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SERVING LOW-INCOME FAMILIES THROUGH PREMIUM ASSISTANCE: A LOOK AT RECENT STATE ACTIVITY

EXECUTIVE SUMMARY

Premium assistance refers to the use of federal and state Medicaid and/or State Children's Health Insurance Program (SCHIP) funding to subsidize the purchase of private health insurance coverage, on the individual market or through employer-based plans, for Medicaid and SCHIP beneficiaries. In an effort to promote private coverage, the Bush Administration's Health Insurance Flexibility and Accountability (HIFA) initiative offers an expedited federal review of certain Section 1115 waivers that include a premium assistance component. Section 1115 waivers permit states to use federal matching funds in ways that are otherwise not allowable under Medicaid and SCHIP guidelines.

Historically, not only the Medicaid statute, but also federal waiver policy have required states to ensure that Medicaid or SCHIP beneficiaries enrolled in employer-sponsored or other private coverage would not pay higher cost-sharing or lose any benefits as a result. In addition, the rules have required that premium assistance be a cost-effective use of Medicaid and SCHIP funds.

The HIFA guidelines significantly weakened the benefit and cost-sharing protections for families participating in premium assistance programs and also relaxed the cost-effectiveness test. Specifically, states with HIFA waivers are permitted to subsidize private coverage for parents and children who are "optional" Medicaid beneficiaries and for children in SCHIP, *without regard to the benefits the private insurance covers or the cost-sharing it requires*. Nor are states required to provide Medicaid "wrap-around" services under HIFA. Further, the guidelines suggest that states may spend more on premium assistance than they would for direct coverage under Medicaid or SCHIP.

Despite the enhanced flexibility the HIFA guidelines offer, state adoption of premium assistance programs has been limited. The states that have most enthusiastically embraced the concept in their HIFA waivers already had state-funded premium subsidy programs and were able to refinance some of their costs with federal dollars (Illinois, Oregon). Three states will establish a new premium assistance program as a result of their HIFA waiver (New Mexico, Tennessee, Utah), but implementation in all three cases has been delayed. Arizona, California, and Colorado have sought to comply with HIFA's premium assistance requirement by conducting a feasibility study rather than by actually establishing a program. The Arizona and Colorado studies cited several practical impediments to implementing a premium assistance program: limited availability of employer-based coverage for low-wage workers; rapidly rising costs of coverage in the private market; high cost-sharing and other obstacles for low-income beneficiaries; and state fiscal and administrative challenges. These same factors are thought to underlie the very low enrollment in the premium assistance programs established prior to HIFA.

Under HIFA, the two defining requirements for premium assistance programs – that enrollees be held harmless and that public dollars be spent efficiently – have been withdrawn. The premium assistance programs approved under HIFA waivers should be monitored to assess whether families participating in them are able to access needed health care services, and whether these programs are, in fact, cost-effective. Notably, even with HIFA's relaxation of the criteria, state take-up of the premium assistance option remains limited. It is unclear, in light of practical obstacles, how much potential premium assistance ultimately holds as a mechanism for covering low-income families and children in Medicaid and SCHIP.

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INTRODUCTION

Policymakers at the state and federal levels have expressed interest in the concept of premium assistance. Premium assistance entails the use of federal and state funds to subsidize the purchase of employer-sponsored or other private health insurance for beneficiaries of Medicaid and the State Children's Health Insurance Program (SCHIP) – primarily families and children. The authority for premium assistance has existed for many years in the Medicaid program, and it was envisioned as a possibility in the SCHIP statute as well. However, a new emphasis on premium assistance by the Bush Administration, articulated in its Health Insurance Flexibility and Accountability (HIFA) waiver initiative (under section 1115 authority), underscores the importance of understanding this model for providing coverage. The HIFA initiative offers states flexibility beyond that available in the Medicaid statute, and provides states with new incentives to adopt premium assistance in their Medicaid and SCHIP programs.

Numerous arguments for premium assistance have been offered, some policy-based and others budgetary. First, premium assistance builds on the employer-based system, the principal mechanism for providing health insurance in the United States. Second, for state and federal governments, a chief attraction of premium assistance is its potential for reducing public costs by capturing employers' premium contribution. Third, some believe that subsidizing employer-based insurance may strengthen low-income workers' attachment to the workforce, and also that premium assistance may reduce the substitution of public coverage for private coverage, commonly known as "crowd-out." Finally, premium assistance may enable all members of a family to be covered in the same health care plan. At the same time, there are obstacles (discussed below) that have hindered state implementation of premium assistance programs.

The employer's premium contribution is essential to the affordability of premium assistance for states because commercial health insurance is typically more expensive than coverage through public programs, and the costs for private coverage are also rising more quickly. The average annual cost of family coverage through employer-sponsored insurance in 2002 was $7,954.[1] The average cost of covering two parents and two children through Medicaid in 2002 was $7,107.[2] From 1997 to 2002, private health insurance premiums rose by an average of 7.1 percent, while Medicaid costs, after adjusting for the increase in enrollment, grew by only 4.8 percent over the same period of time.[3,4] In 2002, premiums for employer-based coverage rose by 12.7 percent, an increase that would have been even greater if purchasers had not reduced the value of their benefits package – primarily by raising employee cost-sharing.[5,6] The average worker's monthly contribution to premiums also increased from $138 to $174 for family coverage – an annual cost of $2,088.[7] Thus, purchasing private coverage without a generous employer subsidy is likely to result in a higher expenditure of taxpayer dollars – perhaps for a less generous benefits package.

