

Supporting Private Insurance Through Premium Assistance

Introduction

Premium assistance is a health insurance purchasing strategy in which a state uses public funds to subsidize the purchase of private health insurance coverage. Typically states use premium assistance programs to directly subsidize an individual's employer-sponsored insurance (ESI) premium.

Premium assistance programs offer states the potential to reduce the number of uninsured, strengthen the system of ESI, and reduce federal and state expenditures for public insurance.

Background

Premium assistance has been available under Medicaid and State Children's Health Insurance Programs (SCHIP) but has had limited success because of regulations governing the programs. The federal government requires that Medicaid and SCHIP funds used for premium assistance satisfy two coverage criteria: (1) be cost-effective (aggregate costs of coverage provided through premium assistance must not be "significantly higher" than in the public program) and (2) be comparable to the coverage provided by Medicaid.

In 2001, the federal government addressed the limited success of premium assistance programs by allowing states to apply for a Health Insurance Flexibility and Accountability Act (HIFA) waiver, a new type of Section 1115 waiver,^{*} to adapt their existing Medicaid programs. HIFA waivers loosened certain requirements for premium assistance programs. They allow states to enroll beneficiaries in programs without providing coverage comparable to Medicaid and/or to increase the amount of cost-sharing (deductibles, co-payments, and coinsurance) for which enrollees would be responsible. The waivers also offered a streamlined application process and an expedited waiver review process by federal officials, which states had requested for many years. The HIFA waivers initiative encourages states to maximize the use of ESI as a way to leverage private health care dollars to increase the number of individuals and families taking up private insurance.

Within the past four years, nearly half of the states have gained federal approval to significantly

modify their Medicaid programs. As of late 2005, 11 states had secured HIFA waivers and another three had HIFA proposals under review at the Centers for Medicare and Medicaid Services (CMS). Furthermore, several additional states are developing waiver proposals (HIFA as well as general Section 1115 waiver proposals) that include some form of premium assistance program. There is extensive variation in the extent to which the waivers have been used. At one end of the spectrum, Arizona, California, and Colorado were reluctant to implement a program altogether; and other states, Maine, New Jersey, and Michigan, have not heavily promoted them. In sharp contrast, Idaho, Illinois, New Mexico, Utah, and Oregon made premium assistance centerpieces of their Medicaid modifications.

Advantages to Premium Assistance Programs

Premium assistance programs are still very much in their infancy, and their role as a cost-effective strategy to provide coverage to the low-income population remains in question. Even so, there are many reasons why states would gravitate to them, including:

- decreasing the cost of providing public insurance by making it affordable for current Medicaid or SCHIP enrollees to take-up the offer of private insurance;
- creating incentives for employers to offer, or continue offering, insurance to their employees; and
- improving access to health care providers by mainstreaming Medicaid and SCHIP enrollees into private insurance.

Disadvantages to Premium Assistance Programs

At the same time, there are several practical constraints in instituting a premium assistance program. These include:

- Only a limited number of Medicaid and SCHIP enrollees have access to ESI. Those firms least likely to offer coverage are those with low-wage workers.
- Unless income eligibility levels as a percentage of FPL are set fairly high, only a small portion of workers would likely qualify for a premium assistance program.
- If eligibility levels are set too high, some employers or workers may change current coverage to take advantage of the subsidy.
- Even for those who do take up insurance through a premium assistance program, coverage with steep cost-sharing or limited benefits may place enrollees at risk of catastrophic costs or lead to under-use of health care services.
- Over time, the public costs of supporting an effective premium assistance program will increase in response to the rising cost of private insurance premiums.

State-subsidized Programs

Freedom from federal programmatic requirements has made state-subsidized premium assistance programs an appealing alternative for many state policymakers. State-subsidized programs depart

from the Medicaid model by offering coverage to a wide range of populations, limiting enrollment, and requiring enrollee cost-sharing. Some states have used Section 1115 waivers to obtain Medicaid federal matching funds for their programs. A few states have integrated Medicaid and state-subsidized programs into a single program. Other states have kept their state-subsidized programs separate from Medicaid. The two biggest challenges to state-subsidized programs are funding and enrollment. Oklahoma and Kentucky operate state-subsidized premium assistance programs that illustrate alternative approaches to these challenges.

