs because the ERISA preemption clause prevents states from requiring employers to cooperate with PA programs. ERISA most significantly affects PA programs in two areas: exchange of information between employers and states, and employees’ access to open enrollment periods for employer-sponsored health plans.

Information Exchange

ERISA precludes states from requiring employers to share health plan information with the Medicaid or SCHIP agency. Employers are often reluctant to become involved with government programs, fearing administrative hassles and increased costs. States usually must rely on voluntary employer participation or request that workers obtain the health plan information from their employers, with varying degrees of success. For example, Maryland found that over 40 percent of employers contacted by the state either did not respond to requests for information or did not provide adequate information. This poses significant problems because, in order to determine whether a health plan qualifies for a premium assistance subsidy, states must collect detailed information from employers about what group 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 on benefits, cost sharing and cost effectiveness are met, as well as to make accurate and timely premium subsidy payments to either employers or workers, depending on the program design. The information must be updated periodically as plan benefits and costs change.

The ERISA preemption clause prevents states from requiring employers to cooperate with PA programs.

While ERISA precludes states from requiring employers to provide this information, states may require the insurers with whom employers contract to provide it. For example, Rhode Island and Massachusetts have enacted state laws requiring commercial insurers to share information with Medicaid about members who are enrolled in group health insurance. Although these laws are helpful, even insurers may not have all the information needed by states. For example, insurers often do not know the amount contributed by employers because they receive only the total premium payment. Further, these state laws do not apply to self-insured employers. Some analysts have posited that new authority enacted in the Deficit Reduction Act (DRA) of 2005, mandating states to enact laws that require all health insurers (including self-insured plans) to provide information to Medicaid about coverage for third-party liability purposes, could be used to obtain this information without triggering an ERISA preemption challenge. However, the authority for PA programs to use this approach is not clear-cut. As a result, states devote significant administrative resources to tracking down the necessary information.

Open Enrollment Periods

Typical benefits rules only permit employees to enroll in group health plans or change their election (for example, to add dependents or select a different plan) 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. Some states with PA programs have enacted laws that make eligibility for Medicaid or SCHIP a qualifying event so eligible workers and their dependents can enroll outside the annual open enrollment period.

However, this strategy does not resolve issues with open enrollment periods when self-insured employers subject to ERISA are involved. Under ERISA, self-insured employers cannot be required to comply with state qualifying event laws. Although some self-insured employers cooperate by permitting special enrollment, in other cases workers may have to wait until the next open enrollment period. Workers may also have difficulty disenrolling from their employer’s plan should they become ineligible for the premium assistance subsidy during the year.

NEW STRATEGIES FOR PUBLIC-PRIVATE PARTNERSHIPS

Several states are pursuing other strategies that build on the options available through Medicaid and SCHIP to utilize public-private partnerships. These strategies are designed to address some of the barriers that have previously interfered with the effectiveness of PA programs, such as high premium costs and low offer rates among small employers. Some programs

have been started under the HIFA initiative, whereas others are solely state-funded and, therefore, are not required to follow federal mandates.

These newer strategies vary significantly from traditional premium assistance approaches in important ways. Some states have developed new insurance products rather than using existing group health plans. In some cases, these new insurance products are not subject to state insurance rules and, in that regard, are more similar to public coverage. The state, rather than the health plan or self-insured employer, may be accepting risk for health care costs that exceed premiums paid.

However, these differing strategies all have one thing in common with more traditional approaches: the combined use of government and private employer funds to insure workers and their families. The following are a few examples of state innovation directed at facilitating the use of employment-based coverage.

■ **Creating new insurance products.** To get around the difficult challenge of finding employer-sponsored health plans that are cost effective and meet the Medicaid and SCHIP benefit requirements, some states have elected to create entirely new insurance products. This has enabled states to better control program costs because they have tailored the benefit package to meet the needs of the program. Because the state has designed the benefit package, there is no need to arrange for wrap-around services. This reduces both the administrative cost and burden. For example, the (non-federally funded) DirigoChoice™ program in Maine was designed to rely on private insurers offering comprehensive coverage at a low enough cost to make the purchase of that coverage affordable to those who are uninsured. The DirigoChoice™ benefit package places significant emphasis on primary and preventive care services and includes additional wellness benefits aimed at improving overall health and preventing disease. However, the state received only one bid, from Anthem Blue Cross and Blue Shield of Maine, and the premium amounts associated with the benefit plan were significant enough to deter enrollment on a broad scale. As an alternative, Maine chose to develop a plan to self-administer the insurance benefit, which will give the state greater control over the pricing and make-up of the benefit package.²⁷ New Mexico has also developed a new insurance product for its HIFA demonstration project that is primarily directed toward small businesses that do not currently offer coverage.

