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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[a] | Capped Subsidy? | Wrap-around? | Savings Data[b] | Enrollment |
|---|---|---|---|---|---|---|
| **Illinois** | No | Amount remaining after subsidy/ employer contribution | Yes | No | None available | 5,500 |
| **New Jersey** | Yes | <150% FPL: None >150% FPL: Fixed amount | No | Yes | $203.97 per family per month (varies from month to month) | 729 |
| **Oregon** | No | Fixed amount/proportion | No | No[c] | None available | 10,564 |
| **Rhode Island** | Yes | <150% FPL: None >150% FPL: Fixed amount | No | Yes | Average of $222.45 per family per month (including administrative costs) | 6,012 |
| **Utah** | Yes[d] | 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 |

[a] Employer contributions are often present even if they are not required.
[b] All savings data represent combined federal/state savings.
[c] Oregon requires subsidized coverage to meet a minimum benchmark that is actuarially equivalent to federally required Medicaid benefits.
[d] 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.

## INTRODUCTION

Premium assistance programs use federal and state Medicaid and State Children's Health Insurance Programs (SCHIP) funds to subsidize the purchase of private health insurance coverage. The recent emphasis on premium assistance programs in the Administration's 2001 Health Insurance Flexibility and Accountability (HIFA)[1] waiver initiative and tough state fiscal climates have combined to provoke increased interest in this approach. Some states are now pursuing this approach as a way to encourage low-income families' participation in private coverage, shore-up the private coverage market, and achieve cost savings by bringing in employer contributions to help offset costs. Some also believe this approach helps prevent "crowd out" of private coverage by providing a public/private blend of coverage to individuals at the upper end of the low-income spectrum. Yet, recent sharp increases in the cost of private coverage along with new federal guidelines permitting states to require low-income families to shoulder more costs raise questions about the efficacy of this approach.

How premium assistance 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.

## BACKGROUND

### *What are the federal requirements for premium assistance programs?*

Under current Medicaid law, states have the option of subsidizing the purchase of private group health plans for Medicaid beneficiaries if it is cost-effective to do so. States can also pay premiums for non-Medicaid eligible family members if it is cost-effective to do so and may make enrollment in a group health plan a requirement of Medicaid eligibility. Cost-effective is defined by statute to mean that the reduction in expenditures for an individual enrolled in a group health plan is likely to be greater than the additional cost of paying premiums and cost sharing for these same individuals.[2]

States that develop premium assistance programs without a waiver must ensure that beneficiaries that enroll in private coverage retain access to all benefits covered under the state's Medicaid program and are protected from costs in excess of amounts allowed in Medicaid. In other words, states must provide "wraparound coverage" for Medicaid benefits that are not covered by the private plan and for excess cost sharing. Federal Medicaid law limits the levels of cost sharing that may be imposed on children and their parents, and premiums are not permitted.[3] Children may not be charged any cost sharing and parents can be charged "nominal" amounts.

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[1] Centers for Medicare and Medicaid Services, "Guidelines for States Interested in Applying for a HIFA Demonstration." Available online: http://www.cms.hhs.gov/hifa/hifagde.asp. For an overview of states' response to the premium assistance component of HIFA, see Alker J. *Premium Assistance: A Look at Recent State Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), November 2003.

[2] §1906 (3)(e)(2) of the Social Security Act.

[3] For a good summary of Medicaid cost sharing rules, see Chapter 2 of *The Medicaid Resource Book* by Andy Schneider (Washington, DC: Kaiser Commission on Medicaid and the Uninsured), July 2002. Some states have

States can also develop premium assistance programs using SCHIP funding. For states seeking to use SCHIP funds for premium assistance, federal regulations require that "The State's cost for coverage for children under premium assistance programs *must not be greater than* the cost of other SCHIP coverage for these children."[4] States also must provide wraparound coverage for benefits and limit cost sharing for families enrolled in SCHIP-funded premium assistance programs if there is no federal waiver.

***What kinds of changes in premium assistance do waivers allow?***

Section 1115 waivers give states authority to use federal Medicaid and SCHIP funds in ways not otherwise permitted under current law. The federal government's 2001 HIFA initiative encouraged states to seek waivers that included premium assistance components and loosened certain requirements for premium assistance programs.

Under waivers, the federal government has permitted some states to enroll beneficiaries in premium assistance programs without providing wraparound coverage for benefits or cost sharing. HIFA guidance and CMS policy for families participating in premium assistance programs whose income exceeds "mandatory" Medicaid categories allows waivers with no benefit requirements and no limits on the cost sharing that families may be required to pay.[5] No state has yet sought a waiver of cost sharing rules for a premium assistance program to serve mandatory Medicaid children.

