Premium Assistance Programs for Low Income Families: How Well Does it Work in Rural Areas?

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EXECUTIVE SUMMARY

The uninsured population has grown steadily over the last two years, and rural areas of the country have a higher proportion of uninsured persons than do urban areas. To begin to address this issue, some states have created public-private partnerships to help make health insurance coverage affordable to small firms and lower-wage uninsured workers.

One form of these partnerships includes programs that use Medicaid or State Children's Health Insurance (SCHIP) funds to help lower-wage workers pay health insurance premium costs ("premium assistance programs"). There are three primary methods by which states can use their Medicaid and/or SCHIP funds for premium assistance programs: through the Health Insurance Premium Payment (HIPP) program (part of the regular Medicaid program), under the SCHIP authorizing legislation, or through a federal 1115 Health Insurance Flexibility and Accountability (HIFA) waiver. Generally, states must show that it is more cost effective to pay the recipients' private premium costs rather than enrolling the person directly into Medicaid or SCHIP.

This study focuses on the viability in rural areas of premium assistance programs that use Medicaid or State Children's Health Insurance program funding to subsidize the premium costs of employer-sponsored insurance or private non-group policies for eligible individuals. Because of the characteristics of rural residents and their employment markets, many stand to benefit from premium assistance programs, but there are also reasons to believe that these programs may be less successful in rural communities.

We identified 16 states with at least one premium assistance program and were able to conduct telephone interviews with Medicaid or SCHIP officials in 14 of these states. We gathered background information about the programs and asked whether there was any perceived geographic variation in access to employer-sponsored insurance, employers' willingness to participate in the program, scope of insurance coverage, cost effectiveness of the program, or ease of program operation.

We find that to date, premium assistance programs have not lived up to their potential. Enrollment in most of the states' programs has been small, and while positive in concept, premium assistance programs have inherent limitations that may preclude more widespread enrollment.

In general, the staff we interviewed did not note significant variations in the implementation, operation, or effectiveness of premium assistance programs by geographic area. Although many respondents believed that there were no differences in program enrollment by geographic area (though this perception was not based on formal analyses of enrollment data), this was not always the case. In the only state that shared county level data, there was actually a higher level of participation from rural areas than from urban areas, and respondents from two other states, while not providing enrollment data, estimated that enrollment was disproportionately higher in rural areas of their states. Conversely, respondents from five states thought that the fact that individuals who work

for small employers are less likely to be offered health insurance coverage created a barrier in terms of rural residents participating in premium assistance programs.

The information gathered from our interviews combined with what is known about rural areas in the literature suggests that there are reasons to believe that rural residents are at a disadvantage in qualifying for premium assistance programs under the program design in many states. Of particular concern is that rural residents are more likely to work for small employers who do not offer health insurance or that have higher premiums or less comprehensive policies when coverage is available.

Although most of the premium assistance funds are used to help subsidize the premium costs of employer-sponsored insurance, all but four states also allow individuals to use premium assistance funds to purchase non-group coverage, a feature that should be helpful in rural areas with little employer-based coverage. However, this option is only available if cost effective, and states will have more difficulty showing cost-effectiveness in paying for non-group plans as employers do not contribute towards the cost of the non-group premiums. Respondents were generally unable to determine whether there were any geographic variations in the extent to which covered individuals were covered by non-group plans, although one respondent thought that rural individuals were more likely than urban recipients to be enrolled.

Reasons that premium assistance programs could be differentially beneficial to rural residents include the fact that incomes tend to be lower and the rate of uninsured persons is higher. States should specifically analyze their enrollment data to determine if rural residents have participation levels that would be expected, given their demographic characteristics and potential eligibility for the program. If participation levels are differentially low, state administrators should identify whether it is the state's program policies or underlying employment or insurance factors that are contributing to the differential program participation. With some creativity in program design, premium assistance programs could be a useful tool in the state's arsenal of efforts to expand health insurance coverage to the rural uninsured.

INTRODUCTION

The uninsured population has grown steadily over the last two years and is currently estimated to comprise 17.8% of the non-elderly population, or 45.5 million people.[1] Rural areas of the country, particularly those counties that are not adjacent to metropolitan areas, have higher uninsurance rates than do urban areas.[2] Rural residents of non-adjacent counties are less likely to have private health insurance than urban residents, and while they are more likely to have publicly-funded insurance coverage (such as Medicaid or Medicare), the higher rates of public insurance coverage does not fully compensate for the lower rates of private coverage. Thus, rural residents are more likely to be uninsured.

