Premium Assistance for Employer-Sponsored Insurance (ESI)
Enrollment Experience in Other States

SUMMARY

Premium assistance programs use Medicaid funds to help beneficiaries purchase private health insurance, rather than to pay directly for care. There are several potential benefits to premium assistance programs, including cost savings for the state, increased enrollment, and reduction in cost shifting.

As part of Act 191, “Health Care Affordability for Vermonters,” the state was directed to explore one type of premium assistance – subsidizing the employee share of employer-sponsored health insurance (ESI). An analysis of the costs and benefits of a Vermont ESI premium assistance program is underway, using Vermont survey and Medicaid data. This issue brief is intended to provide context for that analysis, by examining the experience of other state Medicaid programs, with a focus on enrollment.

Several conclusions can be drawn from the experiences of other states:

- Complex administrative challenges have constrained enrollment in state premium assistance programs
- Only a handful of premium assistance programs have achieved enrollment levels above 1 percent of the eligible populations
- Enrollment of low-income adults in premium assistance programs is especially challenging
- Initial enrollment estimates have been overly optimistic, both in the number who ultimately enroll and the time it takes to achieve ultimate enrollment
- Federal efforts to promote state premium assistance programs under the recent HIFA waiver initiative (2001) have yet to bear fruit.

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1 Total cost savings is a function of the number of Medicaid beneficiaries who enroll in the premium assistance program, their historical costs to the Medicaid program, and their future costs under premium assistance, including direct premium subsidy and any additional costs, such as “wrap around” costs for benefits and cost sharing.
INTRODUCTION

Section 1974 of Title 33 directs the Agency of Human Services (AHS) to implement a mandatory premium assistance program by October 1, 2007 to assist current Vermont Health Access Plan (VHAP) enrollees who have access to employer-sponsored insurance (ESI) coverage. Premium assistance entails using state and federal Medicaid funds to subsidize insurance premiums on behalf of Medicaid beneficiaries for the purchase of private insurance coverage. A premium assistance program that will move current VHAP enrollees from direct VHAP coverage to ESI coverage has been viewed as a way to generate Medicaid “savings.”

During the legislative session, consultants and staff from the administration and legislature settled on a preliminary working estimate of “savings” that could be generated by ESI premium assistance for VHAP enrollees. To put the working estimate on stronger footing, 33 V.S.A. § 1974(g) directed the Agency of Human Services to conduct a survey of current VHAP enrollees, which is expected in October 2006. The AHS survey will provide more precise information concerning the number of VHAP enrollees who are potentially eligible for ESI premium assistance and the budgetary “savings” projected to result by requiring those individuals to enroll in such a program.

This issue brief serves as a companion document to the AHS survey by reviewing the enrollment experience of premium assistance programs in other states. Enrollment is a critical variable along with the change in per-member-per-month cost in estimating the potential budget “savings” on current VHAP enrollees who are eligible for ESI premium assistance. Examining those state premium assistance programs most successful in building enrollment will help inform the assumptions that underlie projections for potential enrollment of VHAP enrollees in ESI premium assistance in Vermont.

DISCUSSION

1. Complex challenges have constrained enrollment in ESI premium assistance over the past 15 years

Despite recent federal efforts to expand ESI premium assistance, state programs continue to wrestle with common administrative and operational challenges that have historically limited efforts to build enrollment. These program challenges are not new. States began operating premium assistance under Medicaid over 15 years ago, and the major program challenges were identified early on. Federal cost reduction legislation in 1990 mandated that states implement “premium payment” programs for Medicaid beneficiaries with access to employer-based health insurance. Congress made this provision voluntary seven years later following a report by the federal General Accounting Office (GAO) indicating that many states had not been effective in implementing premium assistance programs.

In its 1997 report, the GAO delineated the chief administrative “barriers” that are inherent in operating premium assistance programs, including:

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3 33 V.S.A. § 1974 also requires future enrollees in both VHAP and Catamount Health to enroll in available ESI coverage via premium assistance if determined to be less costly than direct coverage. However, this paper focuses only on current Medicaid program eligibles because of their potential to generate “savings” off the currently budgeted Medicaid expenditures.
Difficulty of identifying and investigating individual employee eligibility
Complexity of coordinating coverage with employers
Shifting nature of beneficiaries’ Medicaid eligibility status and employment status
Dynamic nature of employer-sponsored insurance.