The Oklahoma Approach. The Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC), targets workers at firms with 50 or fewer workers with incomes at or below 185 percent (or \$37,000 for a family of four) of federal poverty level (FPL). To qualify, an employer must pay a minimum of 25 percent of the insurance premium costs for each employee. O-EPIC pays for up to 60 percent of the premium, leaving the employee responsible for up to 15 percent (not to exceed 3 percent of gross annual household income). The program has ongoing funding of \$50 million per year provided by a tobacco tax instituted in 2005. As of January 2007, O-EPIC was providing assistance to 731 businesses as well as 664 individuals.

The Kentucky Approach. In 2006, Kentucky's state legislature appropriated \$20 million dollars from general revenue to fund the Insurance Coverage Affordability and Relief to Small Employers (ICARE) Program. ICARE is a premium assistance program that subsidizes small employers (with 25 or fewer workers) and workers with wages at or below 300 percent FPL. The program pays employers a \$40 per employee per month incentive (\$60 per eligible employee per month for an employer group with at least one employee with a defined high-cost condition). The monthly amount decreases by \$10 each subsequent year of the program. To qualify, an employer must: (a) employ between 2-25 people; (b) pay at least 50 percent of the employee's premium for single coverage; (c) pay an average annual salary of no more than \$29,400 (300 percent of FPL); and (d) not have offered ESI for the last two months. The ICARE program has a two year funding commitment from the state legislature.

Policy Issues to Consider

Premium assistance programs attract the attention of state and federal policymakers because of their potential to: control public spending on insurance; increase the purchase and take-up of private insurance by low-income individuals; and reduce the number of uninsured. Successful premium assistance programs address the following questions:

- What populations will be allowed or required to enroll?
- Does an individual have to be uninsured at the time of enrollment?
- What will be the scope and breadth of the benefit package?

- How much cost-sharing will be required by the enrollees?
- What level of subsidy will guarantee adequate participation and cost-effectiveness?

Clearly premium assistance programs offer states opportunities to control costs and reduce the number of uninsured. Implementing such a program warrants careful consideration and study. More information can be found by consulting the following list of references.

Notes

* Section 1115 waivers, named after the section of the Social Security Act that created the waiver option, allow states to receive federal Medicaid matching funds even though they are not in compliance with federal Medicaid law. In addition to comprehensive waivers, some Section 1115 waivers focus on selected services or populations such as family planning or persons with HIV. These more narrowly defined waivers are not included in this brief.

References

Joan Alker, "Premium Assistance Programs: How Are They Financed and Do Sates Save Money," 2005, available at www.kff.org/kcmu.

Joan Alker, "Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity," 2003, available at: <http://www.kff.org/medicaid/upload/Serving-Low-Income-Families-Through-Premium-Assistance-A-Look-At-Recent-State-Activity-PDF.pdf>.

John Holahan and Allison Cook, "Cover Missouri Project: The Missouri Economy and Changes in Health Insurance Coverage, 2000 – 2004," Missouri Foundation for Health, 2006, available at http://www.mffh.org/policy_covermo.html

John Holahan and Teresa A. Coughlin, "Cover Missouri Project: The Quiet Medicaid Revolution: State Waiver Activity in the Early 2000s" Missouri Foundation for Health, 2006, available at http://www.mffh.org/policy_covermo.html

Insurance Coverage Affordability and Relief to Small Employers (ICARE) Program fact sheet, available at <http://doi.ppr.ky.gov/kentucky/Documents/icare01242007.pdf>

Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) fact sheet, available at <http://www.oepic.ok.gov/>

Shruti Rajan, "Publicly Subsidized Health Insurance," Health Affairs, May/June 1998.

**Missouri Foundation for Health
FACT SHEET
January 2007
Thomas McAuliffe, Policy Analyst**