Part of the difference between urban and rural areas in rates of insurance may be due to the fewer opportunities rural residents have to purchase employer-based insurance. Rural workers are more likely to work for small employers and have low wages, two factors associated with lower employer-based insurance coverage. Small firms are less likely to offer health insurance coverage.[3] In fact, firm size is more important than type of industry in explaining variations in employer-based coverage.[4] Only 35.6% of small firms (those with fewer than 10 employees) offer health insurance, compared to 66.2% of firms with 10-24 employees, 81.0% of firms with 25-99 employees, 93.5% of firms with 100-999 employees, and 98.6% of firms with 1000 or more employees.[5] Further, low-income workers are less likely to work in a firm that offers coverage, and they are less likely to take the coverage if offered. For example, only 50% of low-income workers with incomes below 100% of the federal poverty guidelines (FPG) had access to employer sponsored insurance in 2001 through themselves or someone in their family. In contrast, 97% of those with incomes above 400% FPG had access to insurance. Even when offered, lower income people were more likely to decline coverage: 13% of those with incomes below 100% FPG compared to 4% of those with incomes above 400%.[6]

Some states have created public-private partnerships to help make health insurance coverage affordable to small firms and to the lower-wage uninsured workers. These partnerships take a number of forms, one of which is programs that use Medicaid or State Children's Health Insurance (SCHIP) funds to help lower-wage workers pay the premium costs of their employer-sponsored health insurance ("premium assistance programs").[7, 8]

This study focuses on the viability in rural areas of premium assistance programs. Initially, these programs were implemented to help save program costs, but more recently, states have explored these programs as a means of reducing the numbers of uninsured. Because of the characteristics of rural residents and their employment markets, many stand to benefit from premium assistance programs, if they can be successfully implemented, but there are also reasons to believe that these programs may be less successful in rural communities.

While there have been several studies that have examined premium assistance programs, there is very little information on their viability in rural areas.[7, 8, 9, 10, 11] Arizona conducted a feasibility study and identified several challenges to implementing a

premium assistance program for families with incomes below 200% FPG. Specifically, most low-wage workers do not work for firms that offer health insurance. The volatility of the small group market, lack of HMO availability and higher premium costs in rural areas were also cited as rural specific issues. While Arizona noted the difficulty implementing a premium assistance program in rural areas, other states with large rural areas have proven successful at implementing premium assistance programs.

OVERVIEW OF PREMIUM ASSISTANCE PROGRAMS

States can finance premium assistance programs through state-only funds, or they can seek to share the costs with the federal government through Medicaid and/or State Children's Health Insurance Program (SCHIP) premium assistance programs. There are several reasons that have been posited to support the use of premium assistance in publicly-funded health insurance programs: 1) it builds on and strengthens the employer-based health insurance system; 2) federal and state expenditures may be reduced by the amount of the employers' premium contributions; 3) by helping pay for employer-sponsored health insurance, premium assistance programs could strengthen a worker's attachment to the workforce; and 4) all the members of the same family may be covered by the same health plan.[11]

There are three primary methods by which states can use their Medicaid and/or SCHIP funds to subsidize the employee's share of premiums: through the Health Insurance Premium Payment (HIPP) program (part of the regular Medicaid program),[12] under the SCHIP authorizing legislation,[13] or through a federal 1115 waiver.[14] [15] Under the HIPP program, states can only enroll Medicaid beneficiaries into employer-based plans if it is cost-effective to do so.[16] Further, Medicaid beneficiaries have to be held harmless; that is, the state must ensure that recipients have comparable coverage and no higher out-of-pocket costs than under traditional Medicaid coverage. These requirements have served as barriers to states in offering premium assistance programs because the combined costs of enrolling a Medicaid recipient into group health insurance coverage, providing "wrap-around" services and subsidizing the cost-sharing could be no more expensive than what the state would have paid to enroll the person into the state's regular Medicaid program. SCHIP has similar requirements for cost-neutrality, benefits and cost-sharing, and the additional requirement that a child had to be uninsured for at least six months prior to being eligible for premium assistance.

In 2001, the Center for Medicare and Medicaid Services (CMS) announced a new type of 1115 waiver called the Health Insurance Flexibility and Accountability Act (HIFA). One of the goals of a HIFA waiver is to develop statewide approaches "that maximize private health insurance coverage options."[17] Under HIFA guidelines, Medicaid beneficiaries in optional or expansion eligibility groups can be enrolled into employer-sponsored health plans without guaranteeing comparable coverage or similar cost-sharing protections. States also have more flexibility in determining cost effectiveness. CMS is now requiring states that are applying for a HIFA waiver to include a premium assistance component into their waiver request.

METHODOLOGY

We identified sixteen states through the Internet and published literature, with at least one HIPP, SCHIP, or HIFA premium assistance program, although only 15 had any enrollees at the time of our study (Table 1).[18, 19] We contacted Medicaid or SCHIP officials in all of these states and asked if they would be willing to be interviewed about their program. We were able to conduct semi-structured telephone interviews with Medicaid or SCHIP officials in 14 of the 16 states, although in some states with more than one program we were only able to speak with staff from a single program. Table 1 describes each state's premium assistance program, including the targeted populations (e.g., Medicaid, SCHIP or both), authorizing legal authority to operate the program (HIPP, SCHIP, 1115 or HIFA waivers), year the program was initially implemented, covered lives at the time of the interview, and whether we were able to interview program staff. The interviews took place in May-October, 2005.