Federal HIFA guidelines also relaxed the cost-effectiveness requirements. Under the HIFA guidelines, "States should monitor that aggregate costs for those enrolled in premium assistance programs are not significantly higher than costs would be if under a direct coverage program…"[6]

***What kind of private coverage is available for low-wage workers?***

Premium assistance programs primarily, but not exclusively, subsidize employer-sponsored insurance.[7] However, in general, low-income workers have limited access to employer-sponsored coverage (Figure 1). As Figure 1 shows, low-income workers also are less likely to participate in employer-sponsored insurance when it is offered, but the differences by income level are not large. Recent sharp increases in premiums have likely had a disproportionate impact on low-wage workers' ability to participate. From 2003-2004, premiums rose by 11.2%,[8] and the average worker's monthly contribution for family coverage was $222, a very substantial proportion of a low-wage worker's take-home pay. In addition, the smaller the firm the higher

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sought and received Section 1115 waivers of some federal cost sharing rules – most commonly for adults but in some cases for higher-income Medicaid-eligible children. Subsequently a number of these waivers have been successfully challenged in court; thus policy is evolving in this area.

[4] See 42 CFR Part §457.810(c)(1); January 11, 2001.

[5] See Alker, J. op cit.

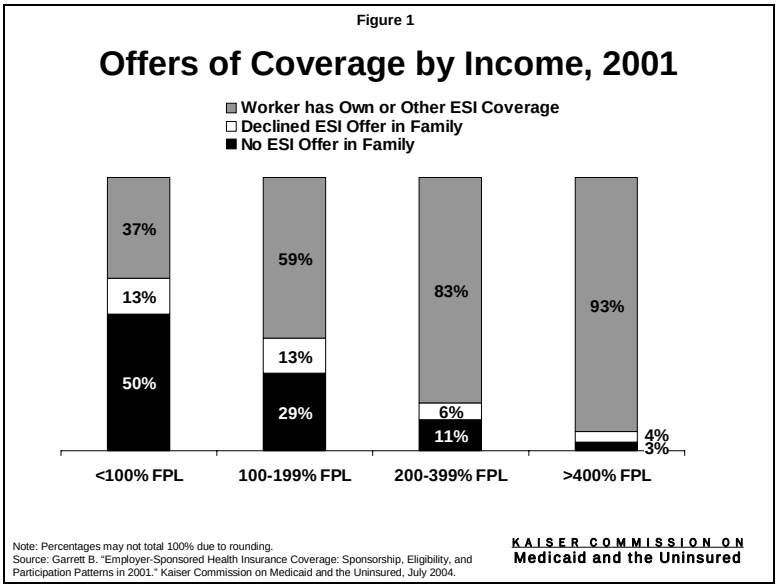
[6] "Guidelines for States Interested in Applying for a HIFA Demonstration," p 5.

[7] Exceptions to this include Oregon, Massachusetts, and Illinois.

[8] *Kaiser/HRET Employer Health Benefits: 2004 Summary of Benefits.* (Washington, DC: Kaiser Commission on Medicaid), September 2004.

the worker's contribution is likely to be.[9] These increases in worker contributions have been accompanied by increases in other forms of employee cost sharing. Deductibles, cost sharing and coinsurance have all been on the rise.[10]

Figure 1




## FINDINGS

This analysis examines premium assistance programs in five states (Illinois, New Jersey, Oregon, Rhode Island, and Utah) to assess how these programs are financed, their eligibility and coverage requirements, the states' methods for determining cost-effectiveness, and whether the programs have achieved cost savings. All five programs were implemented under Section 1115 waiver authority, but they reflect different state choices on issues such as employer contributions, participant cost sharing, and subsidy levels. In addition, Iowa's Health Insurance Premium Payment (HIPP) program, which operates under existing Medicaid law without waiver authority, was included for comparative purposes.

### *How are the Program Costs Shared?*

There are three potential sources of funding for premium assistance programs:
1) federal/state Medicaid and/or SCHIP dollars;
2) employer contributions; and
3) premium contributions made by families.

