

# medicaid and the uninsured

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## PREMIUM ASSISTANCE PROGRAMS: HOW ARE THEY FINANCED AND DO STATES SAVE MONEY?

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### EXECUTIVE SUMMARY

Recently, there has been increased interest in using premium assistance programs to encourage low-income families' participation in private coverage, shore-up the private coverage market and prevent crowd-out, and achieve cost savings by bringing in employer contributions to help offset costs. Premium assistance programs use federal and state Medicaid and/or State Children's Health Insurance Program (SCHIP) funds to subsidize the purchase of private health insurance. They may also utilize employer or enrollee contributions to help pay premium costs. The increased interest in premium assistance has partly stemmed from the Administration's 2001 Health Insurance Flexibility and Accountability (HIFA) section 1115 waiver initiative, which encouraged states to implement premium assistance programs and relaxed certain benefit, cost sharing, and cost-effectiveness requirements.

A number of states have taken advantage of waiver flexibility to implement their premium assistance programs. How these programs are structured and whether they result in savings for states are considerations in assessing the impact of these programs. This brief examines premium assistance programs implemented under section 1115 waivers in five states (Illinois, New Jersey, Oregon, Rhode Island, Utah) to determine how they are financed; their eligibility, benefit, and cost sharing requirements; their methods for determining cost-effectiveness; and cost savings. Key findings include:

*Financing.* The examined states are using a variety of combinations of employer and enrollee contributions and subsidies to finance their premium assistance programs. Most are relying on employer contributions to help offset costs, and they all require individual contributions from at least some families (Table 1). Illinois and Utah cap their subsidy amounts, shifting the risk of remaining premium costs to enrollees, while New Jersey, Oregon, and Rhode Island pay premium amounts remaining after employer and fixed individual contributions.

*Benefit and Cost Sharing Standards.* The examined states also vary in their benefit and cost sharing standards. New Jersey and Rhode Island provide "wraparound coverage," meaning that they cover Medicaid benefits that are not covered by a private plan and any cost sharing in a private plan that exceeds the amounts allowed in Medicaid. In contrast, Utah and Illinois have very limited benefit and cost sharing requirements. Oregon requires that subsidized coverage meet a minimum benchmark that is actuarially equivalent to federally mandated Medicaid benefits.

*Cost Effectiveness and Savings.* The examined states use several different approaches to determine cost-effectiveness, including assessing whether an employer contribution is sufficient to ensure cost-effectiveness on a case-by-case basis (New Jersey and Rhode Island), capping

subsidy amounts (Illinois and Utah), and assessing aggregate program savings (Oregon). Among the examined states, there is limited data available regarding cost savings, but it is evident that Rhode Island and New Jersey are saving money on a per enrollee basis. However, in order to achieve overall savings, enrollment must be robust enough to generate sufficient savings to cover start-up and ongoing administrative expenses.

**Table 1:  
Key Features of Premium Assistance Programs, Selected States, 2005**

	Required Employer Contribution?	Enrollee Contribution <sup>a</sup>	Capped Subsidy?	Wrap-around?	Savings Data <sup>b</sup>	Enrollment
<b>Illinois</b>	No	Amount remaining after subsidy/ employer contribution	Yes	No	None available	5,500
<b>New Jersey</b>	Yes	<150% FPL: None >150% FPL: Fixed amount	No	Yes	\$203.97 per family per month (varies from month to month)	729
<b>Oregon</b>	No	Fixed amount/proportion	No	No <sup>c</sup>	None available	10,564
<b>Rhode Island</b>	Yes	<150% FPL: None >150% FPL: Fixed amount	No	Yes	Average of \$222.45 per family per month (including administrative costs)	6,012
<b>Utah</b>	Yes <sup>d</sup>	Amount remaining after subsidy/ employer contribution	Yes	No	Subsidy is \$50 per member per month, compared to \$80 per member per month for direct coverage	73

<sup>a</sup> Employer contributions are often present even if they are not required.

<sup>b</sup> All savings data represent combined federal/state savings.

<sup>c</sup> Oregon requires subsidized coverage to meet a minimum benchmark that is actuarially equivalent to federally required Medicaid benefits.

<sup>d</sup> Industry practice in Utah requires a 50% employer contribution.

Taken together, the findings suggest the following:

*Two key elements for achieving savings are an employer contribution and robust enrollment. An employer contribution offsets federal, state, and individual costs. In addition, enrollment must be high enough to generate sufficient savings to cover start-up and ongoing administrative expenses. To date, enrollment in premium assistance programs has been relatively low, likely reflecting the limited availability of employer-sponsored coverage among low-income workers and affordability problems for some individuals.*

*States can achieve savings without capping their subsidy amounts, and while still providing wraparound coverage. Rhode Island and New Jersey, which have documented program savings, provide wraparound coverage and do not cap their subsidy amounts. In the other examined states, coverage is not required to meet Medicaid benefit and cost-sharing standards, but it is not clear that these states are saving money.*

*Changes in the private market impact the cost-effectiveness of premium assistance programs. Recently, there have been sharp increases in private coverage premiums, and private market costs have been increasing more rapidly than Medicaid on a per-capita basis. If private premiums continue to increase faster than Medicaid, and workers are asked to share a larger percentage of the growing cost, the calculation of whether it is cost-effective for states to buy families into private coverage becomes less and less favorable. States can limit their costs by capping their subsidies, but this shifts the risk of added costs to enrollees.*