This issue paper will examine: (1) new federal policies associated with using Medicaid and/or SCHIP funds to promote private insurance options; (2) ways that states have responded to these new policies to pursue private insurance options during the first 18 months since the HIFA initiative was launched; and (3) key questions that policymakers and others should consider as they think about premium assistance programs.

BACKGROUND

On August 4, 2001, Health and Human Services (HHS) Secretary Tommy Thompson announced the Bush Administration's HIFA waiver initiative under section 1115 authority. According to Thompson, the goal of the HIFA initiative is to give states more flexibility to "expand insurance coverage to more Americans through innovative approaches, including the kind of health insurance options available in the private sector."[8] This emphasis on private coverage is reiterated in guidelines developed by the Centers for Medicare and Medicaid Services (CMS) for states interested in applying for a HIFA waiver.

Through the HIFA initiative, the Administration sought originally to strongly encourage state strategies that would further integrate, or at a minimum coordinate, Medicaid and SCHIP funding with private health insurance options.[9] However, subsequent to the publication of the HIFA guidelines, HHS decided to *require* a premium assistance component for all HIFA waivers.[10] While states have submitted and can continue to submit section 1115 waivers that do not meet the HIFA guidelines, the simplified application process and expedited review available under HIFA are attractive to states.[11]

State Experience Prior to HIFA

Premium assistance is not a new concept for the Medicaid program. Section 1906 of the Medicaid statute provides states the option to enroll Medicaid beneficiaries in group health plans by paying their premiums, cost-sharing and deductibles, if it is cost-effective to do so. States electing to use this authority can even make enrollment in a group health plan (when it is available) a condition of Medicaid eligibility. Under section 1906, states can also pay the premiums for non-Medicaid-eligible family members if it is cost-effective to do so. (This might occur in the case of a high-need Medicaid-eligible individual who has a family member with access to family coverage through employment). These premium assistance arrangements are commonly known as Health Insurance Premium Payment (HIPP) programs.

States choosing to use the section 1906 authority must cover the premiums, cost-sharing and deductibles associated with private coverage. In addition, they must ensure that beneficiaries enrolled in premium assistance retain access to all the benefits covered under the state's regular Medicaid program, by providing wrap-around coverage for Medicaid benefits not included in private coverage, on a fee-for-service basis or by some other arrangement. In requiring HIPP programs to meet a cost-effectiveness test, while also ensuring that enrollees in these programs are not disadvantaged relative to other Medicaid beneficiaries, the statute balances two principles: it offers states flexibility as long as beneficiaries are not adversely affected.

For a variety of reasons, enrollment in HIPP programs has been very low. Iowa's HIPP program, widely regarded as one of the most successful in the country, currently has 5,370 enrollees – four percent of the children and non-disabled adults enrolled in Iowa's Medicaid program.[12] A major structural obstacle to premium assistance programs is the limited extent to which low-wage workers have access to employer-sponsored health insurance. Other difficulties include identifying beneficiaries' employers and obtaining information from employers necessary to evaluate cost-effectiveness. Mechanisms for providing premium subsidies that burden neither employers nor beneficiaries and systems for paying cost-sharing expenses that adequately protect beneficiaries from out-of-pocket liabilities must also be developed to make these programs workable.

A handful of states have implemented premium assistance programs in Medicaid and/or SCHIP using, not the section 1906 authority, but section 1115 waiver authority. These states are Maryland, Massachusetts, New Jersey, Oregon, Rhode Island, Virginia, and Wisconsin.

Table 1. Enrollment of Medicaid/SCHIP Eligibles in Section 1115 Premium Assistance Programs

State	Date Enrollment Began	Number of Medicaid/ SCHIP Eligibles Receiving Premium Assistance	Percent Participating in Premium Assistance[13]
MA [14]	August 1998	6,800	.76%
MD (SCHIP) [15]	July 2001	* 101	<.5%
NJ (SCHIP) [16]	July 2001	721	<.5%
OR [17]	July 1998	1,080	<.5%
RI [18]	February 2001	3,500	2.99%
VA (SCHIP) [19]	September 2001	* 26	<.5%
WI [20]	July 1999	* 98	<.5%
** Refers to the number of families, not individuals. For these states, a family of four was assumed to estimate the percentage of individuals receiving premium assistance.*			

As the numbers show, these programs generally did not achieve great success in enrollment. Again, a major structural limitation is that many low-income families do not have access to employer-sponsored coverage, even if they are working. A recent study found that only 41 percent of workers with income below the poverty level were eligible for employer-sponsored coverage. Even among workers with family income between 100 and 199 percent of poverty, only 62 percent were eligible for employer-sponsored coverage.[21]

Another important consideration for states has been the cost-effectiveness of premium assistance programs, given the administrative burdens involved. A study commissioned by the state of Colorado to explore the feasibility of purchasing employer-sponsored coverage for SCHIP-eligible children concluded that, "even if applicable federal regulations were eliminated, a Child Health Plan Plus employer buy-in program would enroll only 4,500 children and would require an annual administrative budget of over $1 million a year."[22] The primary reasons for this conclusion were that only 36 percent of SCHIP-eligible children in Colorado had access to employer-sponsored health plans, and that even in the absence of any federal requirements for benefits standards (as in HIFA waivers), only 41 percent of Colorado's employer-sponsored health plans would meet a cost-effectiveness test due to "the relatively high cost of child coverage through employer health plans." [23,24] Other factors cited by states to explain low enrollment numbers included a lack of interest on the part of the employer community and federal requirements that some states argued were too restrictive.