Table 2 provides an overview of how the programs in the study states are financed. All of the states utilize federal and state Medicaid and/or SCHIP dollars. States vary, however, with respect to the mix and level of employer and individual contributions. Illinois and Utah cap subsidy amounts regardless of the cost of purchased coverage, shifting the risk of added costs to

[9] Gabel JR and Pickreign JD. *Risky Business: When Mom and Pop Buy Health Insurance for Their Employees* (New York, NY: The Commonwealth Fund), April 2004.
[10] *Kaiser/HRET Employer Health Benefits: 2004 Summary of Benefits.*

enrollees. New Jersey, Oregon, and Rhode Island pay amounts remaining after employer and individual contributions. Thus, the subsidies vary across families and are driven by the cost of coverage as well as individual and employer contribution amounts. In the comparison program in Iowa, the state covers the entire premium cost after any employer contribution is made.

**Table 2:**
**Distribution of Premium Costs in Premium Assistance Programs, Selected States, 2005**

| | State/Federal Subsidy | | | Employer* Contribution | Individual Contribution | | |
|---|---|---|---|---|---|---|---|
| | Full Premium Amount | Capped Monthly Subsidy | Amount Remaining After Employer/ Individual Contributions | Required? | None | Fixed amount or proportion | Any Amount Remaining After Subsidy and Employer Contribution |
| ***Iowa (comparison program)*** | ✓ | | ✓ | ✓** | ✓ | | |
| **Illinois** | | ✓ | | X | | | ✓ |
| **New Jersey** | | | ✓ | ✓ | ✓ (<150% FPL) | ✓ (>150% FPL) | |
| **Oregon** | | | ✓ | X | | ✓ | |
| **Rhode Island** | | | ✓ | ✓ | ✓ (<150% FPL) | ✓ (>150% FPL) | |
| **Utah** | | ✓ | | ✓*** | | | ✓ |

Sources: see Appendix A
* Employer contributions are often present even if they are not required.
** In order to prove cost effectiveness, an employer contribution is almost always required.
*** Industry practice in Utah requires a 50% employer contribution

Three of the five waiver programs (New Jersey, Rhode Island, and Utah) require an employer contribution, although the level required varies across these states. Illinois and Oregon do not require a contribution but they are common. In Oregon, if an employer offers coverage with a contribution, the premium assistance enrollee must enroll in that plan.

**The role of the employer contribution: The New Jersey experience**

Given that private insurance is typically more expensive than Medicaid coverage for similarly situated families, an employer contribution is often essential to ensuring that premium assistance programs are cost-effective. There are minimal federal requirements with respect to the presence or level of an employer contribution, so this area is largely one of state decision.

The best available information from the states examined comes from New Jersey where the state requires a minimum employer contribution of 50% for a family to be considered for a premium assistance subsidy. Two-thirds of employers participating in the program, however, pay 70% or more of premium costs. New Jersey's program administrator believes that the state could boost enrollment in its program by approximately 10% if the minimum employer contribution was lowered to 30%. Below that, the state believes that it will always be cheaper to keep families in Medicaid. The state's experience suggests that, in most cases, a significant employer contribution is needed to ensure cost-effectiveness, but there are some exceptions. These exceptions might be related to larger family size or high service use.

All five waiver programs require at least some enrollees to cover part of the cost of their premiums. New Jersey and Rhode Island require families at the upper end of income eligibility to pay a fixed share of the premium; lower income families are not required to pay. In Oregon, families pay a proportion of the overall premium cost that ranges from 5%-50%--the proportion is based on a family's income. However, there is no upper limit on the amount of the family's share. In Illinois and Utah, families must pay the share of the premium remaining after the employer's contribution and the state's fixed subsidy. Thus, the amounts families pay vary based on the cost of their coverage and their employer contributions with no upper limit. In Iowa's comparison program, families are not required to contribute anything, because the Medicaid subsidy covers the full premium cost after any employer contributions.

**What kind of employer-sponsored coverage is being subsidized with Medicaid and SCHIP funds? A look at Walmart**

Walmart is the world's largest corporation, the largest private sector employer in the United States, and the country's largest low-wage employer. Walmart offers health coverage to employees who have been employed for at least six months and work at least 34 hours a week. Those who are offered coverage must pay a share of premiums as well as their plan's deductible and other cost sharing requirements.

A Walmart sales associate who is employed 40 hours a week making $7/hour earns less than $15,000 per year or about $1,200 per month.[11] In 2004, the employee premium share for a Walmart-offered plan with a $350 deductible that covers the associate and one child (but no spouse) was $181 per month, representing about 15% of the worker's monthly pre-tax income.[12] The employee share was $250 for full family coverage, constituting about 21% of the worker's pre-tax income.

