Executive Summary
Backgrounder
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State Health Reform: Converting Medicaid Dollars into Premium Assistance

Dennis G. Smith

States can increase the value of Medicaid dollars for recipients and taxpayers through premium assistance. Linking public dollars to private coverage would increase access to needed services for recipients and reduce costs for taxpayers. Medicaid coverage for a family of three (one adult and two children) will cost $9,830 next year in combined federal and state dollars. Using Medicaid dollars to pay the employee share of employer-sponsored insurance would also stretch public funds.

State policymakers can improve Medicaid by using the flexibilities of the Deficit Reduction Act of 2005 (DRA) to redesign coverage of low-income working families into a system of premium assistance—a government contribution to health insurance—that would reconnect much of the Medicaid population to the private health insurance markets that serve the majority of Americans. Such reform would provide a number of significant benefits for the Medicaid population:

- **Continuity of coverage and care.** Medicaid is an unstable platform for continuous care as eligibility changes; continuity of care serves to maintain and improve the health of individuals and families. Premium assistance creates stability.
- **Increased access to doctors.** Private insurance is a better alternative for individuals and families who seek better access to doctors than typical "fee-for-service" Medicaid offers.
- **Stabilized private health insurance and reversal of the detrimental effects of "crowd-out,"** the displacement or loss of individuals' and families' private health coverage due to public expansion that results in increased cost for those who are privately covered.
- **Escape from the stigma of dependence on welfare.** Policy should promote personal responsibility.

The Biggest Program. Medicaid serves more people than Medicare and is estimated to spend nearly $350 billion on behalf of 64 million people. It is projected that federal, state, and local government spending on Medicaid will reach $5.1 trillion over the next 10 years.

The traditional "moms and kids" generally rely on Medicaid for coverage of acute care—the same type of care purchased through private health insurance. They represent about 75 percent of the Medicaid population and account for $117 billion, or 34 percent, of Medicaid expenditures. The State Children's Health Insurance Program (SCHIP) and the Disproportionate Share Hospital (DSH) program are also part of public assistance to low-income working families. Adding spending on SCHIP ($9 billion) and DSH ($16 billion), more than $142 bil-

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lion will be spent on low-income individuals in FY 2009. The 10-year cost associated with these populations is approximately $2 trillion.

Working Families. Medicaid no longer serves only a welfare population. More than 70 percent of children on Medicaid and 90 percent of children on SCHIP have at least one parent in the workforce. In some cases, government funding could follow working families and flow into employer-sponsored insurance (ESI).

Using a Health Insurance Exchange. Where ESI is not available, these persons should purchase private health plans, using Medicaid and SCHIP subsidies. State officials could set up a statewide health insurance exchange wherein health plans would compete directly for consumer dollars. The exchange could serve all employers and employees of a state and those enrolled in public programs. An exchange would help individuals form a group that can then receive discounts on health insurance plans.

Premium assistance would simplify family options. Rather than having a parent covered by one plan through her employer, one child through SCHIP, and another child through Medicaid, the entire family could be served through one plan and a streamlined system of financing. Being connected to the private market means that when families enter or leave Medicaid, they can have a seamless transition in their insurance coverage.

How States Can Overcome Barriers to Private Coverage. Premium assistance has been more a mirage than a reality because of federal conditions that previously discouraged state adoption. The DRA provides the states with tools they need to establish benchmark benefit packages, employ new methods for meeting cost-effectiveness tests, and apply new flexibility in applying cost-sharing requirements for coverage.

To date, only a handful of states are using the "benchmark" plans to increase premium assistance. Much of this inaction is rooted in political or bureaucratic inertia.

Conclusion. For state lawmakers who want to lower costs and improve the quality of health care coverage for low-income workers and children, there is ample opportunity to establish a premium assistance program.

For state health insurance pools, the infusion of a large cohort of relatively young and healthy people would spread the risk and lower per-person costs. For the populations currently covered under Medicaid and SCHIP, it would provide such benefits as continuity of care and coverage and better access to doctors, stabilize private health insurance, reduce the stigma that usually accompanies dependence on public assistance, and bring low-income people into the private health insurance markets, just as far-reaching welfare reform initiatives are integrating low-income people into the economy.

There are many options that state officials can use in pursuing a premium assistance strategy for Medicaid and SCHIP. A combination of zeal for innovation and the political will to improve the financing and delivery of care for low-income Americans could bring about a transformation.

When Congress turns to broad entitlement reform, as it eventually must, Medicaid must be part of that reform. Integrating the $2 trillion spent on low-income working families over the next 10 years with tax credits and state pooling mechanisms would strengthen and stabilize our health insurance system and address the issues of the "uninsured."

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States have the capability to increase the value of Medicaid for recipients and taxpayers alike through premium assistance. Linking public dollars to private coverage would increase access to needed services for recipients and reduce costs for taxpayers. Coverage for a family of three on Medicaid (one adult and two children) will cost $9,830 next year.[1] In most states, this is likely to be significantly higher than the average annual premium for family coverage in the private market. Using Medicaid dollars to pay the employee share of employer-sponsored insurance would also stretch public dollars.

State policymakers can improve Medicaid by using the flexibilities provided by the Deficit Reduction Act of 2005 (DRA) to redesign Medicaid coverage of low-income working families into a system of premium assistance—a government contribution to private health insurance—that would reconnect much of the Medicaid population to the private health insurance markets that serve the majority of Americans. Taxpayers would benefit directly, both by sharing the cost of Medicaid with employers when possible and as a result of competition in the marketplace. Reform would also result in a number of significant benefits for the low-income working families who rely on Medicaid for coverage.

