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Using SCHIP to Subsidize
Employer-Based Coverage:
How Far Can This Strategy Go?

The State Children's Health Insurance Program (SCHIP), enacted by Congress with strong bipartisan support as part of the Balanced Budget Act of 1997 (BBA), created a much-heralded new program to assist states in covering uninsured, low-income children. As the Department of Health and Human Services' Health Care Financing Administration (HCFA) prepares to issue final regulations implementing the program,¹ virtually every state and territory in the country already has implemented an SCHIP program, and more than half of them provide coverage to children in families with income levels at or above 200 percent of the poverty line.² HCFA reports that nearly 2 million children, at some point during the year,³ were covered in 53 SCHIP programs during the fiscal year ending September 30, 1999, including about 1.2 million in stand-alone SCHIP programs and almost 700,000 through SCHIP-funded Medicaid expansions.⁴

Yet, despite the enthusiasm generated by the early experience under SCHIP, several thorny health policy questions remain unanswered. Principal among them is whether the complex design of this program—including capped and ultimately declining federal funding levels,⁵ strict targeting rules designed to prevent the “crowding out” of private insurance and Medicaid coverage, and federal subsidies that increase with rising family income—represent a lasting architecture for reducing the number of uninsured Americans. Some policy analysts assert that SCHIP represents more of a transitional policy that has at least begun the task of stimulating efforts to cover more uninsured farther up the income ladder. Others go farther and call the program a temporary policy whose internal tensions make it difficult for it to function as a transitional vehicle toward covering significant numbers of the uninsured.

In developing SCHIP (by adding Title XXI to the Social Security Act), Congress had to reconcile many conflicting political views that were brought to bear after the demise of the Clinton administration's universal health coverage initiative in 1993. As a result, the statute creating SCHIP is ambivalent in many ways.⁶ While increasing the federal role in financing coverage for low-income children, Congress promised to give states more latitude in how to spend the money than under Medicaid (for example, states are allowed to cap SCHIP spending and enrollment). SCHIP reflects both generosity and parsimony on the part of the federal government. While SCHIP is supposed to help states cover more low-income children, Congress also took steps to protect the federal purse. Under the law, the new SCHIP funds (with a higher federal match rate than

that paid to Medicaid) are not supposed to be used for health insurance for children already eligible for Medicaid or covered by private insurance. Thus, on one hand, the new, juiced-up federal funding under SCHIP was targeted at populations earning more than those eligible for Medicaid but, on the other, was not supposed to crowd out of any form of existing coverage, including that offered by either Medicaid and employers.

One of the last major unresolved sets of issues in the implementation of SCHIP has to do with the program's capacity to subsidize the provision of employer-sponsored insurance. With certain strings attached, states can use SCHIP dollars to subsidize employer-sponsored coverage either for children alone or for families that include eligible children. States must apply for a federal waiver to subsidize family coverage but not to subsidize children alone with SCHIP dollars. Under HCFA's proposed rules implementing SCHIP, states may apply for a waiver allowing them to use SCHIP funds to purchase “family coverage under a group health plan or health insurance coverage that includes coverage for targeted low-income children” if the state establishes that the coverage is “cost-effective” and would not substitute SCHIP funds for (or crowd out, to use health policy vernacular) other forms of coverage.⁷ HCFA defines cost-effectiveness in this part of the regulations to mean that federal funds provided to states for subsidizing family coverage shall not exceed what would have been paid under the program to cover eligible targeted children in a regular stand-alone SCHIP program.

So far, HCFA has given approval to three states—Massachusetts, Mississippi, and Wisconsin—to implement premium subsidy programs under SCHIP. Aside from some limited experience under Medicaid going back about a decade, programs merging federal and state funds to subsidize private health insurance coverage are a new concept posing a steep learning curve for policymakers at all levels of government.⁸ Iowa has one of the nation's most-developed programs that uses Medicaid funds to pay for employer-related and other private health insurance for Medicaid-eligible people. Begun in 1991, the program now serves about 8,000 participants. Using SCHIP funds to subsidize employer-sponsored coverage has drawn a great deal of interest among state policymakers, in part because SCHIP's federal matching rate and eligibility limits are both higher than those for Medicaid.⁹ Yet many state officials have expressed a great deal of frustration with what they perceive as federal barriers (either statutory or regulatory in origin) to implementing premium

subsidy programs under SCHIP. The points they raise include the following:

- In general, federal requirements are overly complex and rigid, thereby making subsidy programs difficult to administer and raising administrative expenses.
- Federal requirements designed to limit the crowding out of existing coverage and federal cost-effectiveness standards are unreasonably strict and raise issues of equity in how different types of employees and employers might fare under SCHIP.
- Federal requirements for benefits and cost-sharing are not consistent with private-sector employee benefit plans (therefore, in many instances, states have to add significant supplemental coverage, which can be a difficult and costly undertaking).
- States are not in a position to enforce federal requirements regarding the characteristics of employer-sponsored health plans or regarding access to appeals processes because the state has no direct contractual relationship with the employer plan (eligibility is triggered when employees apply at a state office).

Many state officials and policy analysts interviewed are taking a wait-and-see attitude toward premium subsidy efforts under SCHIP. While most are generally supportive of giving this approach a try, many question whether it can cover many children in its present form. HCFA officials say they are considering states' concerns in developing the final SCHIP rules.

Organized labor has also expressed interest in exploring ways that SCHIP funds can be used to subsidize health insurance for uninsured dependents of workers covered by union-negotiated health plans (which can be operated either by employers or by unions themselves). Recently, the AFL-CIO and several national unions have begun discussions at both the federal and the state level about how they might work with states, not only to facilitate the development of SCHIP subsidy programs, but also to expand current efforts to make sure that people eligible for Medicaid and SCHIP sign up.

THE BACKDROP: BUILDING ON MEDICAID

So far, the employer subsidy efforts represent only a tiny part of the SCHIP program's spending and enrollment. SCHIP, in turn, is a modest-sized federal/state program that sits on top of a much larger one:

Medicaid. In creating SCHIP, the BBA appropriated \$24 billion over five years and \$40 billion over ten years to help states expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private insurance. In 1998, about 12 million American children and 32 million non-elderly adults lacked health insurance. Of the uninsured children, 4.2 million were in families earning less than 100 percent of the federal poverty level (FPL), 3.8 million were in families earning 100 to 199 percent of the FPL, and 1.8 million were in families at 200 to 299 percent of the FPL.¹⁰

Enacted along with Medicare in 1965 and expanded several times thereafter, Medicaid is an entitlement program that pays for medical assistance for certain vulnerable and needy individuals and families with low incomes and resources, while leaving many other types of low-income people uncovered. All the states have a Medicaid program (though they are not compelled to have one). In fiscal year 1998, about 41 million Americans were enrolled in Medicaid at some point during the year (HCFA estimates about 32 million people at any given point in time), costing federal and state taxpayers a total of about \$168 billion (not including some administrative costs and disproportionate share payments).¹¹ Although children and adults in low-income families make up nearly three-quarters of Medicaid enrollment, most Medicaid spending goes toward the elderly, blind, and disabled. In fiscal year 1998, Medicaid provided medical coverage for more than 19 million children at some point during the year.

Although Medicaid is the largest source of funding for medical and health-related services for the nation's poorest people, as noted above, the program does not cover all poor persons.¹² The following are some of the major categories of people automatically eligible for Medicaid:

- Individuals who would have met the (pre-federal-welfare-reform) Medicaid requirements for the AFDC program that were in effect in their state on July 16, 1996 (states have the option to set more liberal criteria).
- Children under age six whose family income is at or below 133 percent of the FPL.
- Pregnant women whose family income is below 133 percent of the FPL (services to women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).

- Supplemental Security Income (SSI) recipients in most states (some states use more restrictive Medicaid eligibility requirements that pre-date SSI).

Most categories of low-income adults are not automatically eligible for Medicaid. States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria used to establish Medicaid eligibility.¹³ The BBA presents states with three basic choices for structuring their SCHIP programs. They may (a) create a new state children's health insurance program or enlarge an existing one; (b) expand their current Medicaid programs by raising eligibility limits; or (c) use a combination of the two approaches.