The GAO predicted that, because of those barriers, even successful programs would have at best a “modest” impact in terms of enrollment and savings when compared with the total Medicaid populations and expenditures in those states.6

The implementation barriers identified by the GAO in 1997 continue to prevent widespread enrollment in premium assistance programs. Rhode Island’s January 2006 annual report on its premium assistance program identified a virtually identical list of obstacles that have hindered its highly regarded program from realizing greater enrollment7. In addition, the same set of challenges has been examined in extensive detail in the web-enabled “Premium Assistance Toolbox,” released as a technical assistance resource in 2004 to assist states in surmounting the complexities of ESI premium assistance.8

Because of these administrative barriers, most premium assistance programs operated by states for their Medicaid populations have very low enrollment.9 The existing Medicaid “health insurance premium payment (HIPP)” programs in Vermont, New Hampshire, and Maine provide apt examples in this region. The number of individuals enrolled in Medicaid premium assistance for ESI coverage as of January 2006 represents a very small percentage of overall Medicaid enrollees, as follows:

- Vermont - 57 individuals
- Maine - 207 individuals
- New Hampshire - 50 individuals.

Similar to the other two states, Vermont’s program does not require beneficiaries to enroll in premium assistance unless they are already enrolled in ESI coverage. The program pays premiums for Medicaid beneficiaries who have existing health insurance coverage, but can no longer afford the coverage for one reason or another.10 In New Hampshire, most enrollees in Medicaid premium assistance are disabled children (Children with Special Health Care Needs - Katie Beckett program) whose families have access to ESI.11 As with Medicaid premium assistance programs in other states, enrollment in these programs is very small.

11 John Bonds, Office of Medicaid Business and Policy, NH Department of Health and Human Services, July 2006.
2. Only a handful of state premium assistance programs have achieved significant enrollment

Only a handful of premium assistance programs have achieved enrollment levels of more than 1% of the state’s Medicaid eligible populations – namely, Rhode Island, Massachusetts, Oregon, Pennsylvania, and Iowa. The following table shows the number of individuals receiving premium assistance for ESI group coverage in the 13 states with active programs. Only five of these states had enrollment in ESI premium assistance of more than 1% of the nondisabled adults and children eligible for Medicaid and SCHIP.

<table>
<thead>
<tr>
<th>State</th>
<th>Year Implemented</th>
<th>Medicaid eligible individuals enrolled in ESI*</th>
<th>Total of Medicaid children/adults (nondisabled)</th>
<th>Percent of Medicaid children/adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhode Island</td>
<td>2001</td>
<td>5,500</td>
<td>117,000</td>
<td>4.7%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1998</td>
<td>18,973</td>
<td>552,000</td>
<td>3.4%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1994</td>
<td>22,600</td>
<td>1.16 million</td>
<td>1.9%</td>
</tr>
<tr>
<td>Iowa</td>
<td>1991</td>
<td>4,400</td>
<td>275,000</td>
<td>1.6%</td>
</tr>
<tr>
<td>Oregon</td>
<td>1998</td>
<td>5,300</td>
<td>502,000</td>
<td>1.05%</td>
</tr>
<tr>
<td>Idaho</td>
<td>2004</td>
<td>456</td>
<td>Less than 1% of Medicaid children/adults</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>1998</td>
<td>4,922</td>
<td>Less than 1%</td>
<td></td>
</tr>
<tr>
<td>Maine</td>
<td>2005</td>
<td>200</td>
<td>Less than 1%</td>
<td></td>
</tr>
<tr>
<td>New Jersey</td>
<td>2001</td>
<td>770</td>
<td>Less than 1%</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>1996</td>
<td>11,912</td>
<td>Less than 1%</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>2003</td>
<td>75</td>
<td>Less than 1%</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td>1991</td>
<td>1,600</td>
<td>Less than 1%</td>
<td></td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1999</td>
<td>1,691</td>
<td>Less than 1%</td>
<td></td>
</tr>
</tbody>
</table>

* “Medicaid-eligible individuals enrolled in ESI” does not include individuals who lack access to ESI coverage, but receive Medicaid premium assistance to purchase insurance in the individual (nongroup) market. Nor does it include family members who are ineligible for Medicaid/SCHIP benefits but who receive subsidized coverage incidental to family coverage purchased to cover Medicaid-eligible children.

The table above enables a general comparison of ESI premium assistance enrollment across different state Medicaid programs, but its usefulness is limited. Apples-to-apples comparisons across programs are difficult because the Medicaid population groups eligible for premium assistance vary from state to state as a reflection of different state environments and program goals. Generally, the different covered groups targeted for premium assistance include one or more of the following three groups:

- Children and parents eligible for Medicaid
- Children and pregnant women eligible for SCHIP
- Children and adults eligible under a Medicaid 1115 waiver coverage “expansion.”

Because premium assistance for the VHAP program would target adults in the income eligibility range of 0-185% of poverty, it is more useful to examine the states with effective programs that target a similar

12 For the top five states, the number of Medicaid eligible individuals enrolled in ESI premium assistance is based on direct personal communications with the program directors administering those programs. Enrollment numbers for the lower eight states are based on personal contact or recent issue briefs on state premium assistance programs, including, e.g.,


population of adults. The states with programs that meet that criterion include Rhode Island, Massachusetts, and Oregon.14

3. Enrollment of adults at the VHAP income eligibility range has remained very low

In Massachusetts, Oregon, and Rhode Island, enrollment of adults in premium assistance at the VHAP income eligibility range (0-185% FPL) has remained very low. These states have many more adults enrolled in their Medicaid, SCHIP, and Medicaid expansion programs than does Vermont. In Rhode Island, for example, adults comprise about one-third (39,000) of the 117,000 nondisabled adults and children enrolled in its Medicaid and SCHIP program, yet only 1,500 adults are enrolled in premium assistance. The following table shows the enrollment of adults at the VHAP income eligibility range (0-185% FPL) in these three states. None of the three states is predicting anything more than very gradual enrollment increases for adults in this eligibility range.

