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Premium Assistance

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Twenty states currently use premium assistance, a program in which federal and state Medicaid and/or SCHIP funds help pay for employer-based or other private health insurance coverage, often using employer or enrollee fees to help pay premium costs. The program is used both as a strategy to cover individuals already eligible for Medicaid and to expand health coverage to the uninsured. Premium assistance has appeal for a number of reasons.[1] It gives states the potential to save money by capturing employer contributions and shifting some individuals and families from Medicaid and SCHIP programs to private, employer-sponsored insurance (ESI). If offered as an option to program participants, premium assistance can also provide people with a choice of coverage and provider options. And, by helping some low-wage workers take up offers of ESI, it may help employers reduce turnover and attract more qualified employees. Premium assistance may also make health coverage more convenient and improve access to care by keeping family members together under one plan, rather than having parents enrolled in employer coverage or uninsured and children enrolled in Medicaid or SCHIP.[2]

Yet premium assistance programs have faced implementation challenges and criticism. Premium assistance is not always cost-effective for states.[3] Administration and other costs can easily consume any potential savings. In addition, many employers of low-wage workers do not offer health coverage at all, and employers who offer coverage may not consider becoming eligible for participation in a premium assistance program a "qualifying event"[4] like a birth, adoption, marriage, or divorce.[5] As a result, employees may have to wait for the next annual enrollment period to join the employer's health plan, making it much more difficult for states to coordinate enrollment efforts. If individuals become ineligible for premium assistance between enrollment periods, they may be unable to drop the plan, forcing them to pay monthly premiums without subsidies from the state.[6] Also, while those who employ low-wage workers may benefit from decreased employee turnover if their employees have health coverage tied to their jobs, increased enrollment in ESI likely means higher costs for employers than if their employees remain covered through traditional Medicaid. Employers may be unwilling to pay these extra costs, and they may also be unwilling to commit the resources necessary to provide the information Medicaid needs to administer the program.

Finally, some have argued that premium assistance is potentially harmful to participants. Depending on how the programs are designed, participants may face unaffordable cost sharing in private insurance plans. Additionally, unless states provide wrap-around[7] Medicaid coverage, people in premium assistance programs may lose access to benefits and services they would have received under traditional Medicaid.

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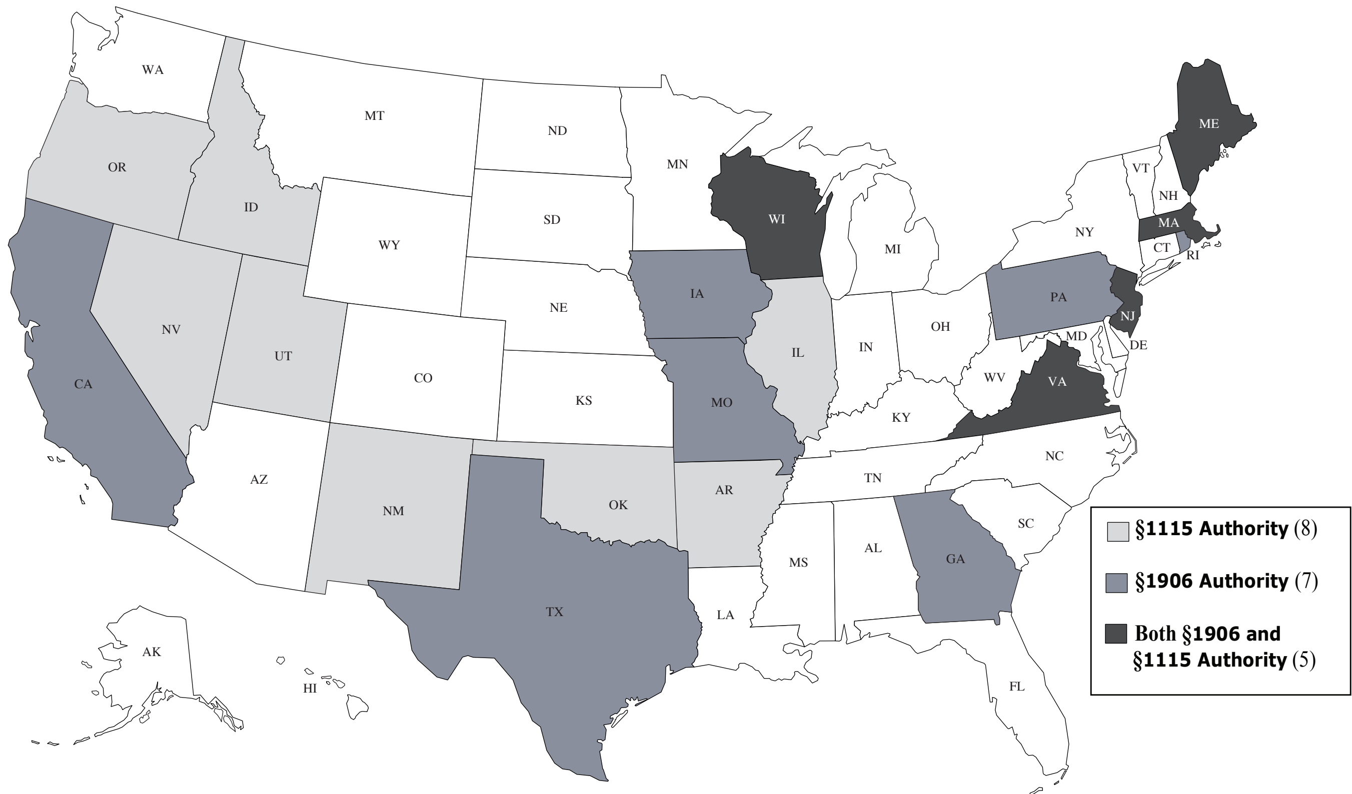
FIGURE 1. STATES WITH PREMIUM ASSISTANCE PROGRAMS