The Biggest Program

Medicaid serves more people than Medicare and is estimated to spend nearly $350 billion[2] on behalf of 64 million[3] people enrolled at least for some

Talking Points

- States have the capability to increase the value of Medicaid for recipients and taxpayers through the use of premium assistance. Linking public dollars to private coverage will increase access to needed services for recipients and lower costs for taxpayers.
- State policymakers can improve Medicaid by using the flexibilities provided by the Deficit Reduction Act of 2005 (DRA) to redesign coverage of low-income working families into a system of premium assistance—a government contribution to health insurance—that would reconnect much of the Medicaid population with the private health insurance markets that serve the majority of Americans.
- The infusion of a large cohort of relatively young and healthy people would have a positive impact on the health insurance pools, broadening the risk pools and lowering per-person costs.

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period ("ever enrolled") during the year. It is projected that federal, state, and local government spending on Medicaid will total $5.1 trillion between 2009 and 2018.[4]

Properly understood, Medicaid is not a single program. It is a combination of several programs spread across 56 jurisdictions—the 50 states, the District of Columbia, and U.S. territories—including direct payment for health care services, health insurance, public assistance income support, and long-term care that serves four distinct population groups: low-income children and able-bodied adults, generally parents or caretaker relatives ("moms and kids"); low-income people who are not eligible for Medicaid (served through the Disproportionate Share Hospital [DSH] program and emergency services); people with disabilities; and low-income seniors.

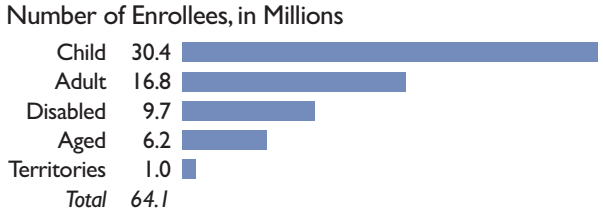
Each of these different Medicaid groups requires workable solutions that match their needs. Members of these groups will resist any attempt at change, and understandably so, unless and until they can be sure that the changes will improve their lives and the lives of their families.

The DRA included several modest improvements in Medicaid that created opportunities for states to begin reform, especially in the area of premium assistance, but much remains to be done. Convincing elected officials at the federal and state levels to take on the challenge of modernizing Medicaid is a difficult task.

How Medicaid Spends Taxpayer Dollars

Costs and spending patterns vary greatly among the different population groups. In fiscal year (FY) 2009, the per capita cost for a full year of coverage is projected to be $2,876 for a child, $4,078 for an able-bodied adult, $15,347 for a senior, and $17,336 for a disabled person.[5]

Projected Medicaid Enrollment, FY 2009



Source: Centers for Medicaid and Medicare Services, Office of the Actuary, 2008.

Chart 1 • B 2169 heritage.org

The traditional "moms and kids" and other indigent populations generally rely on Medicaid for acute care needs—the same type of care purchased through private health insurance. Together, they represent about 75 percent of the Medicaid population and account for $117 billion, or 34 percent, of Medicaid expenditures.[6]

The State Children's Health Insurance Program (SCHIP) and the DSH program should be considered a part of public assistance to low-income working families. Indeed, within the same family, one child can be eligible for Medicaid and another eligible for SCHIP. DSH provides direct payments to hospitals for uncompensated care due to either low Medicaid reimbursement rates or care provided to indigents. Adding SCHIP spending ($9 billion)[7] and DSH spending ($16 billion)[8] to the $117

1. Centers for Medicare and Medicaid Services, Office of the Actuary, "FY 2009 President's Budget Federal Medicaid and SCHIP Per Capita Expenditures by Eligibility Category," unpublished summary table for the FY 2009 President's budget, 2008. These data are presented in Table A1 in the Appendix.
2. Centers for Medicare and Medicaid Services, Office of the Actuary, "President's FY 2009 Budget Medicaid Expenditures," unpublished summary table for the FY 2009 President's budget, 2008. These data are presented in Table A3 in the Appendix.
3. See Table A1.
4. See Table A3.
5. See Table A1.
6. See Table A3. FY 2009 data.
7. U.S. Department of Health and Human Services, Budget in Brief, FY 2009, p. 66, shows SCHIP outlays of $6.1 billion in FY 2009 (*http://www.dhhs.gov/budget/09budget/2009BudgetInBrief.pdf*). Under the SCHIP matching formula, a total of $9 billion would be spent.

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billion in Medicaid expenditures, more than $142 billion will go to individuals who generally are in families with income below 200 percent of the federal poverty level ($42,400 for a family of four).[9]

Seniors represent about 10 percent of enrollment but $79 billion, or 23 percent, of expenditures.[10] Individuals with disabilities account for $151 billion, or 43 percent, of expenditures[11] but just 15 percent of the Medicaid population. Many seniors and people with disabilities are also served by Medicare.

A Policy Paradox. Medicaid is a paradox. It is criticized as both too stingy and too generous; comprehensive but incomplete; unreliable yet essential; too complex and too inflexible; a program that is both shunned and embraced by individuals and providers.

Medicaid promises rich benefits but restricts access, promotes welfare dependency, and creates new inequities among working families who pay for a welfare program. It is generally a state's largest budgetary expenditure, and it is a big government program that is least understood by the general public and state policymakers alike.

Perverse Incentives. In Medicaid, government is financier, purchaser, regulator, and competitor. Government hospitals, nursing homes, and local governmental mental health agencies often receive preferential treatment.

Flaws in the current system include the "provider entitlement" that thwarts competition, special deals often hidden from public view, institutional bias, and rewards for inefficiency. States that try to innovate or make positive changes in their existing Medicaid programs are often penalized by "losing" federal dollars. Government often assumes the role of consumer. As a result, people must follow the money, often into more expensive and less appropriate types of health care because that is where the government has already allocated taxpayer dollars.

State Reform for Low-Income Working Families

For policymakers, there is plenty of work to be done on behalf of low-income families, especially at the state level. State lawmakers already have ample opportunity under current law to develop a workable solution for coverage while improving the financing, delivery, and quality of care for low-income families.

This can be done through an innovative system of premium assistance: using existing Medicaid funding to offset the cost of health insurance premiums for an employer-sponsored insurance (ESI) plan or a private health plan of the beneficiary's choice. Premium assistance would not only broaden and improve the risk pool of a state's private insurance market, but also result in a number of significant improvements for low-income people now enrolled in Medicaid.

