Medicaid, CHIP and Employer-Sponsored Coverage Coordination Working Group

Report to the Secretary of Labor and the Secretary of Health and Human Services

August 4, 2010

Table of Contents

Working Group Charter

In response to section 311(b)(1)(C) of the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, the Secretary of Health and Human Services (HHS) and the Secretary of Labor (DOL) jointly established the Medicaid, CHIP, and Employer-Sponsored Coverage Coordination Working Group, referred to as the "the Working Group," in April 2009.

Under CHIPRA, the Working Group is responsible for developing a model coverage coordination disclosure form for plan administrators of group health plans to complete for purposes of permitting a State to determine the availability and cost-effectiveness of coverage available under group health plans to employees who have family members who are eligible for premium assistance offered under a State plan under title XIX (Medicaid) or title XXI (CHIP) of the Social Security Act (SSA), and to allow for coordination of coverage for enrollees of such plans (See Appendix B). The Working Group is also charged with writing a report that identifies the impediments to the effective coordination of Medicaid, CHIP and employer-sponsored coverage and making recommendations for overcoming these challenges (this report fulfills this requirement).

The model form and the report must be submitted to the Secretary of DOL and the Secretary of HHS not later than August 4, 2010, 18 months after the date of enactment of CHIPRA. The Secretaries must also submit the report recommendations to Congress not later than October 4, 2010. The Working Group will be terminated 30 days after the report is submitted to the Secretaries. The Secretaries have the flexibility to comment on the proposed recommendations, but must submit the attached report to Congress in its current form.

The Federal government has long recognized the important role of the public in developing effective policies. Advisory committees are a way of ensuring public and expert involvement and advice in Federal decision-making. In response to the growing number of advisory committees, Congress enacted the Federal Advisory Committee Act (FACA) of 1972, which established the guidelines under which all Federal advisory committees must operate. This Working Group is subject to FACA and complied with all FACA requirements, including public disclosure of meetings and ethical guidelines for committee members.

Working Group Membership

The Secretary of DOL and the Secretary of HHS selected the following members of the Working Group. The statute called for the inclusion of representatives from DOL, HHS, State Medicaid and CHIP directors, employers (including small businesses and human resource professionals), health insurance plan administrators, health insurance issuers, and representatives of children and other beneficiaries.

The members of the Working Group included:

Joan C. Alker, M.Phil., Research Associate Professor and Co-Executive Director, Center for Children and Families, Health Policy Institute, Georgetown University
George Askew, M.D., FAAP, Deputy CEO, Voice for America's Children
Terry Bayer, Esq., Chief Operating Officer, Molina Healthcare
Emma Bennett-Williams, Esq., Benefits and Human Resources Subject Matter Expert, Benefit Focus
Phyllis C. Borzi, Assistant Secretary, Department of Labor
Barbara Caress, Director of Strategic Planning and Policy, 32BJ Benefit Funds
Miguel A. Carranza, Ph.D., Professor of Sociology and Ethnic Studies, University of Nebraska-Lincoln
Roberta Casper Watson, Esq., Partner, Trenam Kemker
Greta E. Cowart, Esq., Partner, Haynes and Boone
Ellyn Fuchsteiner, Esq., Associate General Counsel, United Healthcare
Kevin Hayden, President, State-Sponsored Business, WellPoint, Inc.
Howard "Rocky" King, Senior Policy Advisor on Health Reform, Oregon Department of Business and Consumer Services
Ann Clemency Kohler, Executive Director, National Association of State Medicaid Directors
Rhonda Medows, M.D., FAAFP, Commissioner, Georgia Department of Community Health
Janet Olszewski, M.S.W., Director, Michigan Department of Community Health
Kaye L. Pestaina, Esq., Vice President, National Health Compliance, The Segal Company
Linda Sheppard, Esq., Director, Accident and Health Division, Kansas Insurance Department
Anita Smith, Chief, Bureau of Medical Supports, Division of Financial, Health, and Work Supports, Iowa Department of Human Services
Mari Spaulding-Bynon, Esq., Bureau Chief, Insure New Mexico!, Medical Assistance Division, New Mexico Human Services Department
Mark Stember, Esq., Partner, Kilpatrick Stockton, LLP
Victoria Wachino, M.P.P., Director, Family and Children's Health Programs Group, Center for Medicaid, CHIP and Survey & Certification, Centers for Medicare and Medicaid Services

Executive Summary and Recommendations

Premium assistance programs, which subsidize the purchase of employer-sponsored health coverage using Medicaid and CHIP funding, provide important coverage options for families, but States have historically struggled in implementing these programs in terms of experiencing high administrative costs, operational challenges, and low enrollment. CHIPRA mandated the establishment of a Working Group to identify the impediments to the effective coordination of Medicaid, CHIP and employer-sponsored coverage and to make recommendations for overcoming these challenges.

The working group identified several challenges for the various stakeholders involved in premium assistance programs: (1) challenges for families with enrolling in premium assistance programs and accessing essential benefits, (2) challenges for employers, insurance companies, and third-party plan administrators with responding to State data collection requirements and increasing employer participation, and (3) challenges for States and the Federal government in achieving cost savings after administrative costs are taken into account. Additionally, limited access to employer-sponsored coverage for low-income families who are eligible for Medicaid and CHIP, the declining availability of employer-sponsored coverage and other factors of the private health insurance market may pose underlying challenges for premium assistance programs.

CHIPRA includes new provisions designed to improve the viability of premium assistance programs, but there has been little time for implementation, and thus it is difficult to assess whether these new provisions are working effectively.

Moreover, the passage of the Affordable Care Act of 2010 (ACA)[1] introduces new coverage options and policy changes that change the role of premium assistance programs in providing access to affordable health coverage for low- and moderate-income families. For example, new premium tax credits in health insurance exchanges and the expansion of Medicaid to 133 percent of the Federal poverty level (FPL) may supplant the need for premium assistance programs, but the maintenance of effort requirements and the rules for exchange tax credits may make premium assistance an attractive option to close gaps in affordability of coverage for moderate-income families. New requirements on individuals and employers, as well as administrative simplification efforts and enhanced payments to primary care providers may also affect the viability of premium assistance programs in complex ways.

As a result of this changing health care landscape, the Working Group recommends that States exercise caution in establishing entirely new premium assistance programs. States with existing premium assistance programs should explore opportunities to coordinate their programs with new provisions in ACA in order to reduce administrative burdens and achieve the larger ACA goals of quality, affordable health care for all American families. Regardless of the final role of

premium assistance programs after ACA has been implemented, the lessons from over 15 years of implementing premium assistance programs are important to consider as States explore new options for providing public subsidies for private coverage.

Overall, the Working Group makes the following recommendations to Congress, as well as State and Federal policymakers:

1. **Exercise caution prior to investing resources in the design and implementation of a new premium assistance program:** Given the many uncertainties facing the future viability of this program in the context of ACA and the lack of availability of state or national data on important issues such as the impact of beneficiary access to care and cost-effectiveness under premium assistance, States should be deliberate in assessing whether such an investment is a priority in the short-term.

2. **Identify potential opportunities for integrating existing premium assistance programs with related initiatives in ACA:** States with existing premium assistance programs should closely examine how some of the new provisions in ACA might provide new opportunities for enhancing existing premium assistance programs. The Working Group provides the following areas for consideration:

    a. The expansion of Medicaid to 133 percent of the FPL creates new alternatives and opportunities for the lowest income families. In 2014, families below 133 percent of the FPL will be able to obtain traditional Medicaid coverage for their entire family. If these families have access to employer-sponsored coverage, their health plan may be more likely to qualify for premium assistance because the cost of the parent's coverage would also be included in the cost-effectiveness calculation.
    b. ACA has important implications for families between 133 and 400 percent of the FPL. Premium assistance could provide an option for some families to maintain coverage under the same health plan in cases where children are eligible for public coverage at higher income levels than adults. More guidance is needed about how exchange tax credits and premium assistance subsidies may interact for this population.
    c. Penalties for large employers that take effect in 2014 are connected to the availability of affordable coverage for employees. Premium assistance may help some large employers meet some of these requirements by making insurance coverage more affordable for low-income workers.
    d. Small Business Health Options Program (SHOP) exchanges established in 2014 will help small employers enroll in small group health insurance plans. States

could consider incorporating some premium assistance information into these exchanges as a way to help small businesses obtain affordable coverage for their employees.

e. In general, new benefit requirements in ACA for private health insurance may help more employer-sponsored plans meet the requirements for premium assistance for families who are Medicaid or CHIP eligible. Administrative simplifications for standardizing the communication of health plan information may also help States to more easily collect information about benefits, cost-sharing, and cost-effectiveness in order to identify qualifying health plans.

3. **Apply lessons learned from premium assistance programs to health insurance exchanges:** States should apply lessons from existing premium assistance programs when developing individual exchanges and SHOP exchanges. Some general lessons learned for consideration include:
    a. The administrative costs of evaluating health plans on an individual basis are high. Premium assistance programs have reduced the costs of evaluating employer-sponsored plans by pre-approving certain plans or developing electronic systems for collecting information.
    b. Strong relationships with employers are necessary to gain cooperation with data collection requirements and encourage more uptake of the program. Premium assistance programs have had success working with employers by coordinating with State agencies that regulate private health insurance and by working with independent insurance agents who already have existing relationships with employers.
    c. The process for enrolling and disenrolling from public subsidies for private insurance is important to consider, since eligibility rules for public programs and open-enrollment periods for private insurance may not always coincide. Successful premium assistance programs streamline program entry and exit by developing a standard process for coordinating eligibility, enrollment, and payment of premium subsidies.

4. **Consider the Working Group Coverage Disclosure Form as model for related ACA data collection efforts:** The data elements in the attached model coverage disclosure form were developed by Medicaid and CHIP Directors, health plan insurers and administrators that served on this Working Group and should be considered in the development of various data collection efforts that are part of health reform, including, but not limited to:

a. The working group for health information technology enrollment standards and protocols that will develop recommendations for facilitating the enrollment of individuals into Federal health care programs with 180 days of enactment of ACA (section 1561 of ACA)
b. Standardized explanation of benefit forms that insurance plans will be required to provide to beneficiaries two years after the enactment of ACA (section 1001 of ACA)
c. The standards for electronically transmitting information on eligibility, health care claims, and enrollment information that will be developed by the Secretary of HHS with advice from the National Committee on Vital Health Statistics (section 1104 of ACA)
d. The transparency requirements for health plans that are certified to offer coverage in insurance exchanges and by group and individual health insurance plans that are not offered in exchanges (sections 1001 and 1311 of ACA)
e. The information on insurance coverage that employers must submit to employees after 2014 in order to help employees meet the individual responsibility requirements (section 1502 of ACA)

When possible, any data collection efforts, including the model coverage disclosure form, should be made available electronically to key stakeholders and on a national level.