Brief Review of Federal Rules

States can operate premium assistance programs under §1906 authority, through §1115 waivers, or by using both methods. Currently, among the 20 states that have premium assistance programs, 12 states operate programs under §1906 authority and 13 operate under §1115 waivers, including five states that operate their programs under both §1115 and §1906 authority.[8]

SECTION 1906 AUTHORITY

Under Medicaid §1906 authority, benefits must be "cost-effective," meaning that enrolling individuals into premium assistance programs must cost less than enrolling eligible individuals into public programs.[9] If the coverage is deemed cost-effective, states operating under this authority can require eligible beneficiaries to enroll in their employer sponsored plans.

States operating §1906 premium assistance programs must also, under federal rules, ensure that participants retain access to the same package of benefits at the same cost as they would under traditional Medicaid. Because Medicaid generally offers a more comprehensive benefit package than most private insurance plans, states operating under §1906 often have to supplement both the benefits and the cost of the employer's coverage.[10] This supplemental coverage is often referred to as wrap-around coverage, and the cost of providing and administering wrap-around coverage must be considered when calculating cost-effectiveness.[11]

SECTION 1115 WAIVER AUTHORITY

Under Medicaid §1115 waiver authority, states can request waivers from many of the federal Medicaid and SCHIP requirements, including some that have made implementation of premium assistance under §1906 challenging.

The Center for Medicare and Medicaid Services (CMS) has fostered these efforts. A major goal of its Health Insurance Flexibility and Accountability (HIFA) initiative, launched in 2001, has been to develop premium assistance programs using §1115 waiver authority.[12] CMS has approved §1115

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TABLE 1: AUTHORITY, DATE STARTED, AND ENROLLMENT BY STATE

States with PA programs	Authority		Year started	Enrollment (5/06* unless noted)
	§1906	§1115		
Arkansas		✔	2006	167 (6/07)
California	✔		1986	Not reported
Georgia	✔		1994	889 (07/07)
Idaho		✔	2005	456
Illinois		✔	2002	2,409
Iowa	✔		1991	9,211
Maine	✔	✔	2005	297
Mass.	✔	✔	1997	33,318
Missouri	✔		1995	8,640 (2006)**
NJ	✔	✔	2001	770
NM		✔	2005	4,509
Nevada		✔	2006	NA
Okla.		✔	2006	2,757 (7/07)
Oregon		✔	2002	15,776
Penn.	✔		1995	23,657
RI	✔		2002	5,300
Texas	✔		1995	8,197
Utah		✔	2003	61
Virginia	✔	✔	2005	1,629
Wisconsin	✔	✔	1999	1,691

* All May 2006 enrollment numbers from Cynthia Shirk and Jennifer Ryan, "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum, July 17, 2006.
**Missouri number from Missouri Division of Medical Services, "Division of Medical Services Budget Book." February, 2007.
Arkansas, Georgia, and Oklahoma numbers from conversations with state officials.

waivers that allow states to vary from some of Medicaid's benefits, cost-sharing, and cost-effectiveness requirements, and that expand to populations states could not otherwise cover.[13] When wrap-around and cost-sharing requirements are waived under section §1115 waivers, participants who move from Medicaid to premium assistance programs may lose some benefits and face increased cost-sharing obligations.