■ **Stop/loss reimbursement (or reinsurance).** Some states have adopted a strategy to keep premiums low whereby the state indirectly subsidizes premium costs by reimbursing health plans for health care expenses (or a portion of claims) that exceed a specified threshold. Healthy NY, a private-market program operated by the New York State Insurance Department using no federal funds, appears to be effective in controlling premium costs.²⁸ The State of New York implemented

Healthy NY in January 2001 to provide affordable insurance to small businesses, sole proprietors, and workers who cannot obtain coverage through their employers. Healthy NY provides a streamlined benefit package, coupled with a reinsurance pool, to keep premiums below market rates. Premiums are community-rated, set by health plans, and vary from county to county. Healthy New York has had a rapid rate of enrollment, reaching over 106,994 members in December 2005. Enrollment distribution among the three eligible groups targeted by the program is as follows: 26 percent from small businesses (fewer than 50 employees with at least 30 percent of employees earning \$34,000 or less), 18 percent from sole proprietors, and 56 percent from working individuals who cannot otherwise obtain coverage through an employer. Individual premiums (including drug coverage) for the Healthy NY program averaged \$159 per month in 2004, significantly lower than the national average which was \$308 in 2004.²⁹

- **Streamlined benefits.** States have increasingly pursued offering more limited benefit packages that are primarily focused on preventive care and chronic disease management as a means of promoting healthy lifestyles and generating cost savings. For example, Arkansas has designed a limited “safety net” benefit package that includes six physician visits per year, seven inpatient acute care hospital days per year, two outpatient hospital services per year (such as outpatient surgery, radiology, and/or emergency room visits), and two prescription drugs per month (through a tiered formulary). The state received approval from CMS to offer this benefit package through its HIFA section 1115 waiver program, which is scheduled for implementation in January 2007.³⁰
- **Local initiatives.** Some states, counties and local communities have taken it upon themselves to design health care delivery initiatives that fall outside the parameters of federal funding rules. Operating beyond the constraints of federal standards offers nearly unfettered flexibility; however, the resulting absence of federal funds creates significant concerns about long-term sustainability. Nonetheless, these local coverage initiatives offer innovative and educational examples that could be used as models for larger-scale PA programs. One example that has gained prominence on the national landscape over the last few years is the Access Health program in Muskegon County, Michigan. The program provides care through a three-way financial commitment—known as the “three-share model”—among employers, employees, and the community-owned health plan, Access Health.

Access Health helps small and mid-sized businesses provide health coverage to employees and their families. Under the plan, which began enrollment in 1999, more than 400 businesses now provide coverage to some 1,500 individuals. Eligibility is limited to full or part-time employees; seasonal, contract, and temporary employees, as well as employees who have other insurance, are not eligible. The median wage of the employees must be no more than \$11.50 per hour, and the business

Healthy NY provides a streamlined benefit package, coupled with a reinsurance pool, to keep premiums below market rates.

must not have been offering another health insurance product for the past 12 months. Young adults aged 19 to 23 can be covered as part of the plan, and dependent coverage is also available (although rarely utilized).

Outreach efforts have been targeted to restaurants, day care centers, hair salons, and other small businesses. In addition, the program reaches out to pools of employers and larger businesses that offer some commercial coverage but do not offer health coverage to all of their employees. The program is financed by a three-way partnership in which the employer and employees each pay 30 percent of the cost (\$46 per month) and Access Health covers the remaining 40 percent (\$56 per month), for a total of \$148 per month. The community share (in this case, Access Health) is made up of a combination of local government, community, and foundation funds, as well as federal disproportionate share hospital (DSH) funds. This three-share concept has been well received by employers and the broader community. And in April 2006, Rep. Peter Hoekstra (R-MI) introduced a bill (H.R. 5171) that would provide \$45 million over seven years for grants to communities to replicate the Muskegon model.³¹

In most cases, programs using approaches such as these have been operating for only a short period of time, so it is difficult to judge their effectiveness in reaching more workers and their families. However, a demonstration initiative by the Robert Wood Johnson Foundation in the late 1980s, called the Health Care for the Uninsured Program, tested these same strategies. Ten projects either developed new insurance products or subsidized existing products. Despite premium reductions averaging between 25 and 50 percent, no single site enrolled over 10,000 people and most never reached even 10 percent of their target market.³² Reluctance of small employers to participate, mainly due to increased labor costs and the high cost of administering health plans for a small number of employees, was a major factor in this disappointing outcome. Interestingly, while Healthy NY has experienced good enrollment growth since its implementation in 2001, over half of the enrollment is in individual coverage and the same is true in Oregon's Family Health Insurance Assistance Program (FHIAP).

