

**Maryland Children's Health Program (MCHP) Premium  
Private Option:  
The Employer Sponsored Insurance  
Premium Assistance Program**

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## **MCHP Premium Private Option: The Employer Sponsored Insurance Premium Assistance Program**

### **Background**

The State Children's Health Insurance Program (SCHIP) (Title XXI of the Social Security Act) was created as a part of the Balanced Budget Act of 1997. SCHIP was intended to allow states greater flexibility with regard to providing insurance coverage for low-income children while providing a higher federal match rate than with Medicaid. A key component of SCHIP is the ability of states to use program funds to provide premium assistance in order to subsidize employer-sponsored insurance (ESI). Within the confines of federal requirements, states are permitted to use SCHIP funds for the purpose of subsidizing employer-sponsored insurance for eligible children and, with a federal waiver, the families of eligible children. Maryland implemented a child-only premium assistance program in July 2001 as part of a larger program expansion (MCHP Premium) that increased income eligibility levels and introduced enrollee cost-sharing through premiums for the newly eligible expansion population. During the 2001 legislative session, the Maryland General Assembly tasked the Department of Health and Mental Hygiene (Department) with preparing a report specifically focused on the implementation of the MCHP Premium ESI premium assistance (private) option by December 1, 2003.

In the 2003 legislative session, the General Assembly voted to discontinue the ESI premium assistance program effective July 1, 2003. As a result, continued enrollment in state subsidized employer-sponsored health insurance plans is no longer an option for MCHP Premium enrollees. The employees currently participating in the ESI premium assistance program will no longer receive monthly subsidy checks, or a secondary insurance card covering co-pays, deductibles and co-insurance. The parents/guardians of these enrollees received a lump-sum payment in June 2003 sufficient to cover the remaining balance for their current plan benefit year. Upon request, all children enrolled in a subsidized ESI plans will be transferred to the MCHP Premium Medicaid "look-alike" program at the end of their current employer-sponsored benefit period. They will be required to pay a monthly premium for this coverage.

The analyses presented in this report were already underway when the General Assembly eliminated the premium assistance program. The report provides a comprehensive overview of the premium assistance program. The report details the Maryland-specific experiences with premium assistance by examining employer participation, enrollee participation, and program cost-effectiveness. The report is concluded with the findings from a cross-state study of six other states that implemented premium assistance programs in a time and manner similar to Maryland. The cross-state study provides a valuable context within which to consider the Maryland premium assistance experience.

### **Section I: Employer Participation**

The premium assistance program could not function without a network of qualified, participating employers from whom prospective enrollees could obtain subsidized health insurance. As of February 2003, the state had nearly 400 employers with at least some health plans that were qualified for the premium assistance subsidy. The state had started 2002 with 75 employers with qualified plans. In order for an employer plan to qualify, it had to meet a series of requirements. These requirements were established in accordance to federal and state law and stipulated that the employer sponsored plan must be cost-effective (less expensive than direct enrollment in the state plan), the plan must provide a level of benefits such that it is the equivalent of an established benchmark (the State's Comprehensive Standard Health Benefits Plan for Small Employer) and the employer must contribute at least 30 percent of the cost of the coverage (although initially 50 percent, the requirement was relaxed in May of 2002).

As of February 2003, the state (via a third party contractor) had contacted or attempted to contact over 2,200 employers for possible participation in the program. The vast majority of those employers (in excess of 80 percent) did not become program participants. Although the specific reasons for non-participation were varied, most could be categorized into two groups – those that did not meet the participation requirements previously detailed and those that either actively or passively declined participation in the

program. A third group includes those employers who simply did not offer health insurance.

Employer participation/non-participation since the start of the program is charted in Figures I-1 and I-2. The two charts show that there was little change with regard to the reasons for non-participation. As of February 2003, the state had 2,215 unduplicated potential employers to review for program participation. From that initial pool, 1,968 responded to the state’s request for information regarding their health insurance offerings. More than one in five (23 percent) of employers were ultimately qualified for participation or still awaiting qualification. This is equal to the proportion in the same categories in June 2002 (although a higher percentage were qualified as opposed to pending). In both the June 2002 and the February 2003 analysis, over three-quarters of the contacted employers were ultimately disqualified. The most common reason for disqualification among the vast majority of employers who could not participate was failing to adequately respond to the state’s information requests. Slightly fewer employers were rejected because their health plans did not meet the minimum program requirements and about one in five simply did not offer health insurance. As data in the charts show, these ratios changed little during the course of CY 2002, although there was a slight increase in the proportion of employers declining to participate in the program and a slight decrease in the proportion who failed the employer contribution test (reflecting the decrease in the minimum contribution in May of 2002).