Improvements Resulting from Transition. Enabling these young and healthy recipients (about 34 million are below age 19) who are now enrolled in Medicaid and SCHIP to take advantage of private health insurance through a stable stream of public funding would have a number of positive consequences:

- **Continuity of care.** When families are forced to switch between public and private coverage, they risk losing their relationships with physicians and other health care providers. Re-establishing such relationships may increase costs (new patient histories, duplicative tests, administrative costs) or delay care (practices closed to new patients). Maintaining the same health plan for the whole

8. Centers for Medicare and Medicaid Services, Office of the Actuary, "President's FY 2009 Budget Medicaid MAP Aggregate Service Summary—Including Impact of DRA," unpublished summary table for the FY 2009 President's budget, 2008. These data are presented in Table A2 in the Appendix.
9. The Department of Health and Human Services calculates that income at the poverty level for four-person family is $21,200. U.S. Department of Health and Human Services, "The 2008 HHS Poverty Guidelines," revised January 23, 2008, at *http://www.aspe.hhs.gov/poverty/08poverty.shtml* (August 5, 2008).
10. See Table A3.
11. See Table A3.

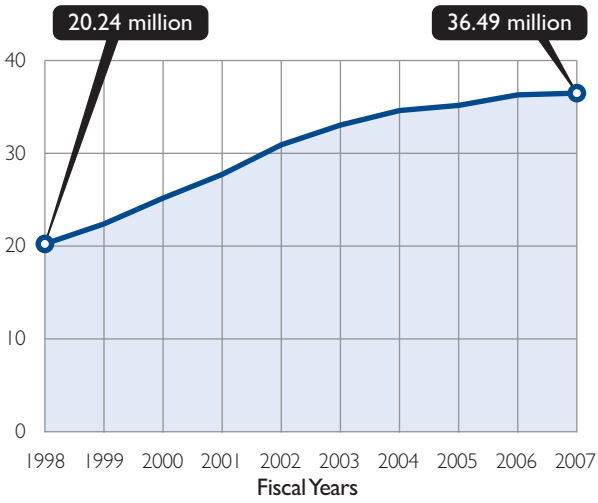
family with the same network of doctors and medical professionals helps to ensure continuity of care. Joan Alker of the Georgetown University Center for Children and Families cites a study conducted by the Commonwealth of Virginia that "found that the top reason for participation [in premium assistance] was the ability to have the whole family covered under the same insurance plan (28 percent)."[12]

- **Continuity of coverage.** Since eligibility for Medicaid and SCHIP is based on income, keeping families connected to the same health plan means that a change in family income (which can occur frequently, both up and down) will not automatically mean a change in coverage. The traditional "all or nothing" character of Medicaid is unstable for families.
- **Increased access to physicians and dentists.** Because of low reimbursement and a high regulatory "hassle factor" (paperwork, prior authorization, demands for documentation), Medicaid often suffers from a poor image among providers and enrollees alike for providing its low-income recipients with limited access. Alker found that "[p]remium assistance is often viewed as a way to increase availability of providers by providing access to private plans' provider networks."[13] Use of private health plans would give Medicaid and SCHIP enrollees access to a much wider network of health care professionals.
- **Stabilized private health insurance and reversal of the detrimental effects of "crowd-out."** A premium assistance program that integrates millions of younger and healthier persons into the private insurance markets would help everyone. Integration would also start to reverse the detrimental effects of "crowd-out" due to the expansion of public programs. The number of children on Medicaid and SCHIP has increased by 80 percent since 1998. (See Chart 2.) The percentage of children living in families with public coverage and income between 100 percent and 200 percent of the federal poverty level (FPL) increased from 24.3 percent in 1997 to 50.1 percent in 2006,[14] while the percentage of children in families with private coverage and income between 100 percent and 200 percent of FPL decreased from 55 percent to 36.1 percent during the same period.[15] As the private insurance pool is slowly drained, the cost of insurance for those who remain in the pool goes up.

Government Health Care for Children

The number of children in Medicaid and SCHIP has increased 80.3% since 1998.

Total Number of Children Ever Enrolled in Medicaid and SCHIP, in Millions



Source: Centers for Medicare and Medicaid Services, SEDS and MSIS data compiled by Families and Children Health Programs Group, February, 2008.

Chart 2 • B 2169 heritage.org

12. Joan Alker, "Choosing Premium Assistance: What Does State Experience Tell Us?" Kaiser Commission on Medicaid and the Uninsured *Issue Paper*, May 2008, p. 6, at *http://www.kff.org/medicaid/upload/7782.pdf* (August 5, 2008).
13. *Ibid.*, p. 7.
14. Robin A. Cohen and Michael E. Martinez, "Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–June 2006," Centers for Disease Control and Prevention, National Center for Health Statistics, December 2006, p. 12, Table 5, at *http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur200612.pdf* (August 5, 2008).
15. *Ibid.*, p. 13, Table 6.

- **Elimination of the welfare stigma.** In the landmark Welfare Reform Act of 1996, with its themes of independence and personal responsibility, Medicaid was left behind. Some people, even in an era when government entitlements are expanding, still associate Medicaid with an undesirable stigma. States have adopted a number of approaches to try to overcome negative images of Medicaid as a welfare program. As states expanded public coverage through SCHIP, they also marketed their programs under names such as Dr. Dynasaur, Hawk-I, PeachCare, and SoonerCare. Even the federal government has used a similar strategy of avoiding the use of the word "Medicaid." In outreach activities to low-income seniors, the Centers for Medicare and Medicaid Services (CMS) advises senior citizens to sign up for "Medicare Savings Programs," disguising the fact that such assistance will come from Medicaid. Premium assistance helps to integrate aid recipients into the broader economy with a fresh emphasis on personal responsibility and independence.