THE DEFICIT REDUCTION ACT

The Deficit Reduction Act of 2005 (DRA) made significant changes to Medicaid that will likely make it easier for states to administer premium assistance programs. Under the DRA, states can modify the Medicaid benefit packages provided to many populations, such as parents, children, pregnant women, and young adults.[14] This benefits flexibility may enable states to establish premium assistance programs that do not have to prove cost-effectiveness,[15] feature wrap-around benefits, or include cost-sharing protections, without first obtaining approval of a §1115 waiver. States could use this flexibility as a mechanism to enroll already eligible populations in premium assistance or to expand coverage to higher income populations.

States' Policy Choices in Operating Premium Assistance Programs

Enrollment varies significantly from state to state and depends on numerous factors including program design, which populations are deemed eligible, and whether enrollment is mandatory or voluntary for those who meet eligibility criteria. Some states like Massachusetts, Oregon, and Pennsylvania have more than 10,000 enrollees in their premium assistance programs. Other states like Idaho, Maine, and Utah have fewer than five hundred enrollees in their programs.

Key Features of Premium Assistance Programs Under §1115 Authority

As previously mentioned, the state policies governing the 12 premium assistance programs operated under §1906 are standardized under federal law. There is little variation among these programs in terms of eligibility, whether beneficiaries are required to enroll into premium assistance, and whether the state supplements the employer's benefits and/or cost sharing. These programs must be cost-effective and provide enrollees with wrap-around benefits. In contrast, however, there is much variation among the state policies that govern the thirteen premium assistance programs operated under §1115 waivers.

WHO IS ELIGIBLE?

Eligibility differs widely from state to state. Some states have received permission from CMS to cover childless adults and otherwise ineligible populations under their §1115 waivers. Among the thirteen §1115 states, one (Maine) only covers childless adults, three (Illinois, Nevada, and Wisconsin) cover parents and children only, and three (Arkansas, Idaho, Massachusetts) cover parents, children, childless adults, and pregnant women. Two states (New Mexico and Utah) only cover parents and childless adults, while one state (Oregon) covers parents, children, and childless adults. Oklahoma covers parents, childless adults, and pregnant women; New Jersey covers only parents and pregnant women; and Virginia only covers children in its premium assistance program. Income limits also vary among states, but range up to 200 percent of the federal poverty level (FPL).

Additionally, given that children are more likely to qualify for Medicaid than their parents, in some circumstances premium assistance may be used to cover whole families if the cost of supplementing family coverage is less than the cost of providing Medicaid coverage to the children alone.[16] In this way, premium assistance can be used as a tool to expand coverage to otherwise ineligible family members.

IS ENROLLMENT MANDATORY?

Most states with premium assistance programs under §1115 authority require enrollment in premium assistance for at least some populations.[17] In six states, enrollment is mandatory for all premium assistance eligible populations, and one state (Idaho) exempts children from mandatory enrollment. In some, but not all states where enrollment in premium assistance is mandatory, Medicaid supplements benefits and cost sharing.

DOES MEDICAID SUPPLEMENT BENEFITS AND/OR COST SHARING?

Some states have continued to supplement at least some Medicaid and/or SCHIP benefits. Among the thirteen states that operate premium assistance programs under a §1115 waiver, eight supplement benefits. Five states (Maine, Massachusetts, New Jersey, Oregon, and Wisconsin) supplement all benefits for all premium assistance participants, and three states (Idaho, Illinois, and Virginia) supplement immunizations only. In addition, six states supplement cost sharing: two states (Oregon and Utah) fully supplement cost sharing for all participants; three states (Massachusetts, New Jersey, and New Mexico) supplement cost sharing only after costs exceed a five percent cap; and one state (Nevada) supplements cost sharing for pregnant women only.

WHAT ARE THE MINIMUM EMPLOYER CONTRIBUTION STANDARDS?

Nine of the thirteen states that operate premium assistance as part of a §1115 waiver require employers to contribute a portion of the premium for their workers to enroll in premium assistance. Five states (Idaho, Massachusetts, New Jersey, Nevada, and Utah) have a requirement that employers contribute 50 percent or more of the costs and one state (Wisconsin) requires an employer contribution of between 40 and 80 percent. However, since employers paid on average 66 percent of the cost of premiums for family coverage for workers earning less than $15 per hour in 2006[18], employer contribution requirements are generally below this average.

