Introduction

One of the issues considered during the 2007 reauthorization debate was the use of premium assistance programs under Medicaid and SCHIP. Premium assistance programs have been advocated as a mechanism for lowering public spending by maintaining or even increasing employer funding of health insurance coverage, increasing access to private providers, and keeping parents and children together on the same insurance policy. At the same time, however, concerns have been raised that premium assistance programs may not be cost-effective relative to providing coverage directly through Medicaid and SCHIP, that they may promote crowd-out, and that it may be difficult to ensure that children receive the wrap-around benefits that are not included in the employer plan.

Background

States can create premium assistance programs in one of four ways: through their Medicaid program under the authority of Section 1906 of the Social Security Act, through a separate SCHIP program, through a Section 1115 waiver, or using state funds. Programs created under Section 1906 or through a separate SCHIP program must meet a number of requirements for approval: the program must be shown to be cost-effective, the state must provide wrap-around benefits to cover services that are included in the Medicaid or SCHIP benefit package but excluded from the employer plan in which participants are enrolled, and cost sharing must not exceed 5 percent of family income. Children who drop other insurance coverage in order to enroll in an SCHIP premium assistance program must satisfy a six-month waiting period before being allowed to enroll. In contrast, states operating premium assistance programs under a Section 1115 waiver have greater flexibility in designing their programs, limited by little other than the discretion of the Secretary of the Department of Health and Human Services.

At least 20 states currently administer premium assistance programs and to date, enrollment levels have tended to be low. A 2007 study found that four out of six SCHIP premium assistance programs examined enrolled less than 1 percent of eligible children. In 2006, the three Medicaid premium assistance programs with the highest enrollment—Rhode Island, Massachusetts, and Pennsylvania—had enrolled 4.7, 3.4, and 1.9 percent, respectively, of their total Medicaid population in the premium assistance program. While evidence from some states, such as Rhode Island and New Jersey, shows that cost-savings can be achieved, enrollment in the program must be sufficiently high to offset the administrative costs associated with setting up and maintaining the program.

Seeking to encourage the creation of premium assistance programs under SCHIP, reauthorization legislation passed in 2007 would have given states a new option to implement premium assistance programs for children who are eligible for SCHIP but not already covered by private insurance. It also attempted to mitigate administrative...
hurdles to operating premium assistance programs by requiring employers to provide states with information about the benefit packages in their plans, and it would have amended the Internal Revenue Code to expand the scope of qualifying events to include gaining or losing eligibility for Medicaid/SCHIP. This change would have allowed children to enroll immediately in an employer plan if they were found to qualify for premium assistance or if they lost their Medicaid/SCHIP direct coverage, instead of having to wait for the next open enrollment period. At the same time, it also would have changed the cost-effectiveness test.

This brief examines the extent to which broader reliance on premium assistance programs could reduce uninsurance among Medicaid- and SCHIP-eligible children. We also examine the potential implications for program costs if premium assistance programs were expanded to all SCHIP-eligible children who have access to employer-sponsored insurance, including those who already have such coverage.

Data and Methods

Our analysis relies primarily on the 2005 Annual and Social Economic Supplement (ASEC) to the Current Population Survey (CPS) which is a nationally representative survey of the non-institutionalized population.

To identify children eligible for Medicaid and SCHIP coverage, we use a simulation model developed by researchers at the Urban Institute’s Health Policy Center that counted Medicaid, SCHIP or state coverage prior to ESI, this analysis relies on a hierarchy that counts ESI first so as to most generously estimate the number of parents and children with access to ESI. This results in lower estimates of Medicaid/SCHIP coverage and higher estimates of ESI for both children and parents. Among all children reported to have Medicaid/SCHIP, some 17 percent are also reported to have ESI at some point during the year. Similarly, some 18 percent of all parents reported to have Medicaid/SCHIP coverage also reported having ESI during the prior year.

Information on parents’ insurance status is used to classify children according to whether all, some, or no parents have ESI. Our primary measure is whether the child has at least one parent with ESI. This measure likely overstates the ease with which children could be added to an existing policy since the existence of families in which only one of the two parents is covered by ESI may indicate that the available family coverage is not affordable to that family. We also provide estimates of the share of uninsured children who have all (i.e., one parent in single-parent families and two parents in two-parent families) parents covered by ESI since that may be more indicative of the availability and affordability of dependent coverage through the employer plan.