A Healthy Population. States should refill the risk pool by moving Medicaid and SCHIP populations into the market in which private health plans will compete for their coverage. Most of these individuals are generally healthy: In FY 2005, 77 percent of children and 73 percent of able-bodied adults used less than the $2,500 provided by Medicaid. Only 4.5 percent of children and 3.5 percent of able-bodied adults used more than $5,000 in services.[16]

Using Employer Coverage. The objective of health insurance is to provide access to health care and protect individuals and families against the financial devastation of serious illness. A key function of health insurance is therefore to spread costs and risk: The larger the insurance pool, the lower the cost per person.

One way to broaden the spread of risk and reduce per capita costs is to open the private health insurance market to those who are currently getting acute care coverage through Medicaid, most of whom are young and healthy. Those who have lost private coverage because of a change of employment or who have found themselves with lower income and thus eligible for Medicaid—more than 30 million children and 16 million able-bodied adults (mostly parents or caretakers of Medicaid children) and 6 million children served by SCHIP—could be integrated into the mainstream private health insurance system.[17]

Medicaid no longer serves only a welfare population. Urban Institute researchers studying the characteristics of Medicaid and SCHIP enrollees in California and North Carolina found that more than 70 percent of children on Medicaid and 90 percent of children on SCHIP have at least one parent in the workforce.[18] In an analysis of employer-sponsored health insurance for 1996 to 2004, Tom Buchmueller, a business professor at the University of Michigan and visiting scholar at the Federal Reserve Bank of San Francisco, and Federal Reserve research adviser Rob Valletta found that "[d]eclining employee participation in ESI programs may relate to rising costs."[19] They concluded that:

> [M]ost of the drop in [ESI] coverage has occurred because employees are increasingly declining coverage that is offered to them, suggesting that cost increases are directly affecting employees' participation decisions.

16. Centers for Medicare and Medicaid Services, "FY2005 Summary of Medicaid Eligibles: Total per Person by Basis of Eligibility Groups," FY 2005 Annual Person Summary Data for MSIS (Medicaid Statistical Information Statistics) data compiled by the Finance, Systems, and Budget Group, 2008.
17. Centers for Medicare and Medicaid Services, "President's FY 2009 Budget Medicaid and SCHIP Enrollment."
18. Genevieve Kenney, Jamie Rubenstein, Anna Sommers, Stephen Zuckerman, and Fredric Blavin, "Medicaid and SCHIP Coverage: Findings from California and North Carolina," *Health Care Financing Review*, Vol. 29, No 1 (Fall 2007), p. 75, Table 2, at *http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07Fall.zip* (August 5, 2008).
19. Tom Buchmueller and RobValletta, "Health Insurance Costs and Declining Coverage," Federal Reserve Bank of San Francisco *Economic Letter* No. 06–25, September 29, 2006, p. 2, at *http://www.frbsf.org/publications/economics/letter/2006/el2006-25.html* (August 5, 2008).

> This view is supported by recent research findings that use formal statistical analysis to investigate the link between rising costs and declining coverage."[20]

Researchers in 2005 found that "most of the decline in ESI coverage between 1987 and 2002 is attributable to declining affordability (i.e., more rapid growth in premiums than in personal income); Chernow et al. (2005) also found that rising health insurance costs are the dominant explanation for falling coverage over time."[21]

A family of four with income at the FPL ($21,200) would have to spend 12 percent of its income to pay the average employee contribution for family coverage available through the employer ($2,585 in 2005),[22] while a family at 300 percent of FPL ($63,600) would have to spend just 4 percent of its income on employer-sponsored premiums.[23] The average family will also typically face additional cost-sharing through co-payments, deductibles, and co-insurance, making the total price tag around $3,000 a year.

There really is no mystery, then, as to why low-income families, even when employer-sponsored insurance is available, decline such coverage. To participate, low-income individuals will need a source of subsidy in order to make coverage affordable to them.

With an estimated $142 billion in combined Medicaid, DSH, and SCHIP spending to cover low-income working families, there is no reason why a substantial portion of these funds should not be redirected to eligible persons to enable them to secure health coverage of their choice, either through their employers or through the states' health insurance markets. To a limited extent, this is already happening, but while Medicaid is projected to spend $70 billion in FY 2009 in capitation payments (most of it on the "moms and kids" population), Medicaid and SCHIP recipients are still separated from rest of the health insurance pool in the states under the existing terms of governmental contracts. As a result, key advantages of premium assistance for the state health insurance markets are lost.

A new public–private partnership that included state officials, private health plan providers, and employers could significantly improve and expand coverage for low-income Medicaid and SCHIP populations through the private sector. Government funding could follow the employed and into employer-sponsored insurance where available.

Using a Health Insurance Exchange

Where ESI is not available, recipients should buy private health plans, using Medicaid and SCHIP subsidies. To facilitate the purchasing of private health plans, state officials could set up a statewide health insurance exchange: in effect, a single market for health insurance in which health plan organizations would compete directly for consumer dollars.[24] The exchange could allocate government subsidies—including premium assistance based on Medicaid and SCHIP funding—to help eligible recipients buy private health insurance. The exchange could also serve all state employers and employees as well as those who are enrolled in Medicaid and SCHIP. The collection of insurance premium payments, transmittal of plan payments, and processing of related paperwork would be the responsibility of the exchange's administrators.

Most Americans cannot afford to be uninsured. An exchange helps individuals to join a group that can offer health insurance plans at competitive prices.

20. *Ibid.*
21. *Ibid.*, "Health Insurance Costs and Declining Coverage," p. 3.
22. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Center for Financing, 2005 Medical Expenditure Panel Survey, Table II.D.2, at *http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiid2.htm* (August 5, 2008).
23. Workers really "pay" for both the employer and the employee shares of health insurance through lower wages, but because the employer share is hidden, the employee share is used in the comparison.
24. For a description of the state-based health insurance exchange and its functions, see Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *http://www.heritage.org/Research/HealthCare/wm1230.cfm*.

