WebMemo
Published by The Heritage Foundation
No. 1466
May 22, 2007

Reforming SCHIP: Using Premium Assistance to Expand Coverage

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The State Children's Health Insurance Program (SCHIP), jointly financed by the federal and state governments but administered by the states, should focus on transitioning eligible lower-income children into private, family coverage. Unfortunately, the current structure of SCHIP displaces private coverage instead of strengthening it. In the upcoming reauthorization of SCHIP, Congress should encourage more states to adopt premium assistance as a way to expand access to private coverage options.

Premium Assistance Now. SCHIP does allow states to pay premiums for enrollees' private health insurance. According to the Centers for Medicare and Medicaid Services (CMS), 12 states have premium assistance programs,[1] either through traditional SCHIP authority or through waivers, which give states greater latitude in designing more effective models within the context of the law. Moreover, while premium assistance is typically applied to employer-based plans, some states have also qualified plans from the private, individual market.[2]

At the time of its enactment, the premium assistance provision seemed to hold great promise.[3] The details of the measure, however, have undermined its effectiveness. Coverage provided under premium assistance must meet "cost effectiveness" tests and the SCHIP benefit and cost-sharing standards set by law. If a plan does not meet these standards, a state must provide "wrap-around" coverage to fill in the gaps. The complexity and costs of administering a premium assistance option not only deter greater adoption but also stifle its potential to transform SCHIP into a program that helps lower-income working families obtain private coverage, which most insured workers prefer to a government-run plan.[4]

The Benefits of Premium Assistance. Many lower-income families already participate in the private health insurance market. Half of all children in families with incomes between 100 percent and 200 percent of the federal poverty line (FPL) had private coverage in 2005.[5] That figure jumps to 77 percent of children in families with incomes between 200 percent and 300 percent above the FPL.[6] Since SCHIP is designed to target children in families that earn too much to qualify for Medicaid (i.e., working families), a strong case can be made that these families could afford private coverage with some form of assistance.

Thus, one of the biggest policy benefits of premium assistance is that it can help preserve and expand private coverage for lower-income, working families instead of displacing it. Recent analysis by the Congressional Budget Office (CBO) estimates that the "crowd-out" effect of SCHIP—the correlation between increases in SCHIP enrollment and decreases in private coverage—is between 25 percent and 50 percent.[7] In other

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/wm1466.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
214 Massachusetts Avenue, NE
Washington, DC 20002–4999
(202) 546-4400 • heritage.org

words, for every 100 children enrolled in SCHIP, 25 to 50 fewer are in private coverage. Moreover, the CBO reports that most estimates have generally focused on children and not the family as a whole, so figures likely underestimate the full impact of the crowd-out effect.[8]

Second, premium assistance helps to unify children and parents under one private, family plan and promotes greater continuity of care. Today, the parent of a child enrolled in SCHIP may be insured or uninsured. If the parent is covered, the benefits and participating providers will likely differ from the child's. Further complicating the family's health care situation is that income fluctuations may affect the child's eligibility and insurance status. Some children may eventually join their parents' plan, and some may face periods of not being insured. Thus, premium assistance can help mainstream these children off the government plan and into private, family coverage. Most importantly, it would ensure that parents, not government bureaucrats, control the medical decisions affecting their children.

Researchers found that in Oregon, families who chose the premium assistance option "were more likely to receive their care in a doctor's office or health maintenance organization (HMO), whereas children [enrolled in the traditional SCHIP plan] were more likely to visit a hospital clinic or community health center." [9] Families using the premium assistance option also reported fewer unmet primary and specialty care needs than those in traditional SCHIP.[10]

Recommendations. While premium assistance in SCHIP holds great promise, it is riddled with burdensome administrative and regulatory obstacles. The following reforms would make premium assistance a viable and robust piece of any state's SCHIP plan.

- **Expand the application of premium assistance.** Today, premium assistance is applied to the child's portion of a premium. This is unnecessarily complex and burdensome. Instead, SCHIP premium assistance should provide families with a standard contribution calculated based on the average per-child spending in SCHIP.[11] Families could use this standard contribution for premiums, cost-sharing responsibilities, and savings for the future health care needs of their child.
- **Remove the benefit constraints on premium assistance.** SCHIP currently requires states applying the premium assistance option to a private plan to meet one of the SCHIP benchmark