Rhode Island's waiver program has been the most successful in terms of percentage of persons enrolled. The state expanded its premium assistance initiative because of reports about employers dropping coverage after Rhode Island expanded Medicaid eligibility for parents to 185 percent of the poverty level in 1998. Today, families eligible for Medicaid must enroll in available employer-sponsored coverage if and only if it is cost-effective for the state to do so. The state provides a wrap-around benefit to ensure that beneficiaries required to enroll in premium assistance do not lose benefits as a result.[25]

How Has Federal Policy Changed?

Premium assistance programs in Medicaid – whether under section 1906 or under section 1115 waiver authority – have historically been required to ensure that beneficiaries enrolled in employer-sponsored or other private coverage did not pay higher cost-sharing or lose any benefits as a result. States could comply with this requirement in one of two ways – either by subsidizing only those private policies with benefits equivalent to Medicaid's or SCHIP's (depending on the program for which the beneficiary is eligible), or by providing a wrap-around benefit, generally on a fee-for-service basis, to cover those public program benefits not covered by the private insurance plan. Medicaid and SCHIP cost-sharing limits had to be observed as well.

As indicated earlier, some states criticized these requirements as being excessively burdensome, both administratively and financially. They cited the staffing required to track down policies from employers often reluctant to share the information, as well as the time and expense associated with conducting actuarial analyses to determine the adequacy of private policies. In addition, states viewed the monitoring of cost-sharing to prevent Medicaid limits from being violated as an administrative challenge.

In response to these concerns, HIFA guidelines published in August 2001 announced HHS' intent to waive many benefits requirements and to lift limitations on cost-sharing for "optional" Medicaid beneficiaries and for "expansion populations" who, because they do not meet Medicaid's categorical criteria, can be covered by the program only under a waiver.[26] Optional beneficiaries could include, for example, children over age 6 whose family income is above the poverty level, and parents whose income is above the state's mandatory income eligibility threshold (45 percent of the poverty level in the median state).[27] Expansion populations are generally comprised of childless adults who do not satisfy Medicaid's requirements for eligibility based on disability.

In a distinct departure from earlier federal policy under section 1115, the HIFA guidelines state that, "The Secretary will permit flexibility in the State's definition of benefit package and cost-sharing for optional and expansion populations in support of increased use of private group health plan premium assistance programs." Therefore, CMS is now prepared to permit states to enroll Medicaid and SCHIP beneficiaries (who are in optional or expansion groups) in private coverage without requiring them to maintain Medicaid and SCHIP benefits and cost-sharing protections. It appears that, under HIFA, CMS evaluates states' proposals with regard to the benefit and cost-sharing provisions of their premium assistance programs on a case-by-case basis, as opposed to applying specified minimum standards.

In addition to relaxing the beneficiary protections that previously existed, the HIFA guidelines appear to weaken the cost-effectiveness test. SCHIP 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."[28] By contrast, the HIFA guideline reads, "States will not be required to meet a specific cost-effectiveness test for premium assistance programs as part of comprehensive approaches that promise to decrease the number of uninsured under 200 percent of the FPL. States should monitor that aggregate costs for those enrolled in premium assistance programs are not significantly higher than costs would be if under a direct coverage program…"[29]

When HIFA's looser standard for cost-effectiveness at the state level is taken together with its looser standard for benefits and cost-sharing at the beneficiary level, it is unclear that premium assistance programs will ensure either that optional or expansion populations in Medicaid and SCHIP are held harmless, or that public dollars are spent efficiently, as required prior to HIFA – even under section 1115 waivers. In the simplest terms, it appears that a state could incur higher per capita costs through premium assistance for less comprehensive coverage than its direct program provides, and still meet the HIFA guidelines for "cost-effectiveness."

How Have HIFA Waiver Proposals Incorporated a Premium Assistance Component?

Eight section 1115 waivers have been approved under the new HIFA guidelines. These states, in order of approval, are Arizona, California, New Mexico, Illinois, Maine, Colorado, Oregon, and New Jersey.[30] One additional waiver, Utah's, was approved under section 1115 authority and, although not technically a HIFA waiver, will be considered in this report because of its HIFA-like design. Three other states – Arkansas, Delaware, and Washington – have HIFA waiver requests pending.[31]

Of the nine states with approved waivers, only three – Illinois, Oregon, and New Mexico – featured premium assistance as a central component of their original waiver design. Illinois and Oregon received approval to refinance and expand state premium assistance programs that were already in existence. New Mexico has, for now, placed its waiver on hold due to budget constraints.

Four states (Utah, Arizona, California, Colorado) did not initially include premium assistance components in their waiver submissions but, during waiver negotiations with federal officials, agreed to conduct a study of the feasibility of premium assistance programs. Maine officials indicated they would attempt to maximize use of the state's existing section 1906 HIPP program, but cited that the rural character of the state and the lack of access to private insurance were limiting factors.[32] New Jersey plans to continue its existing premium assistance program, which was originally approved in 2000 as part of the state's section 1115 waiver known as FamilyCare.