**Figure I-1: Employer Participation As of June 2002**

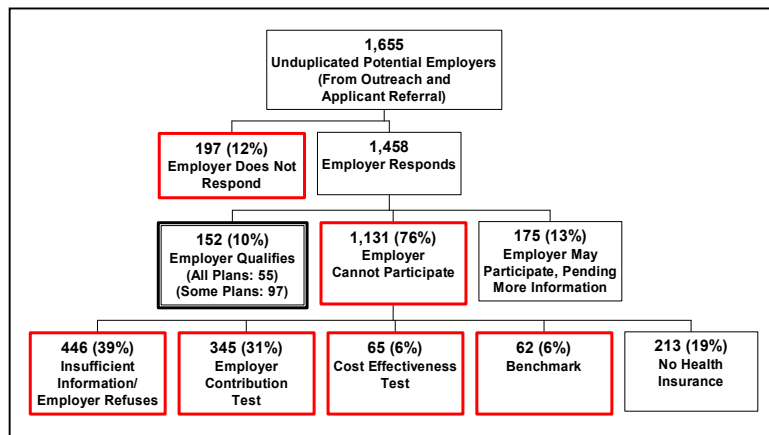
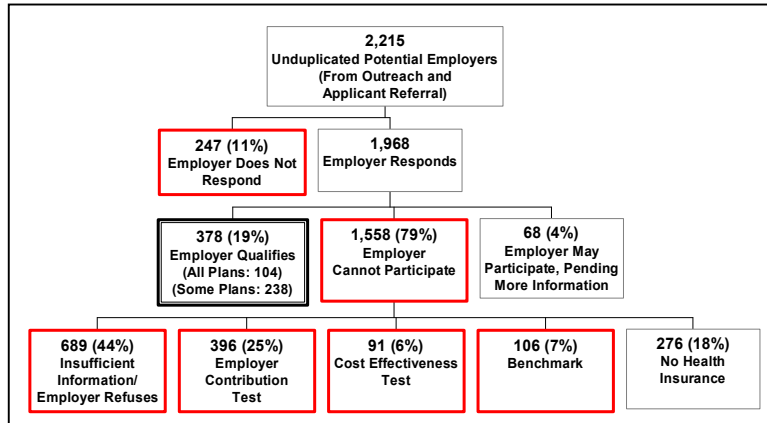
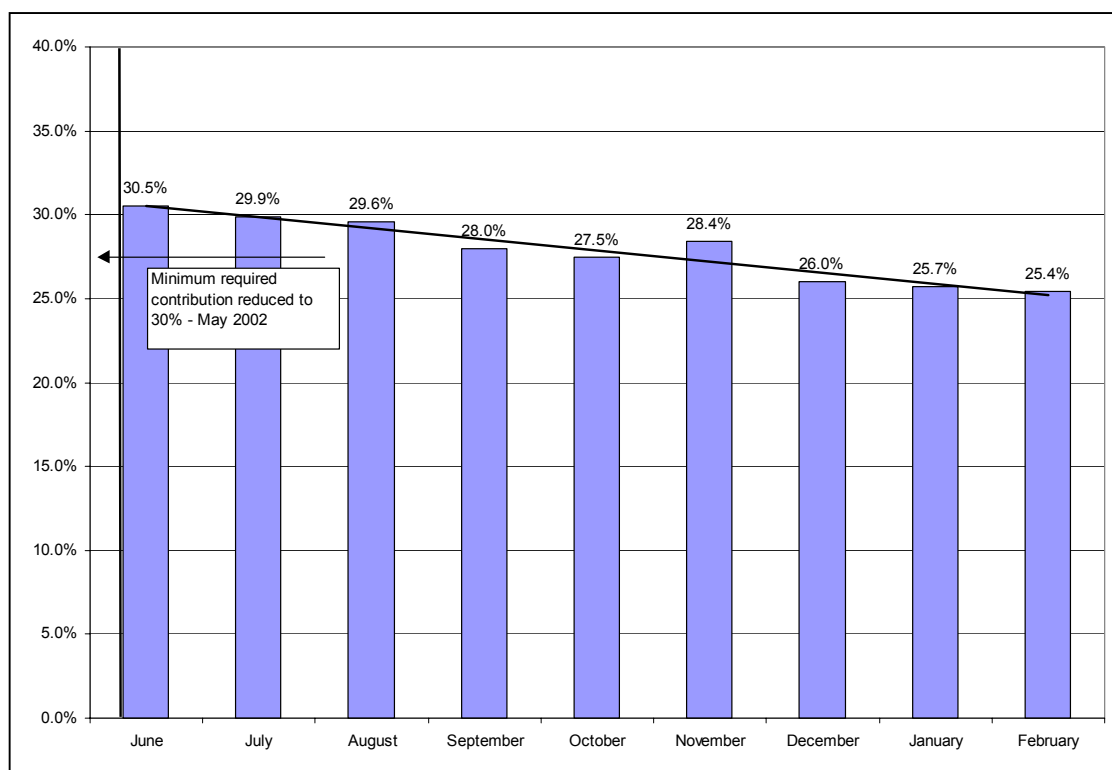


Figure I-2: Employer Participation As of February 2003



With regard to the minimum employer contribution requirement, the state reduced that minimum level in May 2002 in an effort to better reflect the realities of the private insurance market place. Available trend data suggest, however, that the reduction of the minimum contribution from fifty percent to thirty percent had minimal impact on employer participation or qualification levels. Figure I-3 presents the percentage of employers prevented from program participation beginning with the last month of the fifty percent requirement. As the table shows, prior to reducing the minimum contribution level, slightly more than thirty percent of employers failed to meet the required fifty percent premium match. In the months following the reduction in that requirement, the percentage of employers failing to meet the newly required thirty percent match declined modestly to just over 25 percent. As these numbers are cumulative, that decline includes previously rejected employers who were subsequently re-evaluated.

**Figure I-3: Percentage of Employers Failing to Meet the Minimum Contribution Requirement**

Finding and qualifying employers for program participation is essential to the success of any premium assistance initiative in order to enroll potential participants. As of February 2003, the state had more qualified employers (378) than program enrollees (194). Even though 378 employers have had at least some of their plans qualified for program participation, not all are actually participating in the program. As of February 2003, there were approximately two employers per one enrollee. This employer/enrollee ratio was roughly the same throughout CY 2002.

The preceding data on employer participation raise the question: *why are employers not participating in the program?* Possible answers to that question can be found in the results of the *2003 Small Employers Focus Group Project*, conducted by Shugoll Research on behalf of DHMH and the Maryland Health Care Commission.<sup>1</sup> Shugoll Research conducted a series of focus groups with small employers (separate from those

<sup>1</sup> Results of the 2003 Small Employer Focus Group Project. Shugoll Research. Bethesda, MD. 2003  
<http://www.dhmf.state.md.us/hrsa/pdf/FinalReptShugoll5-27-03.pdf>

employers approached about participation in MCHP Premium private option) and health insurance brokers in Maryland in an effort to gain insight into potential programmatic or regulatory changes that may be appropriate for the small group market, and to inform the development of options for expanding health coverage to the working uninsured. A total of 12 focus groups were conducted. Ten focus groups were conducted with small employers that employ 2-50 full-time employees (working at least 30 hours per week) in five geographic regions of Maryland. Two additional focus groups were conducted with registered brokers and agents selling health insurance to Maryland small employers<sup>2</sup>.

The focus groups revealed that there was virtually no awareness of the premium assistance program, but even if employers had been aware they would have been reluctant to participate. In principle, small employers supported the concept of premium assistance, but felt that the program would be ineffective. Small employers believed that the income qualifications were too narrow and would have excluded most of their employees. Employers also believed that the program would be a drain on resources since participation required that they contribute at least 30 percent of a family's premium. That amount was above what most small employers contributed, with many not picking up any costs for family coverage at all. Discussions with brokers and agents revealed that none of the focus group participants were even aware of the program. While they were aware of MCHP, the brokers had no knowledge of premium assistance component and following a description of the program they were confused about how it worked.