5. **Develop mechanisms for holding insurers and third-party administrators accountable for public/private sector exchanges of health care information:** Congress should make changes to Federal laws, such as Employee Retirement and Income Security Act (ERISA) of 1974, in order to hold insurers and third-party administrators accountable for providing information to employers and States, in addition to the parties listed in current law. Another option for ensuring accountability would be requiring Memorandums of Understanding between employers, insurers and/or third-party administrators.

6. **Establish a public/private sector Advisory Board to assess the ongoing challenges and successes of private/public partnership under the health insurance exchanges:** We recommend that the Secretary of HHS establish a Public and Private Health Care Coverage Coordination Advisory Board with support from the HHS Office of Consumer Information and Insurance Oversight (OCIIO) in 2012. The composition of the Advisory Board would be similar to this Working Group and be comprised of representatives of small and large employers, plan administrators and sponsors of group health plans,

State agencies administering Medicaid and CHIP programs, health insurance issuers and children and other beneficiaries. The purpose of the Advisory Board will be to provide ongoing guidance and recommendations to OCIIO on private and public sector coordination efforts.

7. **Conduct a Government Accountability Office Report:** CHIPRA made several changes designed to improve the effectiveness of premium assistance programs. GAO should examine the impact of some or all of the following CHIPRA provisions by February 4, 2011, two years after the implementation of CHIPRA:

    a. The provision that requires that children can opt back in to direct Medicaid/CHIP State plan coverage for more comprehensive benefits and cost-sharing protections. Participation is voluntary, and children can "opt-out" to get back to CHIP/Medicaid at the end of every month[2]
    b. The impact of requiring States to include administrative costs in the cost effectiveness test under new CHIPRA premium assistance options[3]
    c. The impact of requiring employers to provide employees State-specific contact information on premium assistance programs, as well as information on eligibility, benefits, and cost sharing[4]
    d. New rules designed to ease transition between public and private coverage and to a guaranteed right to enroll in a group health plan without waiting for an open enrollment period[5]

Introduction

Access to quality, affordable health care coverage is important to the health and well being of families. Unfortunately, families with low and moderate incomes have been increasingly challenged to find affordable health insurance coverage, even if they are offered health benefits at work. Premium assistance programs help to subsidize the purchase of group health coverage for family members who are eligible for Medicaid or CHIP and who have access to qualified employer-sponsored coverage, but may need assistance paying their premiums.[6] In the absence of national solutions to address the growing number of individuals without health coverage prior to the passage of ACA, States have pursued premium assistance as an opportunity to expand affordable options in the employer-based insurance market and leverage private sector funds to generate cost savings for Medicaid and CHIP.

States have had long-standing authority to operate premium assistance programs under section 1906 and section 2105(c)(3) of the SSA. In addition, some States have operated premium assistance programs authorized through section 1115 demonstration authority. The Children's Health Insurance Program Reauthorization Act (CHIPRA) further expands the available options for States considering premium assistance programs to subsidize qualified employer-sponsored plans by adding sections 1906(a) and 2105(c)(10) to the SSA.

Considering that States have the option to implement premium assistance under a variety of Federal authorities as well as certain State flexibilities to address the needs of the unique circumstances within each State, there is no single model for premium assistance. However, based on lessons learned from some 15 years of State, employer, and group health plan administrator's experience in coordinating health insurance coverage for Medicaid and CHIP families, this Working Group report aims to provide:

- A discussion of impediments to coordinating public and private coverage through premium assistance programs,
- Recommendations to Congress for addressing the major impediments to the effective coordination of coverage, and
- Key considerations for Federal and State policymakers and regulators about the viability of the premium assistance model in the short term, and, more importantly, in 2014 and beyond, when the main provisions of ACA are implemented.

Current State options and Federal rules for premium assistance programs

Medicaid and CHIP are both jointly funded by the Federal and State governments and administered by the States. The CMS is the agency responsible for overseeing Medicaid and CHIP, including premium assistance programs. The Federal government establishes parameters within which States construct these programs. For premium assistance, these parameters relate to eligibility, insurance status, voluntary versus mandatory enrollment, benefits, cost sharing, waiting periods, employer contribution level, and cost effectiveness. The rules vary depending upon the authority that the State elects to use to establish its premium assistance programs. States currently have four State plan options for implementing premium assistance under Medicaid and CHIP, as well as additional options through section 1115 demonstration authorities:

Medicaid

Section 1906 of the SSA is a Medicaid premium assistance option, referred to as Health Insurance Premium Payment (HIPP). This option was available to States for Medicaid-eligible families prior to CHIPRA and continues to be an option for States. Section 301(b) of CHIPRA provides States with an additional premium assistance option for Medicaid-eligible children under age 19 by adding section 1906A to the SSA. States may also enroll family members who are not eligible for Medicaid under both of these options, if this is necessary to reach Medicaid-eligible family members.

CHIP

Section 2105(c)(3) is a CHIP premium assistance option, referred to as "Purchase of Family Coverage." This option was available to States for CHIP-eligible children and to families that include at least one CHIP-eligible child prior to CHIPRA, and continues to be an option for States. Section 301(a)(1) of CHIPRA provides States with an additional premium assistance option for CHIP-eligible children who have access to qualified employer-sponsored coverage by adding section 2105(c)(10) to the SSA.

Section 1115 Demonstration Authority

States make also seek section 1115 demonstration authority to operate a premium assistance program that may not follow all of the Medicaid or CHIP statutory requirements that apply under title XIX or title XXI State plan authority. To do so, States must obtain approval from CMS to operate a demonstration under section 1115 of the SSA. Section 1115 of the SSA allows the Secretary of HHS to waive certain statutory requirements in the case of experimental, pilot, or demonstration projects that are likely to promote program objectives. Under these demonstrations, benefit, cost-sharing, and cost-effectiveness requirements under title XIX and

title XXI of the SSA have frequently been waived. States with section 1115 demonstrations in effect prior to the date of CHIPRA enactment (February 4, 2009) can continue to provide premium assistance to the Medicaid and CHIP populations served under section 1115 authority. CHIPRA added section 2111 of the SSA, which prohibits the CMS from approving any new demonstrations to cover parents with title XXI (CHIP) funds, regardless of whether or not these demonstrations involve premium assistance. States are, however, permitted to cover non-eligible parents under title XXI through incidental coverage, which occurs when the per-child subsidy for covering children under a premium subsidy results in coverage for the parents at no additional cost to the States or the Federal government when compared to direct CHIP coverage for the child or children only.

Benefit and cost-sharing rules

Under section 1906(A) Medicaid State plan premium assistance authorities, States must ensure that Medicaid-eligible individuals receiving premium assistance are enrolled in qualified employer-sponsored coverage[7] and receive the same benefits and cost-sharing protections as any other Medicaid beneficiary covered under the Medicaid State plan. For premium assistance programs operating under 1906, if the group health plan or qualified employer-sponsored plan does not provide the full range of Medicaid benefits, or the cost sharing is greater than what individuals would pay under the Medicaid State plan, the State must wraparound these benefits and pay on behalf of the individual all premiums, deductibles, coinsurance, and other cost-sharing amounts that exceed the statutory limitations. Families not eligible for Medicaid are only eligible to have group health plan premiums paid on their behalf if necessary to obtain access for the Medicaid enrollee. These family members not eligible for Medicaid are liable for any additional cost sharing on their behalf.

Similar to Medicaid, States with the authority under either sections 2105(c)(3) or 2105(c)(10), CHIP State plan premium assistance authorities must ensure that CHIP-eligible children receive the same benefits as those provided directly under the CHIP State plan. Under section 2105(c)(10) authority, qualified health insurance plans must specifically meet requirements for CHIP benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage, provided fully through the employer-based plan. Under section 2105(c)(3) authority, States provide wraparound benefits for covered services not provided by the private plan. Non-eligible family members do not receive wraparound benefits. Cost sharing for eligible children in premium assistance must meet the same requirements as those for children receiving CHIP benefits directly under the CHIP State plan, consistent with title XXI cost sharing requirements.

In both Medicaid and CHIP, specific limits exist for cost sharing for families at or below 150 percent of the FPL, and total premium and cost sharing for eligible individuals in the family cannot exceed 5 percent of the family's income for children of all income levels. Medicaid and

CHIP also have statutorily mandated services that may or may not be covered in the private market health plans. For example, children in Medicaid are entitled to the Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT), which covers a full range of services for screening and treatment. And CHIP requires the coverage of services, such as well-baby and well-child services, immunizations, and dental services.

CHIPRA provides one exception to these benefit and cost sharing rules under CHIP premium assistance programs. If a State can demonstrate that qualified employer-sponsored coverage is certified by an actuary as health benefits coverage that is a benchmark benefit package described in section 2103(b) or benchmark-equivalent coverage that meets the requirements of section 2103(a)(2), then enrollment in the employer plan meets the CHIP benefit and cost-sharing standards. Although no State has elected this option to date, this option has raised concerns among some policymakers since it does not ensure that the mandatory title XXI CHIP benefits and cost-sharing protections are in place for children.

Cost-effectiveness tests

Prior to CHIPRA, States were required to demonstrate cost effectiveness on an individual/family or aggregate basis, compared to the cost of providing direct CHIP coverage to a targeted low-income child. Section 301(a)(2) of CHIPRA amends the cost-effectiveness test under section 2105(c)(3) of the SSA to permit States to compare the costs of covering the entire family relative to direct CHIP coverage of the entire family, rather than just the targeted low-income child. States can continue to calculate these costs on the individual or aggregate basis, and must now also include administrative costs in the cost-effectiveness test. ACA also makes the new CHIP cost effectiveness test applicable to sections 2105(c)(10) and 1906(A). The impact of this change is difficult to assess given that few States have submitted State plan amendments (SPAs) to elect this option under Medicaid or CHIP. And for those States that have submitted and received approval for these SPAs, it is too early to determine the effect of requiring administrative costs in the cost effectiveness test.