In most states premium assistance is used primarily as a method to capture employer contributions by enrolling people eligible for public coverage into ESI. However, the programs in Arkansas, New Mexico, and Oklahoma are unique. These states seek to encourage small employers who have not previously offered insurance to their workers to begin contributing towards their employees' coverage rather than simply making use of coverage already offered. The premiums are paid for by contributions from the employer, the worker, and the state.[19]

Among these, New Mexico (with a comprehensive benefit package and a benefit maximum of $100,000) is the only state with an offer similar to a basic commercial plan. Oklahoma and Arkansas offer more limited coverage than what is typically offered through Medicaid or traditional ESI.[20] New Mexico has a requirement that employers contribute a flat amount of $75 monthly for each employee, Oklahoma requires employers to contribute at least 25 percent of the cost, and Arkansas requires an annual employer enrollment fee of $15 for each participant.

Conclusion

Nearly half of states currently operate premium assistance programs, and additional states are considering integrating premium assistance into their broader state healthcare reform plans. Program goals, design, enrollment, and size vary dramatically from state to state. Under the Deficit Reduction Act of 2005 and benefits flexibility guidance that followed, states have new flexibility to design premium assistance programs without proving cost-effectiveness or providing wrap-around benefits, and without obtaining approval of a §1115 waiver. The full impact of the Deficit Reduction Act remains to be seen, and despite implementation challenges states will likely continue to experiment with premium assistance programs for years to come.

States	Is enrollment mandatory?	Does the state supplement benefits?	Does the state supplement cost sharing?	What is the minimum employer contribution?	Parents	Children	Childless adults	Pregnant women
	Key Features of §1115 Premium Assistance Programs * ♦				**Income Eligibility by Category as Percentage of Federal Poverty Level**			
*Arkansas**	Yes	No	No	$15/ enrollee annually	15-200%	1-6 yrs 133-200% 6-19 yrs 100-200%	0-200%	133-185%
Idaho	Yes, except for children	Immunizations only	No	50%	43-185%	100-185%	0-185%	133-185%
Illinois	No	Immunizations only	No	No minimum	32-185%	133-200%	—	—
Maine	Yes	Yes	No	No minimum	—	—	0-125%	—
Massachusetts§	Yes	Yes	Yes, if they exceed 5% cap	50%	0-200%	0-1 yr. 0-200% 1-18 yrs 0-150%	0-200%	0-200%
Nevada	No	No	For pregnant women only	50%	25-200%	0-5 yrs. 134-200% 6-18 yrs. 101-200%	—	133-185%
New Jersey	Yes	Yes	Yes, if they exceed 5% cap	50%	0-200%	—	—	185-200%
New Mexico	Yes	No	No	$75/enrollee monthly	0-200%	—	0-200%	—
*Oklahoma***	Yes, except for pregnant women	No	Yes, if they exceed 5% cap♦♦	25%	0-200%	—	0-200%	0-200%
Oregon	No	Yes	Yes	No minimum	0-185%	0-185%	0-185%	—
Utah	No	No	Yes	50%	50-150%	—	0-150%	—
Virginia	No	Immunizations only	No	No minimum	—	133-200%	—	—
Wisconsin	Yes	Yes	No	Between 40-80%	0-185%	0-200%	—	—

* Virginia and Nevada operate their premium assistance programs through an SCHIP §1115 demonstration.

♦ Italicized states (Arkansas, New Mexico, and Oklahoma) are unique because they have designed their programs to encourage small employers to begin offering their workers ESI rather than as a tool for making use of coverage already offered.

* The Arkansas Safety Net Benefit Program is currently limited to parents of Medicaid/SCHIP children, spouses, and childless adults.

§ Under Massachusetts' recent "Commonwealth Care" expansion up to 300% FPL, no additional premium assistance is provided to adults between 200% and 300% FPL.

** Oklahoma operates two premium assistance programs. The Premium Assistance Employer Sponsored Insurance (ESI) program is available to low-income non-disabled workers and their spouses. The Oklahoma Individual Plan program offers premium assistance to working disabled adults and non-disabled workers and spouses whose employers elect not to participate in the ESI program and also the self-employed, temporarily unemployed, and qualifying working disabled without access to employer sponsored insurance. Also, while Oklahoma's waiver gives the state the authority to cover those with incomes up to 200% FPL, the state currently (August 2007) covers individuals up to 185% and will expand up to 200% FPL on November 1, 2007.

♦♦ There is a $900 cap on reimbursement of out-of pocket expenses over the 5% cap per eligibility period.