New Jersey, which determines the cost-effectiveness of subsidizing private coverage by assessing the adequacy of the employer contribution and provides wraparound coverage protections, has concluded that it is never cost effective to subsidize Walmart's coverage because of the high out-of-pocket costs.[13]

However, a state like Illinois, which provides a capped subsidy and has limited requirements for subsidized coverage, would likely subsidize Walmart's coverage. Illinois provides a maximum subsidy of $75 per child per month, which would reduce the premium costs for the worker and child to $106 per month. After receiving the subsidy, premium costs still constitute almost 9% of the worker's pre-tax income.[14] And, before receiving any benefits from the plan, the worker would need to pay a $350 deductible, another 2% of the worker's annual pre-tax income.

### *Who is Eligible and Who is Enrolled?*

Table 3 provides an overview of the eligibility requirements and characteristics of enrollees for premium assistance programs. The examined programs cover both children and their parents, with the exception of Utah where children are not eligible. A number of the programs offer

[11] Based on Olivio A. *Walmart wages grass-roots campaign to crack Chicago*. The Chicago Tribune, May 23, 2004.
[12] Center for Children and Families analysis based on information from *MyBenefts WalMart Stores, Inc 2004 Associate Guide* and WalMart *Open Enrollment News* September 2003. Premium costs used for the Network Saver Associate Child and Network Saver Family coverage option.
[13] Phone Interview with Dennis Doderer, Deputy Assistant Director, New Jersey Division of Medical Assistance and Health Services 4/14/04.
[14] Center for Children and Families. A good comparison to bear in mind is that federal tax law considers health care expenses in excess of 7.5% of a family's adjusted gross income to be deductible for income tax purposes.

coverage to people at very low-incomes, yet as Table 3 shows, in every state examined, enrollees tend to cluster in the higher income ranges even when they are eligible at lower income levels. This likely reflects the fact that availability of employer-sponsored coverage diminishes as income level decreases.

**Table 3:**
**Eligibility and Enrollment in Premium Assistance Programs, Selected States, 2005**

| State | Who is Eligible? | Participation Mandatory? | Enrollment | Income Breakdown of Participants |
|---|---|---|---|---|
| ***Iowa (Comparison program)*** | *Children <133% FPL*<br>*Pregnant women <200% FPL*<br>*Parents <84% FPL* | *Yes, if have access to cost-effective ESI* | *9,342* | *Not available, all enrolled are below Medicaid eligibility* |
| **Illinois** | Children 133-200% FPL* | No | 5,500 | 133-150% FPL 29%<br>150-200% FPL 71% |
| **New Jersey** | Children <350% FPL<br>Parents <200% FPL | Yes, if have access to cost-effective ESI | 729 | <150% FPL 22%<br>150-200% FPL 73%** |
| **Oregon** | Children <185% FPL<br>Pregnant women <185% FPL<br>Parents & other adults <185% FPL | Yes for parents and other adults with access to state-approved ESI | 10,564 | <100% FPL 38%<br>101-185% FPL 62% |
| **Rhode Island** | Children <250% FPL<br>Pregnant women <250% FPL<br>Parents <185% FPL | Yes, if have access to state-approved ESI | 6,012 | <100% FPL 20%<br>100-150% FPL 44%<br>150-250% FPL*** 36% |
| **Utah** | Parents & other adults 50-150% FPL<br>Must be uninsured for >6 months and have ESI premium that is >5% of income | Yes, unless premium for ESI is >15% of income | 73 | 0-100% FPL 41%<br>101-150% FPL 49% |

Sources: see Appendix A
Note: ESI Employer Sponsored Insurance
* The state is currently phasing-in an expansion of parent eligibility. When parents in this income range become eligible, they will also have the option to enroll in KidCare Rebate.
**5% at >200% FPL
***Some eligible beneficiaries may be over 250% FPL because of Transitional Medical Assistance

In Illinois, eligible individuals can choose between receiving premium assistance or direct coverage. In New Jersey, Oregon, and Rhode Island, as well as in the comparison program in Iowa, eligible individuals must enroll in premium assistance rather than receive direct coverage if they have access to cost-effective employer-sponsored insurance. In Utah, eligible individuals with access to employer-sponsored insurance must enroll in premium assistance unless the premium for such insurance exceeds 15% of their income. If their premiums exceed this amount, eligible individuals can choose between direct coverage or premium assistance.