Of the 43 premium assistance programs that subsidize employer-sponsored insurance (ESI), only eight premium assistance programs required that employers contribute a minimum amount toward the cost of enrollees' premiums, with the required minimum contribution ranging from 25 to 50 percent. More employers may opt to provide a contribution, but it has not historically been a Federal requirement in programs operating under 1906 State plan or section 1115 demonstration authority. States that are interested in electing the new CHIPRA premium assistance option either under sections 1906(a) or 2105(c)(10) must ensure that employers provide a 40 percent minimum contribution toward the total premium amount.

Figure 1: Side-by-Side Analysis of Title XXI and Title XIX Premium Assistance Options (Eligibility Criteria)

Conditions	Purchase of Family Coverage *Section 2105(c)(3)*	Additional Premium Assistance Option *Section 2105(c)(10)*	Medicaid Premium Assistance *Section 1906*	Premium Assistance Option for Children *Section 1906A*
Eligibility	Targeted low-income children and families that include at least one targeted low-income child.	Targeted low-income children who have access to qualified employer-sponsored coverage.	All Medicaid eligibles if State has elected this option in its Medicaid State plan.	At State option, individuals under age 19, who are eligible for title XIX (and the parent of such individuals).
Coverage for Non-Eligible Family Members	May provide premium assistance to non-eligible CHIP family members.	Only States with section 1115 demonstration authority to cover families prior to the passage of CHIPRA can continue to cover families. All States, however, can continue to cover parents on an incidental basis under the CHIP State plan.	States may enroll family members who are not eligible for Medicaid in employer coverage when that enrollment is necessary to achieve coverage of Medicaid-eligible family members. However, noneligible family members do not receive any wrap-around benefits.	States may enroll family members who are not eligible for Medicaid when that enrollment is necessary to achieve coverage of Medicaid-eligible family members.
Substitution Strategy	States must have a six-month waiting period.	States must apply same waiting period (if applicable) to premium assistance as is applied to direct coverage.	No requirement.	No requirement.

Source: Adapted from CMS State Health Official Letter #10-002

Figure 2: Side-by-Side Analysis of Title XXI and Title XIX Premium Assistance Options (Benefits and Cost-Sharing)

Conditions	Purchase of Family Coverage *Section 2105(c)(3)*	Additional Premium Assistance Option *Section 2105(c)(10)*	Medicaid Premium Assistance *Section 1906*	Premium Assistance Option for Children *Section 1906A*
Benefits	Coverage must meet the same requirements as those for CHIP direct coverage. These benefits can either be provided fully through the employer-based plan or through the private plan plus the State providing wrap around benefits.	Coverage must meet the same requirements as those for CHIP direct coverage. If coverage offered through an employer is certified by an actuary as benchmark or benchmark-equivalent, enrollment in the employer plan meets the CHIP benefit standards. For coverage that does not meet benchmark or benchmark-equivalent standards, benefits must be provided through a combination.	Medicaid-eligible individuals are covered for all items and services covered under the Medicaid State plan.	Children who are Medicaid eligible (and their parents) are covered for all items and services covered under the Medicaid State plan.
Cost Sharing	Cost sharing in premium assistance must meet the same requirements as CHIP direct coverage.	Cost sharing for premium assistance must meet the same requirements as CHIP direct coverage. If coverage offered through an employer is certified by an actuary as coverage that is benchmark or benchmark-equivalent, the plan shall be determined to meet CHIP cost sharing standard. For coverage that does not meet benchmark or benchmark-equivalent standards, States must ensure all CHIP cost sharing protections apply.	Cost-sharing protections as any other Medicaid beneficiary and must have all premiums, deductibles, coinsurance, and other cost sharing for items and services otherwise covered under the State plan, as specified by the group health plan, paid on their behalf. Non-Medicaid eligible family members are eligible only to have group health plan premiums paid on their behalf (if necessary to obtain access for the Medicaid enrollee).	The State must pay all premiums, deductibles, coinsurance, and other cost sharing for the individual under age 19 and the parent.

Source: Adapted from CMS State Health Official Letter #10-002

Figure 3: Side-by-Side Analysis of Title XXI and Title XIX Premium Assistance Options (Cost-Effectiveness)

Conditions	Purchase of Family Coverage *Section 2105(c)(3)*	Additional Premium Assistance Option *Section 2105(c)(10)*	Medicaid Premium Assistance *Section 1906*	Premium Assistance Option for Children *Section 1906A*
Employer Contribution	States must identify a minimum contribution level; there is no Federal minimum.	Employer must contribute at least 40 percent toward the cost of the premium.	No minimum employer contribution.	Employer must contribute at least 40 percent toward the cost of the premium.
Cost Effectiveness	CHIPRA changes the cost effectiveness test to permit States to compare the costs of covering the entire family relative to direct CHIP coverage of the entire family, rather than just the targeted low-income child. States can continue to calculate these costs on the individual or aggregate basis, and must now also include administrative costs in the cost-effectiveness test.	ACA also makes the CHIPRA cost-effectiveness test applicable to section 2105(c)(10).	Expenditures for an individual enrolled in a group health plan, including wraparound benefits and cost sharing, are likely to be less than expenditures required by the plan. Costs for premiums for non-title XIX eligible family members are included when testing for cost-effectiveness.	ACA also makes the CHIPRA cost-effectiveness test applicable to section 1906(A).

Source: Adapted from CMS State Health Official Letter #10-002

State adoption

A January 2010 Government Accountability Office (GAO) Report mandated by CHIPRA to identify the baseline characteristics of premium assistance programs (hereafter "GAO report") identified 47 premium assistance programs currently operating in 39 States.[8] Of the survey results from 45 of the 47 premium assistance programs, the GAO determined that the majority (29) of the programs operated under section 1906 authority, 16 programs operated under section 1115 demonstration authority, one program operated under section 2105(c)(3) of the SSA, and nine programs operated under other authorities (e.g., section 1902(a)(10)(F) permits States to use Medicaid funds to pay premiums for COBRA continuation coverage for certain low-income individuals).

According to the GAO report, premium assistance program enrollment as of June 30, 2009, ranged from fewer than 10 individuals in five programs to more than 10,000 individuals in four programs, including one program with more than 30,000 individuals. Over half of the programs (25) had fewer than 1,000 enrollees.

Coordination of Medicaid, CHIP, and Employer-Sponsored Coverage

Stakeholders

Although each premium assistance program is unique, Working Group members determined that all programs generally rely on the interaction of five primary stakeholders: (1) the individual or family, who is eligible for employment-based health coverage; (2) the employer, who provides coverage through insurance or a self-insured employer-sponsored health plan; (3) insurance companies or third-party plan administrators, which administer the private health coverage; (4) the State government, which administers the program; and (5) the Federal government, which sets the overall rules for premium assistance programs and also issues regulations for employee benefits.

Families targeted by premium assistance programs are diverse. Some may not have prior experience with Medicaid or CHIP and many may have difficultly navigating various options for health coverage. This report refers to "consumers" or "beneficiaries" of premium assistance as "families" throughout, but it should be noted that it is possible for premium assistance to be applied to individuals as well.

Employment-based group health plan coverage can be insured or self-funded. The type of coverage (e.g., group or individual coverage, large or small group, insured or self-funded), and the State and Federal rules governing the coverage, influence the data that States need to collect from employers regarding eligibility, benefits, and cost sharing.

Insured group health plan coverage is provided by a health insurance issuer. Issuers are regulated under State law. For example, all States have laws that require issuers selling health coverage to offer coverage for certain mandated benefits. The number and type of these mandates varies considerably across states. Although the coverage offered by an issuer is primarily regulated by the States, a number of Federal laws contain requirements that may also apply to health insurance issuers.

Self-funded group health plans operate under Federal law, namely ERISA, and are not generally subject to the State regulations applicable to issuers. Many large employers establish self-funded plans. Under a self-funded group health plan, the plan sponsor assumes the risk of providing coverage to plan enrollees by directly funding the plan rather than using an insurer. In some cases, self-funded health plans contract with one or more third-party administrators (TPAs) to administer the plan. Some insurers also provide third-party administrative services to plans. The TPA will manage the administration of the health plan, but coverage will be provided through the plan fund, not through insurance. As discussed later in this report, the complexity of these arrangements can play a role in the challenges States face in collecting the information they need from employers to ensure that families are eligible for premium assistance in a particular State.

ERISA applies to group health plans, both insured and self-funded. ERISA requires group health plans to provide a summary plan description (SPD) to participants and beneficiaries covered under the plan. The SPD must clearly inform participants and beneficiaries of their benefits and obligations under the plan and of their rights under ERISA. The SPD is typically the information that a State receives from employers to assess whether the services meet Federal Medicaid and CHIP rules.

Many recent Federal health laws have set new requirements for insurers in all States. For example, numerous laws relating to health coverage, including the Health Insurance Portability and Accountability Act (HIPPA) of 1996, the Genetic Information and Nondiscrimination Act, the Mental Health Parity and Addiction Equity Act, The Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and now the Affordable Care Act amend ERISA, the Public Health Service Act (PHS Act) and the Internal Revenue Code and thus apply new requirements for insurers in all States. The group market provisions of these laws generally apply to insured and self-funded group health plans. Employer sponsored plans are subject to the requirements under ERISA. Insurers are often subject to the parallel requirements under the PHS Act. States have primary authority with respect to implementing the Federal requirements applicable to insurers. HHS has fallback authority if a State is not substantially enforcing these laws. States generally must implement standards at least as protective as the Federal requirements, but can implement requirements that are more protective of consumers.

The requirements of these Federal laws applicable to insured and self-funded group health plans impact coverage provided by employment-based plans and influence the data states are interested in collecting with respect to coverage offered by plans.

The State agencies that administer Medicaid and CHIP premium assistance programs are often the same agencies that manage the regular Medicaid and CHIP programs. Some States, such as Oregon, have created a separate agency to manage premium assistance in order to help avoid the stigma sometimes perceived by families under public sector programs and ensure better coordination with private health insurance regulations.