Notes

1 According to a 2006 published survey of 15 states with premium assistance programs, nine states or 60 percent reported they created their programs to reduce Medicaid and/or SCHIP costs. Five states or 33 percent reported that they created their programs to help increase the employees' connection to the workforce. Only two states or 13 percent said their program was implemented in part to reduce the number of uninsured in their state. However, eight states or 53 percent noted that their programs could be used to help subsidize family members who are not eligible for traditional public coverage. Pam Silberman et al, "Premium Assistance Programs for Low Income Families: How Well Does it Work in Rural Areas?" (Chapel Hill, NC: North Carolina Rural Health Research and Policy Analysis Center, The University of North Carolina at Chapel Hill January 24, 2006). pp. 6-7.

2 See Marquis and Kapur, "Employment Transitions and Continuity of Health Insurance: Implications for Premium Assistance Programs" *Health Affairs*, V. 22, N.5, 199-209. 2003. See also Neuschler and Curtis, "Premium Assistance: What Works? What Doesn't?" Institute for Health Policy Solutions, 2003

3 While federal rules require "cost-effectiveness," some waivers contain no specific monitoring strategies and it does not appear that CMS is closely monitoring whether or not these states are saving money. See Joan Alker, "Premium Assistance Programs: How are they Financed and do States Save Money?" Kaiser Commission on Medicaid and the Uninsured, 2005.

4 For more information see *Making Medicaid Work for the 21st Century: Options for Premium Assistance Programs.* (Portland, ME: National Academy for State Health Policy, November 2004). Access at www.nashp.org/Files/IssueBrief2.pdf.

5 Some SCHIP reauthorization proposals currently include language that would amend ERISA to make eligibility for Medicaid or SCHIP a qualifying event. States can use their insurance rules to make eligibility for premium assistance a "qualifying event" that allows immediate entry into fully insured employer plans (and some have, including Massachusetts, Maryland, and Rhode Island). But this approach is not applicable to self-insured employer plans due to ERISA constraints.

6 "Premium Assistance Toolbox for States: Assisting States to Develop Premium Assistance Programs." National Academy for State Health Policy, 2004. Available at www.patoolbox.org.

7 States that operate premium assistance programs without a §1115 waiver are obligated to ensure "wrap-around" coverage. In other words, under §1906 authority, if enrollees' private coverage does not include benefits available under the state's regular Medicaid program, Medicaid must continue to provide these benefits at no excess cost to enrollees.

8 It should be noted that §1906 authority exists only for Medicaid, and §1115 waivers can be used to operate both Medicaid and SCHIP premium assistance programs.

9 "Premium Assistance Toolbox for States." 2004.

10 Some states have issued beneficiaries a Medicaid fee-for-service card, which has made meeting this requirement fairly simple and not as costly. States with only Medicaid managed care programs do not have this ability and therefore have had more difficulty in meeting wrap-around requirements.

11 *Making Medicaid Work for the 21st Century: Options for Premium Assistance Programs*. National Academy for State Health Policy, November 2004.

12 CMS, HIFA Webpage (http://www.cms.hhs.gov/HIFA/). Accessed 7/23/07.

13 Expansions must meet budget neutrality requirements; that is the costs of program expansion under a §1115 waiver must be offset by other changes in Medicaid that lower the overall spending. See Milligan, Charles. "Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage," State Coverage Initiatives. May 2001.

14 See SMDL #06-008, March 31, 2006. See also Sonya Schwartz, *Financing State Coverage Expansions: Can New Medicaid Flexibility Help?* (Portland, ME: National Academy for State Health Policy, September 2007).

15 SMDL #06-008, March 31, 2006. Use of a benchmark or benchmark-equivalent coverage is at the discretion of the state and may be used in conjunction with employer-sponsored health plans as a coverage option for individuals with access to private health insurance. For example, if an individual has access to employer-sponsored coverage and that coverage is determined by the state to be a benchmark-equivalent, a state may, at its options provide premium payments on behalf of the beneficiary to purchase employer coverage. The premium payments would be considered medical assistance and the state could require the beneficiary to enroll in the group plan.

16 Silberman et al, 7.

17 That is to say the state requires those eligible for Medicaid or SCHIP and for employer coverage to enroll in that coverage as a condition for receiving assistance from the state.

18 U.S. Department of Labor, U.S. Bureau of Labor Statistics. "National Compensation Survey: Employee Benefits in Private Industry in the United States," March 2006, p. 16.

19 Alice Burton et al, *State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policy Makers* (New York: Commonwealth Fund, January 2007).

20 "Medicaid HIFA Waiver Comparison: Arkansas, New Mexico and Oklahoma." State Coverage Initiatives. (http://statecoverage.net/waivers.htm) Accessed 8/09/07.

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