While the ASEC lacks information on whether the parent’s coverage could include a spouse or child (i.e., whether dependent coverage is offered), previous research indicates that only 6 percent of all employers offer insurance without dependent coverage to their employees. The ASEC also lacks information on how much the employee would have to contribute to the premium payment for dependent coverage, though prior research has documented that employees have to contribute more toward dependent coverage (both in absolute and relative terms) than for single coverage.

Without information on the premium contributions that would be required for dependent coverage or the benefits and cost sharing associated with the employer plan, we cannot gauge the cost-effectiveness of the premium assistance option for the children whose parents are already covered under an employer plan.

Our estimates overstate the extent to which uninsured children whose parents are covered by ESI could be brought into premium assistance programs since the ESI covering the parents may not include an option for dependent coverage and it may not be able to meet the cost effectiveness test or other requirements. At the same time, however, while our estimates focus on whether a parent has taken up ESI, as opposed to having an offer of ESI for themselves, it is possible that the subsidy available through the premium assistance program could induce some parents to take up employer-sponsored insurance coverage for both themselves and their children. However, the fact that these parents have not taken up the offer for themselves (and their children) may be an indication that the ESI coverage that is available to them requires a large employee contribution, has high out-of-pocket cost sharing, or has a lean benefits package, which would make it difficult for the plan to meet the cost effectiveness test or to satisfy other requirements. It also seems unlikely that many parents who rejected ESI for themselves would choose to enroll themselves and their children in ESI with a premium assistance subsidy instead of enrolling their children directly in SCHIP.

Results

Among the 3.7 million uninsured children who are eligible for Medicaid, just 4.6 percent have a parent who is covered by ESI (figure 1). The 1.7 million uninsured children who are eligible for SCHIP have more access to employer coverage, but still just 15.9 percent have a parent who is covered by ESI. And the proportion of Medicaid/SCHIP eligible uninsured children who have all parents covered under ESI is even lower—3.0 percent of children eligible for Medicaid and 9.5 percent of children eligible for SCHIP (data not shown). Overall, just 8.1 percent
of all uninsured children who are eligible for either Medicaid or SCHIP have at least one parent with employer-sponsored coverage. Even if all the uninsured children who are eligible for Medicaid or SCHIP and who have a parent with ESI were to enroll in a premium assistance program, the number of uninsured children would decline by at most only 440,000, leaving approximately 5 million uninsured children who are eligible for public coverage but not yet enrolled.

While premium assistance programs have a limited scope for reducing the uninsurance problem among children who are eligible for Medicaid and SCHIP since so few of those children have parents with ESI, more aggressive reliance on premium assistance programs could provide ESI to up to 850,000 children who are currently enrolled in SCHIP but have a parent with ESI (figure 2). Covering these children under premium assistance programs has the potential to benefit states and families by using the employer contribution to help finance coverage, thus shifting costs from the state and federal government to employers; by allowing all family members to be on the same insurance plan; and by giving children potentially improved access to providers, since reimbursement rates are typically higher with employer-sponsored insurance than with Medicaid and SCHIP. On the other hand, to the extent that full wrap-around coverage is not provided, shifting children from public to private coverage might reduce access to necessary care since employer-sponsored plans typically offer fewer benefits and have higher out-of-pocket cost-sharing than do Medicaid and SCHIP.

For a much larger number of children, however, premium assistance programs could shift costs in the opposite direction, from private sources to the taxpayers. An estimated 7 million children could be eligible for SCHIP but are covered under their parent’s ESI plan (figure 2). If these children qualified for and received premium assistance, premiums now paid by the parents would be paid by public dollars instead. Taxpayer funds could also substitute for employer dollars since premium assistance programs could provide greater incentives for firms to reduce the amount they contribute for dependent coverage.