STATE PROFILES

Illinois: A State with a History of Premium Assistance

Illinois received approval for its "FamilyCare" waiver on September 12, 2002. The central feature of the waiver is the use of unspent federal SCHIP funds to expand coverage to very low-income parents and a refinancing of an existing state program that provided premium assistance to children – KidCare Rebate. KidCare Rebate enrolled children who were eligible for SCHIP based on income, but were ineligible for federal SCHIP funding because they had private coverage at the time of application.[33] Children who were previously enrolled in the state-funded KidCare Rebate program are now eligible for the state's regular SCHIP program or they may choose to remain in KidCare Rebate.[34] As a result of the waiver, the state will receive federal Medicaid and SCHIP matching funds for those children who choose to receive premium subsidies.[35]

Illinois' waiver design envisions an expansion to parents up to 185 percent of poverty over a period of five years. In October 2002, the state implemented the first stage – a small eligibility

expansion, from 38 to 49 percent of poverty. The state received permission in its waiver to offer all newly enrolled parents a choice between traditional Medicaid (or, at higher income levels, the state's SCHIP program) and a premium subsidy. Families may use this subsidy to purchase private coverage on the individual market or to assist with their premium payments for employer-sponsored coverage. However, the state has chosen not to implement the premium subsidy option for newly enrolled parents (between 38 and 49 percent of poverty) at this time because this could result in parents having different coverage from their children, who, at this income level, are enrolled in Medicaid.[36] Furthermore, a study done for the state found that the rate of employer-based and individual coverage for KidCare parents with income at or below 185 percent of poverty is 29 percent.[37]

How does KidCareRebate work? Children whose families elect to receive coverage through KidCare Rebate receive a subsidy of up to $75 a month per eligible child towards the purchase of employer-sponsored or other private coverage.[38] The subsidy may not be used to reimburse the employer's share of the contribution. While there are no data available on what types of policies are being purchased with these subsidies, according to state officials the majority of families are using the subsidies to purchase employer-sponsored coverage.[39]

There are a few standards attached to KidCare Rebate. First, a private insurance policy qualifies for a subsidy as long as it covers physician visits and hospital inpatient services. Second, there are no minimum requirements with respect to the scope of inpatient coverage or physician visits. Third, the state will pay for immunizations for children who are uninsured at the time of enrollment if immunizations are not covered by the family's private insurance plan. Lastly, there are no limits on the cost-sharing requirements of these plans, and the state's maximum subsidy is $75, a fixed amount linked to the state's average per person cost in its fee-for-service Medicaid program. There is no minimum employer contribution.

According to state officials, the advantages of building on the KidCare Rebate program include the following:[40]

- *The program supports employer-based health coverage.* While no data are yet available on the impact of the rebate program on the level of employer-sponsored coverage, state officials believe that promoting the purchase of private coverage will help to stabilize the employer-based system;

- *The program makes fiscal sense because it takes advantage of any available employer contribution.* Because the state's fiscal contribution is capped at $75 per child per month, the state is assured of fiscal certainty despite the rapid increases in the cost of private coverage;

- *Access to providers may be better.* Private insurance plans may pay providers higher reimbursement rates than Medicaid;

- *Families may experience less "churning."* Families enrolled in public coverage may experience a break in coverage if their income fluctuates and they become ineligible for Medicaid or SCHIP;[41]

- *Some families may prefer private coverage due to a perceived "stigma" with public programs*. According to state officials, anecdotal evidence suggests that some families prefer private coverage for this reason.

No data are yet available to assess the impact of KidCare Rebate on, among other things, the rate of employer-sponsored coverage or access to care for families facing higher cost-sharing.

Arizona: Premium Assistance Not a Good Match

Arizona received approval on December 12, 2001, to refinance a previously existing Medicaid expansion to childless adults and to expand coverage to parents between 100 and 200 percent of poverty with unspent SCHIP funds. All of these changes built on previous waivers the state had received to design and expand its Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS). Premium assistance was not part of the state's initial design, but as part of the waiver agreement the state agreed to conduct a feasibility study of providing premium assistance to families below 200 percent of poverty for the purchase of employer-sponsored insurance (ESI).

The feasibility study was submitted to CMS on May 1, 2002, by the Director of Arizona's AHCCCS program. In the accompanying letter, the state informed CMS that, "Due to the dominance of small employers in Arizona, the lack of health insurance coverage and the skyrocketing costs of health insurance premiums for small employers not offering health insurance, AHCCCS has concluded that an ESI pilot program is not feasible."[42]

The state considered the feasibility of an ESI program that would be mandatory for beneficiaries who had access to ESI and would require a minimum premium contribution of 50 percent by the employer. Other assumptions were that enrollees would have no limits on their cost-sharing, nor would these families be eligible for a benefits wrap-around if private coverage was less comprehensive than the state's AHCCCS coverage. In other words, the study envisioned a program that accorded with the new flexibility in the HIFA guideline.

Despite the new flexibility, the state concluded that an ESI program would neither save money nor reduce the number of uninsured persons in Arizona. In particular, the state identified seven challenges. These challenges included:

- *Lack of employer based coverage for low-wage workers.* The state concluded that, "While a majority of the families with family incomes between 100 and 200 percent of FPL have a working parent, many of them will not be working for firms who offer health insurance since only one-third of small employers offer health care coverage to employees in Arizona."[43] The state also concluded that it was unlikely employers would step forward to offer coverage in growing numbers due to the economic climate in Arizona; the lack of interest among small employers in providing health care benefits and/or participation in an ESI program; and perhaps most importantly, the difficulty of purchasing affordable insurance for the small group market in Arizona.

- *Instability in the private insurance market.* The report found, "The lack of available and affordable coverage options is further complicated by the current health care market in Arizona. It is very volatile, premiums and co-payments are increasing from 15 to 70

percent in the urban area of Phoenix and employers are dropping coverage or increasing the amount the employee must contribute. The situation is much worse in rural geographic areas since HMO plans are withdrawing and premiums tend to be much higher than in the urban areas."[44]

- *Obstacles for beneficiaries.* The state cited a number of problems for beneficiaries should an ESI program be adopted. These included the reduced benefits package, increased cost-sharing, possible lengthy waiting periods, and family concerns about confidentiality with respect to their employers. The state also noted that the target population experienced a high degree of job mobility which could lead to movement in and out of the ESI program and resulting periods of uninsurance.