<table>
<thead>
<tr>
<th>State</th>
<th>Eligibility Group</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>Parents 133–200% FPL</td>
<td>4,725</td>
</tr>
<tr>
<td></td>
<td>Childless adults 0–200% FPL</td>
<td></td>
</tr>
<tr>
<td>Oregon</td>
<td>Parents/Adults 0-185% FPL</td>
<td>2,998</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Parents/Adults 0-185% FPL</td>
<td>1,500</td>
</tr>
</tbody>
</table>

The very low enrollment of adults at the VHAP income eligibility range is relevant to making assumptions about the potential ESI enrollment of VHAP beneficiaries. These states’ experience raises concerns about the preliminary working estimate of enrollment that the legislature and administration agreed to and included on the H.861 Committee of Conference “Balance Sheet.”15 The Balance Sheet projected that 3,180 current VHAP beneficiaries would be enrolled in ESI premium assistance by the second year. This would be more than twice the number of adults enrolled in ESI by Rhode Island, even though Rhode Island has over 1½ times as many adults in Medicaid — 39,000 in RI compared to less than 24,000 in VHAP. The Balance Sheet projection appears especially optimistic given the income eligibility distribution of VHAP enrollees. As reflected in the table below, only 8,618 individuals of the 23,286 individuals enrolled in VHAP had incomes over 100% of poverty in July 2006. While the survey will provide empirical evidence, it is likely that access to ESI declines at lower income, especially below poverty.

<table>
<thead>
<tr>
<th>VHAP Enrollment, July 200616</th>
<th>% FPL</th>
<th>Persons Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-50%</td>
<td>9,271</td>
</tr>
<tr>
<td></td>
<td>50-75%</td>
<td>2,479</td>
</tr>
<tr>
<td></td>
<td>75-100%</td>
<td>2,918</td>
</tr>
<tr>
<td></td>
<td>100-150%</td>
<td>6,891</td>
</tr>
<tr>
<td></td>
<td>150-185% (caretakers)</td>
<td>1,727</td>
</tr>
<tr>
<td></td>
<td></td>
<td>23,286</td>
</tr>
</tbody>
</table>

Vermont is in the process of reexamining its working estimate of enrollment of adults in ESI premium assistance. Pursuant to 33 V.S.A. § 1974(g), the Agency of Human Services (AHS) is conducting a survey of current VHAP enrollees to provide a sounder foundation for estimating the number of individuals who are potentially eligible for ESI premium assistance. However, based on the experience of other states, those estimates are likely to be lower than the preliminary working estimates included during the legislative session on the H.861 Balance Sheet.

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14 Neither Iowa nor Pennsylvania has comparable experience with Medicaid premium assistance programs for adults up to 185% of poverty.
4. Enrollment has taken longer and been lower than anticipated

The experience of other states suggests not only that the preliminary working estimate of enrollment may be too high, but also that the rapid increase of enrollment over FY08 and FY09 projected on the H.861 Balance Sheet may be too fast. Close examination of the programs in Rhode Island, Massachusetts, and Oregon reveals that ESI premium assistance enrollment in these states has remained lower than anticipated and far lower than originally estimated, and it has increased more slowly than anticipated. For each of the three states, this section will discuss:

- Enrollment estimates at the time of premium assistance implementation
- Actual enrollment experience since implementation
- Current enrollment in 2006.

A. Rhode Island

*Enrollment estimate at the time of implementation.* When Rhode Island’s program was implemented in 2001, it was estimated that about one-half of all working families enrolled in its Medicaid/SCHIP program would have access to employer-sponsored health insurance, which was to amount to some 20,000 persons by July 2002.  

*Actual enrollment experience, 2001-2006.* In February 2001, Rhode Island implemented a voluntary premium assistance program. During the first year, the program worked on developing program infrastructure and building relationships with employers, but achieved negligible enrollment. Upon becoming mandatory in January 2002, the program succeeded in shifting some 2,800 individuals from traditional Medicaid into ESI premium assistance during 2002, and then another 2,000 individuals during 2003. ESI enrollment slowed down after that and has remained in the same range for the past two years, fluctuating between 5,500 – 6,000 individuals since June 2004.