In either case, premium assistance would simplify health care options for families. Rather than having a parent covered by one plan through her employer, one child through SCHIP, and another child through Medicaid, the entire family could now be served through one plan and a streamlined system of financing. When a family moved either onto or off of Medicaid, it would not lose its coverage; the only change would be in the level of subsidy it receives from either the government or the employer. This policy would also have positive social consequences by enhancing family cohesion.

Overcoming Barriers to Private Coverage

The concept of premium assistance is not really new to Medicaid, as states have had the authority to pay for group health insurance under Section 1906 of the Social Security Act under certain conditions for some time.[25] Premium assistance, however, has been more a mirage than a reality under those conditions that have proven to discourage states from adopting it.

States faced three major barriers under the requirements of Section 1906 before they could provide premium assistance in lieu of traditional Medicaid: (1) conduct an "individual cost effectiveness" test, which is administratively burdensome and expensive; (2) supplement the employer health plan by providing "wrap around" benefits and cost-sharing up to the uniform and more generous Medicaid benefit package provided under the state plan; and (3) allow children, the majority of the population, to opt out of the employer's health plan. States faced a fourth barrier in Section 1916, which prevented them from requiring families to participate in cost-sharing.

Nonetheless, Illinois, Maine, Massachusetts, Oregon, and Rhode Island have gamely sought to use premium assistance aided by waivers under Section 1115 authority that allowed the states to vary benefits, apply cost-sharing, and avoid retroactive eligibility. Arkansas, Oklahoma, and Texas are pursuing premium assistance for low-income individuals who are not eligible for Medicaid by encouraging small employers to offer insurance backed by public subsidies. But these efforts are still on a small scale, and waivers are subject to changes depending on how the federal policymakers view them.

New Opportunities for Innovation

States today are in a much better position to pursue innovative premium assistance programs thanks to the reforms provided through the DRA that allow states to overcome the three major barriers under Section 1906 as explained above. Specifically, Section 1937 of the DRA permits states to enroll the majority of the low-income working population in "benchmark coverage," which resembles private insurance benefits more closely than it resembles traditional Medicaid. No additional "wrap around" benefits are required if the private plan meets one of the required benchmarks. However, children under age 19 will still qualify for medically necessary services not covered by the benchmark plan under Medicaid's Early Periodic Screening Diagnosis and Treatment (EPSDT) provision.

Moreover, the language of Section 1937 is deliberately broad ("Notwithstanding any other provision of this title…"); therefore, states should properly use their authority to interpret Section 1937 to supersede the previous barriers related to the individual cost-effectiveness test and the child opt-out in Section 1906.

Available Coverage Options. The benchmark coverage under Section 1937 matches the benchmark coverage under the SCHIP program (Section 2103), so the two programs can be integrated, and premium assistance can be applied to both. A state is permitted to require certain individuals to enroll in health plans that meet one of five different coverage options:

1. *Health insurance coverage equivalent to the Federal Employees Health Benefits Program (FEHBP).* Specifically, this refers to the standard Blue Cross/Blue Shield preferred-provider

25. Title XIX of the Social Security Act provides for Grants to States for Medical Assistance Programs, better known as Medicaid. Section 1906 of the Social Security Act, "Enrollment of Individuals Under Group Health Plans," is therefore a section within Medicaid. 42 U.S. Code § 1396e.

benefit plan, which is the dominant national plan in the FEHBP.

2. *State employee coverage.* This is a health benefits plan that is generally available to state employees.
3. *Coverage offered through an HMO that is the largest commercial plan in the state.*
4. *Secretary-approved coverage.* A state can design a benefits package that, if approved by the Secretary of the U.S. Department of Health and Human Services, could be offered by private health plans in the state.
5. *Actuarially equivalent coverage.* States can require this population to enroll in a health plan that receives an actuarial opinion that its actuarial value is at least the same as the actuarial value of one of the benchmark packages.

For the greatest number of options, state officials can adopt each of these benchmark packages. With the potential for attracting more members that comes with a stable source of funding, employers and health plan providers would have an incentive to demonstrate that the products they offer meet at least one of these benchmarks so that Medicaid and SCHIP populations can join their health plans.

To date, only a handful of states are using the benchmark plans to increase premium assistance. Much of this inaction is simply rooted in political or bureaucratic inertia. It would be a relatively small investment of time and resources to invite private health plans to demonstrate that they provide the level of benefits provided under benchmark plans or to obtain actuarial certification of the private health plans that meet the actuarial equivalence.

Replacing Individual Cost-Effectiveness Test with Average Cost-Effectiveness Test. To promote and expand the use of premium assistance, the programs need to be simplified to ensure that benchmark plans and cost-effectiveness tests are properly synchronized. Accordingly, states should submit state plan amendments to the federal government to adopt benchmark plans. Furthermore, they should adopt a cost-effectiveness test for Medicaid and SCHIP that could be based on average costs as described below. This is *only one* example of how a state could construct a new cost-effectiveness test.

Calculating the Typical Net Family Premium Contribution

	Yearly	Monthly
Begin with a typical family premium of $12,000	$12,000.00	$1,000.00
Subtract a typical single premium of $4,500/year	–4,500.00	–375.00
Net family premium	**$7,500.00**	**$625.00**
Subtract the employer share of 35%	–2,625.00	–218.75
Net family premium contribution	**$4,875.00**	**$406.25**

Table 1 • B 2169 heritage.org

In general, enrollment in a group plan is more likely to be cost-effective if there is more than one family member who is eligible for public assistance. Every year, each state would publish the statewide average of the Medicaid/SCHIP per-member, per-month (PMPM) rates for a child and for an adult. For the examples below, the PMPM is assumed to be $150 for a child and $275 for a non-disabled adult.

Each state would also publish the cost of the average net family premium contribution (ANFPC) for the state each year. The ANFPC is defined as the average total family premium per enrolled employee at all private-sector establishments within the states that offer health insurance minus the average single-employee premium minus the employer share (to avoid cost paid by the employer). It may be based on a state survey or a federal survey such as the Medical Expenditure Panel Survey (MEPS).