## **Section II: Enrollee Participation**

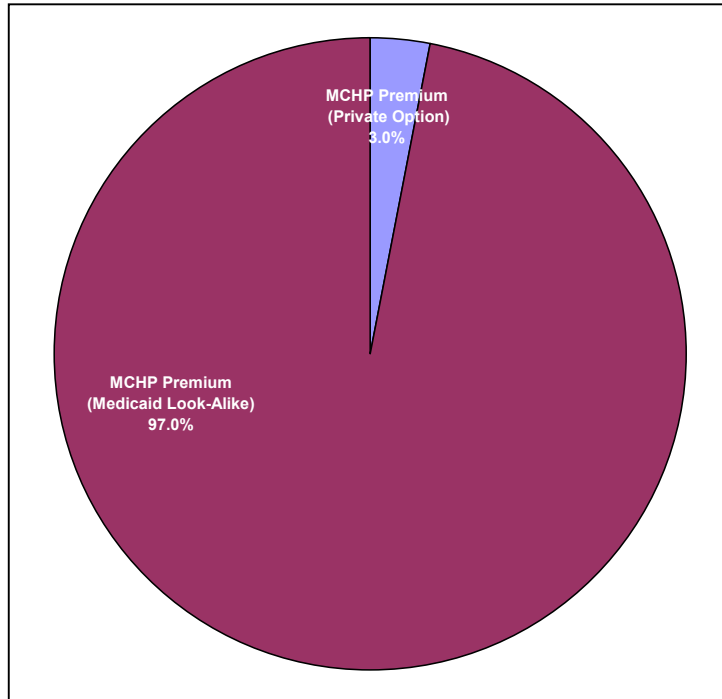
As indicated by Figure I-4, enrollment in the premium assistance component represented a small portion of overall MCHP Premium enrollment. Although that proportion did reach four percent during CY 2002, it had fallen to only three percent by the time the program was discontinued in June 2003. At the start of the 2002, there were 26 children enrolled in premium assistance as compared to 1,314 in the MCHP Premium Medicaid

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<sup>2</sup> Seven groups were conducted with businesses employing 2-10 employees (two groups of businesses offering health benefits and five groups of businesses not offering health benefits). Three groups were conducted with businesses employing 11 to 50 employees; all of these groups offered health benefits.

“look-alike” program. This represented nearly two percent of all MCHP Premium enrollees. By June of 2003, premium assistance enrollment had increased to 194 and three percent of total enrollment. At that time, enrollment in the MCHP Premium Medicaid “look-alike” program had reach 6,239.

**Figure 1-4: Premium Assistance Enrollment Versus MCHP Premium Medicaid Look-Alike – June 2003**



The regional distribution of enrollees in the premium assistance component is different from that of the MCHP Premium Medicaid “look-alike” enrollees. Whereas three-quarters of the “look-alike” enrollees are in the Baltimore/Washington Suburbs, less than two-thirds of the premium assistance enrollees are in those regions. The premium assistance component also has double the proportion of enrollees in Baltimore City as compared to the “look-alike” program. In fact, enrollment distribution in the premium assistance component more closely resembles enrollment in traditional MCHP. The relatively low enrollment numbers in premium assistance tend to preclude drawing any meaningful conclusions with regard to why the enrollment patterns are different from the rest of MCHP Premium or similar to traditional MCHP. These comparatively low levels of program enrollment combined with the difficulties in finding participating employers



suggest that the premium assistance program would not have been able to deliver on the promise of more affordable delivery of care.

### **Section III: Assessing the Cost Effectiveness of MCHP Premium Employer Sponsored Insurance Premium Assistance Program**

One of the rationales commonly cited for establishing a premium assistance program is cost-effectiveness since the programs take advantage of private employer subsidies. Federal SCHIP regulations prevent states from offering premium assistance subsidies if such subsidies would be more expensive than simply enrolling the individual in either SCHIP or Medicaid. Prior to implementation of the premium assistance program in Maryland, actual comparisons of costs between enrollment in premium assistance and the Medicaid “look-alike” program were not possible. An ongoing study was conducted using data from the first 18 months of the program to determine whether providing health coverage under the premium assistance program in Maryland did cost less than providing coverage under the Medicaid “look-alike” program.

This cost-effectiveness analysis yielded two sets of cost estimates. One reflected point-in-time enrollment and used conservative estimates for medical costs (Table I-1). The second was based on optimistic enrollment projections and cost assumptions (Table I-2). Whenever possible the analyses used actual program experience to establish cost estimates. When data was not available, imputed values were derived using reasonable assumptions.

When comparing program costs, this analysis focused on the impact of the two parts of MCHP Premium on the state budget. Both the Premium assistance and the Medicaid “look-alike” portion of MCHP Premium receive enhanced Federal matching under the SCHIP rules. In Maryland, this means that \$100 in program expense will result in only \$35 in state budget costs. All cost comparisons are in terms of state budget dollars, after federal match has been discounted. In addition, all costs presented were net of any premium payments made by families. This analysis expressed health plan medical and health service costs, and administrative costs on a per member per month (PMPM) basis.

*Medical and Services Costs* – Medical and services costs are those costs associated with the purchase of services under Premium assistance or the Medicaid “look-alike.” It is useful to compare the cost of services for children who were enrolled either in Premium Assistance or the Medicaid “look-alike,” as these costs were not sensitive to changes in the relative volume of enrollment. Assessing cost effectiveness by comparing medical and services costs is the strictest test of cost effectiveness, as no amount of efficiencies gained in administering the program, either through increased enrollment or better systems could have offset underlying differences between the two programs. The costs to the state are expressed in terms of PMPM costs. The components of medical and services costs are:

Premium payments. These were the costs associated with the cost of purchasing coverage. For each program, these were:

- *Medicaid “look-alike”*- the average capitation payment paid for children enrolled in the Medicaid “look-alike” program in November 2002.
- *Premium Assistance coverage* – the average private insurance premium subsidy that the state paid per child based on a three month rolling average (in order to smooth out monthly variations due to low enrollment)<sup>3</sup>.

“Wrap around” costs. Under both premium assistance and the Medicaid “look-alike” program, not all services were covered by either the premium or capitation payments. These non-covered costs are commonly called “wrap around” costs. For each program, the wrap around costs were:

- *Medicaid “look-alike”* – the costs for services that were outside of the HealthChoice benefit package and paid directly by the state on a fee-for-service basis. The largest of these costs was for mental health services covered by Maryland Health Partners. The analysis presents actual service costs for the Medicaid “look-alike” population for services through July 2002.

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<sup>3</sup> The months of September through November 2002 were used.

- *Premium Assistance coverage* – Families of children enrolled in premium assistance were protected from any cost-sharing imposed by the employer’s plan. All cost-sharing (e.g., copayments, coinsurance and deductibles) was to be paid by a secondary insurance program that directly reimburses providers. At the time of this analysis, few bills had been submitted for reimbursement for cost-sharing expenditures. This may have been due to providers failing to bill for services or to providers billing enrollees inappropriately<sup>4</sup>. The analysis uses two calculations of these costs -- one calculation based on the actual bills received through October, 2002 and a second, more conservative calculation that estimates likely costs assuming utilization similar to MCHP and common cost-sharing.<sup>5</sup>
- *IEP services* – These are services identified in a child’s individualized educational plan (IEP) and are provided by Maryland public schools. IEP services include a range of activities such as speech and physical therapy as well as case management. IEP services are an obligation of the schools for all children, regardless of insurance status. In the case of a Medicaid covered child, however, the school bills Medicaid for the cost of IEP services allowing the state to claim matching Federal funds. Since children enrolled in ESI were not covered by Medicaid or a Medicaid “look-alike” program the schools could not bill and claim matching funds for the IEP services they provided. Thus, this resulted in an increase in the demands on the Department of Education’s budget.