Taken together, these experiences suggest that there is still a long way to go to if employers are to be a significant source of coverage for uninsured low-income workers and their dependents. In addition, these types of programs can play an important role in making affordable coverage available to individuals who can not obtain coverage through their employer.

PREMIUM ASSISTANCE AND THE DRA

The DRA of 2005 included several significant changes to the Medicaid program with respect to benefits and cost-sharing requirements in particular. The provisions modified the Medicaid statute to be more closely aligned with those of the SCHIP program. States now have several options for designing modified benefit packages for certain populations,

including one option to propose any set of benefits as long as they are considered appropriate by the Secretary of Health and Human Services.³³

The most relevant change for purposes of PA programs is that states will no longer be required to ensure the provision of all Medicaid-covered services in cases where a health plan does not offer a benefit package that is identical to Medicaid's. The absence of this wrap-around requirement for certain populations (low-income parents and a few other optional groups) could make it less difficult for states to qualify ESI plans for subsidies. As a result, more individuals could have the opportunity to enroll in PA programs. However, it should be noted that the DRA excludes most eligibility groups from the benefit changes.³⁴ Further, DRA provisions do not apply to any new groups that states opt to cover. Therefore, its impact for premium assistance is likely to be limited. The long-term effects of the DRA remain to be seen, but the changes signal a continuing evolution of the Medicaid program and its ongoing efforts to meet the needs of its varied constituencies.

Many lessons have been learned from states' and the federal government's experience in designing, regulating, and implementing PA programs.

POSSIBILITIES FOR IMPROVEMENT

Many lessons have been learned from states' and the federal government's experience in designing, regulating, and implementing PA programs and the circumstances under which they can most successfully operate. As a result, analysts have identified several changes that could be made to federal laws to facilitate the broader and more successful utilization of ESI in public health coverage programs. The following ideas are, of course, subject to the prevailing political, budgetary, and ideological climates, and the resistance to modifying a major statute like ERISA cannot be underestimated.

- **Information sharing improvements.** Some policy analysts and state officials have suggested that Congress amend ERISA to allow states to require employers (including those who are self-insured) to share health plan information with states.³⁵ A similar amendment was made to ERISA to facilitate implementation of the Child Support Enforcement Act, so there is precedent for such a change. However, ERISA is under the primary jurisdiction of the U.S. Senate's Committee on Health, Education, Labor and Pensions and the U.S. House of Representatives' Committee on Education and Workforce, whereas Medicaid and SCHIP are authorized by the Senate Committee on Finance and the House Committee on Energy and Commerce, making it difficult to cross-fertilize information and priorities in an always busy and highly charged legislative environment. In addition, employers are likely to raise strong opposition to any new mandate that is proposed.
- **Open enrollment flexibility.** The ERISA statute could also be modified to specify that self-insured employers must comply with state laws designating eligibility for Medicaid or SCHIP as a "qualifying event"

in order to expedite enrollment in PA programs outside of the open enrollment period. (This was actually proposed in President Bush's fiscal year 2005 budget, but the provision was not adopted.) Individuals would also need to be permitted to disenroll from the group health plan coverage upon losing Medicaid or SCHIP eligibility.

- **Wrap-around coverage.** Some have suggested that the statutory requirement for states to provide wrap-around coverage of benefits not included in the ESI plan should be removed. This would codify what has been approved in some of the recent HIFA waivers and enable states to qualify more employer plans for subsidy. It would also obviate the need for states to administer programs differently depending on whether eligible individuals fall into one of the groups that the DRA of 2005 excludes from benefit flexibility. However, enacting such a change seems unlikely, given the result of the debate around the benefits changes in the DRA and the subsequent requirement that states continue to provide a wrap-around of all services mandated by EPSDT (early and periodic screening, diagnosis, and treatment) for children enrolled in Medicaid. As a compromise measure, Congress could consider making enrollment in premium assistance optional when the state does not provide wrap-around coverage, as has been done under HIFA. While enrollment would likely be lower under the optional scenario, states would have more design flexibility for their programs, and beneficiaries would have greater choice of coverage. However, analysts have expressed concerns that such a change may prevent eligible individuals from accessing the comprehensive benefits they are entitled to under Medicaid and that the significantly higher cost sharing in private plans is likely to cause access problems.
- **Cost effectiveness.** The SCHIP statute could be modified to make the cost-effectiveness test consistent with Medicaid. This change would help facilitate the development of more comprehensive PA programs that bridge across both Medicaid and SCHIP and potentially reach more individuals. The cost-effectiveness test in SCHIP would be easier to meet because noneligible family member costs could be considered when determining whether premium assistance is cost effective. However, some SCHIP funds would be expended for premium costs of noneligible family members. This can be done currently by obtaining a SCHIP family coverage waiver, but would likely be used to a greater extent because the cost-effectiveness test would be easier to meet.

