

**Premium Assistance Programs: Do They Work for
Low-Income Families?**

**Testimony Submitted to the
House Education and Labor Committee**

By

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Chairman Andrews, Representative Kline and Members of the Committee:

Thank you for the invitation to testify at this morning's hearing on integrating employer-sponsored coverage with the State Children's Health Insurance Program (SCHIP) and Medicaid. My name is Joan Alker, and I am the Deputy Executive Director of the Center for Children and Families, a research and policy center at Georgetown University's Health Policy Institute. I am also a Senior Researcher at the Health Policy Institute. Much of my recent work has focused on the intersection of public and private coverage --- including two reports on premium assistance and public coverage that I authored for the Kaiser Commission on Medicaid and the Uninsured. I would like to share some lessons learned from states' experience with premium assistance programs and the best way to integrate public and private coverage for low-income families.

As you know, this year Congress will be reauthorizing the State Children's Health Insurance Program -- known as SCHIP. Created in 1997, SCHIP, along with its larger companion program Medicaid, has succeeded in lowering the rate of uninsurance among low-income children by one-third between 1997 and 2005. In 2005, more than one in four children received their health insurance through Medicaid and SCHIP -- the vast majority through the Medicaid program. Because Medicaid is by far the larger program, it is important in any discussion of improving coverage for low-income families to consider both Medicaid and SCHIP. In both programs, the majority of children live in families with at least one employed parent.

For children in low-income families (defined as those with incomes below twice the poverty level, or \$41,300 for a family of four in 2007) these public programs are the largest single source of health coverage -- covering half of all children (See Figure 1). Unfortunately public coverage for parents is typically far less generous, -- the median income level at which a working parent is eligible for Medicaid is 65% FPL (\$13,423 for a family of four in 2007), although some states like New Jersey cover parents at higher income levels. Rates of uninsurance for adults are higher than for children as a result of this less generous public coverage.

As the expansion of public programs for children, and in some cases parents, has occurred, the question of integration with employer-sponsored coverage has arisen. States, especially during challenging budget times, have explored ways to capture employers' contributions as a source of financing for eligible families. This legitimate desire to reduce public costs has been one of the primary motivations to establish premium assistance programs. Other arguments for premium assistance have been offered as well including the need to support the employer-based system of insurance and prevent the substitution of public coverage for private coverage (or "crowd-out"); the ability to cover all family members in the same health care plan; and the possibility of providing families with better access to providers .

Premium assistance programs use Medicaid and SCHIP dollars to subsidize the purchase of private coverage – typically, but not exclusively, employer-based coverage. Premium assistance is an idea that preceded the SCHIP program. Section 1906 of the Medicaid statute permits states to pay premiums for group health plans on behalf of both Medicaid eligible beneficiaries *and other family members* if it is cost-effective to do so. A few states such as Iowa and Pennsylvania have pursued this option aggressively. Under the Medicaid statute, the state must provide a "benefits wraparound" to ensure that families do not lose access to any needed benefits that are otherwise available through Medicaid or incur higher cost-sharing as a result of enrolling in private coverage. For example, an employer's coverage may not offer pediatric dental benefits. Other states, including Florida, Illinois, New Jersey, Oregon, Rhode Island and Utah have implemented premium assistance programs for their Medicaid and SCHIP populations through Section 1115 Medicaid and/or SCHIP waivers – in some cases in conjunction with managed care initiatives and other changes. Some of these states have sought and received a waiver of the benefits wraparound required by Medicaid and SCHIP.

What have we learned from state experience so far? With some exceptions, premium assistance programs have not been terribly successful in terms of enrollment. In New Jersey, for example, which runs an exemplary premium assistance program in many ways, enrollment has hovered around 700-800 family members. While there are certain

logistical challenges that states face, the primary reason for low enrollment is simply that employer-sponsored coverage is not widely available for low-income families. As shown in Figure 2, only 14-15 percent of low-income working families have an offer of employer-sponsored insurance that they are not picking up.

When private insurance is available it is often very expensive. Public coverage tends to be less expensive than private insurance for a number of reasons including economies of scale, lower administrative costs and lower reimbursement rates for providers.¹ In 2004, the average cost of covering a family of four through Medicaid nationwide was \$7,418 whereas the cost of the average employer-sponsored insurance package for a family of four was \$9,950 – 34% higher (see Figure 3).² This annual cost of almost \$10,000 for private coverage does not include significant additional costs families will incur – such as copayments, deductibles and other coinsurance. Similarly, a recent study conducted by the Urban Institute for the state of Illinois found that predicted medical spending would be 31% higher if children were covered by private insurance as opposed to covering them through Medicaid/SCHIP.³

As premium assistance programs continue to hold a lot of attraction, there are two principles that I believe should be given primary consideration when constructing premium assistance approaches. First, participating families should not receive fewer benefits or face higher cost-sharing than they would in the public program for which they are eligible (i.e. Medicaid or SCHIP). In particular, cost-sharing for private policies can be very high and may inhibit access to needed services for low-income families. A recent study found that the average family premium for employer-sponsored insurance in 2006 was \$2,973.⁴ For a family of four at 150% of the poverty level (\$30,000 for a family of four in 2006), this premium constitutes 9.9% of their income. In addition, these families face coinsurance, deductibles and other fees. Premium assistance programs generally

¹ If provider reimbursement rates are too low, this may create access problems for beneficiaries.