Table 1: Characteristics of premium assistance programs operational as of 2005

State	Targeted Populations	Legal Authority	Year implemented	Covered lives at time of interview	Program Staff Interviewed
California	Medicaid	HIPP	1986	993	Yes
Georgia	Medicaid	HIPP	1994	1200	Yes
Illinois	SCHIP	HIFA	2002	5,289 [1]	Yes
Iowa	Medicaid	HIPP	1991	9,417	Yes
Maine	Medicaid	HIPP	1993	207	Yes
Maine	Medicaid	HIFA	2002	[NA]	No
Massachusetts	Medicaid/ SCHIP	HIPP 1115 SCHIP	1994 1997 1998	31,600	Yes
Michigan	Medicaid	1115		None	Yes
Missouri	Medicaid	HIPP	[NA]	[NA]	No
New Jersey	Medicaid	HIPP	[NA]	[NA]	No
New Jersey	SCHIP	HIFA	2001	725	Yes
Oregon	Medicaid	HIFA	2003 [2]	12,100	Yes
Pennsylvania	Medicaid	HIPP	[NA]	[NA]	No
Rhode Island	Medicaid/ SCHIP	HIPP	2000	~6,000	Yes
Texas	Medicaid	HIPP	1996	~26,000	Yes
Utah	Medicaid	1115	2003	76	Yes
Virginia	Medicaid	HIPP	1991	~1,200	Yes
Virginia	SCHIP	SCHIP	2001 [3]	100	Yes
Wisconsin	Medicaid/ SCHIP	HIPP	1999	1,074	Yes

[1] Illinois began its program with state-only funds in 1998, converted to an 1115 SCHIP waiver in 2002.
[2] Oregon began its program with state-only funds in 1998, it converted to an 1115 waiver in 2003.
[3] Subsequent to the interview, the Virginia SCHIP program had a HIFA waiver request approved. It began in August 2005.
[NA] Data were not available at time of interview.

Before focusing on rural-urban differences, respondents to our telephone interviews were asked background information about their programs. Areas covered included the type of program operated, when the program was implemented, eligibility for coverage under the premium assistance program, enrollment trends, why participants leave the program, availability of employer-based insurance and willingness of employers to participate, premium assistance for private insurance coverage in the non-group market, and cost effectiveness analysis (including the comprehensiveness of private insurance coverage and requirements for wrap-around coverage).

We then asked whether there was any perceived geographic variation in access to employer-sponsored insurance, willingness of employers to participate in the program, scope of insurance coverage, cost effectiveness of the program, or ease of program operation. Although our questions about geographic variation focused on urban-rural differences, we did not impose a metropolitan-nonmetroplitan county definition of rural on our discussions. During our interviews with state program staff, we did not define "rural" for them, but let them answer based on what they considered rural for their state. We were interested in the perceptions of state officials as to whether or not program success varies geographically, and many of the characteristics of rural places that might make premium assistance programs harder to implement could be found in both nonmetropolitan counties and rural areas of metropolitan counties. We did seek county-level enrollment data for the premium assistance programs; however, respondents generally reported that these data were not available. The interviews lasted approximately one hour, with follow-up communication to clarify outstanding questions. Respondents were provided with a copy of their responses to ensure accuracy. The information included in this report reflects the program operation at the time of the interview; however, program rules may have changed since the time of the interview. When updated information was available, we included that in the footnotes.

FINDINGS

Initial program implementation: Most respondents reported that they created a premium assistance program to reduce Medicaid and/or SCHIP costs (CA, GA, IA, MA, ME, NJ, RI, VA and WI), increase the employee's connection to the workforce (MA, NJ, RI, VA and WI), or reduce the number of adults or children who are uninsured (IL and OR). In almost all states, the program was initially implemented on a statewide basis. Only respondents in two states reported geographic variation in the initial program implementation, and among these, the approach to including rural areas and the focus on them differed substantially. The Virginia Medicaid HIPP program began in 1991 as a pilot program which operated in three urban areas, chosen because they were densely populated. The Medicaid agency wanted to determine the feasibility of the program before it went statewide. In contrast, Oregon initially developed a totally state-funded premium assistance program that limited the number of people it would serve. The program staff initially focused on marketing in rural and minority-dominated areas to address the concern raised by some rural advocates who were worried that people living in urban areas would fill the limited program slots before employees in rural areas had a chance to enroll.

In addition to these two states that had some geographic variation in their initial program implementation, Massachusetts had a waiver pending at the time of the interview which would have set higher income eligibility standards for the premium assistance program for individuals living on Martha's Vineyard (considered a more rural area of the state). The state requested the geographic variation because of a disproportionate number of uninsured living on the island; the higher cost of living on the island made it more difficult for people to afford health insurance coverage even when available.