Because the Medicaid/CHIP programs are Federal and State partnerships, the States have flexibility to operate their premium assistance programs within the context of Federal rules. In general, the creation and modification of premium assistance programs is governed by State Plan Amendments and/or section 1115 demonstration proposals that are reviewed and subject to approval by the CMS. CMS also monitors the implementation of these programs according to Federal rules.

Enrollment process

Families, employers, and States interact on an ongoing basis during the administration of premium assistance programs, but in general, the enrollment of a family in premium assistance consists of three core processes:

1. Medicaid and CHIP eligible families apply for premium assistance
2. Employers and plan administrators provide health plan information
3. State evaluates benefits, cost sharing, and cost-effectiveness in order to determine whether employer coverage qualifies for premium assistance

Eligibility for premium assistance is targeted to families eligible for Medicaid and CHIP, and it requires an application to first determine Medicaid or CHIP eligibility. The Medicaid and CHIP application process can be difficult for families, and so some States have been developing approaches to simplify the application process, as well as the process for retaining individuals in Medicaid and CHIP. However, in general and not specific to premium assistance, over five million uninsured children and four million uninsured adults are estimated to be eligible, but not enrolled in Medicaid or CHIP.[9] CHIPRA included provisions, such as performance bonus payments, to provide incentives for States to simplify their application processes and to encourage and assist States in reaching and enrolling more uninsured children who are eligible for Medicaid. Simplification efforts include program features, such as continuous eligibility, liberalization of asset requirements, elimination of in-person interviews, and express lane application process. States must also consider methods that simplify enrollment into premium assistance, such as accessing databases to determine whether Medicaid and CHIP eligible

individuals have access to employer-sponsored coverage at the point of application, or instituting a limited waiting period.

Once Medicaid or CHIP eligibility is determined, the State must determine whether the employer-sponsored plan that the applicant selects meets the requirements of the Federal/State premium assistance program. In some programs, the State evaluates benefits in response to data submitted by the employers, and in other instances the State pre-approves certain health plans. In addition to meeting certain benefit benchmarks, ESI plans eligible for premium assistances must also be evaluated for cost-effectiveness by comparing the costs of covering the individual or the entire family relative to the cost of direct Medicaid or CHIP coverage (either on an individual or aggregate basis). As noted previously, States must now include administrative costs in the cost-effectiveness test.

Finally, if the family and the employer-sponsored plans are deemed eligible, the State administers the premium subsidy, either to the family or to the employer directly. The amount of the State/Federal subsidy varies from State to State. Some States provide the full premium amount on behalf of a family, a capped monthly subsidy, or the amount remaining after the employer and individual contributions. The State also manages other requirements of the premium assistance program where applicable, such as providing wraparound coverage.

In addition to these core processes, there are many ongoing components that are important to administering premium assistance programs, such as maintaining relationships with employers and ensuring individuals remain eligible for employer-sponsored coverage.

Overview of impediments to effective coordination

Although premium assistance programs make sense conceptually, States have encountered many challenges implementing these programs in practice. The Working Group was charged with examining these challenges and offering recommendations to improve the coordination of Medicaid, CHIP, and employer-sponsored coverage.

The sections that follow present the findings and recommendations of the Working Group. These sections are organized by the perspectives of three stakeholder groups: (1) challenges for families, (2) challenges for employers, and (3) challenges for States. Challenges from the perspective of insurance companies/third-party administrators are incorporated into the employer challenges section and challenges for the Federal government are incorporated in the State challenges section. In addition, the consequences of the dynamics of the market for employer-sponsored health coverage and potential implications of ACA are discussed.

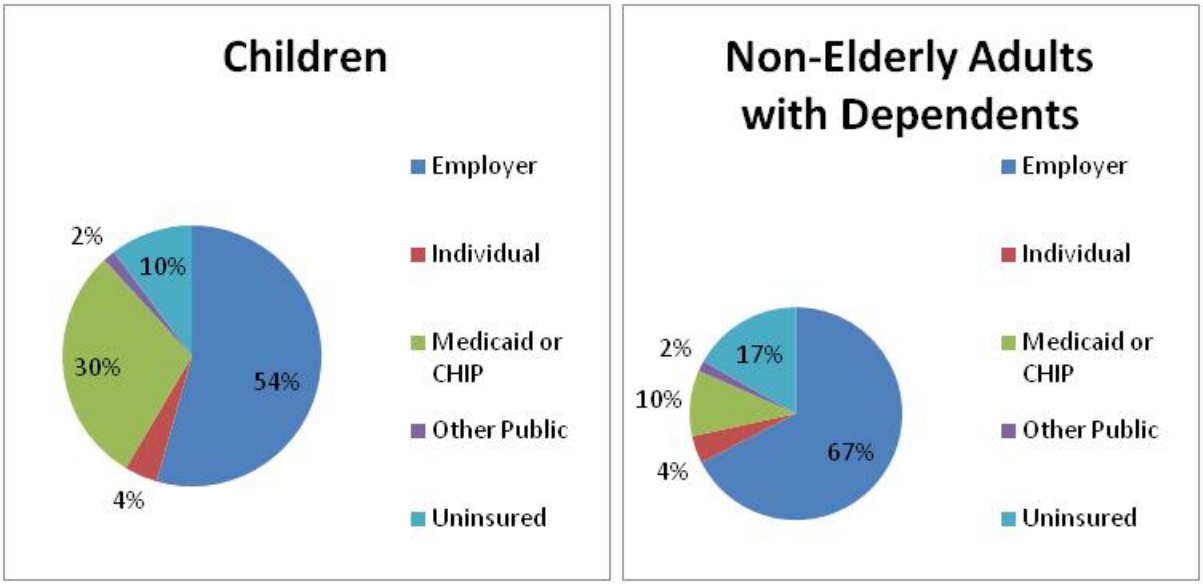
Underlying Challenges in the Private Health Insurance Market

One of the major underlying challenges to premium assistance identified by the Working Group is the lack of access to quality, affordable employer-sponsored health coverage for many low-income families. The existing literature on private health coverage supports this concern and was part of the impetus for the passage of ACA.

Availability

American families currently receive health coverage through a variety of public and private sources. In 2008, 54 percent of children received private employer-sponsored health coverage, 30 percent received Medicaid or CHIP coverage, 4 percent received coverage purchased on the individual market, 2 percent received other public coverage, and 10 percent were uninsured. Non-elderly adults with dependents are more likely to have employer-sponsored health coverage (67 percent) and less likely to have Medicaid or CHIP coverage (10 percent). [See Figure 4 below]

Figure 4: Sources of Health Insurance Coverage for Children and Non-elderly Adults with Dependents (2008)



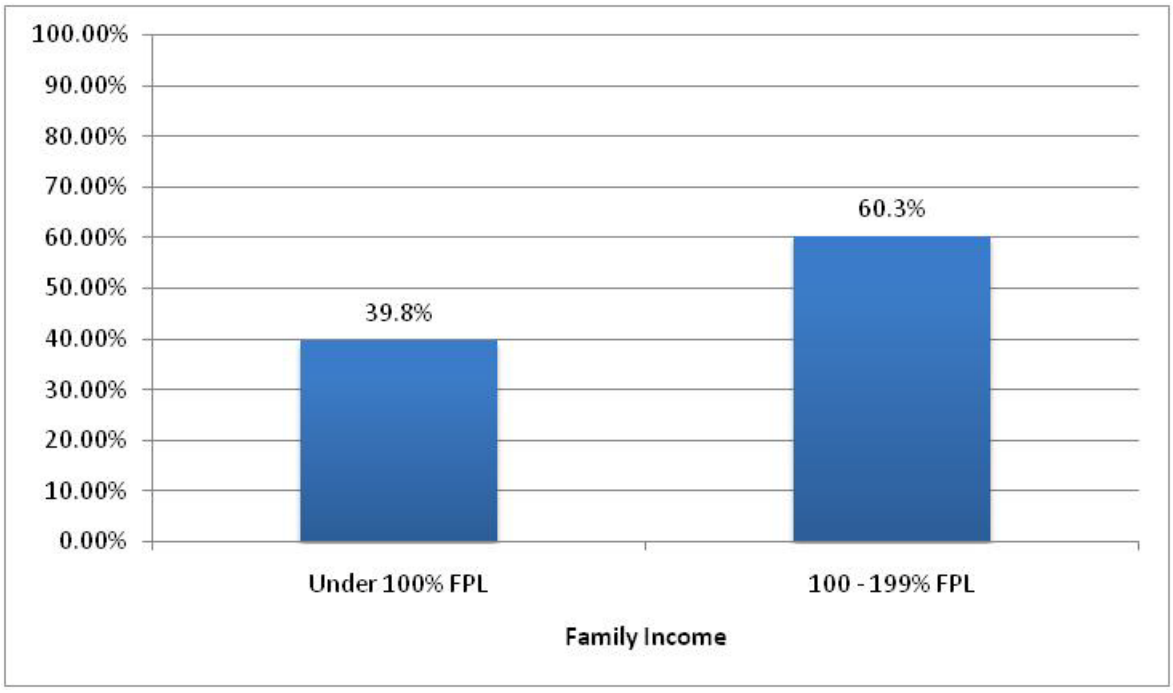
Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements).

Although the majority of non-elderly Americans receive health insurance coverage through employer-sponsored coverage, access to employer-sponsored coverage has been declining. Between 2001 and 2009, the percentage of firms offering health coverage to their employees declined from 69 percent to 60 percent.[10]

Low-income families are particularly likely to be uninsured. In 2008, 34 percent of non-elderly Americans living in families earning less than 133 percent of the FPL were uninsured, compared to an uninsurance rate of 6 percent for Americans living in families earning more than 300 percent of the FPL.[11] Overall, families earning less than 133 percent of the FPL account for about half of the uninsured in the US.[12]

One reason for the high rate of uninsurance among low-income families is that few low-income families have access to employer-sponsored coverage. One study found that only 15 percent of uninsured workers said they were eligible for health benefits through their employer in 2004, and 19 percent of uninsured workers reported they did not personally qualify for the coverage that their firm offered. The remaining 66 percent of the uninsured reported that they did not have access to health insurance coverage.[13] Another study found that, in 2005, 39.8 percent of workers with a family income below 100 percent of the FPL and 60.3 percent of workers with incomes between 100 and 199 percent of the FPL were offered health coverage through their employers.[14] [See Figure 5] Low-income workers may change jobs frequently or work part-time jobs that do not offer health coverage.