- *State fiscal and administrative challenges.* The state found that establishing an ESI program would lead to increased administrative burdens on the state at a time when state administrative funding was being cut. According to the study, "there is no way to operate a new program without costing the state more money."[45]

- *Differences in service delivery systems.* The state's AHCCCS program is primarily a managed care system and the state expressed concern about the incompatibility of ESI coverage that might be provided through a fee-for-service system.

Citing the experience of other states, implementation challenges, and the structure of the health care marketplace in Arizona, the study concluded that feasibility for an ESI pilot program is dependent on many factors – including an outcome that will decrease the number of uninsured and realize cost savings due to the private sector partnership. AHCCCS is not convinced that either of these objectives can be obtained through an ESI program – it appears that only a small number of uninsured will enroll and that the cost savings will be minimal.[46]

Subsequent to receiving the study, CMS officials asked Arizona to reconsider its conclusions and submit a proposal for a pilot program. On January 31, 2003, Arizona submitted a pilot premium assistance component that would create a pilot program in one rural county. The pilot program is expected to enroll 50 people. CMS has expressed concern about the pilot's limited design, and negotiations between the state and CMS are continuing. However, due to state budget constraints further implementation of the HIFA waiver, including the premium assistance component, is uncertain.

Discussion of the Two State Approaches

As the examples of Arizona and Illinois demonstrate, states considering premium assistance may face different sets of circumstances or even assess the same factors differently. As a result, they may come to different conclusions about whether premium assistance is a desirable policy. In both Arizona and Illinois, the availability of private coverage for families below 200 percent of poverty is limited and costs are rising. Illinois has had success in attracting children to its KidCare Rebate program. However, it is unclear what impact, if any, the premium subsidy has had on the uninsured rate among low-income families in Illinois. Prior to implementation of the waiver, eligibility for KidCare Rebate was restricted to children who were already insured, so while the subsidy may have helped families who otherwise would have had to drop coverage, it is unlikely that the program has done much to reduce the ranks of the uninsured.

The two states arrived at different decisions about the attractiveness of using their program dollars to subsidize private coverage for families. Arizona's analysis highlighted concerns about families paying higher cost-sharing and receiving fewer benefits. State officials also expressed concern that families receiving premium assistance from the state might feel stigmatized by employers, whereas Illinois argued that families prefer private coverage, even if it is less comprehensive, because of perceived stigma attached to public programs. Illinois also identified the possible advantage that parents – if they are not eligible for public funding – might be able to cover their children under the same policy in which they are enrolled. The two states analyzed the issue of "churning," or breaks in coverage, differently too. Illinois highlighted the possibility of breaks in public coverage when income fluctuates, while Arizona cited the sometimes lengthy waiting periods for private coverage, as well as volatility in the low-wage job market, as causes of churning in the private sector.

Finally, Arizona (as well as many other states) expressed concern about the administrative costs of premium assistance programs. Illinois values the predictability of the cost of its program because the state has created, in essence, a defined contribution through its $75 cap on monthly subsidies. A defined contribution approach, however, raises questions about the ongoing ability of low-income families to participate and be assured access to care as premiums and cost-sharing continue to rise, if participation is not completely voluntary.

Key Questions for Future Consideration

The response by states to the new HIFA guidelines has been mixed. Most of the states that have applied for comprehensive waivers did not include a premium assistance component as a central feature of their original waiver design. Two of the three states that did, Illinois and Oregon, were motivated, at least in part, by the opportunity to refinance their previously existing state programs for premium assistance. Key questions about the measurement of success and the potential of premium assistance programs to succeed remain unanswered.

Are premium assistance programs a cost-effective use of public funds? With states facing severe fiscal challenges, premium assistance programs will likely come under increased scrutiny with respect to their cost-effectiveness. The state of Maryland, for example, recently eliminated its premium assistance program to save money. Unfortunately, few data are available to assess whether these programs can save money or even cost states money to establish. The more lenient cost-effectiveness test that HIFA permits for premium assistance weakens requirements about what the state and its beneficiaries get for the investment. Particularly as private insurance costs rise and employers scale back the benefits and/or premium subsidies they offer, the content of the coverage and financial protection states purchase with the public dollars they spend on premium assistance should be monitored closely. The balance between the goals of controlling state spending, and spending state dollars efficiently to provide adequate coverage to low-income families and children, can then be evaluated.

Are premium assistance programs good value for Medicaid beneficiaries? While premium assistance may have some attractive features for beneficiaries, such as potentially improved access to providers, HIFA's lack of standards for benefits and cost-sharing could have negative impacts on beneficiaries. Private coverage is likely to cost low-income families more than Medicaid does.[47] Research on cost-sharing consistently shows that even low levels of cost-sharing can negatively affect health care utilization and lead to worse health outcomes for low-

income families.[48] Further, private benefit packages are likely to be less comprehensive than Medicaid, especially for children, who receive Early Periodic Screening Diagnosis and Treatment (EPSDT) under Medicaid. Thus, voluntary participation, as in the Illinois program, is critical.

While premium assistance may be an attractive option for certain states, it has inherent limitations that suggest it is unlikely to succeed in becoming a central feature of the Medicaid program. State experience suggests that even where states have embraced the concept aggressively, a tiny fraction of the Medicaid population has been enrolled. Questions of cost-effectiveness and availability of coverage in the private market will need to be examined by states considering this option.