This analysis assumes that premium assistance children used IEP services to the same extent as children enrolled in the Medicaid “look-alike.” The IEP costs for enrollees in the Medicaid “look-alike” for FY2002 were \$10.84 per member per month (PMPM) and the amount of recouped federal matching funds was \$7.04 PMPM (10.84 X .65).

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<sup>4</sup> Subsequent to this study, additional reimbursement request were received which would have increased the cost assumptions associated with premium assistance.

*Comparison of Medical and Services Costs in Premium Assistance and Medicaid “look-alike”* – Medical and other service costs were compared using two scenarios. The first scenario assumed that secondary insurance costs would reach a level consistent with contemporary utilization and common co-pays. The second, best case scenario, assumed that premium assistance secondary insurance costs would remain static. Under both scenarios, IEP services were viewed as lost state revenue for premium assistance enrollees, and a revenue recovery for Medicaid “look-alike” enrollees.

The results of the analyses of each scenario are displayed in Tables VI-3 and VI-4:

*Conservative Assumptions (Table VI-3)* – Prior to adjusting for lost IEP revenue, premium assistance costs were \$2 PMPM less than for the Medicaid “look-alike” (\$33.37 versus \$35.31). When the Medicaid “look-alike” IEP revenue recoveries were accounted for, the cost of the Medicaid “look-alike” program dropped to \$28.27 PMPM. Thus, when IEP revenue recoveries were included, premium assistance medical and services costs were \$5 greater PMPM than the costs of the Medicaid “look-alike.”

*Best Case Assumptions (Table VI-4)* – Prior to adjusting for lost IEP revenue, premium assistance costs were \$4.50 PMPM less than for MCHP premium (\$30.82 versus \$35.31). When the IEP revenue recoveries were accounted for, the cost of the Medicaid “look-alike” program dropped to \$28.27 PMPM. Thus, when IEP revenue recoveries were included, premium assistance medical and services costs were \$2.50 greater PMPM than the costs of the Medicaid “look-alike.”

The premium assistance medical and services deficit likely increased during 2003 as commercial insurance costs were expected to experience sharp increases of 10 percent or

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<sup>5</sup> The Maryland Comprehensive Standard Health Benefit Plan specifies an HMO product that allows, among others, the following cost-sharing: \$20 per physician visit, \$35 per emergency room visit, and 30 percent for outpatient mental health services (in-network).

more,<sup>6</sup> while family and children capitation payments for the HealthChoice program were scheduled to increase by less than 4 percent.

The finding that premium assistance medical and other services costs exceeded those of the Medicaid “look-alike” program is somewhat confounding. It would be expected that subsidizing insurance where an employer was bearing 30 percent or more of the cost would have been less expensive than purchasing coverage where the state bore the full cost. Analysis of premiums for the CSHBP<sup>7</sup> for 2002 shows that the average cost of adding a single dependent (by going from an individual coverage to individual plus dependent) was over \$240 per month<sup>8</sup>. In contrast, the combined (capitation and wrap around) monthly costs for the Medicaid “look-alike” population were only \$125 (this was before calculating federal match). When the price of insurance in the commercial market place is considered, it is not surprising that, even after employer contributions, the savings from subsidizing premium assistance coverage were marginal at best.

While surprising, this result does make economic sense. Employer group premiums, especially those for small group coverage, include many costs, such as marketing and sales costs that are not elements of the HealthChoice program. In addition, the HealthChoice program represents a group of over 400,000, leading to economies of scale, not easily attainable in the small group market, that contribute to lower medical costs.

*Administrative Costs* – Comparing administrative costs of premium assistance and Medicaid “look-alike” was complicated by the vast differences in enrollment in the programs. At the time of this study, enrollment in the Medicaid “look-alike” (over 4,000) far exceeded that of premium assistance (under 200). As a result, administrative costs for premium assistance were only being spread across a very small population, and presented a distorted comparison.

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<sup>6</sup> Maryland Healthcare Commission Annual Review of the Comprehensive Standard Health Benefit Plan. (November 26, 2002)

<sup>7</sup> Approximately half of all employers participating in premium assistance are small employers and bound by the CSHBP.

<sup>8</sup> As published by the Maryland Insurance Administration (MIA).

It also is not unusual for a program, such as premium assistance, that was in its early, ‘ramp-up’ phase to have extremely high administrative costs on a PMPM basis. High administrative costs may represent an investment in the future, when enrollments would have been larger and economies of scale would come into play. To account for this, the analysis presents administrative costs under two scenarios. One scenario was based on point-in-time enrollment, while the second adjusted costs by incorporating several optimistic assumptions about future enrollment growth and changes in administrative procedures. It also should be noted that these assumptions were intended to be illustrative and were never meant to suggest attainability. Key assumptions under the optimistic scenario included:

- *Equal enrollment in Premium Assistance and Medicaid “look-alike.”* In reality, premium assistance never exceeded four percent of the enrollment in the Medicaid “look-alike” program.
- *Revisions to employer review process to sharply reduce the average cost of enrolling an employer in premium assistance.* These savings were speculative and did not reflect any actual or proposed negotiations with the subcontractor.
- *The average participating employer enrolled two employees.* The program never achieved parity among enrollees and employers. There were always more employers qualified than employees participating. At the time of this study, there were nearly two employers per enrollee. This assumption also reduced the initial sign-up costs for participants, as an existing network of qualified employers was theoretically present.

*Subcontractor Costs* – Both MCHP Premium and premium assistance made use of subcontractors to perform administrative functions. Subcontractor costs were further disaggregated into:

Enrollee Related. These costs were associated with processing and servicing program enrollees. In both programs, these costs were slightly different:

- Medicaid “look-alike” costs included the maintenance of an accounts receivable system and tracking payments.
- Premium Assistance coverage costs included determining insurance status, making subsidy payments to families and periodic checks to assure that families were maintaining private coverage.

Employer-Related. There were a number of tasks required to bring an employer into the premium assistance program. Employers had to be contacted, agree to participate, have insurance that met state standards, and make sufficient contributions. The premium assistance contractor received specific payments for each of the various functions associated with bringing employers into the program. In contrast, there were no employer-related costs for the Medicaid “look-alike” program.