Figure 5: Percent of Workers Offered ESI, by Family Income



Source: Clemans-Cope, Lisa, et al. (2007)

Traditional Medicaid and CHIP provide an alternative source of coverage for low-income families who have difficulty obtaining coverage in the private health insurance market. Income eligibility for Medicaid and CHIP varies from State to State — as of December 2009, the median

Medicaid/CHIP eligibility threshold for children was 235 percent of the FPL and 64 percent of the FPL for working parents.[15] Families who are income eligible for Medicaid or CHIP and who do have access to employer-sponsored coverage are the subset of the population who may qualify for premium assistance programs.

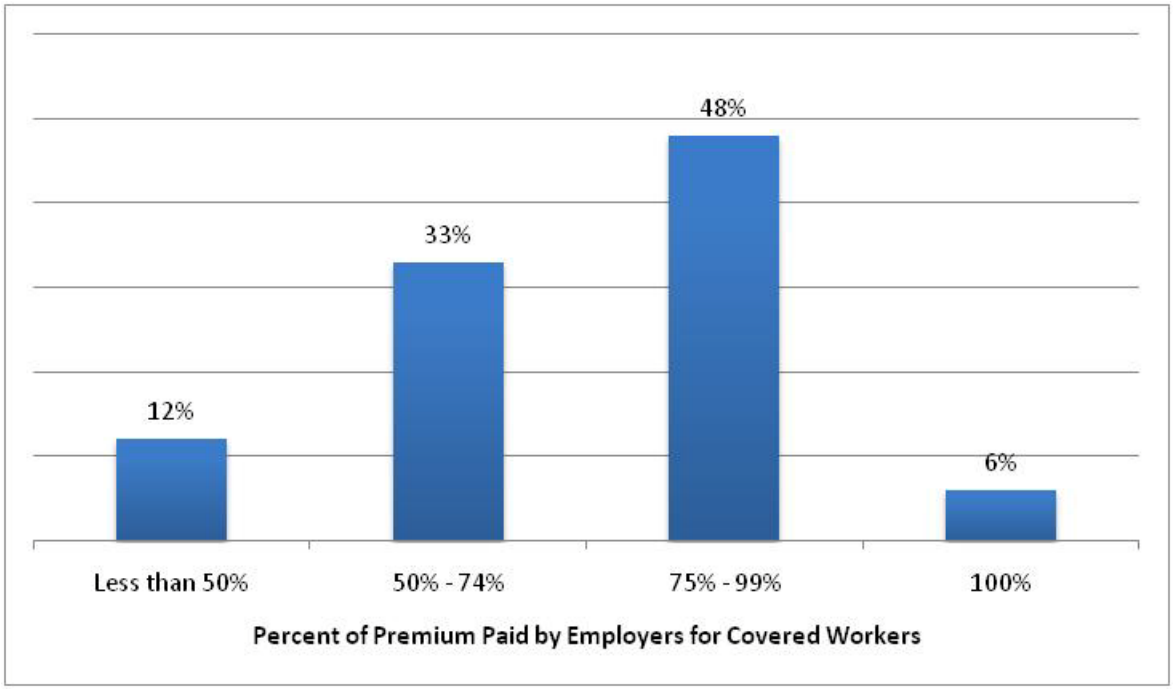
Cost

The rising cost of health coverage is a major concern for both the public and private sectors. Costs have been rising faster than the rate of inflation, increasing the premiums paid by families and the contributions needed from employers.

Cost is the primary reason why people do not take up health insurance coverage offered by their employers.[16] Low-income families are particularly affected. While 85 percent of all workers who are offered coverage take it, only 71 percent of workers with incomes below the poverty level take coverage that has been offered.

Many employers help offset the costs of coverage by subsidizing part of the employee's premium. In 2009, employers subsidized more than half of the health insurance premiums for 99 percent of employees with individual ESI and 88 percent of employees with family ESI [See Figure 6]. On average, employers subsidize 74 percent of the health insurance premium for family coverage.[17]

Figure 6: Distribution of Percent of Premium Paid for by Employers for Covered Workers in Family Coverage, 2009



Source: Kaiser/HRET Survey of Employer-Sponsored Benefits, 2009

Despite employer contributions, the cost to families is increasing. Between 1999 and 2009, the average worker contribution for family coverage increased by 128 percent. [18] In addition to rising premiums, many private health insurance plans are increasing cost-sharing requirements, such as co-pays and deductibles. The percentage of insured workers in a plan with a deductible increased from 18 percent to 22 percent between 2008 and 2009. [19]

The costs of Medicaid and CHIP have also been rising, but at a lower rate than private health insurance. One simulation analysis of Medicaid and private health insurance in 2003 found that health care costs would be considerably higher if Medicaid beneficiaries were enrolled in private health coverage, but that overall spending would be lower if low-income families were enrolled in Medicaid instead of private health coverage. The study authors attributed the differences in health care spending to differences in provider payment rates.[20]

Benefits

In addition to costs, benefits are important to consider when assessing whether a particular benefit package under a group health plan is a good value for Federal and State governments, families and for the taxpayer.

Many States mandate that employment-based group health plans offer certain benefits, but the number of mandated benefits varies from State to State. In addition, State-imposed mandates do not apply to employer-sponsored health plans that are self-insured because of the ERISA.

In addition to having access to comprehensive benefits, continuity of coverage is important, particularly for Americans with chronic conditions that require ongoing treatment. Children who have discontinuous coverage are more than 13 times as likely to delay needed care as the continuously insured,[21] and consequently they tend to be diagnosed at more-advanced disease stages than are those with health insurance.[22]

Challenges for Families

The Working Group identified potential challenges for families ranging from ensuring they have access to affordable and comprehensive benefits to providing families informed choice regarding the differences between coverage offered in the Medicaid and CHIP State plans versus employer-sponsored coverage.

Ensuring access to needed care

According to the Working Group members, a key question for the beneficiary is whether they will have access to the full range of Medicaid or CHIP benefits and cost-sharing protections. Even minimal cost sharing has been shown to be a barrier for low-income persons in accessing services. According to the GAO report, however, few States monitor enrollee's access to care and utilization of services under premium assistance programs. Moreover, even if a State agrees to cover co-payments, families may experience challenges if States do not pay in certain instances when the reimbursement from the insurer exceeds Medicaid reimbursement levels. As a result, there is a potential for significant disparities in the benefits and cost-sharing protections offered to enrollees in premium assistance programs compared with those in direct Medicaid or CHIP State plan coverage.

Programs that operate under section 1115 demonstration often waive benefit and cost-sharing rules and the majority of title XXI premium assistance programs operate under demonstration authority. To protect families however, a critical policy under these demonstrations has been that States have been required to permit children to move into direct CHIP State plan coverage at any time. CHIPRA now requires States operating premium assistance programs to establish a process for permitting parents to disenroll a child from qualified employer-sponsored coverage, and to enroll the child in direct coverage effective on the first day of any month for which the child is eligible for such coverage and in a manner that ensures continuity of coverage for the child.

Private health coverage may offer some families an option to access providers that they could not obtain in a public program. However, in some cases the reverse may also be true — some families who were enrolled in traditional Medicaid have reported challenges when they switch to premium assistance programs and lose access to some of the Medicaid network of providers. Families in premium assistance programs may be faced with the challenge of identifying Medicaid providers in their private sector health plan or potentially be put in the position of paying out-of-pocket costs during a visit to a non-participating Medicaid provider. Some States, such as Rhode Island, have addressed this barrier by identifying providers that agree to participate in Medicaid strictly under a premium assistance arrangement.

Working Group members also pointed out that some of the less tangible benefits of premium assistance programs include reduced stigma sometimes perceived by families under public sector programs and the simplicity of covering family members on the same plan. Also, in instances where children are eligible at higher income levels than their parents, premium assistance may offer an opportunity for the entire family to receive subsidized coverage. According to the GAO report, 33 of the 45 programs responding reported allowing non-eligible family members (often parents) to be covered under a family plan that is receiving a subsidy for at least one eligible family member (often children).

Continuity of coverage is also a potential benefit of premium assistance programs if the family is able to maintain their private coverage as their eligibility for public coverage fluctuates. Prior to CHIPRA, States with State plan CHIP premium assistance programs were required to institute a six-month waiting period for individuals enrolled in group health coverage prior to enrolling them in premium assistance, and States with demonstration authority vary the length of waiting periods. CHIPRA now requires that the waiting period be the same as that under the CHIP State plan. The waiting period requirements that States have adopted for the CHIP premium assistance option may limit the potential for ensuring seamless continuity of care.

Educating families about premium assistance options

The Working Group noted that identifying Medicaid and CHIP eligible families with access to private health insurance programs is difficult for States. States can choose to reach out to families through general, widespread outreach (i.e. mass media or outreach campaigns) or through more focused targeting of families who may be eligible, but not enrolled in this program (i.e. targeted mailings or outreach to specific employers). Because only a limited number of Medicaid or CHIP eligible families are eligible for premium assistance, most States employ targeted outreach efforts. Specifically, some States rely on employers to identify potential beneficiaries while other States reach out to working families enrolled in the traditional Medicaid or CHIP program at the point of application.

Working Group members highlighted that even when States are able to find potentially eligible families, it can be difficult to explain the premium assistance option to them because of language and other barriers. For example, because of low health literacy, some families may not provide accurate information on their application form, which makes it difficult for the State to identify the relevant health plan that should be evaluated. Also, immigrant families may have particular concerns about working with the State, even if the children are U.S. citizens and thus are considered eligible for public coverage. States have worked to overcome these barriers by developing culturally appropriate education materials and by using eligibility workers in settings that families can trust, such as hospitals and clinical settings.

After a family is enrolled in a premium assistance program, continuing education is required to ensure families understand how to obtain Medicaid or CHIP benefits that States wrap around, such as well-baby and well-child services and immunizations and how to ensure that they do not make out-of-pocket payments that exceed the Medicaid or CHIP statutory limits. In addition, families need to have educational materials at the point of application and intermittently to explain the differences in benefits and cost sharing in the Medicaid or CHIP State plan versus the employer sponsored plan. It is important that families are aware of the options available when they choose to leave premium assistance programs as well.