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Appendix: Premium Assistance in Approved "HIFA" and "HIFA"-like Section 1115 Waivers

	Arizona	California	Colorado	Illinois
Description of Waiver	Waiver uses SCHIP funds to refinance existing childless adult coverage and extend Medicaid eligibility to parents.	Waiver uses SCHIP funds to expand eligibility to parents.	Waiver uses SCHIP funds to expand eligibility to pregnant women.	Waiver uses SCHIP funds to expand eligibility to parents and refinance an existing state-funded premium assistance program for privately insured children between 133-185% of the federal poverty level (FPL).
Description of Waiver Premium Assistance Components	At CMS' request, the state agreed to conduct a feasibility study of premium assistance. The study concluded that subsidizing ESI was not feasible for Arizona, but CMS requested that the state submit a pilot proposal anyway. • The pilot proposal, submitted 1/31/03, is estimated to cover 50 people in one rural county contingent on legislative approval and state funding. • The pilot would be mandatory for SCHIP families with income between 100-200% FPL in the chosen county, and optional for Medicaid-eligible family members with SCHIP-eligible parent or spouse. • The proposal is under review at CMS, but further implementation of the HIFA waiver is uncertain due to state budget difficulties.	At CMS' request, the state agreed to conduct a feasibility study of premium assistance. Work on the study will commence when the parent expansion occurs.	A previous feasibility study on ESI for SCHIP-eligible children conducted for the state in 2001 concluded that it would not be cost-effective. • Colorado's HIFA application noted that the study's authors believe that a premium assistance buy-in for adults would also not be cost-effective. • At CMS' request, Colorado agreed to submit a new ESI feasibility study, but it is unclear when the study will be done.	The state received approval to allow all optional Medicaid parents and children to choose between a premium subsidy and Medicaid/SCHIP coverage (depending on their income level). The state so far has only implemented the premium assistance option for SCHIP income-eligible children.
Implementation Date	Date uncertain due to state budget problems.	Date indefinitely delayed due to state budget problems.	N/A	Implemented in part 10/1/02
Premiums and Cost-Sharing Requirements	• Employer pays at least 50% of premium for employee coverage and 30% for dependent coverage. - Enrollees pay $15-50, depending on family income and size – state pays remainder. • Families must pay all cost-sharing with no cap on out-of-pocket costs.	N/A	N/A	• No minimum employer contribution or maximum enrollee cost for premiums. • State pays subsidy of up to $75 per eligible member per month. • Families must pay all required cost-sharing with no cap on out-of-pocket costs.
Benefits Package	• Policies eligible for subsidy are small employer plans that meet state law benchmark for small group market (emergency care, inpatient care, physician/outpatient care including lab and x-ray services, health maintenance, emergency ambulance services). • Minimum three month waiting period unless waived by employer.	N/A	N/A	• Policies eligible for subsidy must cover physician visits and hospital inpatient services (there are no requirements on scope of coverage). • Provides immunizations not covered by private plans as a wrap-around service.

Appendix (cont.): Premium Assistance in Approved "HIFA" and "HIFA"-like Section 1115 Waivers

	Maine	New Jersey	New Mexico	Oregon
Description of Waiver	Waiver redirects allocated but unspent Disproportionate Share Hospital (DSH) funds to expand Medicaid eligibility for childless adults.	Waiver reduces benefits for some parents with incomes at or below 133% FPL who are currently enrolled in Medicaid. Waiver also uses the savings from the reduction to reopen enrollment for a limited number of parents with incomes at or below 133% of poverty who have been on a waiting list due to an enrollment freeze.	Waiver allows the state to use SCHIP funds to provide premium assistance for a state-established commercial benefit package with premiums and cost-sharing.	Waiver reduces benefits, increases cost-sharing, and allows enrollment caps for previously eligible groups; provides limited eligibility expansion; and uses SCHIP funds to refinance and expand a pre-existing state-funded premium assistance program, the Family Health Insurance Assistance Program (FHIAP).
Description of Waiver Premium Assistance Components	Premium assistance will occur where possible through the state's existing Medicaid HIPP program. However, the state envisions limited use of private health insurance in Maine due to lack of access to private coverage in the waiver population and the rural nature of the state.	State will continue its premium assistance program approved in 2000 as part of the state's Section 1115 waiver. State pays a subsidy directly to the employee that covers the entire employee share minus required premium amounts (see benefits). If employee has access to ESI, he/she must enroll in it.	The state will offer premium assistance to uninsured parents and childless adults.	FHIAP subsidizes the purchase of ESI and non-group insurance subject to an enrollment cap. If ESI is available, parents not receiving cash assistance up to 150% FPL must enroll in FHIAP. Other eligibles may choose between FHIAP and coverage through OHP Standard.
Implementation Date	Implemented 10/1/2002	Premium assistance component predated HIFA waiver. Enrollment began July 2001.	Implementation delayed	Implemented 11/1/2002
Premiums and Cost-Sharing Requirements	Same as Medicaid rules	• Originally, the state required employers to contribute at least 50% of the premium (this policy is under review). - Families below 150% FPL do not pay premiums. - Families above 150% must pay $25 for the first adult, $15 for the second adult, and $10 for one or more children – the state pays the remainder of premium. • No cost-sharing for families below 150% FPL. There is a cap of 5% of total income on cost-sharing for families above 150% FPL.	• Employers required to provide coverage to 75%+ of employees to discourage crowd-out. Employers required to contribute $75/month toward premiums. Employees must pay: up to 100% FPL ($0); 101-150% FPL ($20); 151-200% FPL ($35). • If no employer contribution, employee must pay the income-related premium plus the $75 employer share per month to participate. • Cost-sharing is income-related, but significantly higher than Medicaid. For example, inpatient coverage is $25 per day up to 100% FPL and $75 per day for 101-150% FPL.	• FHIAP will subsidize families based on their income. The subsidy reflects the percentage of premium cost the state pays after any applicable employer contribution. The subsidy levels are: - 0-125% FPL (95%) - 125-150% FPL (90%) - 150-170% FPL (70%) - 170-185% FPL (50%) • Cost-sharing allowed up to: - $500 deductible/person - $2,500 maximum out-of-pocket/ person or $10,000 stop loss (for services other than prescription drugs) - 25% of prescription drug costs, with no out-of-pocket maximum on drug costs.
Benefits Package	• Policies are eligible for subsidy if private coverage is cost-effective over traditional Medicaid. • State provides full Medicaid benefits (including cost-sharing limitations) as a wrap-around service in accordance with Section 1906 of the Medicaid statute.	State covers any eligible service not covered by private policy but covered by appropriate NJ FamilyCare category of eligibility (as amended by the waiver) as a wrap-around for families who are in small employer plans only.	• Benefit package will include inpatient and outpatient hospital, ER, physician services, lab and x-ray, home health care, prescription drugs, durable medical equipment, and PT, OT, and SLP. Package will NOT cover optometrists, dentists, podiatrists, dentures, eyeglasses, ICF/MR, long-term care, personal care services, transportation, case management, or hospice. • Minimum six month waiting period.	• Policies must meet or exceed a benchmark adopted by the state's Insurance Pool Governing Board. The benchmark cannot be less than the actuarial equivalent of Medicaid mandatory benefits. Subsidized coverage must also meet or exceed these benchmarks: lifetime maximum benefit at least $1,000,000; plan must cover 20 specific required benefits (no requirements for scope or duration of benefits). • Waiting periods of up to six months are permitted.