Eligibility for coverage under the premium assistance program: Typically, eligibility for Medicaid and SCHIP programs is limited to individuals who meet certain categorical, income, and sometimes, resource restrictions. For example, Medicaid is generally limited to pregnant women, children under the age of 19 (or up to 21 at state option), families with dependent children, older adults (age 65 or older), or people with disabilities who meet state specified income and resource limits. The eligibility income limits are usually higher for children than for adults, so children can more easily qualify than their parents. SCHIP is generally limited to children under the age of 19 who meet the states' income limits. While states can only use federal Medicaid or SCHIP funds to pay for the health services of people who qualify under these program rules, premium assistance programs give states a little more flexibility to cover individuals who would not otherwise be eligible for Medicaid and/or SCHIP. In addition to those who are eligible to participate because they are already enrolled in Medicaid or SCHIP, states that operate a HIPP or SCHIP premium assistance program can pay the premium costs to cover the parents or dependents of Medicaid (or SCHIP) eligible individuals if it is cost effective to do so. For example, if a child is Medicaid eligible and the parent is not, the premium assistance program can cover the families' premium cost if this cost is less than what Medicaid would have paid for the child alone. Non-eligible parents or siblings thereby benefit from this premium support.

Respondents from eight states noted that their premium assistance could be used to help subsidize non-eligible family members (CA, GA, IA, ME, RI, TX, VA HIPP and WI), but in two of these states (CA and GA), they will only use premium assistance funds to cover non-eligible family members if needed to obtain coverage for the eligible family member. In other words, these states will pay for family coverage if that is the only way to cover the child, and it is cost effective to do so. Three programs restrict coverage to the eligible individual only (IL, NJ, and VA SCHIP); however, two of these states have waivers pending to allow premium assistance funds to be used to help support non-eligible family members if cost effective to do so (IL and VA SCHIP).[a]

States that operate their premium assistance program through a HIFA waiver have even more flexibility in covering individuals who would not otherwise be eligible for Medicaid or SCHIP. For example, Oregon covers adults up to 185% of FPG in their premium assistance program, whereas traditional Medicaid is limited to adults with incomes up to 100% FPG. In Utah, traditional Medicaid is limited to individuals with incomes below

[a] Subsequent to the interview, the Virginia SCHIP waiver was approved. The premium assistance payment is a flat amount per child, and can be used to support non-eligible family members.

approximately 60% FPG, but the state will provide premium assistance to adults with incomes up to 150% FPG.[20] The Massachusetts Family Assistance Premium Assistance program provides coverage to children with family incomes between 150-200% FPG, non-elderly adults with incomes at or below 200% FPG, and individuals with HIV disease with incomes at or below 200% FPG. While the state does provide regular Medicaid coverage to children with incomes up to 200% FPG if they do not have access to employer-based coverage, regular Medicaid eligibility is limited to parents with incomes up to 133% FPG.

States are about equally split in whether they require recipients to participate in their premium assistance program if the state determines it is cost effective. Four programs (NJ, RI, TX, and WI) require all eligible recipients to enroll. In Texas participants could voluntarily choose to enroll if the state's premium assistance payment was not sufficient to cover the employee's entire share of the premium payment. In Iowa, Massachusetts, and Virginia HIPP the premium assistance program is mandatory for adults but not for children. In Oregon and Utah, the program is mandatory for the groups who do not otherwise qualify for Medicaid but voluntary for some others.[b] The program is completely voluntary in six other programs (CA, GA, IL, ME, UT and VA SCHIP). None of the respondents reported regional variations in whether the program was mandatory or voluntary.

Enrollment Trends: Most programs are small, operating with fewer than 2,000 enrollees. Only five programs have 5,000 or more enrollees: IA, MA, OR, RI and TX (Table 1). Respondents noted that enrollment was growing in nine programs (GA, IA, MA family assistance program, ME, OR, TX, UT, VA HIPP, and WI), and staying the same in five programs (CA, IL, MA Insurance Partnership, VA SCHIP and RI).[c] Utah is the only program to have an enrollment cap (6,000).[d] Because enrollment of adults into the New Jersey Family Care program was suspended in July 2002, enrollment in the premium assistance program has declined. This, coupled with rapid increases in the costs of employer-sponsored insurance, is making it difficult for the state to show cost-effectiveness. None of the respondents felt there were urban-rural differences in enrollment trends over time.