Table 1 assumes that the total family premium is $12,000, the average total single premium is $4,500, and the average employer share of family coverage is 35 percent. The ANFPC therefore is $4,875 per year, or $406.25 per month.

Examples of How Cost-Effectiveness Is Applied. Using an average cost-effectiveness test, a state can quickly determine at the time of application whether a family with at least three eligible children (even if the children are divided between Medicaid and SCHIP) or one eligible child and one eligible adult should be required to use the

insurance (which the state already has determined meets the criteria of a benchmark plan) available through their employers or through other private coverage.

Example 1: Only one child in the family is eligible. Enrollment is not cost-effective because the ANFPC ($406.25) would be more than the PMPM ($150).

Example 2: Two children in the family are eligible. Enrollment is not cost-effective because the ANFPC ($406.25) would be more than the PMPM ($150 x 2 = $300).

Example 3: One child and one adult are eligible. Enrollment is cost-effective because the ANFPC ($406.25) is less than the combined PMPMs ($150 + $275 = $425).

Example 4: Three children in the family are eligible. Enrollment is cost-effective because the ANFPC ($406.25) is less than the cost of the combined PMPMs ($150 x 3 = $450).

The state would then pay the amount of the employee's share for family coverage (to the employer, employee, or health plan) each month and advise the family as to its responsibilities for any cost-sharing (a share of the premium, any deductibles, co-payments, or co-insurance up to the statutory limit of 5 percent of family income). With the family members enrolled in private insurance, the regular third-party liability rules apply to ensure that Medicaid or SCHIP are not used inappropriately to reimburse the health care provider for services directly.

These examples also reveal that Medicaid may be paying too much to cover low-income families. Medicaid pays on an individual basis rather than a family basis as is typical in private insurance. Under the PMPM example, Medicaid would spend a total of $6,900 for one adult and two children on an annual basis. The average annual premium for family coverage on the individual market for the nation for 2006—2007 was $5,799.[26] The average annual premium for family coverage on the individual market exceeds $6,900 in only nine states.[27]

Moreover, the PMPM example used in Table 1 is probably too low compared to the projected per capita expenditures in Medicaid. The cost per capita for a full year in FY 2009 is $2,876 for a child and $4,078 for an able-bodied adult,[28] so a Medicaid family of three would cost $9,830. Adopting a family approach could stretch public dollars in a variety of ways, including as a means of spreading risk. This comparison also suggests that Medicaid is paying too much to cover the low-income working population.

Flexible Cost-Sharing in Public Programs Key to Premium Assistance. For almost its entire history, the federal government has not allowed states to require non-institutionalized Medicaid recipients to participate in the cost of the program. Cost-sharing generally could be only "nominal" and not enforceable; that is, a provider could not refuse to provide the service if the Medicaid recipient refused to pay. The opposite is true for institutionalized individuals who are required to surrender virtually all of their income and permitted to keep only a "personal needs" allowance for themselves.

The prohibition on cost-sharing may have made sense when Medicaid was serving only a welfare population that was not in the workforce, but times have changed. As indicated previously, more than 70 percent of children on Medicaid have at least one parent who is employed.

Since its creation in 1997, SCHIP has always allowed states to require cost-sharing for its population up to 5 percent of family income, though few states currently require the maximum amount of cost-sharing for families below 200 percent of FPL ($42,400 for a family of four).

Through the DRA, Congress again gave states new authority to coordinate their Medicaid and SCHIP policies to include more reasonable cost-

26. America's Health Insurance Plans, Center for Policy Research, "Individual Health Insurance 2006–2007: A Comprehensive Survey of Premiums, Availability, and Benefits," December 2007, p. 9, Table 4, at *http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf*.

27. *Ibid.*

28. See Table A1.

sharing levels. Under Section 1916A, Congress has allowed states to require certain Medicaid populations to accept some personal responsibility for the cost of their care. Under current law, for this population with family income above 100 percent of FPL ($21,200 for a family of four), states can require families to contribute up to 5 percent of income. Families between 100 percent and 150 percent of FPL ($31,800) cannot be charged premiums but can be required to pay other forms of cost-sharing, such as a co-payment, also capped at 5 percent of income. In determining cost-sharing, states can use a gross-income determination and sliding-scale levels of cost-sharing.

Applying at least some level of cost-sharing to families with income above 100 percent of FPL would not only help to involve families in rational decision-making about their medical services and benefits, but also establish a measure of equity with non-Medicaid families of similar income. This addition of a cost-sharing requirement would also be an important element in assessing actuarial equivalence (differing benefits, but the same dollar value) for purposes of premium assistance, simply because most private health plans require some amount of cost-sharing on the part of their subscribers.

Cost-Sharing Guidelines. Table 2 shows how much states could require in cost-sharing on a monthly basis for a family of four at different income levels.

A Medicaid/SCHIP family at 150 percent of FPL would face potential cost-sharing of $1,596 per year ($133 x 12 = $1,596) if required to contribute up to the maximum 5 percent of income. Considering that a privately insured family typically pays about $3,000 directly under ESI (employee share of premium, co-payments, deductibles, and co-insurance), a Medicaid/SCHIP family is still getting a good deal.

Reversing the comparison, non-Medicaid families with similar income but paying part of their costs may begin to wonder why state officials decline to require Medicaid families with income above the poverty level to participate in the cost of insuring their families. Health care is not "free" as often advertised in public outreach activities. Someone is bearing the cost, and states have an important role in establishing fairness and equity.

Potential Cost-Sharing for Different Income Groups (for a family of four)

Percent of Federal Poverty Level	Monthly Income	Potential Cost-Sharing 2%	3%	5%
100%	$1,767	$35	$53	$88
150%	$2,650	$53	$80	$133
200%	$3,533	$71	$106	$177
225%	$3,975	$80	$119	$199

Source: U.S. Department of Health and Human Services Poverty Guidelines for 2008, at *http://aspe.hhs.gov/poverty/08poverty.shtml*.