Nationwide, enrollment in premium assistance programs has generally been low—a recent study found that, with one exception, enrollment constituted less than one percent of the relevant eligibility groups in Medicaid and SCHIP.[15] This trend generally holds true within the examined states, except for Rhode Island, which has seen considerable growth in its program.

[15] See Alker, J. op cit.

***What are the Requirements for Subsidized Coverage?***

As noted, when states implement premium assistance programs without a waiver, they must ensure that enrollees do not have more limited benefits or higher premiums and cost sharing than the state's regular Medicaid program. However, under waivers, some states have been allowed to subsidize the purchase of private coverage without providing wraparound coverage. Within these programs families may have more limited benefits and higher cost obligations.

As Table 4 illustrates, the examined states have widely varying requirements with respect to benefits, premiums, and other cost sharing obligations. The waiver programs in New Jersey and Rhode Island, as well as the comparison program in Iowa, provide wraparound coverage to ensure that families have the same benefits and are subject to the same cost sharing rules as families in their direct Medicaid coverage. Regular Medicaid rules apply in Iowa where children pay no cost sharing and adults are subject to nominal copays. In New Jersey and Rhode Island, families under 150 percent of the poverty level do not pay any premiums or cost sharing. Above 150 percent of the poverty level, families are subject to the same premium and cost sharing requirements as families in the states' direct Medicaid coverage, which operates under a waiver that allows premiums to be charged. Interestingly, Rhode Island's experience has been that the vast majority of the state's expenditures – 93 percent – has been for the premium subsidy and the remaining seven percent for the cost of wraparound coverage.[16]

Utah and Illinois do not provide wraparound coverage and have minimal benefit and cost sharing requirements for subsidized coverage. As such, enrollees in Utah and Illinois pay all copayments, coinsurance and deductibles required by the private insurance plan with no out-of-pocket limit and any additional premium costs not covered by the state's subsidy. In addition, Utah requires an upfront $50 enrollment fee and the state's maximum premium subsidy of $50 per month is scheduled to decline over time if participants remain enrolled in the program.

Oregon uses an overall actuarial test to assess whether subsidized coverage meets a minimum benchmark equivalent to federally mandated Medicaid benefits. Families are not subject to an out-of-pocket cap, and the coverage, while meeting certain minimum standards, may not be as comprehensive as the state's own waiver coverage.

[16] This is an average for the cost of supplemental benefits and premiums for state fiscal years 2001-2004. Data taken from RIteShare Summary of Payments March 2004 Financial Cycle provided by the RIteShare program, Rhode Island Department of Human Services. It is possible that some families are not aware of the availability of the wraparound services thus lowering their cost.

**Table 4:**
**Benefits and Cost Sharing in Premium Assistance Programs, Selected States, 2005**

| State | State Provides Wraparound Coverage? | Required Benefits | Premiums and Cost Sharing Requirements |
|---|---|---|---|
| ***Iowa (comparison program)*** | ✓ | *Full Medicaid benefits through wraparound* | *Same as state's direct Medicaid coverage though wraparound*<br>*(State covers all premiums, deductibles, and coinsurance; No copays for children; Parents pay nominal copays)* |
| **Illinois** | No | Plan must have inpatient/ outpatient coverage | Beneficiaries pay additional premium costs not covered by subsidy and all cost sharing required by private plan |
| **New Jersey** | ✓ | Full Medicaid benefits through wraparound | Same as state's direct Medicaid coverage through wraparound:<br>(<150% FPL: No premiums or cost sharing<br>>150% FPL: fixed premiums and non-fixed copayments with a 5% cap on cost sharing) |
| **Oregon** | No | Plan must be actuarially equivalent to mandatory Medicaid benefits | Beneficiaries pay a share of premium, based on income, without a cap on the amount<br>Subsidized coverage can have up to $1,000 deductible, $4,000 maximum out-of-pocket costs per individual, and $10,000 stop loss provision |
| **Rhode Island** | ✓ | Full Medicaid benefits through wraparound | Same as state's direct Medicaid coverage through wraparound:<br>(<150% FPL: no premiums or cost sharing<br>>150% FPL: fixed premiums and copayments) |
| **Utah** | No | None | Beneficiaries pay additional premium costs not covered by subsidy and all cost sharing required by private plan |

### *What Impact Does Cost Have on Enrollment and Access to Services?*

Given that Medicaid beneficiaries have very limited incomes, cost obligations can have a significant impact on their ability to enroll in coverage. Existing research has documented that premiums can serve as an enrollment barrier for low-income families.[17] As noted, many premium assistance programs have experienced low enrollment, and the premium contributions required from families may be a contributing factor, as discussed in the examples below.