Appendix (cont.): Premium Assistance in Approved "HIFA" and "HIFA"-like Section 1115 Waivers

	Tennessee	Utah
Description of Waiver	Waiver significantly revises the preexisting TennCare waiver by restricting eligibility and benefits for some children and adults.	Waiver expands eligibility for parents and other adults, providing a restricted benefit package with enrollment fees and copayments subject to an enrollment cap. • Increases cost-sharing and reduces benefits for previously eligible lower-income parents.
Description of Waiver Premium Assistance Components	The state will create a new program, "Tenncare Assist," which will provide premium subsidies to families below 200% FPL who have access to employer-sponsored coverage with certain minimum requirements.	Subsequent to the waiver approval, Utah submitted an Employer-Based Amendment that is pending at CMS. • Eligible persons include parents 50-100% FPL and other adults <150% FPL; uninsured for ≥6 months. • Employee share of employer premiums must exceed 5% of employee's monthly gross income; if premium is between 5-15% of countable income, employee is eligible for subsidy program only; if premium exceeds 15% of income, employee can chose between the waiver package or premium assistance subsidy.
Implementation Date	Target date January 2004	ESI amendment approved May 30, 2003. Enrollment expected September 2003.
Premiums and Cost-Sharing Requirements	• Employers must contribute at least 60% of the premium. • Out-of-pocket costs cannot exceed $2,000 for an individual and $4,000 for families.	• Employer and employee contribution to premiums varies by policy. - In the first year, the state pays $50 per month for the employee. Over time this amount declines to $20 per month in the fifth year of eligibility. - Subsidies for dependant coverage start at $100 per month and decline to $40 per month in the fifth year. • Cost-sharing varies by policy and has no upper limits.
Benefits Package	Policies must be a standard HMO benefit package that meets out-of-pocket limits. The benchmark and upper limit for payment will be tied to the average cost of coverage in TennCare Standard – another portion of the state's waiver, which provides a reduced benefit package.	No minimum benchmark standards other than state's general insurance laws. Benefits may be more limited than and cost-sharing may be higher than the state's Medicaid benefit package.