*Administrative costs of premium assistance compared to Medicaid “look-alike”* – Using current program enrollments and experience (Table VI-3), the state’s cost to administer the premium assistance program was \$81 PMPM as compared to \$0.53 PMPM to for the Medicaid “look-alike.” Applying the optimistic assumptions (Table VI-4), the administrative costs for premium assistance fell to \$20.11 PMPM and the costs for the Medicaid “look-alike” remained at \$0.53. Thus, even when optimistic assumptions were used, the cost of administering premium assistance exceeded the cost of administering the Medicaid “look-alike” by just over \$19 PMPM.

*Conclusion* – Based on the preceding analysis, it does not appear that the premium assistance component of MCHP Premium would have yielded any savings to the state. The data suggests in fact, that the program represented a financial loss for the state. This conclusion is the same for when medical and services costs were considered alone and when administrative costs were included.

Table I-1: State Share Cost Effectiveness Comparison

Medical and Administrative Costs Based on Current Trends and Enrollment			
Medicaid "Look Alike" Costs PMPM		ESI Costs PMPM	
Medical	\$ 35.31	\$ 33.37	Medical
IEP Revenue Recovery	\$ (7.04)	\$ -	IEP Revenue Recovery
<b>Medical Specific Total</b>	<b>\$ 28.27</b>	<b>\$ 33.37</b>	<b>Medical Specific Total</b>
Look Alike Specific Admin Costs	\$ 0.53	\$ 4.30	ESI Specific Admin Costs
		\$ 76.42	Employer Related Admin Costs
<b>Admin Specific Total</b>	<b>\$ 0.53</b>	<b>\$ 80.72</b>	<b>Admin Specific Total</b>
<b>MCHP Premium Cost</b>	<b>\$ 28.80</b>	<b>\$ 114.09</b>	<b>Final ESI Cost Based on Current Enrollment</b>

<b>State Savings or Loss PMPM</b>	<b>\$ (85.29)</b>
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Table I-2: State Share Cost Effectiveness Comparison

Medical and Administrative Costs Based on Optimistic Assumptions			
Medicaid "Look Alike" Costs PMPM		ESI Costs PMPM	
Medical	\$ 35.31	\$ 30.82	Medical
IEP Revenue Recovery	\$ (7.04)	\$ -	IEP Revenue Recovery
<b>Medical Specific Total</b>	<b>\$ 28.27</b>	<b>\$ 30.82</b>	<b>Medical Specific Total</b>
Look Alike Specific Admin Costs	\$ 0.53	\$ 4.30	ESI Specific Admin Costs
		\$ 15.81	Employer Related Admin Costs
<b>Admin Specific Total</b>	<b>\$ 0.53</b>	<b>\$ 20.11</b>	<b>Admin Specific Total</b>
<b>MCHP Premium Cost</b>	<b>\$ 28.80</b>	<b>\$ 50.93</b>	<b>Final ESI Cost Based on Current Enrollment</b>

<b>State Savings or Loss PMPM</b>	<b>\$ (22.14)</b>
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## Summary

The premium assistance component of MCHP Premium faced considerable difficulty in not only enrolling participants but in qualifying employers for participation as well. Although enrollment in premium assistance did grow at an average rate that was greater than that of the MCHP Premium Medicaid look-alike program, enrollment was so low that it would have had to grow at an exponential rate to reach even a third as many enrollees as the look-alike program. Low enrollment combined with the high administrative costs associated with the program precluded any foreseeable chance of attaining cost-effectiveness. This was further confirmed by the finding that the medical component of the costs associated with the program outstripped the medical costs of the



look-alike program. This means that even if premium assistance had had no administrative costs, it would still have cost the state more to enroll a child in premium assistance than in the Medicaid look-alike program. This also means that any increased enrollment in premium assistance would have only increased the financial loss to the state. At the time of this study, the state could have enrolled three children in the Medicaid look-alike program for the cost of enrolling one child in the premium assistance program.

#### **Section IV: Maryland in Context – A Cross-State Comparison**

In an effort to evaluate the implementation of Maryland's premium assistance program, this section analyzes the experience that other states have had with regard to expanding health insurance coverage through the use of SCHIP-related premium assistance programs. The findings of a cross-state study of seven states (including Maryland), offering premium assistance is presented, followed by a summary of state program descriptions. The states used in this study were selected after a review of the State Plan Amendments<sup>9</sup> of all 50 states and the District of Columbia. Upon review, seven states (excluding Maryland) were determined to have premium assistance SCHIP-related programs. The states were: Massachusetts, Mississippi, New Jersey, Rhode Island, Virginia, Wisconsin, and Wyoming. One additional state, Illinois, was operating a state-only premium assistance program that was indirectly tied to the state's SCHIP. Illinois was therefore added to the roster of study states. During the course of preliminary interviews with relevant state representatives it was discovered that two of the eight states, Mississippi and Wyoming, had never implemented their respective premium assistance programs. Both states cited affordability as the primary cause for not implementing their programs.

Of the six remaining states, all had implemented their premium assistance programs and agreed to participate in this study. Although the preliminary identification the states used in this study was obtained via the publicly available State Plan Amendments contained on

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<sup>9</sup> As cataloged by the Center for Medicare and Medicaid Services. Available at: <http://www.cms.hhs.gov/schip/chpa-map.asp>

the Center for Medicare and Medicaid Services (CMS) web site, the majority of the findings presented were culled from direct interviews with relevant officials from the state agencies administering the premium assistance programs.

*Illinois* – Illinois’ premium assistance program, known as KidCare Rebate, began accepting applications on August 1, 1998 and started offering coverage on October 1 of that year. KidCare Rebate is a state-only program that is available to children with family income between 133 and 185 percent of FPL. Although, the state imposes no co-pays or premiums on those enrolled in KidCare Rebate, enrollees are responsible for such payments if they are required by the private health coverage that the state is subsidizing. Federal SCHIP regulations stipulate that subsidized private coverage must meet certain benchmark requirements and that employers must contribute a certain percentage of the cost of insurance, but Illinois’ program is not part of their Title XXI program and therefore not beholden to those restrictions<sup>10</sup>. Illinois imposes no restriction on the amount that an employer contributes toward the cost of an employee’s health insurance. With regard to the coverage offered, the state requires only that the policy cover both hospital inpatient and physician services.

Illinois had enrolled 1,237 children in the KidCare Rebate program by the end of its first year. Although some states produced estimates of intended first-year enrollment, so as to track implementation success, Illinois indicated that they produced no such estimates. As of August 2002, program enrollment had grown to approximately to 5,600. With regard to crowd-out, the state feels that subsidizing employer-sponsored or private insurance encourages families to retain their private insurance thus serving as an anti-crowd out strategy. Although the state imposes a three-month waiting period for enrollment in traditional SCHIP, the restriction is not placed on those wishing to enroll in KidCare Rebate.

