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CHOOSING PREMIUM ASSISTANCE: WHAT DOES STATE EXPERIENCE TELL US?

By Joan Alker, Georgetown University Center for Children and Families

EXECUTIVE SUMMARY

Premium assistance programs use federal and state Medicaid and State Children's Health Insurance Program (SCHIP) funds to purchase private coverage. Overall, few states have premium assistance programs, but interest in premium assistance remains high. The most prevalent type of premium assistance program in state SCHIP programs is the "opt-out" model. In this model, families *choose* to receive a subsidy to apply to the purchase of private coverage rather than receiving direct Medicaid or SCHIP coverage; there are very limited benefit and cost sharing standards for subsidized coverage. Other models of premium assistance require participation in premium assistance but continue to provide benefit and cost sharing protections.

This brief examines six state premium assistance programs (in Florida, Idaho, Illinois, Oregon, Utah, and Virginia) that allow families to choose to receive a subsidy to apply to the purchase of private coverage rather than to receive direct Medicaid or SCHIP coverage. It finds:

- Overall, enrollment in opt-out premium assistance programs remains relatively low, likely due to limited availability of employer sponsored coverage and the high cost of coverage that is available.
- Advantages of the approach may include the ability for an uninsured parent to obtain coverage, the ability for a family to be covered under a single plan, and potentially improved access to providers.
- However, the cost-effectiveness of these programs is limited by low enrollment, which can lead to high administrative costs. Also, coverage subsidized through these programs may have benefit limits and cost sharing requirements that might limit families' ability to access needed services.

Eligiblity

All of the six opt-out programs examined primarily target children. Four states (Idaho, Illinois, Utah, and Virginia) operate with SCHIP funding for SCHIP income-eligible children, one (Florida) operates at lower income levels for Medicaid eligible children, and one (Oregon) is a hybrid using both Medicaid and SCHIP funding. Parents (and, in some states, other adults) are eligible for premium subsidies under some circumstances in all of the states examined except Virginia. The rules around adult eligibility are complex, but eligibility for adults is generally more restricted in a variety of ways than for children.

Enrollment

Overall, enrollment in opt-out premium assistance programs remains relatively low. As a percent of eligible children, participation in the longest established programs, Illinois and Oregon, is highest at 9% and 2%, respectively. Enrollment in programs established in the last few years generally is less than 1% of eligible children. Participation is low likely due to limited availability of employer-sponsored coverage and the high cost of coverage when it is available.

One of the clear advantages of premium assistance programs is that they can sometimes help subsidize coverage for a parent who would not otherwise be eligible for public coverage. In these cases, a family puts the value of a child(ren)'s subsidies toward the purchase of family coverage, enabling the parent to obtain coverage. The clearest example of this is in Virginia. Although adults are not directly eligible for subsidies in the state, because children's subsidies are being used to support family coverage, nearly 40% of program enrollees are adults.

Little data is available that examines exactly why families have chosen to participate in opt-out premium assistance programs. However, available information from studies in Oregon and Virginia suggest at least three potential reasons. First, some families may believe they are only eligible for premium assistance and not understand that they also are eligible for direct coverage. Second, some families choose premium assistance to have the whole family covered under the same insurance plan. Third, some families cite better access to providers.

Coverage

While most of the coverage being purchased through opt-out programs is likely employer-based, four of the six states (ID, IL, OR, VA) do permit families to use their subsidy to purchase coverage on the individual market. Limited data is available on the levels of individual coverage being subsidized by the programs, but the information available suggests that there is variation across the states.

There are few cost sharing and benefit standards for subsidized coverage in opt-out programs. In every examined state, families pay all applicable coinsurance, copayments, and deductibles required by their private plan. The states also have very few benefit requirements and/or wraparound services. No comprehensive data exists on the specific benefit packages of subsidized plans. However, this area merits close study as cost sharing requirements and benefit limits can have significant impacts on families' ability to access needed care, and private plans, particularly individual plans, typically have much higher cost sharing requirements and less comprehensive benefits than Medicaid or SCHIP.

Cost-Effectiveness

States generally assume that opt-out premium assistance programs are cost-effective because they cap expenditures of Medicaid/SCHIP dollars by limiting the per-child subsidy to the amount that a state would have spent on a child in its public program. However, cost-effectiveness is not guaranteed by establishing a fixed subsidy for two reasons. First, because enrollment has been so low in some states, the per capita administrative costs of the program are high. Second, when including family costs (i.e., premiums and cost sharing), the total cost of subsidized coverage may be higher than the cost of providing direct coverage. In this case, public funds are subsidizing coverage that is more expensive overall, but that may be less comprehensive and, thus, provide more limited access to care.