Enrollment in Utah's "Covered at Work" premium assistance program has been extremely low—73 persons according to the most recent enrollment data.[18] Utah program officials believe that the premium requirements as well as cost sharing obligations may be contributing to this low level of enrollment.[19] Policymakers in Utah are considering raising the premium subsidy, which would reduce the burden on individuals, to encourage participation in the program.

Illinois' premium assistance program, "KidCare Rebate," has been in existence for some time—it was funded with state-only dollars prior to the state's Section 1115 waiver approval. In the past, families participating in this program were not eligible for the state's regular direct SCHIP

[17] Artiga, S. and O'Malley, M. *"Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences"* Kaiser Commission on Medicaid and the Uninsured, May 2005
[18] Enrollment data from Utah "Covered at Work" as of 3/26/05.
[19] Interview with Michael Hales, Director Utah Primary Care Network, April 13, 2004.

coverage, KidCare, because their children were insured. Therefore, receiving a $75 subsidy from the state towards the cost of private insurance was a clear benefit for these families. At the time that federal approval was given to use federal dollars for the KidCare Rebate program, families were given the option to switch their children from KidCare Rebate to the regular KidCare program. According to state officials, approximately 1,200 children—or 20 percent—chose to do so. Monthly premiums for regular KidCare participants are $15 for one child, $25 for two children, and $30 for three or more children.[20] These are likely to be lower than private insurance premium costs for many low-wage workers, even after receiving the state subsidy. It is possible that out-of-pocket costs contributed to these families' decision to switch programs, but no specific evidence is available.

Research has also shown that cost sharing can impede low-income individuals' ability to access necessary care.[21] Cost sharing in private insurance plans can be substantially higher than the limited amounts allowed under Medicaid and SCHIP. This raises the question of whether families participating in programs such as Illinois and Utah with unlimited cost sharing are having trouble accessing needed care. Unfortunately, neither Illinois nor Utah has data or plans to seek data to answer this question. In addition, these states have little in the way of minimum benefit requirements.[22] If families are purchasing private plans with limited benefits they may be experiencing difficulty accessing and/or affording care for uncovered services. To date, no data is available about what kind of coverage is being purchased in these states and what additional cost sharing low-income families are being asked to assume.

***How Do the States Determine Cost-Effectiveness and are they Saving Money?***

Table 5 provides an overview of the different methods the states examined use to determine cost-effectiveness for their premium assistance programs and the available data on cost savings. As seen in the table, the states generally used one of two savings approaches—achieving savings through employer contributions or achieving budget certainty by capping subsidy amounts. However, Oregon used its own approach, which focused on aggregate program savings.

[20] Illinois KidCare program website: http://www.kidcareillinois.com/sharing_kc.html
[21] Artiga, S. and O'Malley M. op cit.
[22] Illinois requires that subsidized policies have an inpatient and an outpatient benefit, but there are no requirements regarding the scope of benefits. Utah requires only that plans meet applicable state insurance laws.

**Table 5:**
**Cost- Effectiveness Tests and Cost Savings in Premium Assistance Program, Selected States, 2005**

| | Method for Determining Cost-Effectiveness | | | Cost-Effectiveness Requirements | Data on Savings |
|---|---|---|---|---|---|
| | Assessing Level of Employer Contribution | Capping State Contribution | Assessing Aggregate Program Savings | | |
| ***Iowa (comparison program)*** | ✓ | | | *Paying the ESI premium must save the state at least $5 per month compared to the average cost of Medicaid* | *State believes it is saving an average of 30% per-beneficiary-per-month* |
| **Illinois** | | ✓ | | State's costs controlled by cap on subsidy amount. Amount based on average SCHIP pmpm costs in 1998 | None available |
| **New Jersey** | ✓ | | | Subsidized coverage must realize both a 5% savings in coverage costs and a 5% savings in administrative costs | $203.97 per family per month (this varies from month to month) |
| **Oregon** | | | ✓ | No specific savings requirements | None available |
| **Rhode Island** | ✓ | | | Monthly premium share plus the cost of wraparound coverage must be less than the capitation rate for the average Medicaid family | An average of $222.45 per family per month (including administrative costs) |
| **Utah** | | ✓ | | State's costs controlled by cap on subsidy amount | Subsidy is $50 pmpm, compared to $80 pmpm for direct coverage* |

PMPM: Per member per month
*$80 pmpm represents costs of serving individuals through the state's Primary Care Network waiver program which covers primary care without coverage for hospital or specialty care.