The state has not made any major revisions to the program since implementing it in 1998, however, application and rebate forms were modified in an effort to obtain more accurate

information and to simplify the application process. The state reports that it does not out-source any aspects of program administration, such as billing and enrollment. Illinois indicated that they have conducted no evaluations of the premium assistance program.

*Massachusetts* – Massachusetts' premium assistance program has been in place longer than any other program covered in this study. Implemented in August 1998, Massachusetts includes both a subsidy of premiums for consumers (Family Assistance Premium) and a direct subsidy to qualifying small employers (Insurance Partnership<sup>11</sup>) as a part of their program. Massachusetts employs parallel premium assistance programs with one using federal Medicaid funds and the other relying on SCHIP funds. The Medicaid funds are used to subsidize coverage for currently insured families, whereas the SCHIP funds are solely for uninsured families.<sup>12</sup> Family Assistance Premium provides coverage for children with family incomes between 150 and 200 percent FPL. Qualified adults working for small employers<sup>13</sup> and with income at or below 200 percent FPL became eligible in 1999. In order for employer sponsored insurance to qualify, the employer must contribute at least 50 percent of the cost of the coverage and that coverage must meet the benchmark which is based on the coverage offered by the largest non-Medicaid HMO in the state. Families with incomes between 150 and 200 percent FPL are assessed monthly premiums of \$10 per child, with a maximum of \$30 per family.

The Insurance Partnership program aims to make health insurance more affordable for qualified small businesses and their employees by subsidizing the employer's share of insurance coverage. Under the Insurance Partnership, small businesses that provide health insurance to their qualified employees can have part of their costs, up to \$1000 a year for each qualified employee, paid for by the state. As of May 2002, the state estimated that 3,600 small employers (including the self employed) were participating in the Insurance Partnership.

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<sup>10</sup> On September 12, 2002 Illinois' was granted a waiver allowing the state to receive a federal match for its Premium Assistance program. The state was permitted to maintain its existing program rules.

<sup>11</sup> The Insurance Partnership was implemented in September 1999, after initial enrollment failed to meet expectations.

<sup>12</sup> Karl Polzer, "Using SCHIP to Subsidize Employment-Based Coverage: How Far Can This Strategy Go?" National Health Policy Forum, Washington, D.C., June 2000.

As of June 2002, 12,288 enrollees were receiving premium assistance, 5,861 adults and 6,427 children. Although state enrollment is considerably higher than that of the other states included in this study, the state had anticipated enrollment in excess of 100,000 by the third year of the program. A recently conducted study also determined that over one-third of the program's enrollees already had insurance<sup>14</sup>.

The state indicated that a third-party contractor handles administrative work related to their program. Out-sourced tasks include billing, correspondence, qualifying employers for program participation and outreach to potential participants (enrollees and employers.)

*New Jersey* – Implemented in July 2001 and operated under a CMS approved 1115 waiver, New Jersey's FamilyCare/Premium Support program covered parents/adults & pregnant women from 134 to 200 percent FPL and children up to 350 percent FPL. Enrollment in the Premium Support program is limited to those individuals already qualified for and enrolled in New Jersey FamilyCare with access to employer sponsored insurance. Those deemed to have access to a qualified plan are required to enroll in the Premium Support program, provided that their enrollment would be cost effective and the employer contributes at least 50 percent of the cost of coverage. The state is currently pursuing a waiver from the 50 percent match requirement. The Coverage benchmark requirement is based upon the FamilyCare CHIP HMO plan, but wrap around services are offered from the state. For families with income above 150 percent FPL, premiums are set at \$25 for the first adult and \$10 for each additional member of the family.

Prior to implementation the state had estimated that first year enrollment would reach 8,000 individuals. Enrollment as of as of July 2002, stood at 389, 159 adults and 230 children. The state estimates that approximately 120 employers are participating in the program. Effective June 15, 2002 the state suspended new enrollment of most adults in

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<sup>13</sup> Massachusetts defines small employers as those with no more than 50 full-time equivalent employees.

<sup>14</sup> *Premium Assistance Programs: What are they and could they help Connecticut Families without Health Insurance?* The Connecticut Health Policy Project . New Haven CT, January 2002

the health insurance program and altered the benefits packages for many of the adults who remained. Although enrollment in Premium Support has not met expectations, adult enrollment in the traditional Family Care program has far exceeded expectations. The state made the change in the face of budget constraints in order to preserve the program for its originally intended population – children. Parents of Premium Support children will still receive subsidized coverage via their child’s policy, but they will no longer receive wrap around services or cost-sharing/co-pay exemptions.

Premium Support reimbursement checks are mailed directly to policyholders from the state treasury. An amount equivalent to the premiums paid (to the state) for enrollment in Premium Support are deducted from the reimbursement checks prior to their sending. The state indicated that implementation of the program was free of major difficulties, although time demands placed on staff have been significant.

*Rhode Island* – Implemented in February 2001, the RIte Share premium assistance program applies to families with children (up to 185 percent FPL), children (up to age 19 and 185 to 250 percent FPL) and pregnant women (185 to 250 percent FPL). If qualifying ESI coverage is available, either at the time of application or during eligibility re-determination, enrollees are required to enroll in the ESI plan. In certain circumstances, the state also pays a portion of the costs for covering family members who are otherwise ineligible for Medical Assistance. The state subsidizes coverage of otherwise ineligible family members when enrollment of the eligible family member is contingent upon enrollment of an ineligible policy holder; and when the average cost for covering the otherwise ineligible family member(s) is less expensive than the cost of enrolling the eligible member in the traditional RIte Care program. Ineligible family members are not provided wraparound services and are responsible for cost sharing. Families with incomes between 150 and 250 percent FPL pay a monthly premium of \$61, \$77 or \$92 per month, depending on their income.

The state does not impose an employer match requirements and determines cost effectiveness on an aggregate, not case by case, basis. Although ESI plans must meet minimum benefit requirements, the state offers wrap around services for RIte Share

enrollees. With an eye toward crowd-out, the state requires new enrollees to wait six months to enroll when (1) the employee's share of the premium is less than 50 percent of the total cost of coverage and the employee has participated in any health coverage for the last six months, or (2) the applicant has lost coverage in the past six months as a result of an employer who dropped coverage specifically for a class of employees who would qualify for RIte Share.

As of August 2002, the state had 2,400 enrollees and 130 participating employers. Although the state covers parents and children they do not currently track enrollment at that level.