Conclusion

The opt-out premium assistance approach can facilitate the ability of an uninsured parent to obtain coverage and a family to be covered under a single plan, as well as potentially improve access to providers. However, the cost-effectiveness of these programs is limited by low enrollment, which can lead to high administrative costs. Also, the benefit limits and cost-sharing requirements in subsidized plans may affect families' ability to access needed services. Given these potential access problems, it is important for opt-out programs to ensure that families make an informed choice and that there are adequate protections allowing families to return to direct Medicaid/SCHIP coverage if needed.

INTRODUCTION

Premium assistance programs use federal and state Medicaid and State Children's Health Insurance Program (SCHIP) funds to purchase private coverage. A minority of states has premium assistance programs, and, to date, these programs have had low enrollment and not achieved significant cost-savings.[1] However, because they operate at the intersection of public and private coverage, and because some states are expanding children's coverage up the income scale, interest in the premium assistance model remains high. For example, the President's most recent budget proposal includes a proposal to expand premium assistance in Medicaid and SCHIP.[2]

One proposal put forth in the recent Congressional debate on reauthorizing the SCHIP program was to require states to operate premium assistance programs in which SCHIP-eligible families can choose premium assistance for their children.[3] This model of premium assistance is often referred to as the "opt-out" – so-called because families can *choose* to opt-out of public coverage to purchase private coverage. In making the choice, families generally give up the benefit standards and cost-sharing protections of Medicaid and SCHIP. In contrast, other models of premium assistance may require some individuals to participate in a premium assistance program, but continue to provide benefit and cost sharing protections.

Little is known about "opt-out" premium assistance programs; most are relatively new. Yet this approach is the most prevalent premium assistance model in separate state SCHIP programs, and with SCHIP reauthorization still outstanding, it is important to examine this approach. This policy brief provides an overview of six state opt-out premium assistance programs (Florida, Idaho, Illinois, Oregon, Utah, Virginia) [4] serving children and examines their structure, enrollment, benefits, affordability, and cost-effectiveness.

BACKGROUND

In the opt-out premium assistance model, families can choose to apply a premium subsidy to purchase coverage on the private market rather than receiving direct coverage through the state's Medicaid or SCHIP program. The value of the subsidy is often linked to the cost of providing direct coverage through the state's Medicaid and/or SCHIP program.

While families who receive direct coverage through Medicaid and SCHIP are generally assured access to a comprehensive set of benefits, there are typically few benefits standards for the coverage that can be purchased with the Medicaid/SCHIP subsidy through the opt-out program. In addition, families are usually responsible for any additional costs beyond the premium subsidy – i.e., copayments, coinsurance and deductibles required by the private plan, as well as any additional premium costs not covered by the subsidy. This stands in contrast to the cost-sharing protections in Medicaid and SCHIP.

Because children and families participating in opt-out programs are not receiving the full Medicaid/SCHIP benefits package, these programs must currently operate under a Section 1115 waiver from the federal government. Section 1115 waivers are granted at the Secretary of Health and Human Service's discretion and allow states to waive certain federal program requirements. In other models of premium assistance, states can subsidize private coverage and even require families to participate in premium assistance without a waiver of federal rules. However, in these approaches, states must continue to provide the full range of Medicaid or SCHIP benefits – either through a "wraparound" benefit provided by the state or by ensuring that the private coverage meets benefit and cost-sharing standards.

WHO IS ELIGIBLE FOR OPT-OUT PROGRAMS?

All of the six opt-out programs examined primarily target children. Four states (Idaho, Illinois, Utah, and Virginia) operate with SCHIP funding for SCHIP income-eligible children, one (Florida) operates at lower income levels for Medicaid eligible children,[5] and one (Oregon) is a hybrid using both Medicaid and SCHIP funding.

As seen in Table 1, there is a range in children's income eligibility levels for the programs. In four of the six states, children's eligibility is limited to those above 133% of the federal poverty level.[6] In contrast, Florida and Oregon do not have a lower income limit on children's eligibility. Parents (and, in some states, other adults) are eligible for Medicaid or SCHIP premium subsidies under some circumstances in all of the states examined except Virginia. The rules around adult eligibility are complex, but eligibility for adults is generally more restricted in a variety of ways than for children.

