

Issue Brief

Findings from HSC



PREMIUM SUBSIDIES FOR EMPLOYER- SPONSORED HEALTH COVERAGE:

An Emerging State and Local Strategy to Reach the Uninsured

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With nearly 75 percent of the uninsured living in households with at least one full-time worker, there has been renewed policy interest in strategies to expand coverage by subsidizing employer-sponsored insurance. Six of the 12 nationally representative communities that the Center for Studying Health System Change (HSC) tracks have premium assistance, or subsidy, programs planned or underway. Policy makers are enthusiastic about the potential to expand coverage through these programs, but enrollment has been modest to date. This Issue Brief examines operational challenges facing subsidy programs, such as how to structure a benefits package within budgetary and regulatory constraints and how to attract employers and employees without displacing existing private contributions to premiums. It also discusses the trade-offs policy makers may face to resolve these challenges in the context of rising premiums and a slowing economy.

Renewed Interest in Premium Assistance Programs

State and local governments are beginning to develop subsidy programs to make employer-sponsored health insurance more affordable for the working uninsured.¹ HSC identified such efforts in half of its 12 study sites during its 2000-01 site visits (see Table 1). Some of these programs, such as New Jersey's Premium Support Program, provide subsidies to employees, while others, such as the Massachusetts Insurance Partnership, subsidize employers.

New York state has taken a different approach to help keep the cost of premiums down by subsidizing health plans for some of the program's high-cost claims. Many programs, including New York's, specifically target small

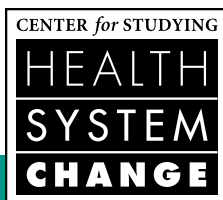
firms where access to coverage is more limited.

Recent legislative and regulatory changes have bolstered interest in premium subsidies. The State Children's Health Insurance Program (SCHIP) allows states to use SCHIP funds to subsidize eligible families' employer-offered health insurance. In addition, the Bush Administration's Health Insurance Flexibility and Accountability (HIFA) initiative, a federal demonstration program, encourages states to explore ways to use Medicaid and SCHIP funds to subsidize private health insurance for low-income people.

Premium subsidies for employer-sponsored insurance are attractive to

policy makers for several reasons:

- Combining public subsidies with employer contributions lessens the strain on public coffers and potentially allows available funds to cover more people.
- Because the subsidies build on employer-based coverage—the primary source of coverage for non-elderly adults—they help to mitigate the stigma often associated with public programs.
- The programs often allow children and parents to have the same source of coverage, which studies indicate increases the likelihood that families will access needed medical services.





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Nevertheless, premium subsidies have had limited success. In 1990, Medicaid created the Health Insurance Premium Payment program, which required states to subsidize the cost of employer-sponsored insurance for eligible adults when this arrangement would be more cost-effective than enrolling them in Medicaid. But states had trouble identifying eligible people and gaining cooperation from employees and employers.² Ultimately, the program was made optional, and its use is minimal. Foundation-funded premium subsidy initiatives were implemented in the late 1980s, but these failed to attract participants because of a lack of public awareness and employers' fears that they would be unable to maintain benefits after the grants ended.³

Operational Challenges

Subsidy programs at HSC's sites developed as part of state or local efforts to expand coverage, such as state Medicaid expansions, SCHIP programs or local programs to care for the uninsured. Since few other public insurance initiatives require interaction with employer-sponsored plans, program officials have faced a steep learning curve in integrating the two. Regulatory requirements have been particularly complex. In addition, program developers have struggled to design subsidies that are large enough to attract enrollees, while not substituting for existing employer contributions to health insurance premiums.

Designing the Benefits Package. The types of funds used to finance premium subsidy programs dictate how much flexibility policy makers have in program design because of associated regulatory requirements. The premium subsidy programs observed in HSC's study sites fall into three major categories:

- federal and state partnerships financed with Medicaid or SCHIP funds (e.g., programs in Massachusetts and New Jersey);
- state programs using state funds exclusively (e.g., programs in New York and Washington); and
- local programs using a combination of county funds and federal and state resources (e.g., proposed programs in Indianapolis and Lansing, Mich.).