Under CHIPRA, DOL and HHS were required to develop a model notice for employers to use to inform employees of potential opportunities currently available in the State in which the employee resides for premium assistance under Medicaid and CHIP. Employers provided this notice to employees by the later of the first day of the first plan year after February 4, 2010 or no later than May 1, 2010.[23] This model notice was another attempt at educating potential beneficiaries of the possible opportunity for premium assistance. However, there have been challenges reported as a result of this effort, including confusion about the need for individuals to first qualify for Medicaid or CHIP, and confusion about which States actually have authority to operate premium assistance programs.

Enrolling eligible families

Once eligible families are identified and informed about premium assistance options, it is important that these families are enrolled (or disenrolled) through a coordinated process. The Working Group noted challenges with special enrollment periods, the process of moving from premium assistance to direct coverage, and mandatory versus voluntary enrollment.

Prior to the passage of CHIPRA, it was difficult for families to enroll in employer-sponsored coverage during a plan or policy year unless there was a special enrollment right under HIPPA. Congress attempted to address this concern by including new rules designed to ease transitions between public and private coverage, and to allow States to enroll individuals into premium assistance regardless of open enrollment periods. Effective April 1, 2009, section 311 of CHIPRA included new provisions that make becoming eligible for Medicaid or CHIP trigger a special enrollment right, allowing an individual a 60-day period to enroll in a group health plan. This now makes it easier for families to switch to premium assistance programs even if it is not an open season when they become eligible for Medicaid or CHIP premium assistance towards employment-based coverage. States have reported some difficulty trying to implement this provision. The Federal government is expected to issue regulations clarifying this new provision.

While CHIPRA made it easier for families to move into employer-sponsored coverage outside of an open enrollment period, Working Group members expressed concerns that the process of

moving from employer-sponsored coverage (in conjunction with a premium assistance program) back to Medicaid or CHIP direct coverage can be a challenge to families. States have reported concerns from families related to coordinating the termination of the payroll deduction prior to being charged for a premium under the Medicaid or CHIP direct State plan.

Prior to CHIPRA, enrollment into premium assistance could be voluntary or mandatory at the State's option under the Medicaid or CHIP State plan authorities. CHIPRA includes a provision to prohibit States from requiring children and/or families to mandatorily enroll in Medicaid or CHIP premium assistance programs operated under new State plan authority. However, there are some States that made premium assistance mandatory under State plan authority prior to CHIPRA, or through section 1115 demonstration authority. The majority of States with mandatory enrollment have been required to wrap around benefits for Medicaid and CHIP, as well as ensure cost sharing protections are in place. Despite these requirements, the Working Group noted that it can still be difficult for families to work with State Medicaid or CHIP agencies and employer plans to obtain wrap around services and that this process is not always seamless.

Challenges for Employers

The Working Group identified several employer concerns related to participation in premium assistance programs, including the administrative burdens associated with obtaining detailed eligibility, benefit and cost sharing information from plan administrators and reporting this information back to States, as well as confusion about premium assistance programs and a general lack of incentive to making the administration of premium assistance a priority relative to the other demands in administering private health coverage.

Gathering information about employer-sponsored health plans

Working Group members identified several impediments to collecting health plan data from employers. For example, employers frequently provide Summary Plan Descriptions (SPDs) rather than detailed benefit descriptions, which require further follow up to evaluate whether the plan meets Federal and/or State eligibility, benefit, cost sharing, and cost-effectiveness requirements. Even if the health plan data is disclosed readily, interpreting this information is difficult because benefit designs are so varied and benefits change annually. To streamline this process, some States, like Iowa, maintain a database of employer health plans to help reduce the burden of gathering information about health coverage from employers and plan administrators. Health plan numbers can be particularly helpful for tracking common group health plans that are purchased by multiple employers.

Employers that contract with insurers or third-party administrators (TPAs) to provide administrative services for their health plans may face additional difficulty responding to State requests because the employer must wait for the insurer or the TPA to provide the required information. Large employers often have complex arrangements with insurers or TPAs, which can be difficult to sort through, and small employers often have limited support staff, which makes it difficult to respond to the State requests.

The division of labor within companies makes it difficult for States to know where to go for information. With increased use of enrollment brokers, automated processes, and overseas customer service centers, knowing where to go for information has become increasingly difficult.

Historically, voluntary data collection from employers has not been particularly successful. For example, the State of Maryland found that over 40 percent of employers contacted by the State either did not respond to requests for information or did not provide adequate information. [24] CHIPRA adds a Federal penalty of up to $100 a day if the plan administrator doesn't respond to the request from the State. Some States may not report this penalty, however, because they do not want to damage relationships with employers in the State, which is ultimately important for administering a successful premium assistance program.

Outside of the premium assistance context, States do collect benefits information from employers regularly for the purposes of identifying private health insurers that provide coverage to Medicaid beneficiaries and may be liable to cover a portion of Medicaid claims (commonly referred to as "third-party liability"). As a result of the Deficit Reduction Act, States are increasing their data collection from employers and many are developing electronic methods for collecting this information. Some States, like Rhode Island, use third-party liability databases to help streamline their premium assistance program and reduce administrative costs.

Increasing employer participation

Working Group members noted that the economic rationale for employers to participate in premium assistance programs is limited. Specifically, premium assistance subsidies may increase employers' costs by having families who previously could not afford the premium, enroll in employer-sponsored coverage. As a result, the employer provides an insurance subsidy to the employee that the employer would not otherwise have paid. Because of the rising cost of health coverage, this potential cost shift to the private sector may serve as a disincentive for employers to invest significant resources in the exchange of information needed for premium assistance programs to succeed.

Because of the potential costs and increased administrative burden associated with premium assistance programs, few employers currently participate in their State programs. According to the GAO report, the number of employers participating in a State premium assistance program varies from 1 (Colorado) to 4,752 (Oklahoma). It should be noted that the number of employers participating in a State premium assistance program is only a proxy measure for the number of families reached by the premium assistance program. For example, the premium assistance program in Colorado is focused on a large employer with over 200 employees while the Oklahoma premium assistance programs primarily includes small businesses with less than 50 employees.

States that devote more resources to employer education, recruitment, and relationship building have generally had more success with their premium assistance programs.[25] Like any relationship, employers tend to cooperate better with premium assistance requirements as they become more familiar with working with the State. Pennsylvania, for example, has staff located in regional offices throughout the State and assigns cases on an employer-by-employer basis so that one State staff member routinely works with the same company representative. This process not only helps to minimize the burden on employers, but it also has resulted in employers becoming more cooperative (some even voluntarily contact the State on a quarterly basis to submit a list of new employees).[26] Oregon is also a model for employer outreach. Oregon has an employer guide that explains the programs to employers and discusses potential

benefits, such as decreasing the average age in their insurance pool since the State makes premium assistance available to children. These outreach efforts can help address common misconceptions about premium assistance programs among employers, such as the belief that employers can not benefit if the employer already pays the employee's premium and the belief that Medicaid third-party payer rules prohibit employers from informing employees about Medicaid and CHIP.

Despite State-specific outreach, employers who operate in many different States may have particular difficulty accessing up-to-date premium assistance information and have difficulty understanding differing requirements in each State. The model notice form mandated under CHIPRA was designed to help identify the contact information for program managers of premium assistance programs in each State, but keeping this contact information up-to-date has been a challenge.

Also, employer's prior experience with a particular State may also influence their willingness to participate in premium assistance programs. In particular, the data collection that States are already involved in for Medicaid third-party liability requirements may make employers reluctant to enroll individuals eligible for Medicaid or CHIP.

The targeted population for the State's premium assistance program can also influence the willingness of employers to participate in the program. In particular, premium assistance programs that only apply to high-cost beneficiaries may be less attractive to employers because some employers have concerns that additional costs for these beneficiaries are being placed on them. The GAO report found that approximately eight programs targeted premium assistance to individuals with high health care costs, such as pregnant women, premature or low birth weight infants, or individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), diabetes, or cancer.

Similarly, some small employers have expressed concerns that State eligibility guidelines may create disparities in premium assistance eligibility for the employees with similar pay and position. In particular, rules on family size and family income can result in different eligibility determinations for employees with the same wages.

Challenges for States

The Working Group noted that in addition to ensuring that families have options for selecting affordable health care, States are primarily concerned with the administrative costs of managing premium assistance programs. In particular, evaluating cost effectiveness, cost sharing, and benefits can be difficult. Working Group members also emphasized that States must place a higher priority on preparation and implementation of ACA and may not have the resources in place to create new premium assistance programs and/or improve existing programs.

Achieving cost effectiveness

Applying the cost-effectiveness test can pose several challenges for States. For example, if all children are not eligible under a family plan, the cost-effectiveness test needs to be adjusted accordingly. Part-time or transient employees also pose particular challenges because they may switch employers by the time the State determines the cost effectiveness.

Beyond the administrative questions of whether the plan meets the cost-effectiveness requirements, States have difficulty assessing whether premium assistance programs as a whole are truly cost-effective once all administrative costs are taken into account. A critical issue raised by the Working Group, is that there is little evidence that premium assistance programs are consistently cost-effective relative to direct coverage provided under the Medicaid or CHIP State plans, particularly when the administrative costs associated with operating the programs are taken into consideration. Section 301(a)(2) of CHIPRA now adds administrative costs in the calculation of cost effectiveness.

Some States have reported successful savings with their premium assistance programs. Iowa has calculated savings of 30 percent compared with its standard Medicaid program, and Rhode Island estimates saving of approximately $1 million per 1,000 people enrolled for a full year.[27] Pennsylvania, which operates one of the largest premium assistance programs, reported that savings for fiscal year 2003 reached $76.3 million. [28] One study reported that Rhode Island and New Jersey appeared to be saving money on a per-enrollee basis, but was unable to determine clear cost-savings in Illinois, Oregon, and Utah because of insufficient data.[29]

State capacity

In practice, creating or modifying premium assistance programs requires significant upfront investment, which the Working Group emphasized may be difficult for States today given competing demands and limited State capacity.

Most notably, the Working Group indicated that ACA presents many competing priorities that States will need to manage in the years ahead, including high-risk pools, the health insurance

exchange, and Medicaid expansions. Although States have been presented with additional opportunities under both CHIPRA and ACA, States are already dealing with limited resources and reduced staff as a result of the current economic climate, and so it may be particularly difficult for States to focus on creating or expanding premium assistance programs at this time.