Table 1:
Eligibility and Enrollment in "Opt-Out" Premium Assistance Programs, Selected States, 2007

State	Program Name and Funding	Children's Income Eligibility Limits (as a % of the FPL)[2]	Date Enrollment Began	Enrollment[1]			% of Eligible Children in Opt-out
				Children	Adults	Total	
Florida	Opt-Out (Medicaid)	Infants: <200% FPL Age 1-5: <133% FPL Age 6-18: <100% FPL	Sept. 2006	8	n/a	8	0%
Idaho	Access Card and Access to Health Insurance (SCHIP)	133-185% FPL	July 2004/ July 2005[3]	160	291	451	<1%
Illinois	All Kids Rebate (SCHIP)	133-200% FPL	Oct. 2002	9,802	1,203	6,005	9%
Oregon	Family Health Insurance Assistance Program (FHIAP) (Medicaid/SCHIP)	0-185% FPL	July 1998	4,549	11,762	16,311	2%
Utah	Utah Premium Partnership (UPP) (SCHIP)	Age 0-5: 133-200% FPL Age 6-19: 100-200% FPL	Nov. 2006	206	152	358	<1%
Virginia	FAMIS Select (SCHIP)	133-200% FPL	Aug. 2005[4]	383	269	652	<1%[5]

[1] All enrollment data are as of June 30, 2007, except for Illinois which is as of December 31, 2006.
[2] In 2007, the federal poverty level (FPL) was $16,600 per year for a family of three.
[3] Access Card/ Access to Health Insurance Program
[4] The FAMIS Select program instituted in August 2005 replaced an earlier premium assistance program that began in September 2001.
[5] Some children in enrolled in FAMIS Select may not be SCHIP eligible

As noted, a key feature of these programs is that they are meant to be optional for families. Consistent with the voluntary nature of these programs, five of the six states allow families to switch back to public coverage – usually at the end of every month. In Florida, after an initial 90-day open enrollment period, families are locked into the opt-out private coverage for nine months. Few of the states track how many families switch – the most reliable data comes from Illinois, which has larger enrollment. The state found that about six percent of families in premium assistance switch in or out over the course of a year. In fiscal year 2006, 314 families

in Illinois moved from private coverage to public, and 216 families switched from public coverage to private.

HOW MANY PEOPLE HAVE ENROLLED IN OPT-OUT PROGRAMS?

As Table 1 shows, enrollment in these programs has been low. As a percent of eligible children, participation in premium assistance in the longest established programs, Illinois and Oregon, is highest. Programs established in the last few years generally have enrollment of under one percent.

A likely reason for low enrollment in these programs, as with all premium assistance programs, is the lack of affordable, employer-sponsored coverage for low-wage workers. A recent study found that families with workers between 100-199 percent of the federal poverty level (FPL) had an offer of coverage 60 percent of the time; and families with workers below 100 percent of the FPL had an offer of coverage only 34 percent of the time.[7]

If families do have an offer of private coverage, the costs are likely to be high. In 2007, the average cost of employer-sponsored family coverage was $12,106, of which the family contribution was $3,281, or almost 13 percent of income for a family of three at 150 percent of the FPL.[8] This equates to $273 a month for the average family contribution. As shown in Table 2 (next page), state subsidies in these programs are often capped at $100 per child, and families are required to pay any additional premium costs not covered by the subsidy. As such, premium assistance is likely an unaffordable choice for many families – particularly those with only one child eligible to receive a subsidy.

One of the advantages of premium assistance programs is that, in some cases, they can help subsidize coverage for a parent who would not otherwise be eligible for public coverage. In a state in which parent eligibility levels for public coverage are much lower than children's eligibility levels, the value of a child's or children's subsidies can go toward the purchase of family coverage, enabling the parent(s) to gain coverage. Virginia is the clearest example of this – although adults are not directly eligible for subsidies, because children's subsidies are being used toward family coverage, 39% of those enrolled in their opt-out program are adults.

Table 2:
Payment of Premiums in "Opt-Out" Premium Assistance Programs, Selected States, 2007

	Federal/State Subsidy	Employer Contribution	Cost to Family
Florida	State pays up to what it would have paid if the enrollee had enrolled in a Medicaid reform plan.	None required	Family pays remainder of premium.
Idaho	*Access to Health Insurance:* State pays up to $100 PMPM up to $500/family of enrollee's premium.	Employers must contribute 50% of the employee's premium.	Families pay remainder of premium.
	Access Card: State pays up to $100 PMPM up to a total of $300 per family.	None required	Family pays remainder of premium.
Illinois	State pays up to $75 PMPM.	None required	Family pays remainder of premium.
Oregon	State pays between 50%-95% of enrollee premium (depending on family size and income level).	None required	Family pays remainder of premium.
Utah	State pays up to $100 per child per month up to family's premium if least expensive insurance option available to family is more than 5% of total family income before taxes.[1] State reimburses an additional $20/month for dental coverage.	Employers must contribute 50% of the employee's premium.	Family pays remainder of premium.
Virginia	State pays up to $100 PMPM.	None required	Family pays remainder of premium.