Programs structured as federal/state partnerships have larger budgets, but a variety of requirements regarding the benefits package and enrollee cost sharing constrain design flexibility and tend to make coverage more expensive. For example, programs using SCHIP funds must ensure the benefits package is comparable to the relatively generous SCHIP package or some other designated benchmark, and employer-sponsored plans often do not meet this standard. Indeed, Massachusetts found very few applicants had access to a SCHIP-qualified benefits package through employers.

Some programs have addressed this problem by providing wraparound benefits packages to supplement employer-sponsored plans. For instance, if the benchmark plan covers 60 mental health visits annually, but an employer's plan only covers 20, the premium subsidy program might cover the remaining 40 visits. However, this can be cumbersome administratively, especially given the variety of benefits packages in the employer-sponsored health insurance market. New SCHIP regulations that allow states more flexibility to determine whether a benefits package is adequate could mitigate this problem.

Medicaid and SCHIP regulations also place limits on costs borne by enrollees to ensure that care is affordable. Medicaid-funded programs cannot charge certain enrollees for any portion of the premium, and copayments cannot exceed those in the state's Medicaid program. Similarly, SCHIP funding requires that families do not spend more than 5 percent of their income on children's health care expenditures, including copayments; states may set even lower caps. Complying with these requirements has challenged programs to find mechanisms to track individuals' health care spending and income to make sure that patients are not billed inappropriately.

Locally and state-funded programs are able to avoid many of these federal constraints, but they tend to have smaller budgets. These programs generally have kept costs down by offering a less generous benefits package than other public programs or employer-sponsored plans. In theory, this also allows employers and employees to purchase less expensive coverage than they typically can find in the private market. For

Table 1
Subsidizing Employer-Sponsored Insurance in Three Communities

Program Type	FEDERAL/STATE PARTNERSHIP		STATE-ONLY PROGRAM	COUNTY/LOCAL PROGRAM
Program Name, Location, Start Date	<i>MassHealth, Mass., 1998</i>		<i>Healthy New York*, N.Y., 2001</i>	<i>Small Employer Subsidized Health Program, Lansing, Mich., expected 2001</i>
	<i>Premium Assistance</i>	<i>Insurance Partnership</i>		
Current Enrollment	<i>12,000 lives</i>	<i>4,000 businesses</i>	<i>More than 1,000 lives</i>	<i>Not applicable</i>
Structure	<i>Provides full or partial subsidies to employees for employer-sponsored insurance</i>	<i>Provides fixed-dollar subsidies to small employers for their share of premium</i>	<i>Indirect subsidy; stop-loss pools reimburse HMOs for 90 percent of costs for claims between \$30,000 and \$100,000 per enrollee per year</i>	<i>Program, employer and employee each contribute roughly one-third of the premium for employer-sponsored insurance</i>
Eligibility	<i>Children and their families with income between 150 and 200 percent of the federal poverty level (FPL); adults with income up to 200 percent of FPL who work for participating small businesses</i>	<i>Small businesses that employ low-income workers and contribute at least 50 percent to health care premium</i>	<i>Small businesses that have not offered group coverage for 12 months; one-third of employees must earn less than \$30,000 a year; employer contributes at least 50 percent of the health care premium</i>	<i>Small businesses that do not offer health insurance and pay a median wage of \$10 per hour</i>

* Individuals, including sole proprietors, also are eligible for Healthy New York.

example, Lansing’s program is considering excluding coverage for maternity care because most women enrollees would be eligible for Medicaid once they become pregnant. Other programs have made difficult cost-benefit trade-offs. For example, New York’s program received an exemption to eliminate some state-mandated benefits, such as chiropractic care and behavioral health, in an effort to keep down the cost of the benefits package, although this has not always proved effective.

Avoiding Substitution. While program officials want to encourage businesses to offer insurance and employees to accept it, they do not want premium subsidy programs to displace existing private contributions to health insurance coverage. Like other public programs, some premium subsidy programs address this problem with look-back periods that exclude individuals who have had private insurance during a specified period in the past. Some programs also have look-back periods for employers to discourage them from dropping existing coverage to gain access to the

public program. To participate in Healthy New York, for example, employers cannot have offered insurance during the previous 12 months.