<table>
<thead>
<tr>
<th>Actual enrollment (children and adults) in Rite Share 2002-2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>----------</td>
</tr>
<tr>
<td>111</td>
</tr>
</tbody>
</table>

*Current enrollment in Rite Share, June 2006*

<table>
<thead>
<tr>
<th>Eligible Population</th>
<th>Eligibles Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and pregnant women up to 250% FPL</td>
<td>Children: 4,000</td>
</tr>
<tr>
<td>Adults up to 185% FPL</td>
<td>Adults: 1,500</td>
</tr>
</tbody>
</table>

B. Oregon

*Enrollment estimate at the time of implementation.* Oregon’s program was designed to provide premium subsidies not only for ESI coverage, but also for coverage in the individual (nongroup) market. When implemented in 1998, Oregon’s program was expected to serve approximately 15,000 individuals after the phase-in period ending in 2001. This goal became fiscally “impracticable” when less than one-quarter of program applicants enrolled in ESI premium assistance, while three-quarters of applicants enrolled in the far more costly individual market (with about one-half of those individual market enrollees ending up in the high risk pool).

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18 Id.
19 Personal communication with Lisa Dimauro, Rite Share Program Director, July 2006.
Actual enrollment experience, 1998-2006. From its start in 1998, Oregon’s program operated with low ESI enrollment (about 940 individuals at its peak\textsuperscript{21}) until it was refinanced with federal matching funds under an 1115 waiver (HIFA) in October 2002. Throughout most of 2003, the program “focused on maximizing new enrollments in the employer-sponsored insurance market” and “engaged in aggressive marketing efforts” for ESI enrollment, while closing down individual market enrollment.\textsuperscript{22} According to the program director, these efforts to build ESI enrollment had limited success because, for most low-income working individuals, either employer coverage was not available or the employer did not contribute toward the premium.\textsuperscript{23} Because of the limited access to ESI, only about 20\% of all premium assistance enrollees were covered by ESI while some 80\% were covered by individual policies. Today ESI group coverage represents a slightly higher proportion of enrollment (about one-third), but ESI enrollment has grown slowly and currently remains much lower than the state anticipated – at around 5,500 individuals.\textsuperscript{24} The program director predicts that enrollment in ESI coverage will continue at the current pace.\textsuperscript{25}

Actual ESI enrollment (children and adults) in FHIAP 2002-2006\textsuperscript{26}

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment</td>
<td>800</td>
<td>1,967</td>
<td>3,655</td>
<td>4,450</td>
<td>5,536</td>
</tr>
</tbody>
</table>

Current ESI enrollment in FHIAP, July 2006

<table>
<thead>
<tr>
<th>Eligible Population</th>
<th>Eligibles Enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &amp; pregnant women up to 185% FPL</td>
<td>Children – 2,538</td>
</tr>
<tr>
<td>Parents/adults up to 185% FPL</td>
<td>Adults – 2,998</td>
</tr>
</tbody>
</table>

C. Massachusetts

Enrollment estimate at the time of implementation. At the onset of its premium assistance program, Massachusetts identified the target population as the approximately 70,000 – 100,000 individuals (with and without children) who worked for small employers and had incomes less than 200 percent of FPL.\textsuperscript{27}

\[\text{http://www.oregon.gov/OPHP/docs/ways_means_report.pdf}\]


\[\text{23 Personal communication with Craig Kuhn, Program Manager, Family Health Insurance Assistance Program (FHIAP), July 2006. See also “A Snapshot of State Experience Implementing Premium Assistance Programs,” National Academy for State Health Policy, April 2003, p. 23 (Although almost 50 percent of the children enrolled in premium assistance had parents who worked full time, many of these parents either lacked access to ESI or had employers who did not make contributions to dependent coverage.), available at http://www.nashp.org/Files/snapshot.pdf#search=%22Premium%20Assistance%20Snapshot%22}\]

\[\text{24 As of early September 2006, 37\% of enrollees (5,390 individuals) received premium assistance for ESI coverage, and 63\% of enrollees (9,171 individuals) received assistance for individual market coverage. Individual market enrollment is closed, with a waiting list of over 24,000 applicants. (Several years ago, Vermont policy makers explored the possibility of subsidizing individual market coverage for high-cost Medicaid/VHAP enrollees without access to ESI coverage, but this was determined not to be a viable policy option. Personal communication with Lori Collins, OVHA, June 2006.)}\]

\[\text{25 Personal communication with Craig Kuhn, July 2006.}\]


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Actual enrollment experience, 1998-2006. Massachusetts operates three separate ESI premium assistance programs for its Medicaid, SCHIP, and expansion populations, respectively. The program director for Massachusetts’ premium assistance programs reports that annual enrollment data are not readily available because, until last year, the state did not break down enrollment by program or separate out individuals who received ESI premium assistance but were not eligible for Medicaid or SCHIP. However, she stated that, from 1998 to 2004, the program relied on referrals from eligibility workers, and enrollment in premium assistance for Medicaid and SCHIP was significantly less than what it is today. Beginning in March 2004, the state began an aggressive program to increase premium assistance enrollment for Medicaid and SCHIP. This effort began after the state made substantial investments in staff and information resources and selected an outside contractor to manage investigations of employee eligibility. As a result of these enhancements, Medicaid premium assistance enrollment has grown substantially during the past two years, and the program director indicates that combined Medicaid and SCHIP enrollment is continuing to grow steadily.28