Policy Implications

Premium assistance programs cannot address many of the existing coverage gaps among children since so few uninsured children have parents with employer-sponsored insurance coverage. In particular, premium assistance programs targeted at SCHIP- and Medicaid-eligible children would have a limited impact on the number of uninsured children since just 4.6 percent of Medicaid-eligible and 15.9 percent of SCHIP-eligible uninsured children have a parent who is covered by ESI. Even in a scenario in which all eligible uninsured children whose parents have ESI were brought in through premium assistance programs, the number of uninsured children would decline by just 440,000.

Premium assistance programs could have a greater impact if states expanded public coverage to more parents since that would likely increase the likelihood that the cost-effectiveness test could be met even for the parents who do not have ESI but have an ESI offer. Moreover, to the extent that they reduce employer and employee contributions toward employer-sponsored coverage, expanding premium assistance programs under SCHIP could lead to a substantial substitution of public for private funding for health insurance coverage given that 7 million children qualify for SCHIP on the basis of their incomes but receive coverage through a parent’s employer-sponsored insurance plan. Of the children who could potentially qualify for premium assistance programs under SCHIP, the number who already have ESI coverage is more than six times the number who...
could potentially gain ESI, either by opting-out of direct public coverage or by a reduction in the uninsured. The administrative burdens associated with premium assistance programs, for both public programs and for employers, raise concerns as well. While policies such as waiting periods could reduce the extent to which premium assistance programs lead to reductions in private financing for health insurance coverage by limiting the enrollment of children who already have employer-sponsored coverage, such policies also raise serious equity issues. Parents who previously paid for their children’s health insurance would be denied assistance, while similarly situated parents who made a different choice would receive help.

Overall, many more uninsured children are eligible for public programs than have access to ESI through their parents. Therefore, policies to increase enrollment and retention in Medicaid and SCHIP have much greater potential than premium assistance programs to close coverage gaps among children.

Note: Children are considered to have access to ESI if at least one parent in the family has ESI coverage. SCHIP income-eligible children refers to children who would qualify for SCHIP if they were not enrolled in ESI. See data and methods section for information on how coverage status was determined.

Notes


4. Under the cost-effectiveness test, the cost of covering an individual or the cost of the premium assistance program as a whole must not be more than what the state would have spent to enroll those individuals in Medicaid or SCHIP.


7. Premium assistance programs require large administrative costs, particularly during program startup (Herman 2004). Existing data sources and management systems in the state may not contain the information necessary to identify eligible children and verify that the employer plan meets the criteria described above. New data systems may also be needed to process the premium subsidy (usually deposited directly into the employee's bank account); to process the cost-sharing payments, especially when the enrollee reaches the out-of-pocket limit; and to administer the provision of wrap-around benefits excluded from the employer plan. These high start-up costs may deter some states from implementing premium assistance programs (Herman 2004).

8. Interestingly, these two states also provide full wrap-around benefits in their programs, demonstrating that a premium assistance program does not have to be lean in order to be cost effective (Alker 2005).


10. Some states, including the three states with the highest enrollment shares in premium assistance programs, have eligibility expansions that include parents, including parents may contribute to higher enrollment likely because subsidizing family coverage premiums is more likely to be cost-effective than subsidizing the child alone (Herman, M. "Premium Assistance Programs: Potential Help for the Uninsured?" Technical Assistance Memo. Washington, DC: National Conference of State Legislatures, Forum for State Health Policy Leadership. 2004). Other program features that may lead to higher enrollment are broad criteria for eligible employer plans; a state law change to make eligibility for the program a qualifying event; no minimum employer contribution to the premium (cannot be done in an SCHIP premium assistance program); expanding eligibility for premium assistance to all children who qualify for SCHIP or Medicaid rather than just a small subset (for example, those with incomes between 200 and 300 percent of the FPL), and a cost-effectiveness test that uses the employer's average per-employee plan cost rather than the individual's cost, which is easier to track (Williams 2003). However, none of these policies will reduce uninsurance substantially if few uninsured children have access to ESI coverage.