Table 2 • B 2169 heritage.org

How Congress Can Help the States

To expand the use of premium assistance, states must be able to administer their programs through their state plans (rather than relying on waivers) and level the playing field between premium assistance and regular Medicaid and SCHIP. Accordingly, Congress should amend Medicaid and SCHIP to:

- **Require** employed individuals to provide information about the availability of their employer-sponsored health insurance or that of an absent parent as a condition of participation in Medicaid and SCHIP. States need to be able to identify the availability of ESI quickly in order to use it.
- **Repeal** the requirement for retroactive eligibility for the "moms and kids" populations. Medicaid requires payment for services rendered *before* establishment of Medicaid eligibility. This is the antithesis of what insurance is supposed to be and may interfere with enrolling eligible families before there is a medical need. Retroactive eligibility is one of the most common provisions of Title XIX of the Social Security Act for which states request a federal waiver. Illinois, Maine, Massachusetts, Oregon, and Rhode Island all have a waiver of this provision to aid their ESI components.
- **Reform** DSH by eliminating its use to supplement low Medicaid rates paid on behalf of Medicaid recipients. In this era of transparency, Medicaid needs to move away from supplemental payments, which mask the true cost of paying for

a service and disrupt the market. With this change, DSH funds could continue to be used to pay for indigent care, but those costs would be more accurately identified as such rather than as a mixture of Medicaid and non-Medicaid eligibles.

- **Allow** states to convert DSH funds to insurance. Congress is behind the times. States as diverse as California, Maine, Massachusetts, and Texas realize the market strength of converting DSH payments from providers to insurance coverage.

Congress should not adopt the premium assistance provisions from last year's SCHIP legislation. Those provisions provide states with less flexibility than does current law and would be a step backward.

Conclusion

For state lawmakers who want to improve the quality of health care for low-income people, there is ample opportunity to establish a premium assistance program, using Medicaid and SCHIP funds, within the legal guidelines already established by Congress. This could significantly broaden access to private coverage, including employer-based coverage, for millions of Americans.

Premium assistance would benefit the populations currently covered under Medicaid and SCHIP. These benefits would include a higher level of continuity of care and coverage, thus greatly improving people's prospects for maintaining their health; increased access to doctors, dentists, and other medical professionals through the superior networks of the private health insurance markets; reducing the stigma that so often accompanies dependence on public assistance; and integrating Medicaid recipients into the private health insurance markets just as far-reaching welfare reform initiatives are integrating low-income people into the economy. In addition, the infusion of a large cohort of relatively young and healthy members would have a positive impact on health insurance pools, broadening the risk pools and lowering per-person costs.

There are a variety of options state officials can use to pursue a premium assistance strategy for Medicaid and SCHIP. A combination of imagination, a zeal for innovation, and the political will to improve the financing and delivery of care for low-income Americans can bring about a transformational change.

Federal officials need to take a fresh look at how the mission of Medicaid has changed, aided by the growth in SCHIP, and understand the potential for integrating the low-income working families of Medicaid and SCHIP into the mainstream. Combined spending over the next 10 years on Medicaid, DSH, and SCHIP for the able-bodied, non-elderly populations will total about $2 trillion.

Policymakers should examine how this fits into the broader national debate over how to achieve the mutually inclusive goals of increasing the number of Americans with health insurance and slowing the rising cost of health care. A path could be constructed if combined with a wider approach such as addressing the issue of the "uninsured" through tax credits.

Integrating the $142 billion that will be spent on low-income working families in FY 2009 with tax credits and state risk-pooling mechanisms would go a long way toward strengthening and stabilizing our health insurance system and addressing the issues of the "uninsured." But for these efforts to be successful, all Americans—the public as well as Congress—need to stop viewing these public programs as outside the rest of the American health insurance system.

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APPENDIX

FY 2009 President's Budget Federal Medicaid and SCHIP Per Capita Expenditures by Eligibility Category

Total Computable Federal and State Expenditures Per Person-Year

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Aged	$14,049	$13,858	$14,533	$15,347	$16,339	$17,433	$18,585	$19,834	$21,160	$22,596	$24,127	$25,782	$27,575
Disabled	14,831	15,507	16,305	17,336	18,540	19,897	21,347	22,943	24,663	26,558	28,613	30,872	33,362
Child	2,279	2,476	2,689	2,876	3,071	3,289	3,516	3,759	4,012	4,280	4,561	4,856	5,168
Adult	3,346	3,556	3,805	4,078	4,351	4,655	4,970	5,307	5,657	6,029	6,415	6,821	7,248
Total	**$5,978**	**$6,227**	**$6,581**	**$6,983**	**$7,445**	**$7,974**	**$8,534**	**$9,142**	**$9,789**	**$10,490**	**$11,240**	**$12,051**	**$12,930**
SCHIP	$1,770	$1,782	$2,086	$2,159	$2,270	$2,390	$2,510	$2,630	$2,747	$2,866	$2,985	$3,104	$3,223

Federal Share of Expenditures Per Person-Year

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Aged	$7,982	$7,836	$8,205	$8,692	$9,252	$9,871	$10,522	$11,227	$11,977	$12,790	$13,655	$14,592	$15,607
Disabled	8,455	8,776	9,221	9,825	10,507	11,273	12,094	12,996	13,968	15,038	16,199	17,474	18,880
Child	1,331	1,441	1,566	1,676	1,790	1,916	2,048	2,189	2,336	2,492	2,655	2,827	3,008
Adult	1,911	2,017	2,157	2,319	2,473	2,645	2,824	3,014	3,213	3,423	3,642	3,872	4,114
Total	**$3,550**	**$3,639**	**$3,821**	**$3,988**	**$4,232**	**$4,523**	**$4,833**	**$5,173**	**$5,533**	**$5,925**	**$6,344**	**$6,798**	**$7,289**
SCHIP	$1,239	$1,248	$1,460	$1,511	$1,589	$1,673	$1,757	$1,841	$1,923	$2,006	$2,090	$2,173	$2,256

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, unpublished summary table for the FY 2009 President's budget, 2008.