Analyzing Medicaid and SCHIP premium assistance enrollment in Massachusetts is complicated by the Insurance Partnership (IP) program. The Insurance Partnership is designed to encourage small employers to offer health insurance to uninsured low-income workers not eligible for direct coverage under Medicaid or SCHIP. However, the Insurance Partnership has attracted a significant number of eligible-but-not-enrolled Medicaid and SCHIP beneficiaries (mostly children) who did not apply directly to those programs but were determined to be eligible after applying for the IP program. About two-thirds of IP participants are self-employed individuals and their families,29 and many of these families have modest incomes that enable their children to qualify for Medicaid or SCHIP eligibility. Whereas the IP had enrolled 13,285 individuals in ESI premium assistance as of April 2006, a substantial number of those individuals (mostly children) have premium assistance payments made under Medicaid and SCHIP premium assistance, rather than the Insurance Partnership.30

The following table reflects the complicated picture of Massachusetts’ premium assistance enrollment, with enrollment counts for each program provided by the program director. Current enrollment of Medicaid and SCHIP eligible beneficiaries was 18,973 individuals, as of April 2006. The table shows that Massachusetts (unlike Rhode Island) includes in its premium assistance count many family members who are ineligible for Medicaid/SCHIP benefits but receive state-subsidized coverage incidental to the purchase of ESI family coverage.

28 Personal communication with Nancy Keeley, Premium Assistance Programs, July 2006.
29 Self-employed individuals find the IP attractive because they qualify for a double benefit – both the subsidy paid to the employer (up to $1000 per employee) and the premium assistance payment available to employees with incomes up to 200% FPL. See “Employer Subsidies for Health Insurance Premiums: Massachusetts’ Unique Experiment,” RTI International, September 30, 2004.
30 Personal communication with Nancy Keeley. For example, in a family of four, an IP-eligible father and non-eligible mother may both qualify for monthly IP premium assistance of $150, whereas the SCHIP-eligible child and Medicaid-eligible infant may qualify for the more generous premium assistance payments available under each of those programs.
Current enrollment in premium assistance in Massachusetts, April 2006

<table>
<thead>
<tr>
<th>Program Authority</th>
<th>Eligible Population</th>
<th>Eligibles Enrolled[1]</th>
<th>Non-Eligible Enrollment[2]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid section 1906 (1994)</td>
<td>Children to 150% FPL Parents to 133% FPL</td>
<td>13,073 Medicaid children and parents*</td>
<td>1,800 non-eligible family members</td>
</tr>
<tr>
<td>SCHIP (1998)</td>
<td>Children 150-200% FPL</td>
<td>5,900 SCHIP children**</td>
<td>3,000 non-eligible family members</td>
</tr>
<tr>
<td>Section 1115 demonstration (1995)</td>
<td>Parents (133–200% FPL) Childless adults (0–200% FPL) working for small employer participating in Insurance Partnership</td>
<td>4,725 qualifying adults***</td>
<td>1,740 non-eligible spouses</td>
</tr>
</tbody>
</table>

* The Medicaid-eligible group includes 7,753 individuals enrolled through Medicaid premium assistance and 5,320 individuals enrolled through the Insurance Partnership.
** The SCHIP-eligible group includes 4,400 children enrolled through SCHIP and 1,500 children enrolled through the Insurance Partnership.
*** The Insurance Partnership has enrollment of 13,285 individuals when the enrollees who are eligible for premium assistance under Medicaid and SCHIP are counted in the IP total.

In summary, enrollment in ESI premium assistance in Rhode Island, Massachusetts, and Oregon has developed more slowly than anticipated and remained substantially lower than anticipated.

5. Even in successful states, enrollment tends to level off at lower-than-expected participation

The experience of three of the five leading states – Rhode Island, Pennsylvania, and Iowa – suggests that enrollment in ESI premium assistance tends to level off at lower-than-expected participation. In each of these states, premium assistance enrollment has remained in the same range in recent years. As discussed later, premium assistance programs must contend with high monthly turnover in participation as enrollees experience changes in Medicaid eligibility, employment, or the health coverage offered by their employer. Although the premium assistance programs in Rhode Island, Pennsylvania, and Iowa have been constantly adding new enrollees, overall enrollment has not grown because an equal number of individuals fall off the rolls each month. Total enrollment in Rhode Island’s program has not grown since June of 2004, and the program director acknowledged that enrollment appears to have stabilized at the current level. Pennsylvania’s enrollment has been relatively stable for over 3½ years (since December 2003). Iowa’s program has remained at its current level for the past four years (since August 2002).