Most respondents reported that their program did not collect county-level enrollment data for the premium assistance program, so they were unable to determine whether there were any rural-urban differences in overall enrollment. We were only able to obtain

[b] In Oregon, participation in the premium assistance program is voluntary for children and mandatory Medicaid populations (e.g., children, pregnant women, elderly and disabled). The Medicaid expansion population with incomes up to 100% FPG must participate in the premium assistance program if the person has access to an employer sponsored insurance that meets the state's benchmark for covered services, and if the employer contributes to the costs of coverage. Adults with higher incomes (between 100-185% of FPG), who would not otherwise qualify for Medicaid can only receive assistance through the premium assistance program.

[c] The VA SCHIP enrollment growth was stagnant before the waiver request was approved. However, enrollment has been growing since the waiver was approved and the program revamped.

[d] Subsequent to the interviews, Oregon capped enrollment in the individual market as it reached its enrollment and budget limits. Enrollment in the program for employer sponsored insurance is still open.

county level enrollment data from Illinois. In their SCHIP premium assistance program, rural residents were more likely to enroll (25% of all premium assistance enrollees) in comparison to the overall percentage of rural residents in the SCHIP expansion (18%). The respondent from Utah provided estimates of the percentage of enrollees by geographic area. Approximately 37% of the premium assistance enrollees were from rural areas; in contrast, 28.5% of all Medicaid recipients were from rural areas. Respondents from Massachusetts also reported that enrollment was higher in the western part of the state (areas considered more rural). However, the respondents attributed higher rural enrollment to the fact that more rural residents had low incomes and so qualified for Medicaid, rather than something that was unique to the premium assistance program. Most of the other respondents believed that there were no differences in program enrollment by geographic area, although this perception was not based on any formal analyses of enrollment data.

Why participants leave the program: Uniformly, respondents thought that there was no geographic variation in why premium assistance enrollees left the program. Typically, enrollees leave because they lose or change jobs, they are no longer eligible for Medicaid or SCHIP, or the state determines that coverage is no longer cost effective. Only one respondent noted some differences in enrollee length of time on the program. This respondent (VA HIPP) reported that rural residents were more likely to change residence or jobs, or to move to a community in search of a better job than were urban workers. Thus, they were typically enrolled in premium assistance programs for shorter periods of time than were urban residents.

Availability of employer-based insurance (ESI) and willingness of employers to participate: Participation in premium assistance programs is predicated, in many states, on access to employer-sponsored insurance. Thus, differences across geographic areas in the availability of ESI can affect program enrollment. Typically, rural residents are more likely to be employed by a small firm than those living in more urban areas. This can be problematic, as small firms are typically less likely to offer insurance coverage. Further, individuals working for small firms in rural areas are less likely to be offered coverage than those in urban areas. Nationally, in 1998, among residents of rural counties that were not adjacent to metropolitan areas, 36% of individuals working for a small firm were offered employer-sponsored insurance, compared to 47% of urban individuals who worked for a small employer.

Some, but not all, of the respondents noted that recipients who work for small employers are less likely to be offered health insurance coverage in their states, and they are therefore less likely to participate in a premium assistance program. Respondents in five states (CA, IA, ME, OR and VA HIPP) thought this created a barrier for rural residents to participate in the premium assistance program through an employer sponsored plan, as rural residents were more likely to work for small firms. In contrast, respondents in two state programs (TX and VA SCHIP) noted that when small employers offered coverage, they were more likely to cooperate with the state in providing the needed information to help their employees enroll in the premium assistance programs because of closer

employer-employee working relationships.[e] The remaining respondents had seen no differences in participation based on size of the firm.

Generally, for employees to participate, the only requirement for employers is to provide initial insurance coverage information to the state (e.g., summary of benefits, carrier information, employment verification, enrollment in the plan, premium costs, etc.). If an employer fails to cooperate, the state will try to get the information directly from the enrollee. After the initial paperwork, most states reimburse the enrollee directly for the premiums paid, although some will send the premium assistance payment to the employer if it would cause a hardship to the enrollee to pay the premium out-of-pocket. None of the respondents noted geographic (as opposed to firm size) differences in the willingness of employers to participate or provide needed information.

Respondents in two states reported that the state offered tax or other incentives to employers to encourage them to offer health insurance (MA and TX). The Insurance Partnership program in Massachusetts was created specifically to create an incentive for small employers to offer insurance to their employees. The premium assistance program and the employer incentive program work together. Employers with 50 or fewer employees can qualify for a tax credit of up to $1,000 per year per family, depending on the number of eligible low-income employees. To qualify, the employer must offer a plan that provides basic coverage and must agree to adjust the amount withheld from the employee's paycheck to reflect the premium assistance paid on the employees' behalf. The respondent believed that the Insurance Partnership program has helped increase employer-based coverage as well as participation in the premium assistance program, particularly among the self-employed, and that the incentive might have a greater impact in rural communities, where many are self-employed.[f]

In contrast, Texas has a tax incentive program that operates independently from the premium assistance program and targets its tax credit to businesses of any size that employ low-income individuals receiving government assistance (e.g., TANF, Medicaid, SSI and Food Stamps). The respondent did not think that the tax incentive affected participation in the premium assistance program in either rural or urban areas.