Because SCHIP dollars are not supposed to cover previously insured children, Medicaid income standards in place in each state as of March 1997 establish the lower boundary for eligibility for that state's SCHIP-funded coverage.¹⁴ The breadth of SCHIP-funded coverage in a state depends on both these lower eligibility boundaries and the upper SCHIP eligibility boundaries, both of which vary widely across states. Lower-income limits under SCHIP for children up to one year of age, for example, range from 133 percent of the FPL (in 17 states) to 275 percent of the FPL (in 1 state). Upper-income limits for SCHIP programs approved by HCFA currently range between 100 percent and 350 percent of the FPL. (HCFA notes that the upper-income levels of SCHIP do not necessarily reflect the upper boundaries of a state's publicly funded coverage for children, in part because of Section 1115 demonstration programs. Some states have used Section 1115 programs to expand children's coverage under Medicaid and are using SCHIP funds for only a limited part of this coverage.)

Although SCHIP dollars by definition are targeted at populations with greater incomes than those covered by Medicaid, the program offers states a much more generous match rate than under Medicaid. The portion paid by the states under SCHIP is 30 percent less than the historic state Medicaid rate. Under SCHIP, state matching requirements range from 15 percent to 35 percent of the total cost of medical assistance, in contrast to the 23 percent to 50 percent states are responsible to pay under Medicaid. (For example, if a state's match rate is 50 percent under Medicaid, it drops to 35 percent under SCHIP. The federal matching rate for SCHIP is capped at 85 percent of total program costs.) (While the total number of dollars that states may draw down under SCHIP is capped, there is no cap under Medicaid.)

It should be noted that the federal welfare reform law enacted in 1996 gives states an opportunity (little-recognized outside Medicaid circles) to use Medicaid funds to provide health coverage to low- and modest-income working parents. Section 1931 of the Social Security Act permits states to use Medicaid dollars to cover populations not specifically eligible for Medicaid by offering states the option of setting their own income and resource requirements when determining Medicaid eligibility for families.¹⁵ By allowing families with higher incomes and assets to qualify for Medicaid, states can cover families with higher incomes and extend transitional Medicaid assistance to parents entering the workforce. States may even eliminate the resource (asset) test altogether. So, states are able to reach the same populations through Medicaid as they can through SCHIP, but they have an incentive to do so through SCHIP, when possible, due to the program's higher federal match rate. Section 1931, however, does not provide states with a mechanism to provide health coverage for single low-income adults or childless couples, only those with children.

SUBSIDIZING EMPLOYER COVERAGE: SCHIP'S FINAL FRONTIER

While SCHIP dollars may not, by law, crowd out employer-provided coverage, they may be used to subsidize it and, as noted above, several states are interested in trying this approach. So far, only Massachusetts has done so to any appreciable extent.

Federal Strings

States interested in using SCHIP funds to subsidize employer-sponsored coverage must meet a number of federal requirements, including crowd-out prevention measures, cost-effectiveness rules, employee cost-sharing limits, and benefits levels. Because of these complex rules, federal officials have cautioned states to weigh the costs of program administration against the benefits of insuring more children.¹⁶ A particularly burdensome aspect of administering premium subsidy programs in both the SCHIP and Medicaid environments, some analysts say, is that states have to ensure that many requirements are met on a case-by-case basis.

Crowd-Out Rules

In February 1998, HCFA issued a letter to state officials outlining rules designed to insure that SCHIP funds used to subsidize employer-sponsored plans would end up covering previously uninsured children, not those

already insured. According to the letter, children have to be without group health insurance for at least the previous 6 months to be eligible (states can require a longer period of uninsurance, lasting up to 12 months). Second, to discourage employers from reducing their existing contributions for dependent coverage, states may subsidize with SCHIP dollars only where the employer contributes at least 60 percent of the cost of family coverage (if states can show the average employer contribution rate is lower in a particular state, HCFA may consider a lower contribution requirement for that state's subsidy program).¹⁷ Third, a cost-effectiveness test is applied to ensure that the state subsidy to the employer plan does not exceed what the state would have paid to cover eligible children in SCHIP or Medicaid. Fourth, families electing to receive the subsidies must apply for the full premium contribution available from the employer. Fifth, states must collect information on and evaluate the amount of coverage substitution, if any, that has occurred under the subsidy program.