[1] UPP pays up to $150 per adult per month.

WHY DO FAMILIES CHOOSE PREMIUM ASSISTANCE?

Little data is available that examines exactly why families have chosen to participate in opt-out premium assistance programs. The most useful information comes from studies of the programs in Oregon and Virginia and suggests three reasons to consider:

Some families may not know they are eligible for direct coverage. A study of Oregon's program surveyed parents with children enrolled in the state's FHIAP premium assistance program, who were also eligible for SCHIP. The study found that although most parents knew that SCHIP existed, over half (52%) mistakenly believed that their child was ineligible for SCHIP.[9] This suggests that in Oregon, at least, a large percentage of families enrolled in the "opt-out" premium assistance program are not aware that they have the option to receive direct coverage through SCHIP. In contrast to Oregon's experience, a smaller study of Virginia's program conducted by the state found that 89 percent of parents were aware that their child could switch to public coverage.[10] Since choice is a defining feature of opt-out programs, these findings highlight the importance of clearly communicating the options available to families in a an easily accessible manner that families understand.

Families want to be covered together under the same health insurance plan. Virginia's study found that the top reason cited for participation was the ability to have the whole family covered under the same insurance plan (28 percent), and the offer of parent coverage was cited by 17

percent in this same study. In Oregon's study, the desire to cover the entire family was cited by 16 percent of respondents.[11]

Some families may believe premium assistance provides better access to providers. Premium assistance is often viewed as a way to increase availability of providers by providing access to private plans' provider networks. In Oregon's study, seven percent of respondents cited the ability to continue to see the same doctors as under their previous coverage as a reason to choose FHIAP and 16 percent cited a broad preference for private insurance over public insurance. The same study found that children in SCHIP were more likely to report higher unmet need for specialty care services in Medicaid/SCHIP as compared to FHIAP (11 percent vs. 4 percent), suggesting improved access in FHIAP for some services.[12] Both FHIAP and SCHIP enrollees, however, reported high levels of unmet need for dental care. SCHIP enrollees' access to dental care is primarily limited because of fewer providers being available, while those in FHIAP are limited by the high cost sharing or lack of coverage in private plans. This underscores that while some individuals may choose premium assistance to gain access to a broader network of providers than available through SCHIP or Medicaid, access for some services may still be limited by the cost sharing requirements or benefit limits of the private plans.

WHAT KINDS OF COVERAGE ARE FAMILIES RECEIVING?

While most of the coverage being purchased through opt-out programs is likely employer-based, four of the six states (ID, IL, OR, VA) do permit families to use their subsidy to purchase coverage on the individual market. Coverage on the individual market tends to be less comprehensive than group coverage.[13] The best data on the type of coverage being purchased through premium assistance comes from Oregon and Virginia again with differing findings. In Virginia, 93 percent of families responding to a state survey said that they were using their subsidy towards the purchase of employer-based coverage.[14] In Oregon, however, a majority of families use their subsidy to purchase coverage on the individual market – this percentage has fluctuated over the years but remains high – currently it is 67 percent of enrollees.[15] While other states do not have precise data, program administrators generally do not believe that the levels of individual coverage being subsidized in their opt-out programs are as high as that in Oregon.

As seen in Table 3, coverage subsidized through opt-out programs—either employer-sponsored or through the individual market—has far fewer minimum benefit standards and cost-sharing protections than state Medicaid and SCHIP programs:

- *Cost-sharing*: In every state, families pay all applicable coinsurance, copayments, and deductibles required by the private insurance plan they enroll in, with virtually no limits or exceptions.

- *Benefits*: The states have very few benefit requirements and/or wraparound services under their opt-out programs. Florida and Idaho require only that products meet state licensure standards, Virginia offers only to cover immunizations if they are not covered in the child's private insurance plan, and Illinois simply requires that packages cover inpatient and outpatient services with no requirement on the scope of those benefits. Utah's benefit requirements are somewhat more comprehensive.