Premium assistance for private insurance in the non-group market: Although most of the premium assistance funds are used to help subsidize the premium costs of employer-sponsored insurance, many states also allow individuals to use premium assistance funds to purchase non-group coverage, a feature that should be helpful in rural areas with less access to employer-based coverage. Only four programs are limited exclusively to employer-sponsored insurance: VA SCHIP, WI, RI and NJ (and Virginia is seeking a waiver to enable families to use premium assistance funds in the non-group market if cost

[e] The Virginia SCHIP program no longer seeks information from the employer to enroll an eligible child.
[f] Nationally, data from 1998 suggests that individuals who were self-employed living in rural areas were more likely to be uninsured than those living in urban areas. Ziller EC, Coburn AF, Loux SL, Hoffman C, McBride TD. Health Insurance Coverage in Rural America: Chartbook. Washington, DC: Institute for Health Policy, Muskie School of Public Services, University of Southern Maine with The Kaiser Commission on Medicaid and the Uninsured; September 2003. 4093.

effective to do so).[g] In states that do allow the purchase of non-group coverage, most covered individuals have employer-sponsored insurance. However, in a few states 30% or more of the covered individuals have non-group policies. In Oregon, for example, about 35% of the individuals are covered through employer-sponsored insurance, 40% through a non-group carrier, and 25% receive coverage through the state's high-risk pool. Respondents were generally unable to determine whether there were any geographic variations in the extent to which covered individuals were covered by non-group plans; although one respondent thought—but did not have data to show—that rural individuals were more likely than urban recipients to be enrolled in non-group plans (Iowa).

Cost effectiveness analysis: To determine cost effectiveness, states generally compare the cost of providing coverage to the enrollee through the Medicaid or SCHIP program to the cost of paying the enrollee's share of the premium and any uncovered costs the state would still pay. Under traditional HIPP or SCHIP premium assistance programs, states are required to provide wrap-around coverage to ensure that recipients get the same coverage and pay no additional costs as would be required under the Medicaid or SCHIP program.[h] However, states that operate their programs through an 1115 or HIFA waiver have more flexibility. While not mandated to do so, some of the states (IL and NJ) that are operating under a waiver also provide wrap-around coverage.

The comprehensiveness of the employer-sponsored health plan can affect the cost effectiveness analysis. Since states that operate HIPP or SCHIP programs generally have to provide wrap-around coverage, they would incur additional costs to enroll individuals into less comprehensive private plans than when enrolling recipients into more comprehensive plans (assuming that employers made similar premium contributions). A few respondents noted some difference in the benefits offered in employer-based insurance coverage available in rural versus urban areas, mostly attributable to differences in the size of the employer. Respondents in three states thought that small employers, more commonly found in rural areas, tended to offer less comprehensive benefits or higher cost sharing (IA, OR and VA HIPP).

These same respondents also thought that premiums were more expensive for the small employers and that these costs were often passed onto the employees, which would increase the cost to the state to pay for the employee's share of premium. If these costs exceeded what the state would pay under its cost effectiveness analysis, the employee may not be eligible to receive coverage or may be required to pay part of the premium him or herself. One respondent (VA HIPP) noted that there may be a larger proportion of Medicaid recipients in rural communities that have to pay part of their own premium, as a higher percentage of people were covered by small employers in rural communities than in urban areas.

[g] As part of the approved HIFA waiver, Virginia SCHIP program allows eligible individuals to use the premium assistance payment to help pay for non-group coverage.

[h] Children enrolled in premium assistance program under SCHIP must receive coverage equal to a SCHIP benchmark plan, through the ESI or wrap-around coverage. 42 USC §1397ee(c)(3).

Only one respondent thought that differences in premiums were based on geography rather than size of employer. Although acknowledging that premiums for small employers are generally higher than similar products for larger employers, a respondent in Massachusetts thought that the premiums for small employers in rural areas were probably less expensive than similar coverage for a small employer in an urban area because the costs of care are lower in rural areas.

In many states, cost effectiveness is an individual determination, based on the enrollee's past use of healthcare services. Thus, the state would be able to spend more in private premium subsidies for individuals with higher historical healthcare costs and still claim cost-effectiveness. When individual-level data were not available, states used average costs based on age, sex, and eligibility category.