While federal and state officials are taking steps to prevent SCHIP funds from crowding out existing coverage, estimates of how much crowding out is going on or might occur (as well as the importance of this phenomenon) vary widely, according to a report published in May 1999 by the U.S. General Accounting Office (GAO).¹⁸ In analyzing the SCHIP legislation, the Congressional Budget Office estimated that, in the long run, about 40 percent of SCHIP participants would have had some other type of coverage. The GAO also reported an Urban Institute projection of crowd-out ranging from 22 percent to 39 percent of SCHIP enrollees. Recent evidence of crowd-out has surfaced in Rhode Island. The *Providence Journal* has reported that up to 20,000 Rhode Islanders have dropped private coverage to join Rite Care, a state program financed with Medicaid and SCHIP funds.¹⁹ Consultants working with the state program, however, estimate that the number is lower—somewhere between 4,000 and 8,000 of the 104,000 people in Rite Care.

Equity Concerns

Requiring recipients to be without group health insurance for at least six months to qualify for SCHIP premium subsidies raises several questions of fairness. For example, among employees at a firm offering insurance but requiring a substantial employee premium contribution, those who have been paying the contribution would not be eligible for government subsidy, while those who had gone uninsured would be eligible. So, some free riders arguably might be rewarded, while those who had acted responsibly would not. It should be

noted that most of the equity issues that arise in the context of subsidizing employer coverage through SCHIP also present themselves in the larger SCHIP program.

Benefit Benchmarks

Premium subsidy programs must provide benefits that meet SCHIP benchmarks. Under the statute, states may choose one or more benchmark plans from among three options: (a) the commercial health maintenance organization (HMO) plan in the state with the largest enrollment, (b) the state employee plan, or (c) the Federal Employees Health Benefit program standard-option preferred provider organization. Programs can qualify either by providing one of the benchmark benefit packages or by offering coverage deemed to be “benchmark-equivalent.” Because most employer plans do not conform to these benchmarks and many offer lesser levels of benefits, states often must cover additional benefits (sometimes referred to as “wrap-around coverage”) in order for that coverage to qualify for SCHIP subsidies. It should be noted that the benefit package required under Medicaid coverage is much more comprehensive than what is required under SCHIP.

Cost-Sharing

Employer coverage provided with SCHIP subsidies must meet the same cost-sharing requirements as those applied under the regular SCHIP program. There may be no cost-sharing requirements for well-baby and well-child visits. Families with incomes below 150 percent of the FPL may pay no more than the Medicaid-level of copayments, which includes a cap of \$5 for office visits. Families with incomes exceeding 150 percent of poverty may pay no more than 5 percent of their total income for cost-sharing in a given year including both premium contributions and cost-sharing required at the point of service.

TARGETING

Subsidized Coverage versus a Stand-Alone Program

One of the arguments in support of covering low-income children by subsidizing family coverage offered in the workplace instead of enrolling them in a separate public program is that family coverage may make it more likely that children will use preventive services and other forms of medical care. It is well established that uninsured people use significantly fewer medical

services than insured people. Recent research shows that the primary parent's use of physician services is a strong indicator of whether a child would use physician services, whether they happened to be insured or not.²⁰ Because of this link, some argue that it is best that children and their parents are insured in the same plan. But others point out that using employment-based coverage to subsidize low-income children's health coverage has several inherent limits. One is that their parents' employment is often not stable. Many low-income people jump from one job to another and in and out of employment, creating many opportunities for a child's health coverage to be interrupted if it is based on a parent's place of work. Another factor is that families are not always stable. (It is only fair to note, however, that Medicaid programs experience high turnover rates as well.)

Most states interested in using SCHIP dollars are interested in subsidizing entire families. Due to federal cost-effectiveness rules and the administrative burdens inherent in the program, it is questionable that this approach will end up covering many families—at least in its current form.

Employment-Based Coverage

A government strategy of subsidizing employment-based coverage for lower-income people requires several preconditions, many of which are outside the control of government officials. For this approach to work, a worker's employer first must offer coverage. Second, the employee has to be eligible under the employer's plan. Third, the government subsidy has to be large enough to enable the employee to afford the coverage. Of course, the employee has to know about the subsidy option, apply for it, and qualify. Finally, the employer (or union) plans must qualify for subsidization and their administrators must be willing to work with whatever requirements are attached to the government subsidy program. In 1997, 83 percent of firms offered coverage for at least some workers.²¹ Among those firms offering coverage, 84 percent of employees were eligible for it. Of those employees eligible, 87 percent signed up for coverage. So, after netting out the effects of employees' being ineligible and declining coverage, only 60 percent of employees were covered (although 83 percent of firms offered coverage).