² Georgetown Center for Children and Families analysis based on Kaiser/HRET 2004 survey and Medicaid MSIS data for 2004.

³ Hadley, J. and Cravens, M. *The Cost of Using Private Insurance to Cover Uninsured Children in Illinois*. Urban Institute, October 20, 2005.

⁴ Kaiser/HRET, *Survey of Employer Health Benefits 2006* (September 26, 2006).

offer help with premium costs; but some states do not provide the “wraparound” protection mentioned above, and participants must pay all applicable copays, deductibles and coinsurance. A recent study found that out-of-pocket costs in employer-sponsored plans are, on average, almost as high as a family’s premium costs.⁵

The second important principle is that public subsidization of private coverage should occur only when it is a cost-effective use of public funds. This is critically important because private insurance is generally more expensive than public coverage, and costs have been rising at a faster rate in the private sector. It is not prudent for state and federal funds to be invested in an expensive product (considering the benefits provided and the cost-sharing imposed) that costs the public program more, even with an employer contribution.

Premium assistance programs that take advantage of a robust employer contribution and operate in states that offer public coverage to the whole family (including parents) are most likely to save money. Because few employers offer child-only insurance products, a state is far more likely to meet the cost-effectiveness test for public dollars if it is offering coverage to the whole family in its Medicaid or SCHIP program and can count the cost of covering the parent in the equation.⁶ Strong participation rates are also essential, as programs with low enrollment are often not able to overcome the high administrative start-up costs to recoup any savings. If all of these factors are not taken into consideration, taxpayer dollars may be wasted by spending the same amount, or in some cases even more money, and buying fewer services for families.

Few data are available to assess whether states are saving money through their premium assistance programs. In an effort to promote the use of private insurance, the Bush Administration’s Section 1115 Health Insurance and Flexibility and Accountability Waiver Initiative (known as “HIFA) actually weakened federal cost-effectiveness requirements for the use of Medicaid and SCHIP dollars through waivers, and there has

⁵ Survey of employer health benefits by Hewitt Associates, LLC (October 9, 2006).

⁶ This is one reason that it has been very difficult for states to meet SCHIP’s cost-effectiveness test, because it only includes the cost of covering children.

been little federal oversight in this regard. The states with proven savings are states such as Rhode Island and New Jersey.⁷ These states design their program in the most optimal way by providing wraparound coverage to families *and* doing a case-by-case assessment to ensure that state and federal governments are saving money.

What should Congress do? As Congress considers SCHIP reauthorization, federal policy should encourage and facilitate the ability of states to follow the example of states like New Jersey and Rhode Island. Some states have reported that it can be difficult to obtain information from employers on their benefits packages in order to assess what “wraparound” services are needed and whether it is cost-effective to subsidize that employer’s coverage. A change to the ERISA statute such as the one Rep. Andrews is proposing which allows states to require this information from “ERISA” employers will make this easier. Another difficulty that states face in implementing premium assistance programs is that a family that becomes eligible for a premium subsidy under a Medicaid or SCHIP program may have to wait for the employer’s plan to have its open enrollment period. A policy change that establishes Medicaid/SCHIP eligibility as a “qualifying event” similar to other events such as births, adoptions, etc. for the purposes of triggering eligibility for subsidized employer coverage will facilitate expedited enrollment.

And finally another related ERISA change which Congress should consider to enhance the coordination of public and private coverage, would be to define the loss of Medicaid/SCHIP eligibility as a qualifying event for purposes of eligibility for employer-sponsored coverage. This could help to prevent periods of uninsurance for children (and in some cases parents) when a parent receives a raise and the child becomes ineligible for public coverage, for example, in April, but the family has to wait for the annual open enrollment period in October and the child is uninsured in the interim.

Even with improvements, premium assistance is not a panacea. Even if these changes are made, state and federal policymakers should have realistic expectations for premium assistance programs, particularly as the cost of private insurance continues to increase.

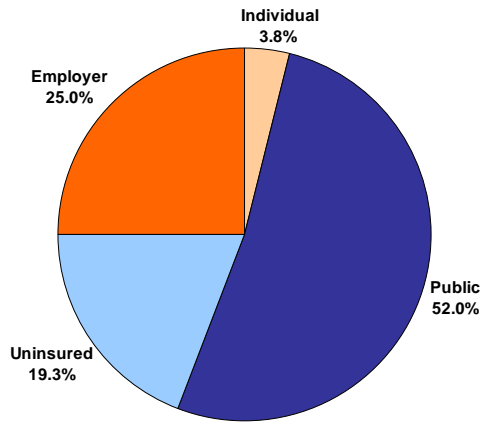
⁷ Rhode Island has been more successful than New Jersey with enrollment.