<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment</th>
<th>Percent of Medicaid children/adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhode Island</td>
<td>~ 5,500-6,000 eligibles since June 2004</td>
<td>4.7%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>~ 22,000 eligibles since December 2003</td>
<td>1.9%</td>
</tr>
<tr>
<td>Iowa</td>
<td>~ 4,500 eligibles since August 2002</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

The implication is that ESI premium assistance enrollment tends to level off in time and that, in each of the three states, it has stabilized at lower-than-anticipated participation. While enrollment in ESI

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31 Massachusetts does not break down Medicaid premium assistance enrollees by children and adults.
32 Employer-sponsored insurance normally covers children through family coverage. Consequently, family members who would otherwise not be eligible often receive coverage as an incidental benefit when a state provides premium assistance for a Medicaid- and SCHIP-eligible child.
33 Personal communication with Lisa Dimarco, Rite Share Program Director, July 2006.
coverage continues to grow slowly in Oregon and Massachusetts, the general pattern evidenced by the three states above, as well as the majority of the other states with active premium assistance programs, is that enrollment tends to level off at lower-than-expected participation.

6. Federal efforts to promote state premium assistance programs under the HIFA waiver initiative during the last five years have yet to bear fruit

Since 2001, the federal government has vigorously promoted ESI premium assistance as a mechanism to reduce Medicaid costs and support private employer-based health insurance. All states that have applied for 1115 demonstration waivers to expand Medicaid coverage to uninsured residents have been strongly encouraged to consider employer-sponsored insurance (ESI) as a mechanism for health coverage expansion.36 In fact, this has been a specific requirement of the federal Health Insurance Flexibility and Accountability (HIFA) initiative launched in August 2001.37 The HIFA initiative offers states fast-track federal approval of 1115 Medicaid waivers that meet the criteria prescribed in the streamlined HIFA waiver application, and exploring premium assistance and related approaches for coordinating private insurance represents a central criterion in the HIFA template.38 Moreover, to create a more favorable climate for states to pursue premium assistance, the HIFA initiative relaxed the federal standards governing cost-effectiveness, cost-sharing, and benefits that have complicated states’ adoption of premium assistance under Medicaid and SCHIP.39 Given the strong push provided by the HIFA initiative, states considering premium assistance should naturally look for guidance to the experience of states with approved HIFA waivers.

Taken as a whole, however, the HIFA experience does not support optimistic assumptions concerning the potential for either quick start-up or robust enrollment. The premium assistance programs required under HIFA waivers have been slow to get off the ground. None of the 12 HIFA waiver states40 has yet to achieve significant enrollment in an ESI premium assistance program. The two programs with the largest enrollment of Medicaid eligibles in ESI premium assistance – Oregon (5,347 individuals) and Illinois (4,922 individuals) – had preexisting state-funded programs that began in 1998, three years prior to the HIFA initiative. Each of those states converted its program to HIFA 1115 waivers for purposes of

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36 Personal communication with Ed Hutton, Center for Medicare and Medicaid Services (CMS), August 2006.
40 This analysis of HIFA waiver states focuses on premium assistance programs that target individuals who are eligible for direct state coverage – i.e., Medicaid and SCHIP programs. As with premium assistance for VHAP enrollees, these programs seek to create “savings” by requiring that beneficiaries enroll in ESI coverage whenever it represents a lower cost alternative to direct Medicaid/SCHIP coverage. Not included in this analysis are premium assistance initiatives that subsidize private coverage for currently uninsured persons not eligible for Medicaid/SCHIP. Those programs are not designed to generate “savings” on the current Medicaid budget, but rather to reduce the future costs of subsidizing private coverage for a population that is not eligible for direct state coverage. Such programs are akin to premium assistance for future Catamount Health enrollees, rather than premium assistance for current VHAP enrollees. Examples of such programs are found in the recently implemented HIFA waivers for New Mexico and Oklahoma (both of which have very low enrollment) and the newly approved HIFA waiver for Arkansas. See “Medicaid HIFA Waiver Comparison: Arkansas, New Mexico and Oklahoma,” State Coverage Initiatives Program, AcademyHealth, June 2006, available at http://news.statecoverage.net/ahstds/issues/2006-06-20/3.html
gaining federal match (both did so in the fall of 2002). Both programs have small enrollment compared to the number of eligibles in the state – i.e., no more than 1% of Medicaid-eligible nondisabled adults and children. Illinois’ enrollment has remained in the same range for the past four years. Current enrollment in its voluntary program has fluctuated around 5,000 individuals, which is actually lower than August 2002 (one month prior to the HIFA waiver) when enrollment in its then mandatory program was at 5,600 children.41

Of the remaining 10 HIFA waiver states, five states have programs with very low enrollment, and the other five states have never implemented a premium assistance program. Three of those states – California, Arizona, and Colorado – did not proceed to implement ESI premium assistance after conducting feasibility studies.42 The disappointing experience to date of the 12 HIFA waiver states is summarized here as follows:

### Four states with greatest enrollment in ESI premium assistance
- Oregon (10/02)* 5,535 (3,000 adults / 2,535 children)
- Illinois (9/02) 4,925 (fewer enrollees today than prior to HIFA waiver)
- New Jersey (1/03) 770 (280 adults / 490 children)
- Utah (2/02) 75

### Three states still too early in implementation, but anticipate small enrollment
- Idaho (11/04) 456 (predicting fewer than 1,400 children; capped at 1,000 adults)
- Virginia (8/05) 1,600 (mostly from previous SCHIP premium assistance program)
- Michigan (1/04) Anticipate low enrollment

### Five states have not implemented premium assistance program under state's HIFA waiver
- California (1/02) Completed feasibility study
- Arizona (12/01) Completed feasibility study
- Colorado (9/02) Completed feasibility study
- Maine (9/02) Report to legislature on premium assistance in 1/06. No action taken.
- New Mexico (8/02) Concluded premium assistance models would not be viable.

* Month/year when HIFA waiver was approved by CMS

7. Enrollment assumptions need to take into account the administrative complexity of implementing ESI premium assistance and the time needed to build infrastructure

Assumptions on VHAP enrollment in ESI premium assistance that underlie projected VHAP “savings” need to account for the administrative challenges of implementing premium assistance programs that can impede and delay enrollment. States with experience in operating premium assistance programs have found that they need to allow as much as 1½ years for the up-front planning and coordination that must be

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42 Feasibility studies for premium assistance in both Colorado and Arizona concluded that enrollment would be small and cost savings minimal. CMS required Arizona to submit a new ESI premium assistance proposal as part of its March 2006 waiver renewal, which is pending CMS review. However, 2006 state legislation to authorize Arizona’s program failed to pass. Personal communication with Arizona program director, July 2006. California’s existing Medicaid premium payment program has under 1,000 enrollees (mostly HIV/AIDS patients with high pharmacy cost), and enrollment is declining as a result of Medicare Part D and other factors. The state has no plans to expand premium assistance under HIFA. See “Serving Low-Income Families through Premium Assistance: A Look at Recent State Activity,” Kaiser Commission on Medicaid and the Uninsured, October 2003, pp. 1, 8-9, available at http://www.kff.org/medicaid/kcmu4143brief.cfm

done prior to implementing their programs.43 Furthermore, states caution that a significant up-front investment is needed, and that savings will not accrue to the program immediately.44

What has enabled the five leading states (Rhode Island, Massachusetts, Oregon, Pennsylvania, and Iowa) to be more successful than others is that they devoted substantial time and resources to develop the staff and infrastructure to meet the complex administrative challenges. The infrastructure needed to support enrollment takes time to develop and cannot be rushed. The three most critical areas of development are as follows:

- Staff capacity
- Information systems
- Coordination with employers.

A. Hire and Train Capable Staff

Because premium assistance programs are highly staff intensive, large investments in staff have been necessary to build and maintain enrollment in premium assistance programs. Hiring and training necessary program staff takes time, and the ongoing personnel cost is substantial. As reflected in the table below, Massachusetts has 33 FTE staff, including contracted staff. Pennsylvania has a program staff of 48 FTEs in five regional offices for its premium assistance program. Iowa has 14 staff administering the program, including five intake workers and seven case managers. Rhode Island has seven FTEs who are contracted staff, which does not include the supervisory functions of state staff.

<table>
<thead>
<tr>
<th>State</th>
<th>Number of FTE Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvania</td>
<td>48</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>33</td>
</tr>
<tr>
<td>Iowa</td>
<td>14</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>7</td>
</tr>
</tbody>
</table>

B. Information Systems

Another critical task to support program enrollment is to compile and maintain information in a program database on a large number of employer benefits plans, including up-to-date information on scope of benefits, employee contributions, and deductibles/coinsurance. For example, Rhode Island’s program maintains information on about 1,000 employers in the database, and Massachusetts maintains information on some 2,000 employers. Program staff in both states indicated that the database is essential to the process of reviewing employer coverage and investigating cost-effectiveness – which is performed in both states by outside contractors.45 While it would be most efficient to collect information directly from employers, Rhode Island found that employers were not returning the forms. The program had to switch to having the employee obtain the information from the employer, which is a more time-consuming process.