For States that have made it a priority to devote resources towards premium assistance, it can be a challenge to build a staff that is able to effectively facilitate communication between State agencies and employers. States have taken different approaches to operating premium assistance programs. Oregon, for example, established the Office of Private Health Partnerships, which is not a Medicaid agency, in order to manage its premium assistance program, and to dedicate separate resources to building understanding the private insurance market and building relationships with employers. Iowa, on the other hand, has a unit within Human Services that coordinates intake and case management, and has developed an automated referral process that alerts the premium assistance unit when someone is employed.

Also, the State computer systems that are used to manage eligibility are often very much out of date and can make it difficult to implement programs such as premium assistance. Rhode Island, for example, must develop special interfaces with its legacy eligibility systems in order to manage its premium assistance program.

Potential Implications of ACA

A key question raised by members of the Working Group was how the recently enacted ACA would affect the future of premium assistance in Medicaid and CHIP. Due to the many uncertainties about how the law will affect a myriad of factors including the cost of coverage in the private market, it is impossible to answer this question with any precision.

ACA directly changed some of the rules for premium assistance programs. For example, the definition of cost effectiveness as it pertains to section 1906 premium assistance programs (the most common form of premium assistance) now explicitly includes administrative expenses in the definition of cost effectiveness. It remains to be seen what the impact, if any, this provision will have on the viability of premium assistance.

However, the indirect effects of other provisions in ACA may have greater implications for the viability of premium assistance. The Working Group identified the following ACA provisions to consider:

1) Expansion of Medicaid to 133 percent of the FPL in 2014

One of the central features of ACA is the expansion of the Medicaid program to adults with incomes below 133 percent of the FPL (P.L. 111-148 §2001).

Extending Medicaid coverage to adults, including parents below 133 percent of FPL, may result in more favorable determinations of cost effectiveness since a State can include the costs of covering all members of the family and not just children—which is often the case today. Moreover, since premiums for employer-sponsored coverage are often structured as a family premium, as opposed to a child-only premium, this eligibility expansion to all family members in Medicaid is more likely to result in a favorable determination of cost effectiveness.

However, a significant barrier to the success of premium assistance programs in this context is the limited availability of employer-sponsored coverage to families at this income level. Recent studies have shown that only 39.8 percent of workers with a family income below 100 percent of the FPL and 60.3 percent of workers with incomes between 100 and 199 percent of the FPL were offered health coverage through their employers.[30] There is some evidence that premium assistance programs that have had higher enrollment tend to be those that have income eligibility standards above 133 percent of FPL, and that enrollees in these programs tend to cluster at the higher range of the income eligibility level. [31]

In addition, the cost of private coverage is expected to continue to grow between now and 2014, and while the implementation of ACA may temper its growth,[32] Medicaid costs of coverage, as compared to private sector costs for a similarly situated population, tend to be lower already.[33]

2) ACA may make premium assistance an attractive option for some States

ACA contains a provision requiring States to maintain their Medicaid and CHIP eligibility for children (as opposed to adults) until 2019 (P.L. 111-148 §2001 and §2101). This maintenance of effort provision, however, means that for families with incomes higher than 133 percent of FPL, there is a strong likelihood that in 2014 parents will purchase coverage for themselves through new State-based exchanges with newly available Federal subsidies, but in many cases may have their children enrolled in either Medicaid and/or CHIP. This situation may result in some States exploring the possibility of using Medicaid and CHIP dollars to subsidize purchase of family-based coverage in the exchange for children whose parents are employed in the small-group market. Whether or not this will be a cost-effective approach is hard to predict. This issue awaits further Federal regulatory guidance.

3) Comparing public-private benefits packages may be easier under ACA administrative simplifications

Working Group members identified a number of provisions in ACA that might simplify States efforts to compare public and private benefits packages in order to determine what "wraparound" services a State needs to provide, and in order to determine cost effectiveness.

These provisions include the development of a uniform explanation of coverage for all private health coverage which might make these efforts simpler (P.L. 111-148 §1001), as well as the development of a new web portal, www.healthcare.gov, that HHS launched on July 1, 2010 (P.L. 111-148 §1103). This web portal is expected to contain significant amounts of information on available coverage in the small-group market, which might also make it easier for States to assess private benefits packages.

Another feature of the new law that may come into play is the link between the adult "benchmark" benefits package in Medicaid and the "essential benefits package" in the exchange (P.L. 111-148 §1302). However, it is important to note that children must still receive the full range of EPSDT services even if their parents are receiving benchmark services.[34]

4) Access to primary care providers in Medicaid may improve, reducing one often cited reason for Medicaid premium assistance programs

Proponents of premium assistance programs often cite the difficulties families in Medicaid have in accessing providers as a reason to pursue premium assistance. ACA does contain important provisions that increase reimbursement for primary care providers in Medicaid to Medicare levels in 2013 and 2014 with full Federal funding (P.L. 111-152 §1202). While data on access to primary care services in Medicaid versus private coverage suggests that children receive similar levels of medical care in both,[35] this provision may improve whatever disparities exist in accessing primary care providers, but will not help address disparities that may exist in accessing specialty care.

5) It is difficult to predict how new requirements on employers and other group health plan sponsors under ACA will impact premium assistance programs

ACA places new requirements on employers and/or the group health plans that they sponsor. How these new requirements will impact the availability and cost of this coverage could impact the future of premium assistance programs. The impact could differ based on the size of the employer. New requirements include new standards for group health plans, such as the extension of dependent coverage to age 26, as well as the prohibition of lifetime and annual dollar limits (P.L. 111-148 § 1001). Many of these new plan standards will be effective for plan years beginning September 2010.

Small employers will be able to participate in State exchanges that will start to operate in 2014 (P.L. 111-148 §1311). In addition, starting in 2014, large employers will be assessed a penalty where a full-time employee enrolls in an exchange and receives Federal subsidies (P.L. 111-148 §1513). This "employer shared responsibility" provision has been referred to as the "free rider penalty." Under these rules, full-time employees can enroll in an exchange and receive Federal subsidies to help pay for the coverage if their employer-sponsored coverage is not "affordable" (the employee's required contribution to the plan exceeds 9.5% of their household income) or their employer-sponsored coverage does not provide a minimum value (the employers share of the total "allowed cost" of coverage is less than 60 percent of the cost).

Also, certain employers will have to meet free choice voucher requirements (P.L. 111-148 §10108). These employers must make free choice vouchers available to any employee where (1) the employee's contribution for the employer-sponsored coverage is between 8 percent and 9.8 percent of household income, (2) the employee's household income is not greater than 400 percent of the FPL, and (3) the employee is eligible but not enrolled in the employer-based coverage. The voucher is essentially the portion of the monthly cost of the employer-sponsored coverage that is paid for by the employer. The voucher must equal what the employer would pay if the employee were enrolled in the plan option to which the employer pays the largest portion of the cost. Employees use the voucher to assist them in paying for coverage in an exchange. The employee would get to keep any amount above the cost of the exchange coverage.

In contrast to premium assistance programs, which help individuals to pay for employer-sponsored coverage, the free rider penalties and free choice voucher provisions appear to provide incentives for employers either to provide more affordable coverage for lower wage workers or allow these individuals to access State exchanges with either Federal subsidies or free choice voucher dollars. It is too early to know how these new rules, effective in 2014, will actually operate.

Finally, at some point after 2017 large employers may be allowed to provide coverage to their employees through State exchanges. All of these dynamics make for a great deal of uncertainty about the future of premium assistance programs.

Appendix A: State Examples

Oregon: Reaching out to the community

Oregon's largest premium assistance program, the Family Health Insurance Assistance Program (FHIAP), has been operating since 2002 under a section 1115 demonstration. The program covers children and adults under 200 percent of the Federal poverty level. Eligible plans must cover certain services and be actuarially equivalent to Medicaid benefits specified in Oregon's section 1115 demonstration, but the State does not provide wrap around benefits or cost-sharing subsidies. The program is optional, and children may opt out of premium assistance into CHIP State plan direct coverage at any time. The plan subsidizes 50 to 95 percent of the employee's share premium for eligible family members.

As of June 28, 2010, FHIAP enrolled 7,192 Medicaid- or CHIP-eligible individuals. The State currently has a waiting list of over 50,000 individuals, and prior to cutbacks in State funding, FHIAP enrolled up to18,500 people.

Extensive outreach efforts are a major reason why so many families have applied for the FHIAP program. The State has conducted outreach through a wide variety of public service announcements, a comprehensive employer guide, outreach to employees through human resource departments, trainings for insurance agents, and local events at schools, churches, and other community centers. Culturally competent outreach efforts to minority communities are also becoming a new area of focus for the program.

FHIAP is able to differentiate its outreach efforts from traditional Medicaid and CHIP outreach because the program is located in the State health insurance department rather than the State social service agency. As a result, FHIAP is able to leverage other State efforts to increase awareness and understanding of private health insurance and reduce the stigma associated with applying for a public program. In addition, the agency is able to incorporate FHIAP into the continuing education certification requirements for health insurance agents.

Administratively, the State has developed a database of qualified health insurance plans and provides this information to insurance agents and employers. The State system for administering the program is also flexible enough to provide subsidies to either the employer or the employee depending on the circumstances.

Oklahoma: Engaging small businesses

Oklahoma's premium assistance program, the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC), has been operating since 2005 under a section 1115 demonstration. The ESI premium assistance component of Insure Oklahoma covers adults under 200 percent of the Federal poverty level for small businesses with less than 99 employees, and is expanding to cover certain children as well. The State and the Federal governments cover at least 60 percent of the cost of covering the employee and employers pay 25 percent of the premium. The employees pay the remaining 15 percent of the premium, but the government provides additional subsidies if the employee's contribution is greater than 3 percent of their gross income.

The program has grown rapidly since its inception. As of June 2010, 18,753 Oklahomans from 5,496 businesses were covered by the Insure Oklahoma ESI program. About 84 percent of participating employers have less than 25 employees, and about one-third have five or fewer employees.

The State has achieved high participation from small employers as a result of the use of independent insurance agents and strong outreach efforts. The State pre-approves certain private health insurance plans, and works with small businesses to offer these plans to their employees. Currently, Insure Oklahoma provides over 400 options through about 20 carriers.