Respondents in six states (MA, NJ, OR, UT, VA SCHIP and WI) noted that employers were required to pay a minimum percentage of the enrollees' premium (generally 40-50% of the costs of an individual or a family plan, depending on whether the state was covering adults or children), although two of these respondents (UT and VA SCHIP) noted that they were moving away from minimum contribution requirements and relying instead on an individual cost-effectiveness determinations.[i] Four states specifically limit the amount of their contribution. Illinois contributes no more than $75/child each month; Massachusetts contributes up to $150 per person per month (after the enrollee pays a monthly premium), and Utah limits their premium contribution to $50/month.[21] In two state programs (VA HIPP, and WI), the amount of the maximum state premium assistance payment varies by geography, as they are set using capitation rates that included geographic adjustment factors.[j]

DISCUSSION

Premium assistance programs have the potential to help the state and federal governments reduce Medicaid and SCHIP program expenditures by capturing the employer's contribution for private health insurance coverage. Individual recipients also stand to gain through premium assistance programs. If provided wrap-around coverage, individual recipients can obtain the same coverage and cost sharing as offered through the Medicaid or SCHIP program directly. However, obtaining insurance through the private market may offer additional benefits, including a greater choice of providers (in some states) and less social stigma.[22, 23] Even if wrap-around coverage is not offered, some beneficiaries may still prefer to enroll in private plans. Low-income families may also benefit if the state uses its premium assistance dollars to help subsidize the premium costs for non-eligible family members, or if the state, through an 1115 or HIFA waiver, expands Medicaid to cover individuals who would not otherwise be eligible for any

[i] The Virginia SCHIP program no longer requires a minimum employer contribution. In Oregon, employers are required to contribute 50% of the employee's premium as part of state insurance laws. There is not a minimum employer contribution threshold for the premium assistance program.
[j] Under the Virginia SCHIP waiver, the state will pay up to $100/child/month in premium assistance payments, not to exceed the actual amount of the family's premium.

coverage. Rural residents, who are more likely to be uninsured, could benefit greatly if this subsidy were more readily available.

Overall, the premium assistance staff we interviewed did not note significant variations in the operation or effectiveness of premium assistance programs by geographic area, reporting that the program operated the same throughout the state. However, most respondents noted that they had not analyzed their premium assistance programs specifically to determine whether there were geographic differences in enrollment, cost effectiveness, or other program operation. Respondents almost uniformly reported that their state did not track data at the county or regional level, so they may not be aware of any actual differences in program enrollment. Additionally, most of the programs are small, so it would be difficult to determine whether geographic differences in enrollment, if any, were due to outreach efforts in local eligibility agencies, geographic differences in employment or insurance characteristics, or other program policies which differentially affect rural or urban recipients.

In Illinois, the only state that shared county level data, there was actually a higher level of participation in the premium assistance programs from rural areas than from urban areas. Respondents from Utah and Massachusetts, while not providing enrollment data, estimated that enrollment was disproportionately higher in rural areas of their states. While the underlying reason for the higher rural enrollment in all three of these states is not known and may be due to underlying geographic differences in insurance status, source of coverage for children, or family income, it does appear, at least in these three states, that premium assistance programs are a promising vehicle for addressing the problem of lack of insurance in rural areas.

Despite the experience in Illinois, Utah and Massachusetts, the information gathered from our interviews combined with what is known about rural areas in the literature suggests that there are reasons to believe that rural residents are at a disadvantage in obtaining the benefits of a premium assistance program under the program design in many states. As noted earlier, the program was initially designed to help low-income recipients pay their share of employer-sponsored health insurance. Thus, rural residents, who have less access to employer-sponsored health insurance, are at a distinct disadvantage relative to urban residents in participating in premium assistance programs. Although rural enrollment should be helped by the fact that some (but not all) states also allow recipients to use Medicaid or SCHIP funds to help them purchase non-group plans, this option is only available if cost effective, and states will have more difficulty showing cost-effectiveness in paying for non-group plans as employers do not contribute towards the cost of the non-group premiums.

After accounting for differences in access to employer-sponsored insurance, a likely impediment to participation is that it may not be cost effective to the state; states can only use Medicaid or SCHIP funds to help pay the premium costs of private insurance if the premium payment is less than the expected Medicaid (or SCHIP) payment for the same package of covered services. There are many factors in the cost effectiveness analysis

that could create a rural-urban differential in premium assistance program enrollment, but in the absence of data, it is difficult to determine the combined effect.

The higher the cost under a premium assistance program, the less likely participation will be found to be cost effective. Factors influencing these costs include geographic variations (if any) in the cost of private health insurance coverage and the comprehensiveness of the employer-sponsored insurance coverage. At least one respondent thought that the premiums were generally lower in rural areas than in urban areas for the same size employer and the same scope of coverage, because rural areas had lower health care costs, on average, than urban areas, which could inure to the benefit of rural residents. However, rural residents are more likely to be employed by small employers or obtain coverage through non-group plans, and the cost of health insurance offered to small employers or in the non-group market is often more expensive than a similar product offered to large employers, which works to the detriment of rural residents.[24, 25] Small group policies and non-group plans are also generally less comprehensive or have higher cost sharing than those offered by larger employers.[26 27] This could create barriers for rural residents in obtaining the benefits of a premium assistance program, as to meet wrap-around requirements in HIPP or SCHIP premium assistance programs (without a waiver), states will incur additional costs to fill in the gaps in the private coverage.