In implementing premium subsidy programs, some policy experts point out that it will be easier for states to target them toward employees of large firms because almost all larger firms offer coverage, while many smaller firms do not. (In 1997, 99 percent of firms with

500 or more employees offered health coverage, while 55 percent of firms with fewer than 50 employees offered it.) On the other hand, the families of people working for small firms are far more likely to have lower incomes and be uninsured—that is, to qualify for SCHIP subsidies. (In 1997, the coverage rate was 76 percent in firms with 500 or more employees, compared to 38 percent in firms with fewer than 50 employees.) Using a subsidy approach to reach employees at small firms often involves a more complex strategy. If the employer does not offer a plan or the employee is not eligible for a plan, there is nothing to subsidize. The Institute for Health Policy Solutions, which is providing technical assistance to states attempting to implement SCHIP subsidy programs, has estimated that more than one in three uninsured children may have access to an employer plan offered to one or both of their parents (with the caveat that the percentage of children falling in income categories eligible for SCHIP may be different because the data is not adjusted to account for variance in access to employer coverage based on family income).

STATE EXPERIENCES

As mentioned above, HCFA has approved applications by three states to subsidize employer-provided coverage under SCHIP. As of this writing, the Massachusetts program has covered several hundred people through SCHIP premium subsidies after two years, while Wisconsin's SCHIP subsidy program managed to cover only a few families after about one year. Mississippi is still attempting to implement its program. The following are brief descriptions of efforts to implement the programs in these states. Several other states interested in beginning such subsidy programs also have approached HCFA. The approaches proposed in two of those states, Maryland and Oregon, are described as well.

Massachusetts

Under Section 1115 of the Social Security Act, Massachusetts gained federal approval of a five-year Medicaid research and demonstration project with a broad policy objective of increasing health insurance coverage while curbing the growth of the state's disproportionate share hospital and uncompensated care pool expenses. At the end of the demonstration program's second year (state fiscal year 1999), the program's total enrollment was more than 776,000.

The Section 1115 waiver gave the state authority to subsidize employer-based insurance with Medicaid

dollars. Massachusetts Medicaid officials have developed parallel premium subsidy programs, one utilizing federal Medicaid funds and the other SCHIP funds. Under the state's premium assistance program, SCHIP funds are used only for uninsured families, while Medicaid funds can be used to subsidize premiums for currently insured families. After two years, the program subsidizes a total of about 7,000 people with employment-based coverage (3,815 children covered by 1,837 family policies) and also purchases about 500 policies for adults, according to a state official. The vast majority of these people are subsidized with Medicaid funds. Only a few are subsidized with SCHIP dollars, partly because the administrative complexity of doing so is greater.

Massachusetts implemented SCHIP as a mixed model that includes both a stand-alone program and a Medicaid expansion. Children with incomes between 150 percent and 200 percent of the FPL may receive SCHIP coverage two ways, either directly or through the premium subsidy program (called the MassHealth Family Assistance Program). If families have access to suitable employer-based coverage, they must take it in order to receive assistance (instead of enrolling in the stand-alone program). Premium subsidy payments are made in one of two ways, either directly to families or to employers via fiscal intermediaries.

Among the reasons that the state developed a premium assistance program are that officials believed that many of the people in the targeted income range had access to employer coverage and they wanted to take advantage of private dollars already available to go toward premium payments. Officials also believed that people would be more likely to accept assistance for a program that resembled private coverage rather than a separate public program. They also believed that children would fare better in the same plans as their parents.

The subsidy program is one part of Massachusetts' multi-faceted approach to increase coverage. The state also is offering employers currently not providing health plans incentive payments equaling \$1,000 for family coverage, \$800 for dual coverage (for example, two adults or an adult and a child), and \$400 for one adult if they begin offering a plan (if they have employees who are eligible under either subsidy program). By May 1, 122 employers were receiving payments under this program.

According to state officials, Massachusetts has negotiated some flexibility from federal regulators that may have facilitated the development of its premium subsidy program. For one thing, under its Section 1115 waiver, the state is allowed to tap into Medicaid funds

to cover previously insured people. Also, under both the Medicaid waiver and the SCHIP initiative, the state gained federal approval to subsidize job-based coverage in instances where an employer contributes only 50 percent of premium (as compared to the 60-percent employer contribution typically required for subsidies under SCHIP).