Programs subsidizing employees’ share of premiums often require employers to make a minimum premium contribution to ensure they maintain some financial responsibility for health care coverage. For example, states receiving federal funds must set minimum contribution levels for employers; currently these range from 40 percent to 60 percent. One drawback to this approach is that employers may decrease their existing contributions to the required minimum, which would increase the burden on public funds and could make insurance less affordable to other low-income employees who are ineligible for premium subsidies.

If You Build It, Will They Come?

After grappling with design decisions, developers of premium subsidy programs

have confronted the next problem: modest enrollment. Some of this can be attributed to the newness of the programs. For example, New York’s program, implemented in January 2001, had just over 1,000 individuals enrolled by August. Massachusetts’ program aimed to enroll 100,000 people in its first full year, but, after 17 months, premium subsidies provided coverage for only 12,000 people.

Programs have faced reluctance from employers and employees. One obstacle for employers has been the perception that the subsidies are too small to reduce costs significantly. Indeed, recent HSC research found that very large subsidies would be needed to increase insurance coverage by even a modest amount.⁴ Some employers do not view providing health insurance as a high priority, and others are suspicious that subsidies will be temporary.

Technical issues also are hampering enrollment. For example, firms with employees whose income varies monthly, such as hourly or commissioned workers, may have workers eligible one month but

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and rising health
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could increase
demand for
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programs.**

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not the next. Administrative responsibility for the program poses another technical problem. New Jersey's FamilyCare found a solution for this: When a focus group revealed employer concerns about the administrative burden, the program responded by bypassing the employer and sending the subsidy directly to the employee.⁵

From the employees' perspective, workers may not want their employer to know they receive a public subsidy, or they may be reluctant to seek their assistance to enroll in the program. Frequent changes in employment status and fluctuations in monthly earnings present additional obstacles to employees' enrolling. And, most employees have only a narrow window to sign up—during an employer's open-enrollment period. To address this, some policy experts have proposed making eligibility for the program a qualifying event, similar to marriage or birth of a child, that allows off-cycle enrollment.

Despite slow enrollment, there is still optimism that premium subsidy programs have the potential to expand coverage. Experience has shown that cultivating relationships with employers and employees takes time, particularly when a new program is perceived as temporary or vulnerable to funding cuts. Program officials note that planning for slow enrollment—including managing expectations of what these programs can and cannot do—may help build both employers' and employees' confidence and generate greater enrollment over time.

Policy Implications

Premium subsidy programs offer an innovative approach to expanding coverage by leveraging public and private funds and building on the nation's employer-based health insurance system. Yet, initial experience suggests these programs are costly and difficult to design and operate. Moreover, neither employers nor employees have embraced them enthusiastically.

A fundamental issue is the number and complexity of federal and state regulations pertaining to the programs that—while

offering important protections—increase costs and reduce the number of potential enrollees. Federally funded programs are subject to requirements concerning eligibility, benefits packages and copayments that can increase costs and administrative burdens. At the state level, mandated benefits and consumer protections can make coverage quite costly.

Looking ahead, the combination of a slowing economy, increasingly strained federal funding, state budget shortfalls and rising health insurance premiums could increase demand for premium subsidy programs. Policy makers may need to address difficult trade-offs between the scope of benefits and the number of people covered if premium subsidies are to serve as a viable way to encourage uninsured, low-income workers to gain coverage. ●

Notes

1. For a description of other programs, see Silow-Carroll, Sharon, Stephanie E. Anthony and Jack A. Meyer, *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured*, The Commonwealth Fund (November 2000).
2. *Medicaid: Three States' Experiences in Buying Employer-based Health Insurance*, U.S. General Accounting Office, GAO/HEHS-97-159 (July 1997).
3. Silow-Carroll, Sharon, *Employer Tax Credits to Expand Health Coverage: Lessons Learned*, Economic and Social Research Institute for The Commonwealth Fund (February 2000).
4. Reschovsky, James D., and Jack Hadley, *Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly*, Issue Brief No. 46, Center for Studying Health System Change (December 2001).
5. *Coordinating State Children's Health Insurance Programs with Employer-Based Coverage: Design and Implementation of Premium Assistance Programs—Conference Highlights and Related Information*, Institute for Health Policy Solutions and the National Governors' Association (Oct. 5, 1999).