44 See “Premium Assistance Toolbox” at http://www.patroolbox.org/ docdisp_page.cfm?LID=F3FEE0F8-71BE-4420-AC920C621B6FBFAE5
45 The classic example of the need for an information database is Wisconsin’s experience in implementing premium assistance under SCHIP in 2001. After over 64,128 employer coverage forms for premium assistance eligibility were screened, only a very small percent of the applicants were enrolled in the program -- 47 families, working for roughly 27 employers. “Premium Assistance Programs under SCHIP: Not for the Faint of Heart?” The Urban Institute 2003, p.17, available at http://www.urban.org/UploadedPDF/310794_OP-65.pdf The pioneering work of Pennsylvania in building its information system for premium assistance was profiled in a state health policy newsletter in April 2004. “Profiles in Coverage: Pennsylvania’s HIPP program,” State Coverage Initiatives, April 2004, available at http://www.statecoverage.net/pennsylvaniaiiprofile.htm
The database improves a state’s ability to identify up-front both whether the employer may have coverage that is sufficiently comprehensive to meet benefit standards and whether the employer contribution is high enough to keep down the subsidy cost. Rhode Island categorizes employers as “approved,” “non-approved,” and “unknown.” In response to changing employer health plans, this employer information must be continually modified to take into account changes in tier structure, prescription co-pay structure, and member cost-sharing (deductibles, coinsurance). The state’s eligibility systems generate daily referrals of applicants or families who have been recertified and who also work for approved employers so that program staff is daily reviewing a constant stream of cases.

Recently, Massachusetts developed key “markers” for staff to identify individuals with greater probability of meeting cost-effectiveness. For example, if a Medicaid applicant is a wage earner working more than 100 hours per month and has 2 or more children, this increases the likelihood that the individual will have access to health insurance, and that premium assistance (for the adult and children) would be cost-effective. Rhode Island is currently in the process of reconfiguring its data system to obtain better information to support its investigation process. Previously, Rhode Island imposed a requirement on small group employers to submit data quarterly on all their covered lives so that Medicaid could perform a data match, but the data was not sufficiently timely to be of much use.

C. Outreach to Employers

Initiating a premium assistance program also requires considerable start-up time to build relationships with employers and information on the ESI coverage they offer. Effective coordination with employers is critical due to the continuously changing circumstances that make it an unending challenge to maintain enrollment. Premium assistance programs experience high monthly turnover, primarily because enrollees experience changes in Medicaid eligibility, employment, or the health coverage offered by their employer, as shown by the following examples:

<table>
<thead>
<tr>
<th>State</th>
<th>Monthly Turnover</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>In Medicaid, 1,080 new enrollees, but 908 dropped off</td>
</tr>
<tr>
<td></td>
<td>In SCHIP, 895 new enrollees, but 856 dropped off (April 2006)</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>About 280 new enrollees each month, but an equal number fall off</td>
</tr>
<tr>
<td>Oregon</td>
<td>About 250 new enrollees each month, but about 180 fall off</td>
</tr>
</tbody>
</table>

In addition, more than one-half of the individuals investigated for premium assistance are not found to be cost-effective. Rhode Island has found that, after accounting for those families who have lost Medicaid eligibility or left employment, approximately 45% of cases are cost-effective by the time they are reviewed. This is similar to Oregon’s experience where a December 2005 report found that more than one-half of those approved for premium assistance could not be enrolled.

Because employer cooperation with premium assistance programs is essentially voluntary, programs need to engage in extensive outreach and one-on-one communication. Rhode Island and Massachusetts both emphasized that an enormous amount of time and resources was required to gain credibility and to build effective working relationships with employers. For example, Rhode Island had to send letters manually to employers and employees requesting information about employer-based insurance. Rhode Island started out trying to collect information directly from employers, but after the forms were not returned, the state switched to having the employee obtain the information from the employer. The state identified

46 Vermont’s group market is also subject to changes in employer coverage. Early in 2006, Vermont’s small existing Medicaid premium assistance program lost almost one-quarter of its enrollment due to changes in employer coverage that made ESI no longer cost-effective (OVHA, Lori Collins, April 2006).


approximately 6,000 employers for its Medicaid/SCHIP enrollees and determined that 69% (4,410 employers) offered coverage. Eventually, the state whittled the group down to over 1,000 employers that were approved for premium assistance based on factors such as benefit design and premium cost. In addition, Rhode Island found that it had to revamp completely how it made premium subsidies to employees to remove administrative burdens that were found to hinder employer participation.

In summary, these three critical areas of planning and infrastructure development — staff capacity, information systems, and coordination with employers — take considerable time and effort to put in place. Assumptions on VHAP enrollment in ESI premium assistance must account for the impact of these challenges that can impede and delay the ramp-up of enrollment in a new premium assistance program.

CONCLUSION

The message from other states’ experience with premium assistance is that careful analysis of data and cautious assumptions concerning potential enrollment are warranted. Premium assistance programs are highly complex to establish, and they face many ongoing challenges to success. Even the state programs considered most successful have enrollment levels that are substantially lower than originally expected. While shifting current VHAP enrollees into premium assistance may produce net savings for the State of Vermont, the enrollment assumptions that underlie projected VHAP “savings” need to account for the administrative complexity and related challenges that have consistently prevented premium assistance programs in other states from meeting expectations for enrollment, and thus expectations for savings.