1. U.S Department of Health and Human Services, Center for Medicare and Medicaid Services, "The State Children's Health Insurance Program," PowerPoint presentation, March 5, 2007, p. 14.
2. For example, Oregon's premium assistance program allows eligible individuals to access employer-based coverage or coverage in the individual market. See Janet B. Mitchell, Susan G. Haber, and Sonja Hoover, "Premium Subsidy Programs: Who Enrolls, and How Do They Fare?" *Health Affairs*, Volume 24, No. 5, September/October 2005, at *www.healthaffairs.org*.
3. Carrie J. Gavora, "KidCare Implementation: A Helpful Guide for the States," Heritage Foundation *FYI* #168, December 31, 1997, at *www.heritage.org/Research/HealthCare/fyi168.cfm*.
4. Jennifer N. Edwards *et al.*, "The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care: Findings from The Commonwealth Fund 2002 Workplace Health Insurance Survey," *Issue Brief*, Commonwealth Fund, August 2002, p. 7, at *www.commonwealthfund.org/usr_doc/edwards_erosion.pdf?section=4039*.
5. See footnote No. 39, Congressional Budget Office, "The State Children's Health Insurance Program," May 2007, p. 12 at *www.cbo.gov/ftpdocs/80xx/doc8092/05-10-SCHIP.pdf*.
6. *Ibid.* Interestingly, 15 states have set SCHIP eligibility above 200 percent of the FPL, and recent proposals for SCHIP reauthorization are suggesting raising the eligibility to 300 percent of the FPL and 400 percent of the FPL respectively.
7. Congressional Budget Office, p. 12.
8. *Ibid.*
9. Mitchell, *et al.*, p. 1350.
10. *Ibid,* p. 1351.
11. Some estimates place this figure at about $1,220. See "Children's Health First Act," U.S. House Energy and Commerce Committee, Summary of Legislation, at *http://energycommerce.house.gov/chfa/031407%20Kids%20Bill%20Summary.Final.pdf*.

plans or provide wrap-around. Like calculating a premium, this can be administratively prohibitive, and while some states have utilized the waiver process to mitigate these requirements, obtaining a waiver can also be a tedious and challenging process. Premium assistance contributions should be applicable to any employer-based or individual policy available on the market regardless of whether it meets the government-set standard and without state wrap-around requirements.

- **Establish and enforce legitimate cost-sharing requirements under traditional SCHIP.** Although cost-sharing is allowed in SCHIP, recent trends and efforts reveal states are easing these requirements.[12] Traditional SCHIP should be required to maintain cost-sharing obligations that more closely resemble private coverage in order to help prepare families for transitioning to private coverage. It would also put premium assistance on a fairer and more level playing field with traditional SCHIP.
- **Give parents the premium assistance option.** Parents with SCHIP-eligible children should be able to receive a premium assistance contribution to purchase private health insurance for their child in lieu of the traditional SCHIP plan. Families should be able to use these funds to obtain the coverage of their choice through their employer or on the broader market. These choices should not be limited simply because they are using a subsidy.
- **Require states to implement premium assistance for non-targeted populations.** Numerous states have chosen to use SCHIP to cover children above the 200 percent of the FPL threshold as well as adults. These states should be required to convert these and other expansion populations to premium assistance.
- **Adopt non-SCHIP policies to complement premium assistance.** Premium assistance could work even better if the federal government would reform the tax treatment of health insurance. A health care tax credit for lower-income families, for example, could be further supplemented by a SCHIP contribution for targeted low-income children. Under this approach, premium assistance in lieu of traditional SCHIP should be mandatory for children whose parents accept the health care tax credit.

Conclusion. As the debate on SCHIP reauthorization gains momentum, policymakers should consider ways to preserve and improve access to the private market for lower-income families. Premium assistance is a viable solution to counteract the pressure to expand SCHIP to populations well beyond the original intent of the law. Without premium assistance and its reforms, SCHIP will continue to supplant private coverage and replace it with more government control over health care decisions for a growing number of families. Premium assistance in SCHIP would help transition working families into private coverage and be a stepping stone for future changes to the overall health care system.

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12. See Kathryn G. Allen, U.S. Government Accountability Office, "Children's Health Insurance: States' SCHIP Enrollment and Spending Experiences in Implementing SCHIP and Considerations for Reauthorization," statement before the subcommittee on Health, Committee on Energy and Commerce, U.S House of Representatives, February 15, 2007, GAO-07-447T, p. 19 at *www.gao.gov/new.items/d07501t.pdf*, and Donna Cohen Ross, Laura Cox, and Caryn Marks, "Resuming the Path to Health Coverage for Children and Parents: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006," Henry J. Kaiser Family Foundation, January 2007, pp. 59-62, at *www.kff.org/medicaid/upload/7608.pdf*.