CONCLUSION

Premium assistance continues to be one mechanism for covering at least a small portion of the growing uninsured population, and it shows potential to generate cost savings in a time of state and federal budget deficits. The use of premium assistance is of great interest to some states as they attempt to contain Medicaid costs, provide access to workers who want affordable private coverage, and assist employers who might benefit from

a healthier and more stable workforce. These efforts also coincide with the federal government's promotion of market principles and increased emphasis on personal responsibility.

Despite its many flaws and foibles, the concept of building on public-private partnerships may be a viable mechanism for health coverage expansion in the coming years. As in the past, the Medicaid and SCHIP programs may be well-positioned to serve as a laboratory for continuing such expansion. However, experience seems to indicate that public-private partnerships, even with changes to statutory provisions and flexibility under section 1115, are unlikely to reach significant numbers of the uninsured population given the general reluctance of employers to participate on a voluntary basis and high administrative costs involved in insuring small numbers of workers and their families. The recently enacted Massachusetts health reform plan, which hinges on concessions from providers, employers, the state, and individuals in its effort to achieve universal health coverage, may be instructive for the future to determine whether public-private partnerships can truly succeed in covering large numbers of low-income uninsured individuals.

ENDNOTES

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5. All family members are usually not Medicaid-eligible because income criteria differ depending on age. Income limits for adults are typically much lower than for children.
6. As presented in the January 2001 SCHIP regulations, these benchmarks are: (i) the standard BlueCross BlueShield preferred provider option offered under the Federal Employees Health Benefit Program, (ii) a health benefits plan offered to state employees, and (iii) health benefits coverage with the largest commercial enrollment in the state offered by an HMO. 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), either through the employer plan or through the employer plan combined with a state-provided supplement to the employer plan. The state can use a different SCHIP benefits benchmark for its direct coverage and its PA program. Plans can be qualified as meeting benchmark requirements through either a benefit-by-benefit comparison or by meeting a test of actuarial equivalence.

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7. HCFA originally required that employers contribute a minimum of 60 percent toward the cost of dependent (children's) coverage to participate in premium assistance. Most states felt that this created a significant barrier to employer participation. As a result, the final SCHIP regulation eliminated this requirement.
8. Mississippi, South Dakota, and Wyoming were also approved to operate premium assistance under their SCHIP state plans but never implemented their programs.
9. Virginia also operates a HIPP program for lower-income Medicaid populations.
10. It should be noted that premium assistance is not the main element of most section 1115 waivers. Many waivers expand coverage in public programs well beyond the premium assistance component or without using premium assistance at all.
11. The Deficit Reduction Act of 2005 prohibits any new waivers using SCHIP funds to cover childless adults.
12. Massachusetts and Wisconsin received approval from HCFA for section 1115 demonstration projects that included premium assistance components in 1997–1998, and New Jersey followed suit in 2001.
13. The state must ensure that all plans provide well-baby and well-child care and emergency services. The state must also reimburse families for immunizations provided if they are not covered by the ESI plan.
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15. Centers for Medicare & Medicaid Services (CMS), "Special Terms and Conditions: State of Arkansas," February 28, 2006; available at www.cms.hhs.gov/MedicaidStWaivProgDemoPGL/downloads/ArkansasHIFA1115.zip.
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25. States may apply certain exceptions to this rule, for example, when coverage has been lost because a parent changed jobs or is unaffordable.

Endnotes / continued ►

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26. Employers who have self-insured plans are companies able to assume risk for health care costs incurred under that plan. The exemption of self-insured plans from ERISA regulations is significant because a substantial proportion of workers participating in employer-sponsored plans are enrolled in fully or partially self-insured plans. For more information, see Mark Merlis, "Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform," National Health Policy Forum, Background Paper, April 13, 2005; available at www.nhpf.org/pdfs_bp/BP_Underwriting_04-13-05.pdf.
27. For more information about Maine's Dirigo Choice™ program, see Jill Rosenthal and Cynthia Pernice, "Dirigo Health Reform Act: Addressing Health Care Costs, Quality and Access in Maine," NASHP, June 2004, available at www.nashp.org/Files/GNL_56_Dirigo_brief.pdf; and "Designing Maine's DirigoChoice™ Benefit Plan: Striving to Improve Health at an Affordable Price," NASHP, December 2004, available at www.nashp.org/Files/Dirigo_Issue_Brief_on_Benefit_Design_final_hp.pdf.
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