*Achieving savings through the use of employers' contributions:* The waiver programs in New Jersey and Rhode Island, as well as the comparison program in Iowa, perform individualized determinations of cost-effectiveness, assessing whether an employer's contribution is adequate to save the state money. All three states provide families with "wraparound" coverage—ensuring that families retain the same benefits and pay the same cost sharing in the premium assistance program that they would have if they were in the state's regular Medicaid program. Thus, the cost-effectiveness determination examines the cost of providing comparable coverage either through the state's regular Medicaid program or by providing a premium subsidy—in other words these states are comparing "apples to apples." Iowa, New Jersey, and Rhode Island compare state costs for the premium subsidy plus the anticipated cost of the wraparound coverage to the cost of serving a family through the state's regular Medicaid program. In Rhode Island, for example, the cost-effectiveness test determines the maximum subsidy amount the state can pay towards the employee's share based on the actuarial value of plans popular in the private marketplace.

Because these states undertake a rigorous case-by-case cost-effectiveness analysis, they are able to say with some level of certainty that they are saving money—indeed the state would not subsidize families' coverage otherwise. As such, these states had the best available data on cost savings of those examined. New Jersey subsidizes coverage only if the state saves at least 5% compared to the cost of serving families in their regular Medicaid program. On average the state

data show that it is saving $203.97 per family.[23] However, overall savings have been limited because only 791 family members are enrolled in the program. Rhode Island reports average savings of $222.45 per family per month in federal and state Medicaid costs, and enrollment is substantially higher.[24]

While these states are saving money per enrollee on a documented basis, program administrators in Rhode Island and New Jersey underscore the point that, to achieve overall savings, enrollment must be high enough to cover start-up and administrative costs. In addition, it is important to note that not all of the savings accrue to the state. Because of the federal matching payments for Medicaid and SCHIP coverage, at least half of the savings go to the federal government – the precise amount depends on the state's matching rate.

*Achieving budget certainty by capping the state's contribution:* Utah and Illinois provide fixed premium subsidies in their premium assistance programs. Because their subsidy amounts are capped, there is a level of budget certainty for federal/state payors and, as long as the subsidy amounts are set below the cost of providing direct coverage, the state should achieve savings on a per person basis. However, in Utah, enrollment is so low that it is not clear if savings from the small number of enrollees are adequate to cover start-up and administrative costs. Further, it appears that the low level of the capped subsidy may be contributing to the program's limited enrollment. Illinois did not have data available regarding cost savings, and state officials stressed that saving money is not the intent of their program.

*Assessing aggregate cost-effectiveness:* Under its waiver, Oregon is only required to show that its premium assistance program is cheaper on an aggregate basis, but there are no specific terms and conditions regarding how the state should monitor this. Oregon does not have a limit on its subsidy amounts, although enrollment is capped to control overall costs. The state does not make any comparisons to ensure that it is saving money compared to its larger Medicaid waiver program, and does not have any clear data available on whether it is saving money, but believes it is saving on an aggregate basis.

In the past, Oregon primarily subsidized coverage purchased in the individual market, but the state has moved to subsidizing more group coverage largely because of cost concerns. Subsidizing coverage in the individual market is much more expensive; the most recent data available from the state shows that the average monthly state subsidy per individual enrolled in coverage purchased through the individual market is $236.67. For individuals enrolled in group coverage, the average monthly subsidy is $101.91.[25] Today approximately 40% of enrollment is in the group market, an increase from 17% prior to the waiver, according to state officials.[26]

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[23] Email communication with John Dickson, New Jersey Department of Human Services, May 6, 2005.
[24] Data provided by Rite Share Summary of Payments from March 2004 Financial Cycle. The average savings per family based on data from October 2003-March 2004.
[25] Data from 5/2/05 FHIAP snapshot of Program Activity. Available online at http://egov.oregon.gov/IPGB/FHIAP/statistics.shtml
[26] Current individual/group breakdown from 5/2/05 FHIAP snapshot. Prior enrollment statistic from email communication with Craig Kuhn, September 23, 2004.