Table A1 • B 2169 ☎ heritage.org

President's FY 2009 Budget Medicaid MAP Aggregate Service Summary, Including Impact of the Deficit Reduction Act of 2005

Key: MAP – Medical assistance payments FFS – Fee for service LTC – Long-term care DSH – Disproportionate Share Hospital

Total Computable Federal and State Expenditures, in Billions of Dollars

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Acute FFS	$125.42	$136.52	$142.27	$152.01	$162.44	$173.93	$186.21	$199.64	$214.04	$229.76	$246.67	$265.01	$284.90
Capitation Payments	48.94	53.21	63.13	70.60	77.58	85.14	93.04	101.46	110.21	119.43	128.99	138.98	149.38
Medicare Premiums	9.46	10.09	10.80	12.02	13.24	14.57	15.97	17.45	19.00	20.63	22.33	24.09	25.94
Subtotal Acute	183.82	199.82	216.20	234.63	253.27	273.65	295.23	318.55	343.25	369.82	397.99	428.09	460.22
Institutional LTC	59.58	58.87	60.99	63.63	67.04	70.76	74.72	79.02	83.60	88.56	93.87	99.61	105.83
Community LTC	37.70	42.19	46.62	50.75	56.62	63.37	70.93	79.59	89.33	100.49	113.15	127.68	144.41
Subtotal LTC	97.28	101.07	107.61	114.39	123.65	134.14	145.65	158.61	172.92	189.06	207.02	227.29	250.25
DSH	13.66	15.60	15.85	16.09	16.33	16.70	17.09	17.48	17.88	18.29	18.71	19.15	19.59
Adjustments	3.92	-1.53	-1.65	-1.78	-1.92	-2.07	-2.23	-2.41	-2.61	-2.82	-2.82	-2.82	-2.82
Total	**$298.68**	**$314.96**	**$338.00**	**$363.32**	**$391.33**	**$422.42**	**$455.73**	**$492.23**	**$531.44**	**$574.35**	**$620.91**	**$671.70**	**$727.23**

Federal Share of Expenditures, in Billions of Dollars

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Acute FFS	$73.00	$78.00	$81.74	$87.54	$93.54	$100.14	$107.20	$114.92	$123.19	$132.22	$141.95	$152.49	$163.91
Capitation Payments	27.59	30.24	35.71	40.00	43.96	48.25	52.74	57.50	62.45	67.67	73.06	78.68	84.53
Medicare Premiums	5.51	5.90	6.11	6.80	7.49	8.24	9.03	9.87	10.75	11.67	12.63	13.62	14.67
Subtotal Acute	106.10	114.14	123.56	134.33	144.99	156.64	168.97	182.29	196.39	211.56	227.63	244.79	263.11
Institutional LTC	33.77	33.29	34.57	36.21	38.15	40.27	42.52	44.97	47.57	50.39	53.41	56.68	60.21
Community LTC	20.93	23.35	25.78	28.10	31.35	35.10	39.30	44.11	49.53	55.75	62.80	70.90	80.24
Subtotal LTC	54.71	56.64	60.35	64.31	69.50	75.37	81.82	89.08	97.10	106.14	116.21	127.58	140.45
DSH	7.79	8.82	8.96	9.09	9.23	9.42	9.61	9.80	10.05	10.30	10.55	10.82	11.09
Adjustments	1.77	-0.89	-0.96	-1.04	-1.12	-1.21	-1.30	-1.41	-1.52	-1.64	-1.64	-1.64	-1.64
Total	**$170.36**	**$178.70**	**$191.90**	**$206.70**	**$222.60**	**$240.23**	**$259.10**	**$279.77**	**$302.02**	**$326.36**	**$352.75**	**$381.54**	**$413.00**

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, unpublished summary table for the FY 2009 President's budget, 2008.

Table A2 • B 2169 ☎ heritage.org

President's FY 2009 Budget Medicaid Expenditures

Total Computable Federal and State Expenditures, in Billions of Dollars

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Aged	$68.6	$69.9	$74.3	$79.3	$85.3	$92.0	$99.2	$107.0	$115.4	$124.6	$134.6	$145.4	$157.2
Disabled	123.4	132.2	140.9	151.4	163.6	177.3	192.3	208.9	226.9	247.0	268.9	293.3	320.3
Child	52.1	58.1	64.4	70.2	75.9	82.2	88.7	95.8	103.2	111.2	119.7	128.8	138.4
Adult	36.2	39.4	43.1	47.0	50.8	54.9	59.2	63.9	68.8	74.0	79.5	85.4	91.7
Total*	**$280.3**	**$299.6**	**$322.8**	**$347.8**	**$375.7**	**$406.4**	**$439.4**	**$475.5**	**$514.4**	**$556.9**	**$602.8**	**$652.9**	**$707.6**

Federal Share of Expenditures, in Billions of Dollars

	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017	FY2018
Aged	$39.0	$39.5	$42.0	$44.9	$48.3	$52.1	$56.1	$60.6	$65.3	$70.5	$76.2	$82.3	$89.0
Disabled	70.3	74.8	79.7	85.8	92.7	100.5	108.9	118.3	128.5	139.9	152.3	166.0	181.3
Child	30.4	33.8	37.5	40.9	44.3	47.9	51.7	55.8	60.1	64.8	69.7	74.9	80.5
Adult	20.7	22.3	24.4	26.7	28.9	31.2	33.7	36.3	39.1	42.0	45.2	48.5	52.0
Total*	**$160.4**	**$170.5**	**$183.6**	**$198.3**	**$214.2**	**$231.6**	**$250.4**	**$270.9**	**$293.0**	**$317.2**	**$343.3**	**$371.7**	**$402.8**

* Excluding Disproportionate Share Hospital, territories, and other unallocated expenditures.
Source: Centers for Medicare and Medicaid Services, Office of the Actuary, unpublished summary table for the FY 2009 President's budget, 2008.

Table A3 • B 2169 ☎ heritage.org