The costs under a premium assistance program are compared to those that the state would have expected to pay otherwise. Factors that influence expected Medicaid (SCHIP) payments include levels of provider reimbursement in the Medicaid or SCHIP programs and the utilization of services by recipients. The lower the expected payments, the less likely it will be found cost effective for an individual to participate in a premium assistance program. The extent to which there may be rural-urban differentials in expected payments depends on a state's method of determining cost effectiveness. In states where the expected payment is calculated based on averages (eligibles are stratified by characteristics such as age but not by geography), there would be no geographic differentials. However, where cost effectiveness is calculated at the individual level, rural residents could be penalized in states that pay providers differential geographic rates. If the state pays lower reimbursement rates to rural providers, then the Medicaid or SCHIP base rate in calculating cost effectiveness could be lower. Similarly, rural residents often use fewer services than urban residents. Lower historical spending would make it more difficult for a state to show cost effectiveness for rural recipients.

States have some flexibility in designing their programs to address these potential problems. First, states can use Medicaid or SCHIP funds to help pay for non-group coverage as well as ESI. This could be particularly beneficial to rural recipients who have less access to ESI. Second, the state can use average Medicaid or SCHIP costs for Medicaid or SCHIP recipients (in addition to an individual determination) in determining cost effectiveness. In this way, any regional variations in provider payments or use of services would not work to the detriment of rural recipients. Third, states can offer recipients the use of limited premium payments when paying the full premium would not be cost effective to the state. This is particularly important in states that are using their

premium assistance program as the sole vehicle for extending Medicaid to an optional eligibility group. Recipients then can use this payment to help them purchase private coverage, even if it did not offset the full cost of the private insurance. Presumably, this would be most beneficial to recipients with slightly higher incomes, who could potentially pay part of the premium costs themselves. If the program was implemented as part of an 1115 or HIFA waiver, the state may have more flexibility in determining cost-effectiveness and could potentially pay larger amounts for individuals who are purchasing health insurance in the non-group market, or for lower-income workers (as opposed to higher income employees).

Additionally, states could use their HIFA waivers to develop creative policies to try to encourage employers to offer insurance coverage. If successful, this could help mitigate problems that rural recipients have in accessing ESI. States that are developing premium assistance programs as part of larger plans to expand coverage to the uninsured may be able to combine the premium assistance with other incentives to encourage more employers to offer insurance. For example, as part of an 1115 waiver, Massachusetts uses Medicaid funds to help subsidize the *employer's* premium costs for certain qualifying low-wage employees. This, coupled with the premium assistance provided to the low-wage workers, can make health insurance affordable to both the employer and the employee. Using Medicaid funds to provide incentives for employers to offer insurance could help address the differential lack of access to ESI in rural communities. Similarly, states could couple the Medicaid or SCHIP premium assistance programs with other state initiatives designed to lower the premium costs for small employers and/or individuals. New York, for example, has created a state-subsidized reinsurance pool available to help reduce the premium costs for small employers, solo-proprietors and individual workers who lack access to employer-sponsored insurance.[28] Healthy New York is available for certain small employers (with low-wage workers) as well as low-income solo proprietors and working individuals. A premium assistance program could help the lower wage workers pay for their share of the premium coverage. Similarly, premium assistance programs could help lower income individuals pay for coverage in a high-risk pool (if available in the state).

CONCLUSION

To date, premium assistance programs have not lived up to their potential. Enrollment in most of the states' programs has been small, with few programs enrolling more than 10,000 recipients. While positive in concept, premium assistance programs have inherent limitations that may preclude more widespread enrollment. First, it is difficult to implement a premium assistance program in a state that has low Medicaid or SCHIP income eligibility levels, as few individuals with very low incomes have access to employer-sponsored insurance, and enrollment in non-group plans is likely to be cost prohibitive (to both the state and low-income individual). Second, although offering wrap-around coverage offers greater protection to the recipients (so that their coverage is comparable to what they would have if enrolled in Medicaid or SCHIP directly), it does make it more difficult for the state to demonstrate cost effectiveness.

There are reasons to believe that rural recipients may be at a disadvantage in qualifying for premium assistance programs, as rural residents are more likely to work for small employers who do not offer health insurance, or that have higher premiums or less comprehensive policies when coverage is available. There are also reasons that premium assistance programs could be differentially beneficial to rural residents, as incomes tend to be lower and rates of uninsurance higher. States should specifically analyze their enrollment data to determine if rural residents have participation levels that would be expected, given their demographic characteristics and potential eligibility for the program. If participation levels are differentially low, state administrators should identify whether it is the state's program policies, or underlying employment or insurance factors that are contributing to the differential program participation. With some creativity in program design, premium assistance programs may be a useful tool in the state's arsenal of efforts to expand health insurance coverage to the rural uninsured.

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