## DISCUSSION

In sum, the examined states are using a variety of approaches to implement their premium assistance programs. Most of the examined states are relying on employer contributions to help offset the cost of coverage, and they all require individual contributions from at least some relatively higher-income families. Some provide wraparound coverage, while others do not. With the exception of Oregon, the study states used two approaches for determining the cost-effectiveness of providing premium subsidies, either by assessing whether an employer contribution was sufficient to ensure cost-effectiveness on a case-by-case basis or by capping subsidy amounts. Among the study states, there was limited data available regarding cost savings, although it is evident that some states are saving money on a per enrollee basis. However, in order to achieve overall savings, enrollment must be robust enough to generate the savings necessary to cover start-up and administrative expenses. Taken together, the findings suggest the following:

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

*States can achieve savings without capping their subsidy amounts and while still providing wraparound coverage.* The two examined states (Rhode Island and New Jersey) that clearly documented savings did not cap their subsidy amounts and provided full benefits and cost sharing protections through wraparound coverage. In the other examined states, coverage provided through the premium assistance programs may be significantly more limited than regular Medicaid or SCHIP coverage because they have few benefit and cost sharing requirements for purchased coverage and do not provide wraparound services. Further research is needed to evaluate the types of coverage being purchased under these programs and how well it meets enrollees' needs.

*There is limited data available regarding cost savings.* While federal policy requires premium assistance programs to be cost-effective, it does not appear that the Centers for Medicare and Medicaid Services is closely monitoring whether these programs are saving money. Neither Oregon nor Utah's Section 1115 HIFA waivers include specific terms and conditions to monitor the cost-effectiveness of their premium assistance programs. To the extent that good data is available, it is because individual states are applying rigorous methodologies to ensure state savings.

*Changes in the private market impact the cost-effectiveness of premium assistance programs.* Recently, there have been sharp increases in private insurance premiums. Not only have private market costs been increasing, they have been doing so more rapidly than costs in Medicaid on a per-capita basis.[27] If premiums in the private market continue to increase faster than the costs of

[27] Holahan, J. and Ghosh, A. "Understanding the Recent Growth in Medicaid Spending," *Health Affairs*, 26 January 2005.

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 employer-sponsored coverage becomes less and less favorable. States can limit their costs by capping their subsidy amounts, but this shifts the risk of added costs to enrollees. Low-income families, in turn, may not be able to shoulder increased costs, further limiting enrollment.

In conclusion, New Jersey and Rhode Island were able to document clear savings without capping their subsidy amounts and while still providing wraparound coverage for benefits and cost sharing. States must, however, be realistic about the potential for savings from premium assistance programs, which is limited by the scarce availability of employer-sponsored coverage for low-wage workers and relatively low levels of enrollment in those programs. Further, the ability for premium assistance programs to be cost-effective will only become more challenging over time as costs in the private market continue to rise. In the words of one state official: "One or two more years with double-digit premium increases and we may be priced out of the market."[28]

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[28] Interview with Dennis Doderer, Deputy Assistant Director, Division of Medical Assistance and Health Services, New Jersey.

## APPENDIX A: SOURCES

*Illinois*: Phone interview and subsequent email communications with Vicki Mote, Chief Bureau of KidCare, 5/12/05. Enrollment data is as of March 31, 2005.

*New Jersey*: Phone interview and subsequent email communications with Dennis Doderer, Deputy Assistant Director, Division of Medical Assistance and Health Services, and John Dickson, Manager, Premium Support, 4/14/04. Enrollment and savings data as of 5/6/05 and income breakdown as of 9/21/04 based on email communications with John Dickson.

*Oregon*: Phone interview and subsequent email communications with Craig Kuhn, Program Manager, and Kelly Harms, Policy and Legislative Liason, Family Health Insurance Assistance Program, 5/18/04. Enrollment data and subsidy amounts from FHIAP Snapshot of Program Activity 5/2/05. Available at http://egov.oregon.gov/IPGB/FHIAP/statistics.shtml

*Rhode Island*: Phone interview with, and written materials provided by Tricia Leddy, Administrator, Center for Child and Family Health, Rhode Island Dept. of Human Services, and Kate Brewster, Employer Contact Unit Manager, Rhode Island Dept. of Human Services, 5/18/04. Enrollment data as of February 28, 2005, from John Andrews, Rhode Island Department of Human Services, 3/4/05.

*Utah*: Phone interview and subsequent email communications with Michael Hales, Director, Utah Primary Care Network, 4/13/04. Enrollment data and income breakdown as of 3/26/05. Income breakdown data does not equal 100% due to rounding error.

*Iowa*: Phone interview and subsequent email communications with Anita Smith, Chief Bureau of Health Insurance, Division of Financial, Health and Work Supports, 4/14/04. Enrollment data is as of 3/1/05, based on email communication with Kaye Kellis, Iowa Dept. of Human Services, 3/22/05.

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