Table 3:
Cost Sharing and Benefit Standards for Subsidized Private Plans in "Opt-Out" Premium Assistance Programs, Selected States, 2007

State	Point-of-Service Costs to Families: Copays, Coinsurance, Deductibles	Benefits[1]
Florida	Families pay all applicable copayments, coinsurance and deductibles	No minimum standards.
Idaho	Families pay all applicable copayments, coinsurance and deductibles	No minimum standards.
Illinois	Families pay all applicable copayments, coinsurance and deductibles	Insurance product must cover physician and inpatient hospital services.[2]
Oregon	Families pay all applicable copayments, coinsurance and deductibles	Must meet or exceed benchmarks that are actuarially equivalent to Medicaid mandatory benefits.
Utah	Families pay all applicable copayments, coinsurance and deductibles Deductibles cannot exceed $1,000	Employer insurance must cover at least 70% of inpatient hospital stays (after deductible), and must cover well baby/well child care, immunizations, physicians visits, inpatient, and pharmacy benefits. Lifetime maximum benefit cannot be less than $1,000,000.
Virginia	Families pay all applicable copayments, coinsurance and deductibles	No minimum standards. State will cover childhood immunizations if not covered by employer insurance plan.

[1] All states require that insurance products meet minimum state licensure standards.
[2] Level of coverage is not mandated by the state.

No comprehensive data exists on the specific benefit packages of private plans that are being purchased through opt-out programs. However, this is an area that merits close study as cost sharing requirements and benefit limits in private plans could have significant impacts on families' ability to access needed care. Cost-sharing has been shown to be a barrier to care for lower-income populations.[16] Further, private plans typically do not cover the comprehensive set of benefits provided through Medicaid and SCHIP, particularly coverage purchased through the individual market. Dental and vision coverage, for example, are two areas in which private coverage is likely to be less generous.

ARE THESE PROGRAMS AN EFFICIENT USE OF PUBLIC FUNDS?

Other models of premium assistance (for example programs in Iowa, Rhode Island, and New Jersey) assess levels of employer contributions to ensure that purchasing private coverage is cost-effective to the state. However, "opt-out" programs typically do not specify a minimum level of employer contribution nor do they assess whether employer contributions are adequate to ensure that purchasing coverage is cost-effective for the state or the family. Idaho and Utah's opt-out programs do require that employers pay 50% of the premium for employee coverage, but there is no contribution required for dependent coverage.

Instead, states generally assume that opt-out premium assistance programs are cost-effective because they cap expenditures of Medicaid/SCHIP dollars by limiting the per-child subsidy to the amount that a state would have spent on a child in its public program. Also, it is often

posited that the elimination of a wraparound benefits requirement will simplify administration and help assure cost-effectiveness.

As seen in Table 4, some states are able to meet a meaningful cost-effectiveness standard that includes administrative costs (e.g., Idaho and Virginia). However, cost-effectiveness is not guaranteed by establishing a fixed subsidy for two key reasons. First, because enrollment in these programs has been so low in many states, the per capita administrative costs of establishing and maintaining such a program can be high. This effect is most dramatically shown in the case of Florida, which has such low enrollment that per capita administrative costs have been near a thousand dollars per child.[17]

Table 4:
Cost-Effectiveness of "Opt-Out"
Premium Assistance Programs, Selected States, 2007

State	Average Premium Subsidy (PMPM)	Administrative Costs (PMPM)	Cost Effective?[3]
Florida	$77.33[1]	$971.51 [2]	No
Idaho	$72.00	$32.72	Yes
Illinois	$57.52	Unknown	Unknown
Oregon	$203.21	$23.31	Unknown
Utah	$51.77	Unknown	Unknown
Virginia	$100.00	$11.90	Yes

[1] This is the average premium assistance paid for the 10 individuals who were enrolled in the opt-out program as of February 2007.
[2] Through first 7 months of the opt-out program (September 2006 - March 2007), assuming average enrollment of 7 persons.
[3] Calculation based on Georgetown analysis of state data on subsidy and premium costs as compared to cost of public coverage.

The second important consideration is the total cost of coverage. In opt-out programs, families are paying additional premium costs and cost-sharing amounts that may limit their access to needed services. In this case, public funds are being used to subsidize coverage that is more expensive for all payers combined (i.e., including families), but may result in more limited access to services that children need. As such, a state may end up spending just as much or slightly less on a premium assistance subsidy as for a child enrolled in SCHIP, but the child getting the subsidy may be receiving fewer services. This issue may be of particular concern for coverage purchased on the individual market, which tends to be less comprehensive and more costly than employer-sponsored coverage.