Initially Rhode Island reimbursed employers, not employees, for the employee's share of health insurance cost. As of November 2001, the state began reimbursing employees as this was viewed as a more viable option. It was felt that paying employers presented a barrier to employees if the employer refused to participate.

*Virginia* – Implemented in August 2001, Virginia subsidizes employer sponsored health insurance (ESHI) through the state's Family Access to Medical Insurance Security (FAMIS) program for children in families with income below 200 percent of FPL. To qualify for the ESHI program, children must be enrolled in the FAMIS program and the children must also be eligible for health insurance coverage through their parent's, stepparent's, or guardian's employer. If a child has access to group health insurance and qualifies for the ESHI program, the policy holder is reimbursed for part of the cost related to covering the child. Families must apply for the full premium contribution offered by the employer, but enrollment in the ESHI program is optional. Families that do not wish to participate in the premium assistance program are permitted to enroll in the traditional FAMIS program.

Participating employers must contribute a minimum of 40 percent of the cost of family coverage; the coverage must be cost-effective and meet the benchmark standards. Similar to other states, potential enrollees must have been without health insurance for six months

prior to enrolling in the program. Although the state does not specifically cover parents, some incidental coverage may result from the subsidy provided to cover children. As of June 2002 the state had 66 ESHI enrollees and 24 participating employers.

Although the state initially imposed premiums on program participants, the premiums were suspended in April 2002 as they were viewed as an impediment to enrollment. Beyond being viewed as an impediment, a May 2002 report by the Virginia Department of Medical Assistance Services estimated that the administrative costs borne by the state for collecting premiums exceeded the amount of premiums collected. The report determined that it costs the state \$1.39 for every premium dollar collected.<sup>15</sup>

The state indicates that it does not out-source the bulk of the administrative tasks associated with the ESHI program. A third-party contractor is retained, however, to handle referrals for possible program participation. The state also indicated that developing an efficient system to reimburse recipients for co-pays and premiums continues to be a challenge.

*Wisconsin* – Wisconsin's BadgerCare includes both the traditional Medicaid/SCHIP program as well as a premium assistance program, which was implemented in October 1999. The BadgerCare premium assistance program covers children and parents up to 185 percent FPL and eligibility is retained up to 200 percent FPL. Enrollees with family incomes above 150 percent FPL are required to pay premiums not to exceed 3 percent of income each month (approximately \$60 per month for a family of three at 185 percent FPL). Wisconsin was granted a waiver by CMS to use Title XXI funds to cover parents if it is cost-effective – that is, the cost of covering both the children and the parents does not exceed the cost of covering just the children in the public program. If cost-effectiveness is proven, the state receives the enhanced FMAP for the whole family. If Title XXI cost-effectiveness is not met, the state then tests for Title XIX cost-effectiveness and potential enrollment in the state's Medicaid Health Insurance Premium Payment Program (HIPP), which receives a lower federal match. Wisconsin has an employer match requirement of

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<sup>15</sup> This applied to all premium paying enrollees, not solely those in the ESHI program.

40-79 percent. If an employer contributes less than 40 percent or more than 79 percent of the costs of the insurance, then the plan would not be eligible for BadgerCare. The plan benchmark is based on state Medicaid, but wrap-around services are available. The costs of any wrap-around benefits are calculated into the cost-effectiveness test.

The premium assistance program had enrolled 5 families for a total of 20 people one year after implementation. As of July 2002, enrollment had reached 217 (53 families, 82 adults, and 135 children) and 35 participating employers. Reasons given for the low enrollment include low employer response rate to the questionnaire, frequent job transitions common for low-wage workers, employer contributions are too low, employer packages that do not meet minimal standards, and subsidies were not cost-effective to the state.

The state has found that very few families meet the cost-effectiveness criteria of either program. The state also determined that 90 percent of BadgerCare enrollees have incomes below 150 percent FPL and few have access to employer-sponsored insurance.<sup>16</sup> Individuals with access to qualifying employer-sponsored insurance are required to enroll or lose BadgerCare eligibility. Potential enrollees are also required to have been without health insurance for a period of three months prior to enrolling.

### **Summary of Findings**

State approaches to premium assistance vary widely. This variety is very much a reflection of the dynamic nature of the SCHIP premium assistance initiative. Many states designed programs based on original federal requirements, while others submitted waiver requests to allow them greater flexibility. CMS issued changes to the original federal requirements, largely in an effort to boost program participation, and several states responded with more program revision. As a result of these changes, and in the absence of existing program models, there is little uniformity of program design. Employer match requirements range from zero to 50 percent, plan benchmarks are considerably different,

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<sup>16</sup> Alberga J, "Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage," State of the States Report, State Coverage Initiatives, Robert Wood Johnson Foundation, January 2001



income eligibility differs greatly and whereas some states cover children only, others offer subsidies to parents and adults. Yet with all of this variety, there is little evidence that any one combination of program requirements has proven more beneficial.

Illinois has by far the most relaxed requirements of any premium assistance program, but as a state-only program, it has not had to comply with the federal requirements detailed in the first section of this paper. Illinois has had considerable success enrolling children into their premium assistance program, but given the unique nature of its program, comparisons to other states may be inappropriate. The state's recent receipt of a CMS waiver to receive federal match dollars for its program suggests that other states may be able to emulate its structure. Doing so would require considerable legislative and structural changes to existing state programs and raise questions of program cost-effectiveness and enrollee equity. States would need to consider whether or not it would be prudent or appropriate to subsidize private insurance that is not comparable to the level of coverage offered to enrollees in the traditional state program. Compensating for coverage inequities could result in states offering wrap-around benefits, benefits that would vary according to each enrollee's private plan and add new factors to any cost-effectiveness calculations.

Massachusetts has also enrolled considerably more individuals than other states in this study, but the subsidies paid to small employers and the parallel premium assistance programs using federal Medicaid funds and SCHIP funds minimizes the utility of comparing it to other states. Efforts to replicate the Massachusetts model would also require significant changes and efforts to subsidize employer costs would necessitate a considerable investment of state dollars without federal match. The enrollment figures from Illinois and Massachusetts would suggest that program participation can be enhanced if a state operates a program unfettered by federal requirements or if a state is willing to provide financial subsidies.

The remaining states are more comparable in terms of program age and rules and demonstrate the challenges facing premium assistance initiatives. None of the states that

produced first-year enrollment estimates met those goals. Maryland expected to enroll 5,500 children in their premium assistance program, but had enrolled only 118 at the end of its first year. New Jersey had estimated first-year enrollment of 8,000, but enrolled only 389. Virginia anticipated first-year enrollment of 3,000, but was on track to enroll fewer than 100. First-year estimates were not available from Rhode Island and Wisconsin, but their enrollment was not notably different from the other states. After one year, Rhode Island had enrolled 350 and Wisconsin had enrolled 19.