Because employer-sponsored insurance is simply not widely available to low-wage workers, traditional premium assistance programs will not address the causes of uninsurance for these workers. Premium assistance can be a useful tool in some but not all circumstances; it is not a substitute for direct coverage through Medicaid and SCHIP.

In the absence of a broader public program expansion (or in the case of Maine as part of a broader effort), a few states such as Maine, New Mexico and Oklahoma have tried a different approach – offering a public product to small businesses and individuals who are unable to otherwise afford the growing cost of purchasing insurance in the private market. These programs are relatively new so it is hard to assess their ultimate success. It is often difficult to induce employers to participate. In addition, a number of other states offer the opportunity to “buy-in” to SCHIP for children whose family income exceeds eligibility thresholds. These programs have had mixed success with enrollment, but this coverage is a welcome resource for some families who are unable to afford coverage in the private market. Participation rates for both approaches will improve to the degree that government subsidies are available to reduce the costs of participation to employers and families. There is little doubt that public coverage is less expensive than private coverage, so creating these kinds of opportunities for families and employers to purchase public coverage is an intriguing new direction and one that should certainly be explored.

In conclusion, it is important to remember that covering children and their families is an important public policy objective, and one that enjoys widespread public support. We look forward to working with members of the committee on this effort.

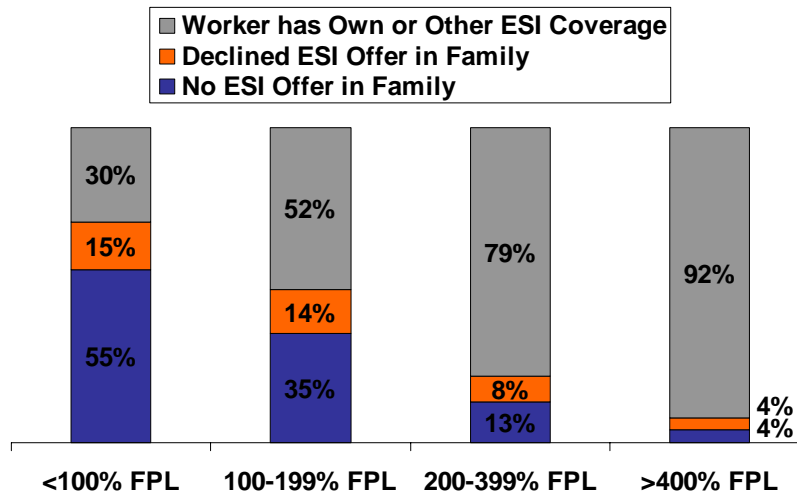
Figure 1
Low-Income Children's Sources of Health Care Coverage, 2004-2005



33.3 million low-income children under 19

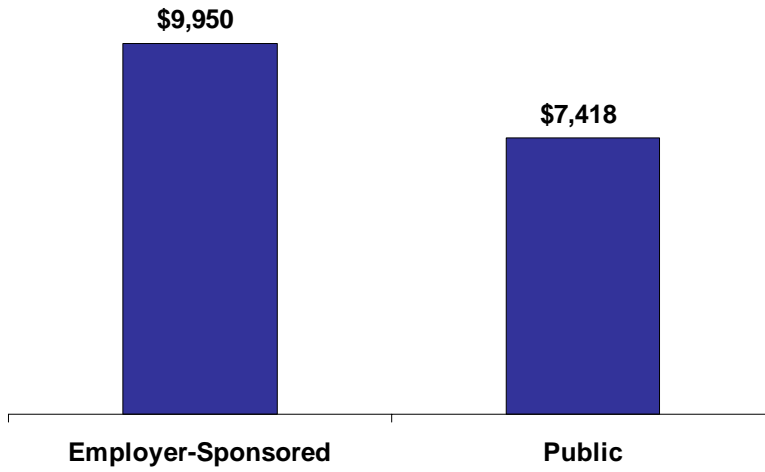
Source: K. Schwartz, C. Hoffman, & A. Cook, *Health Insurance Coverage of America's Children*, Kaiser Commission on Medicaid and the Uninsured (January 2007).

Figure 2
Offers of Coverage by Income, 2005



Note: Percentages may not total 100% due to rounding.
 Sources: L. Clemans-Cope and B. Garret, *Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005*, Kaiser Commission on Medicaid and the Uninsured (December 2006).

Figure 3
**The Cost of Covering Families Through
Employer Coverage vs. Medicaid, 2004**



Note: Average cost of coverage for a family of four. These costs do not include family deductibles, co-payments, or coinsurance, which tend to be much higher in employer-sponsored coverage
Sources: Kaiser/HRET, *Survey of Employer Health Benefits, 2004*; and Georgetown Center for Children and Families/Center on Budget and Policy Priorities analysis of 2004 Medicaid Statistical Information System (MSIS) data.