CONCLUSION

States considering an opt-out premium assistance program will need to address whether or not these programs are an efficient use of public funds and their impact on children's access to needed services. The opt-out premium assistance approach provides a means to improve the

ability of an uninsured parent to obtain coverage, particularly if publicly funded coverage is not otherwise available to them, and may enhance the ability of a family to access providers participating in the private plan. However, the cost-effectiveness of these programs is currently limited by low enrollment, which can lead to high administrative and start-up costs. Also, the benefit limits and cost-sharing amounts in subsidized private plans may limit families' ability to access needed services. Therefore, it is important for opt-out programs to ensure that families make an informed choice and that protections exist so that they are able to return to direct Medicaid/SCHIP coverage if needed.

This brief was prepared by Joan Alker of the Center for Children and Families at the Georgetown University Health Policy Institute. This research was commissioned by the Henry J. Kaiser Family Foundation. Conclusions or opinions expressed in this report are those of the authors and do not necessarily reflect the views of the Foundation.

ENDNOTES

[1]See J. Alker, "*Premium Assistance Programs: How Are They Financed and Do States Save Money*?" Kaiser Commission on Medicaid and the Uninsured (October 2005); and C. Shirk & J. Ryan, "*Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?,*" National Health Policy Forum (July 17, 2006).
[2]Office of Management and Budget, "Fiscal Year 2009 Budget of the U.S. Government," (February 2008), available at http://www.whitehouse.gov/omb/budget/fy2009/budget.html
[3]*SCHIP Reauthorization and Reform Act of 2007*, H.R. 3176, 110th U.S. Congress, 1st Session (July 25, 2007).
[4]Nevada also operates a similar program that serves SCHIP-eligible children. It is the newest of the programs so was not included in this analysis. Much of the information in this report comes from survey responses and subsequent verbal and electronic communication with the following state officials between April 2007 and April 2008: Jennifer Barrett (AHCA Administrator, Third Party Liability, Bureau of Program Analysis, Florida), Patti Campbell (Senior Project Manager, Access to Health Insurance, Idaho), Lynne Thomas and Theresa Eagleson (Chief, Bureau of All Kids, and Medicaid Administrator respectively Illinois), Kelly Harms (Policy & Legislative Liaison, Oregon Family Health Insurance Assistance Program), Melissa Goggins (FAMIS Select Specialist, Virginia), and Gayleen Henderson (CHIP Program Manager, Utah).
[5]Premium assistance is only available in the two counties – Broward and Duval -- operating under a Section 1115 Medicaid waiver agreement. The General Accounting Office's Legal Counsel has raised questions about the legality of this program because children do not receive the full EPSDT benefits package. See letter from G. Kepplinger, Office of General Counsel, Government Accountability Office, to M. Leavitt, Secretary of Health and Human Services, "*Medicaid Demonstration Projects in Florida and Vermont Approved Under Section 1115 of the Social Security Act*," (July 24, 2007).
[6]Idaho, Illinois, Utah and Virginia. Utah allows children age 6-19 to participate from 100-200% FPL.
[7]B. DiJulio & P. Jacobs, "*Change in Percentage of Families Offered Coverage at Work 1998-2005*," Kaiser Family Foundation (July 2007).
[8]Kaiser Family Foundation/HRET, "Survey of Employer Health Benefits, 2007," (September 2007).
[9]K. VanLandeghem, *et al*., "*Who Enrolls in Oregon's Premium Assistance Program and How do they Fare?"* Child Health Insurance Research Initiative, Issue Brief No. 6 (March 2007).
[10]Virginia Department of Medical Assistance Services, "*First Year FAMIS Select Evaluation: August 1, 2005 to July 31, 2006,*" Submitted to the Centers for Medicare and Medicaid Services. 64 participating families responded to the survey.
[11]VanLandeghem, p. 3.
[12]Ibid*, p.*16.
[13]Kaiser Family Foundation, "*Comparison of Expenditures in Nongroup and Employer-Sponsored Insurance*" **(**November 2006, Revised: February 2007).
[14]Virginia Department of Medical Assistance Services, op cit.
[15]Oregon FHIAP enrollment data from January 22, 2008.
[16]For example, see S. Artiga & M. O'Malley, "*Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences,*" Kaiser Commission on Medicaid and the Uninsured (May 2005).
[17]Florida Office of Program Policy Analysis & Government Accountability, "*Medicaid Reform Implementation*," Memorandum No. 2, (March 2007).

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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