The review of premium assistance programs suggests that there are no “key ingredients” that would serve to accelerate program enrollment. Although Massachusetts has comparatively higher enrollment, the state experienced only moderate enrollment growth prior to subsidizing small employers and approximately one-third of their enrollees are estimated to have already had private coverage. There has been considerable debate as to whether covering parents/adults would lead to greater enrollment, but Illinois has covered nearly 6,000 children since 1998 without covering parents. Conversely, Wisconsin has enrolled only 217 individuals after four years, and the state does extend coverage to parents. There is no evidence that differing income eligibility requirements have a discernable impact on enrollment success. Although Maryland and New Jersey have comparatively generous income limits (up to 300 percent FPL in Maryland and up to 350 percent FPL in New Jersey), their enrollment experience differs little from either Virginia (up to 200 percent FPL) or Wisconsin (up to 185 percent FPL).

The impact of premium levels on program enrollment appears to be negligible when comparing states. Although the two states with the greatest enrollment - Illinois<sup>17</sup> and Massachusetts - have the lowest premiums, enrollment in these states seems tied more to other program rules. New Jersey and Virginia<sup>18</sup> assess premiums on a per enrollee basis and Maryland and Rhode Island have set premiums that do not vary by the number of enrollees per family. Wisconsin has a sliding scale premium level that is set at 3 percent of family income. Given that these states have varying income eligibility rules, and that

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<sup>17</sup> Illinois does not impose a premium on KidCare Rebate enrollees, they are instead responsible for premiums set by their individual policies above what the state subsidizes.

<sup>18</sup> Virginia suspended all premiums in April 2002.

some states assess per enrollee premiums, the average dollar value of their premiums is difficult to estimate and compare. It would appear, however, that Rhode Island and Maryland have the highest premium levels. Although their premium levels are not enrollee dependent, most of the states with enrollee dependent premiums have maximum per family caps that are equivalent to or lower than the Maryland and Rhode Island levels. This does not appear to have greatly affected enrollment since Rhode Island has enrolled far more individuals than states with lower premiums and Maryland's enrollment is comparable to lower premium states.

As would be expected, the states with highest enrollment have the highest number of participating employers. Massachusetts has 3,600 small employers participating via the Insurance Partnership (this includes the self-employed) and 1,000 large employers. Maryland has qualified over 230 employers, though currently not all are participating. As of July 2002, both New Jersey and Rhode Island reported having 120 participating employers and Wisconsin indicated that the state had 35. Many of the states retain third party contractors to handle the responsibility of finding and qualifying employers, but indicate that qualifying employers has been a difficult task. Most have responded to this by minimizing the administrative burden placed on employers and by working more directly with employees. Rhode Island established a Business Advisory Committee, comprised of 12 people representing diverse areas within the business sector. The committee assists the state to maximize participation in Rite Share by addressing such issues as ensuring administrative simplicity for employers and employees, ensuring compatibility with the existing employer health insurance programs, and developing strategies for employer and employee education about the program. With the exception of the Massachusetts Insurance Partnership, which subsidizes small employer insurance costs, no state offers any financial incentives to employers in order to boost participation.

## **Section V: Conclusion**

Premium assistance programs present great promises: extending health insurance coverage to lower income individuals, expanding private insurance coverage, and providing cost savings to states. The findings contained in this report, however, indicate

that these promises are yet to be realized. In Maryland as well as many other states, enrollment has failed to meet expectations, and any potential savings resulting from premium assistance programs would require considerably higher enrollment just to offset the costs associated with administering the programs. Findings from Maryland suggest that even with higher enrollment, cost savings may be unattainable. Although difficult to quantify, many of the administrative cost associated with premium assistance programs are clearly separate from the costs of operating traditional state programs. The time demands placed on state staff to manage these programs, contracting with third-parties to handle specific aspects of premium assistance, coordinating wrap-around benefits and developing systems to handle aspects such as mailing premium reimbursement checks to enrollees represent unique costs specific to premium assistance initiatives. Any true measure of cost-effectiveness would require an accurate accounting of these costs.

States have encountered reluctance not only from employers wishing to avoid participation in public programs, but also from employees not wishing to approach their employers about program participation. Those states that enroll the uninsured directly into premium assistance have experienced difficulty in outreach to potential enrollees and those states that cull premium assistance enrollees from the state's traditional SCHIP or Medical Assistance programs have encountered enrollee resistance to swap the public for the private program.

Those states with the greatest enrollment success have met that success through measures that question the value of premium assistance. Offering coverage to the currently insured does not address the issue of uninsurance and eliminating or reducing benchmark requirements decreases the value of the insurance that is extended to the previously uninsured. Subsidizing private coverage that does not meet the standards afforded to traditional program enrollees may be cost-effective, but would such inequitable care represent an appropriate use of public funds? Addressing equity concerns by offering wrap-around services would not only limit cost-effectiveness but also the need for state funded wrap-around services would question the very value of subsidizing private insurance.

States also surrender a certain level of quality control when entering into public/private partnerships. In Maryland, for example, the state has access to all utilization data for enrollees in the traditional state program. This data is used to assess access to and quality of care for enrollees. This data is not available for enrollees in the premium assistance program since they are enrolled in a private insurance plan. The state is therefore more limited in its ability to assure that premium assistance enrollees enjoy the same level of care as traditional plan enrollees.

The findings of this study are consistent with those of a recently released report by the Urban Institute. In that study, *Premium Assistance Programs under SCHIP: Not for the Faint of Heart*, the Urban Institute examined the premium assistance programs in Massachusetts, Mississippi<sup>19</sup> and Wisconsin. After reviewing state and federal requirements and interviewing key state personnel the report concluded that:

“... the administrative complexity associated with premium assistance and small overall effect witnessed in Massachusetts and Wisconsin, it seems reasonable for states to question whether this is an efficient strategy for reducing rates of uninsurance among low-income children.”<sup>20</sup>

As the contrary pressures of expanding coverage and decreasing funds continue to rise, policy makers will undoubtedly wish to explore program alternatives such as premium assistance initiatives. States considering such programs may wish to consider whether limited funds might be better invested in enhancing traditional state programs, and those states currently operating premium assistance programs may need to assess whether those programs have lived up to their cost savings and enrollment expectations. Premium assistance programs have thus far failed to meet these expectations.

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<sup>19</sup> At the time of the study, Mississippi had not yet implemented a premium assistance program.

<sup>20</sup> Lutzky, Amy Westpfahl & Ian Hill. *Premium Assistance Programs under SCHIP: Not for the Faint of Heart?* The Urban Institute. 2003