[1] *Summary of Employer Health Benefits* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured/Health Research and Educational Trust, September 4, 2002), p. 1.
[2] Analysis based on data from the Congressional Budget Office's (CBO) March 2003 Medicaid Baseline.
[3] Based on an average taken from the Kaiser/HRET Summary of Employer Health Benefits from 1999-2002.
[4] Analysis based on CBO Medicaid Baselines 1996-2003.
[5] *Summary of Employer Health Benefits*, p. 2.
[6] A recent analysis found that premiums would have risen 15% during the same timeframe if employers had not "bought-down" the value of insurance by 2.3% – primarily by raising copayments for prescriptions drugs and raising in-network deductibles. See Bradley Strunk, Paul Ginsburg, and Jon Gabel, "Tracking Health Care Costs: Growth Accelerates Again in 2001," *Health Affairs* web exclusive, September 25, 2002.
[7] *Summary of Employer Health Benefits*, p. 2.
[8] U.S. Department of Health and Human Services, *HHS to Give States New Options for Expanding Health Coverage* press release (Washington, DC: August 4, 2001).
[9] "Guidelines for States Interested in Applying for a HIFA Demonstration" www.cms.gov/hifa/hifagde.asp, p. 4.
[10] Presentation by Theresa Sachs at the National Eligibility Conference, Atlanta, GA, November 2001.
[11] For more information on the Section 1115 waiver process, see Jeanne Lambrew, *Section 1115 Waivers in Medicaid and the State Children's Health Insurance Program: An Overview* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, July 2001).
[12] Email with Anita Hill, Chief of Iowa Bureau of Health, 1/10/2003. For more information on Iowa's program, see Jennifer Sexton, *Overview of the Iowa Health Insurance Premium Payment (HIPP) Program* (Washington, DC: Institute for Health Policy Solutions, February 4, 2000). Also, see Silow-Carroll, Waldman, and Meyer, *Enhancing Health Coverage for the Working Uninsured: Lessons from Six State and Local Programs* (Washington, DC: Economic and Social Research Institute, October 16, 2000).
[13] Calculated as a percentage of children and non-disabled/non-elderly adults participating in Medicaid for MA, OR, RI, WI. SCHIP states are calculated as a percentage of total SCHIP enrollment.
[14] Phone conversation with Nancy Kealey, Massachusetts Division of Medical Assistance Family Assistance Program, 4/3/03. Enrollment as of 12/31/02.
[15] Phone conversation with Joseph Fine, Maryland Department of Health and Mental Hygiene, 3/4/2003. Enrollment as of 12/31/02.
[16] Phone conversation with Dennis Doderer, New Jersey Department of Human Services, NJFamily Care Premium Support Program, 3/6/03. Enrollment as of 2/28/03. As of this date, 593 persons were on a list for the open enrollment period.
[17] Email with Craig Kuhn, the Manager of Family Health Insurance Assistance Program, 1/30/03; Caseload data from: *Medicaid Enrollment in 50 States: December 2001 Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2002). Enrollment as of 12/30/02.
[18] Phone conversation with Rhode Island Rite Share staff, 1/24/03. Enrollment as of 1/24/03.
[19] Email with Linda Nablo, the Director of Children's Health in VA (via Jill Hanken at the Virginia Poverty Law Center), 2/4/03; Caseload data from: *Medicaid Enrollment in 50 States: December 2001 Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2002). Enrollment as of 12/02.
[20] Email with Greg DiMiceli, BadgerCare analyst, 1/10/03. Caseload data from: Wisconsin Medicaid website: http://www.dhfs.state.wi.us/medicaid1/caseload/481-caseload.htm. Enrollment as of 1/03.
[21] Bowen Garrett, Len Nichols, and Emily Greenman, *Workers without Health Insurance: Who Are They And How Can Policy Reach Them?* (Washington, DC: Community Voices, May 1, 2001).
[22] See Sarah Schulte, Barbara Yondorf, Linde Howell and Leif and Associates, State of Colorado Department of Health Care Policy and Financing, *Few Child Health Plan Plus Eligibles Would Qualify for an Employer Subsidy* (Denver, Colorado: September 2001). Available at www.chcpf.state.co.us/titlexxi/reports/employer.html.
[23] Ibid, p. 5.
[24] Ibid, p. 16.
[25] See Richard E. Curtis and Edward Neuschler, "Premium Assistance" in *The Future of Children: Health Insurance for Children* (The David and Lucile Packard Foundation: Volume 13, Number 1, Spring 2003), p. 216.
[26] See "Guidelines for States Interested in Applying for a HIFA Demonstration."
[27] Cindy Mann and Jocelyn Guyer, *Taking the Next Step* (Washington, DC: Center on Budget and Policy Priorities, August 1998), p. 37.
[28] See 42 CFR Part §457.810(c)(1); January 11, 2001.
[29] "Guidelines for States Interested in Applying for a HIFA Demonstration," p 5.
[30] Arizona and California resubmitted previously pending proposals under the HIFA guidelines subsequent to the guidelines being announced.

[31] Two states, Michigan and Minnesota, had submitted HIFA waiver proposals but have since officially moved these waivers to inactive status.
[32] See cover letter and Attachment D of Maine's HIFA application.
[33]The federal SCHIP statute prohibits SCHIP funds being used for children who are privately insured at the time of enrollment.
[34] No data is yet available on how many children have chosen to switch from private coverage to SCHIP. In its budget assumptions the state estimated that of the 6,431 children enrolled in KidCare Rebate at the inception of the waiver, 5,481 or 85% would chose to remain enrolled in private coverage while 950 would choose to enroll in KidCare.
[35] For children who come to the program with private insurance, the state will receive the lower Medicaid matching rate. For children who choose premium assistance but were previously on Medicaid or uninsured, the state will receive the higher Title XXI matching rate.
[36] Even though the state has chosen not to implement the premium subsidy option for parents, the state intends to request additional waiver authority to pursue this option for families at this income level in the future. This would require a waiver of EPSDT benefits standards and cost-sharing limitations for children who are covered in a mandatory Medicaid category.
[37] Illinois HIFA Application Template, p. 11, September 3, 2002.
[38] At the time of the waiver submission, there were approximately 6,000 children enrolled in the KidCare Rebate program.
[39] Interview with Jane Longo, Illinois KidCare Director.
[40] Ibid.
[41] The reverse is of course also true. Families who experience the loss of a job or see their income decline and are no longer able to purchase private coverage would experience greater continuity of care if they had selected the option of receiving their coverage through Medicaid or SCHIP.
[42] Letter from Phyliss Biedess, Director, Arizona Health Care Cost Containment System, to Jane Peterson, Project Director, Centers for Medicare and Medicaid Services, May 1, 2002.
[43] Arizona Health Care Cost Containment System, *Feasibility Study of an Employer-Sponsored Insurance Pilot Program in Arizona* (Phoenix, AZ: May 2002), p. 7.
[44] Feasibility Study p. 8.
[45] Ibid, p. 9.
[46] Ibid, p. 10.
[47] Medicaid cannot charge premiums, and children cannot be required to pay cost-sharing. Cost-sharing limitations are less stringent in SCHIP.
[48] For a good summary of the issues, see *Health Insurance Premiums and Cost-Sharing: The Impact on Low-Income Populations* (Washington, DC: Kaiser Commission on Medicaid Key Facts Series, March 2003).

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