12. Estimates of eligibility take into account the underreporting of Medicaid and SCHIP on the CPS by adjusting the CPS partially to state administrative enrollment totals for Medicaid and SCHIP and reducing the uninsured and privately-insured by one-third and two-thirds, respectively, of the undercount. Estimates are adjusted for immigration status to reflect that some noncitizen children may not be eligible for coverage despite meeting income and resource requirements. The precision of eligibility estimates may be undermined by the fact that some individuals may report annual income on the CPS that implies that they are not eligible for public coverage, when in fact they were income eligible for Medicaid or SCHIP for one or more months of the year. In addition, child support disregsards have not been taken into account in determining eligibility. Moreover, information on documentation status is not collected on the CPS. While an adjustment is made to the data to address this issue, it is derived from external estimates and may introduce error to the model. The misreporting of coverage on the CPS leads to imprecision in coverage estimates. While the adjustment for underreporting partially addresses this issue, uninsured estimates may be biased upward if the adjustment does not fully account for the undercount, or they may be biased downward if it overcorrects for this issue.

13. Although the CPS added a question in 2001 asking respondents specifically about whether any family member had been enrolled in a separate SCHIP program, the distinction between Medicaid and SCHIP is unreliable.
Therefore, we define SCHIP enrollees as children whom we have simulated to be eligible for SCHIP, and who reported enrollment in Medicaid or SCHIP on the CPS.

A long-standing debate surrounds CPS uninsured estimates and whether they represent the number of individuals without coverage for the entire prior year (as intended) or at a point in time in the past year. The Census Bureau has commented that CPS estimates more closely align with other surveys’ point-in-time estimates (DeNavas-Walt, C., B. Proctor, and J. Smith, U.S. Census Bureau, Current Population Reports, P60-235, Income, Poverty, and Health Insurance Coverage in the United States. 2007, U.S. Government Printing Office, Washington, DC. 2008). In this analysis, estimates of coverage are interpreted as reflecting the average experience in the past year.


Urban Institute tabulations of the 2005 ASEC to the CPS.


Supplemental estimates from the 2005 Contingent Worker Supplement to the CPS that have been merged with the 2005 ASEC and the Urban Institute Health Policy Center simulation model provide insights about the extent to which parents of uninsured Medicaid- and SCHIP-eligible children are not taking up offers of ESI that are available to them. These estimates indicate that about one quarter (24.6 percent) of all uninsured eligible children have a parent with an offer of employer coverage. An estimated 17.2 percent of uninsured Medicaid-eligible children have a parent with an offer; the share rises to 39.6 percent for uninsured children eligible for SCHIP. It is important to note that these estimates do not provide information on the extent to which parents have an offer of dependent coverage or provide information about what was offered. In addition, unlike the estimates used in the text, they do not include an adjustment for documentation status and they also reflect Census Bureau revisions to the 2005 ASEC that resulted in a lower number of uninsured.

Among the uninsured children who are not eligible for Medicaid or SCHIP, fewer than a fifth have a parent who has employer-sponsored insurance (figure 1).

To the extent that premium assistance programs could induce parents to take up an offer of ESI that they haven’t already taken up, the number of uninsured children that could gain coverage under a premium assistance program could be somewhat greater than that reported here. However, the majority of Medicaid- and SCHIP-eligible uninsured children could not gain coverage because they do not have an offer of ESI.

This enrollment estimate likely overstates access to ESI among children enrolled in SCHIP since families may be reporting on their coverage at different points over the course of the preceding year. This means that the parents may have had ESI coverage at a different time than when the children were covered under SCHIP.

Owcharenko and Moffit 2007.


Currently under SCHIP and in SCHIP reauthorization legislation passed in 2007 (H.R. 976), premium assistance programs are required to provide wrap-around benefits to enrollees. However, premium assistance programs under 1115 waiver authority are not required to provide these benefits.

The exact amount of the cost-shifting that would occur is difficult to estimate because it would depend on a number of factors including both the employer and employee shares of the premium, the amount of the potential subsidy through the premium assistance program, and the cost of covering a child in traditional Medicaid/SCHIP.

Moreover, premium assistance programs targeted at the higher-income uninsured children who are not eligible for either Medicaid or SCHIP would only have a modest effect on children’s coverage, since only a fraction (less than a quarter) have a parent with employer-sponsored coverage (data not shown).

This equity issue is not specific to premium assistance programs under SCHIP as the SCHIP statute explicitly targets children who do not have employer-sponsored coverage. As a consequence, most states have some type of waiting period for general SCHIP coverage.
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