Independent insurance agents play a large role in Oklahoma's outreach to small employers. These agents already had relationships with employers and experience with selling a wide variety of insurance products in the State. Insure Oklahoma provided training for the agents, who were able to use the training to fulfill continuing education requirements for licensure. The agents receive commissions from commercial insurance companies for each company they sign up, and the pre-approved Insure Oklahoma plans have become a key selling point for these plans.

The program also uses social media, public service announcements, and a toll-free hotline to provide assistance to employers and employees. About 20 State Full Time Equivalents (FTEs) have been hired through a contractor to help answer questions about Insure Oklahoma.

By covering low-income employees in small businesses, Insure Oklahoma has helped encourage greater insurance coverage for other small business workers. A report by BlueCross BlueShield of Oklahoma found that 37 percent of Insure Oklahoma employers were offering coverage for the first time and that 90 percent of these employers credited Insure Oklahoma as one of the most important factors for their decision. Overall, for every five employees that the State covers through Insure Oklahoma, another seven employees are offered employer coverage for the first time.

Rhode Island: Achieving savings for the State

Rhode Island's premium assistance program, RIte Share, has been operating since 2001 under a section 1115 waiver. The program is mandatory for families who are enrolled in Medicaid or CHIP (250 percent of FPL for children and 175 percent of FPL for parents) and have access to employer-sponsored coverage. The program provides up to 100 percent of the eligible enrollee's share of premiums and cost-sharing. Also, the State provides complete benefit wrap around coverage and monitors access to care and utilization of services for its RIte Share beneficiaries.

Rhode Island is notable for its ability to develop a public/private partnership that demonstrates substantial cost savings. In State fiscal year 2005, Rhode Island estimated saving over $1 million for the State and Federal government per 1,000 people enrolled for a full year, and reported State savings of $23.92 per member per month after accounting for administrative costs.[36]

The State evaluates cost-effectiveness on an aggregate basis. That is, the total expenditures on ESI premium subsidy amounts and actuarial value of benefits not covered by ESI along with co-pays, deductibles and co-insurance are less than or equal to what the average expenditures for a person of that age or gender would have been under RIte Care, Rhode Island's Medicaid managed care program. These cost-effectiveness tests are reevaluated every 12 to 18 months.

Rhode Island's streamlined data systems are an important contributor to its cost-effectiveness. The State maintains a database of employers who offer ESI plans that have been approved for RIte Share coverage. This information interfaces with the State's eligibility system to identify applicants and recipients who may be eligible for RIte Share. The State manages the RIte Share program with seven FTEs. The State also performs quarterly tape matches with commercial carriers to identify beneficiaries on Medicaid who have active commercial insurance. When such information is identified, the State can cost avoid claims and/or move beneficiaries out of RIte Care and into RIte Share.

Rhode Island has also developed processes to reduce fraud in its program. For example, the advance payment of premium subsidies directly to beneficiaries, a process which benefits the beneficiaries, has also resulted in a relatively high rate of false payments to beneficiaries who are no longer receiving employer-sponsored insurance. As a result, Rhode Island has worked with its State tax department to develop a process to reclaim these overpayments by withholding tax refunds.

Also, the program has been growing steadily, even in the current economic downturn. As of June 2010, over 11,000 Medicaid- or CHIP-eligible individuals were enrolled in RIte Share.

References

[1] ACA is comprised of the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, and the Health Care and Education Reconciliation Act (HCERA) of 2010, P.L. 111-152

[2] Sections 2105(c)(10)(G) and 1906(A)(d)(3) of the Social Security Act (SSA), added by section 301 of CHIPRA

[3] Section 2105(c)(3)(A) of the Social Security Act, modified by section 301 of CHIPRA

[4] Section 9801(f)(3)(B) of the Internal Revenue Code of 1986 and section 701(f)(3)(B) of the Employee Retirement and Income Security Act of 1974, added by section 311 of CHIPRA

[5] Section 9801(f)(3)(A) of the Internal Revenue Code of 1986 and section 701(f)(3)(A) of the Employee Retirement and Income Security Act of 1974, added by section 311 of CHIPRA

[6] In some cases, premium assistance is used to subsidize non-group coverage from the individual market and to subsidize coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). However, this report is limited to identifying improvements in the coordination of coverage between Medicaid, CHIP, and employer-sponsored health insurance.

[7] See section 2105(c)(10)(B) of the Social Security Act for the definition of qualified employer sponsored coverage.

[8] Government Accountability Office. *Medicaid and CHIP: Enrollment, Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs.* GAO-10-258R. 19 January 2010.

[9] Holahan, John, Allison Cook, and Lisa Dubay. 2007. "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Kaiser Commission on Medicaid and the Uninsured Issue Paper (February). Available at http://www.kff.org/uninsured/upload/7613.pdf

[10] The Kaiser Family Foundation and Health Research & Educational Trust. "2009 Employer Health Benefits Survey." September 2009. Available at http://ehbs.kff.org/

[11] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements). Available at http://www.Statehealthfacts.org

[12] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2008 and 2009 Current Population Survey (CPS: Annual Social and Economic Supplements). Available at http://www.Statehealthfacts.org

[13] Paul Fronstin, "Sources of Health Insurance Coverage and Characteristics of the Uninsured: Analysis of the March 2005 Current Population Survey," Employee Benefits Research Institute, Issue Brief No. 287, November 2005; available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_11-2005.pdf

[14] Clemans-Cope, Lisa, Genevieve Kenney, Matthew Pantell, and Cynthia Perry. "Access to Employer-Sponsored Health Insurance amount Low-Income Families." The Urban Institute. 2007. Available at http://www.urban.org/UploadedPDF/411533_fringe_benefits.pdf

[15] Cohen-Ross, Donna and Marian Jarlenski. "A Foundation for Health reform: Findings of a 50 State Survey of eligibility Rules, Enrollment and renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009." Kaiser Commission on Medicaid and the Uninsured. December 2009. Available at http://www.kff.org/medicaid/upload/8028.pdf.

[16] Bowen Garrett, "Employer-Sponsored Health Insurance: Coverage, Sponsorship, Eligibility, and Participation Patterns in 2001," Kaiser Commission on Medicaid and the Uninsured, July 2004; available at http://www.kff.org/uninsured/upload/Employer-Sponsored-Health-Insur ance-Coverage-Sponsorship-Eligibility-and-Participation-Patterns-in-2001-Full-Report.pdf.
[17] The Kaiser Family Foundation and Health Research & Educational Trust. "2009 Employer Health Benefits Survey." September 2009. Available at http://ehbs.kff.org/
[18] The Kaiser Family Foundation and Health Research & Educational Trust. "2009 Employer Health Benefits Survey." September 2009. Available at http://ehbs.kff.org/
[19] The Kaiser Family Foundation and Health Research & Educational Trust. "2009 Employer Health Benefits Survey." September 2009. Available at http://ehbs.kff.org/
[20] Hadley, Jack and John Holahan. "Is Health Care Spending Higher under Medicaid or Private Insurance?" Inquiry 40(4): 323–42, Winter 2003/2004.
[21] Olson, Lynn M., Suk-fong S. Tang, and Paul W. Newacheck. 2005. "Children in the United States with Discontinuous Health Coverage." *New England Journal of Medicine. 353* (4).
[22] Hadley, Jack. 2003. "Sicker and Poorer—the Consequences of being Uninsured." *Medical Care Research and Review* 60 (2): 3S-75S.
[23] The Department of Labor published a Federal Register notice on February 4, 2010, announcing the availability of the model notice for employers and providing guidance on how employers should provide the notice. See 75 FR 5808.
[24] Shirk, Cynthia and Jen Ryan. "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum. July 2006. Available at http://www.allhealth.org/briefingmaterials/nhpfschip-867.pdf
[25] Shirk, Cynthia and Jen Ryan. "Premium Assistance in Medicaid and SCHIP: Ace in the Hole or House of Cards?" National Health Policy Forum. July 2006. Available at http://www.allhealth.org/briefingmaterials/nhpfschip-867.pdf
[26] Cynthia Shirk, "The Premium Assistance Toolbox for States," prepared for the National Academy for State Health Policy (NASHP), October 2004. Available at http://www.patoolbox.org.
[27] Cynthia Shirk, "The Premium Assistance Toolbox for States," prepared for the National Academy for State Health Policy (NASHP), October 2004; available at http://www.patoolbox.org.
[28] Isabel Friedenzohn, "Profiles in Coverage: Pennsylvania's HIPP Program," AcademyHealth State Coverage Initiatives, April 2004; available at http://www.Statecoverage.net/pennsylvaniaprofile2.htm.
[29] Alker, Joan, "Premium Assistance Programs: How Are They Financed and Do States Save Money?" Kaiser Commission on Medicaid and the Uninsured, October 2005; available at http://www.kff.org/medicaid/upload/Premium-Assistance-Programs-How-are-they-Financed-and-do-States-Save-Money-Issue-Brief.pdf.
[30] Clemans-Cope, Lisa, Genevieve Kenney, Matthew Pantell, and Cynthia Perry. "Access to Employer-Sponsored Health Insurance amount Low-Income Families." The Urban Institute. 2007. Available at http://www.urban.org/UploadedPDF/411533_fringe_benefits.pdf

[31] Alker, Joan. "Choosing Premium Assistance: What does State Experience Tell Us?" Kaiser Commission on Medicaid and the Uninsured. May 2008. Available at http://www.kff.org/medicaid/upload/7782.pdf.
[32] D. M. Cutler, K. Davis, and K. Stremikis, The Impact of Health Reform on Health System Spending, Center for American Progress and The Commonwealth Fund, May 2010.
[33] Hadley, Jack and John Holahan. "Is Health Care Spending Higher under Medicaid or Private Insurance?" Inquiry 40(4): 323–42, Winter 2003/2004.
[34] C.F.R. 42 § 440.365
[35] "Medicaid Beneficiaries and Access to Care." Kaiser Commission on Medicaid and the Uninsured. April 2010. Available at http://www.kff.org/medicaid/upload/8000-02.pdf.
[36] RI Department of Health and Human Services. "Rhode Island's Rite Share Premium Assistance Program: Estimated Savings." January 2006. Available at http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/RCRS/RS_Savings_Report_06.pdf.