Wisconsin

Wisconsin's SCHIP premium subsidy program has been up and running for one year. Despite considerable effort by state officials and a not insignificant investment in computer technology used to determine eligibility, by the end of July 2000 only five families (or a total of 20 people) will have been found to be eligible for the subsidy program.

Under a federal waiver, state officials have tapped into both Medicaid and SCHIP funds to develop a program called BadgerCare, basically targeted at families with incomes too high for Medicaid. Children and their parents with income at or below 185 percent of the FPL are eligible and, once enrolled, may remain in BadgerCare until family income exceeds 200 percent of the FPL. Begun about one year ago, the program so far has enrolled more than 60,000 people (representing about 25,000 "cases"). A state official characterized enrollment in BadgerCare as "phenomenal," noting that about two-thirds of the targeted population already has signed up. The official also said that there was evidence that some people had dropped their employer coverage a few months before enrolling.

As part of their strategy to keep families covered in the same health plans, state officials built the SCHIP employer coverage subsidy program—called the Health Insurance Premium Payment (HIPP) program—into BadgerCare and developed a computer system to determine eligibility for subsidies as a routine part of the application process. If a person with income too high for Medicaid comes in to apply for assistance, state officials first determine whether he or she is eligible for BadgerCare. Once a person is found eligible for BadgerCare, officials begin the process of determining his or her eligibility for the employer subsidy program. First, they call to ask who the person's employer is. Once that is determined, the computer system generates a form that state officials mail to the employer, asking a series of questions to ascertain the employee's eligibility for SCHIP subsidies (for example, the employer's contribution level and benefit levels). If there is no response in 28 days, officials attempt to contact the employer. After 56 days, if no contact has been made,

they enroll eligible applicants in a BadgerCare HMO, which offers coverage similar to that provided to Medicaid recipients. (While people are waiting for evaluation of their eligibility for premium subsidies, the state covers them under BadgerCare on a fee-for-service basis.) In about 65 percent of the 25,000 cases to date, state officials have received information back from employers—information that is often bulky, misleading, and outdated. Of the employers responding, 31 percent reported that the BadgerCare recipient in question was no longer employed by them. (One reason for this is that up to three months can elapse between the beginning of the BadgerCare application process and the end of the HIPP program eligibility process.) From the information they receive from employers, state officials discover that many people are ineligible because the employer's contribution rate is less than 60 percent of premium (breaking the federal limit) or greater than or equal to 80 percent (exceeding a state limit). This is the main factor causing the majority of BadgerCare recipients to fail the HIPP eligibility process. The second major reason is the nature of the health coverage offered by their employers; in many cases, the coverage available to employees is too limited to qualify for subsidy under the law.

For those applicants still possibly eligible, the employer-provided information is fed into a computer program to determine the employee's eligibility for SCHIP premium subsidies. According to a state official, to determine whether the subsidy program will be cost-effective, the computer program compares (a) the cost of paying for BadgerCare HMO coverage along with a small fee-for-service wrap-around to (b) the cost of paying the premium subsidy plus any necessary benefit and co-payment wrap-arounds plus the state's cost of administering the program. The difference between the cost of the benefit wrap-around for BadgerCare HMOs (about \$5 a month because the HMOs cover most benefits required by Medicaid) and the benefit wrap-around for the employer plan may be quite large because a private-sector plan's level of coverage may require the state to pay for additional benefits costing up to \$150 a month to meet federal benefit requirements.

Given the steps they must go through for people to qualify for the subsidies, state officials say it comes as no surprise that only a few families have qualified, despite the deluge of information from employers. Nevertheless, state officials have no plans of discontinuing the subsidy program and say that whatever they might learn from the exercise could be very valuable in the future, should federal rules be made more flexible.

Mississippi

After gaining HCFA approval, officials in Mississippi hired the largest insurer in the state (Blue Cross and Blue Shield of Mississippi) to help administer the state's SCHIP program to subsidize employment-based coverage. The insurer has identified several administrative issues that state officials say may prevent them from implementing the program. For one thing, the insurer has determined that only about 10 percent to 15 percent of employer plans in the state would qualify for SCHIP subsidies. Mississippi is a largely rural state with almost no HMOs and many small employers. While most employers offer dependent coverage, they often do not contribute towards it, thereby violating HCFA's employer contribution rule. In applying to HCFA, Mississippi officials made the argument that the agency's requirement that employers pay at least 60 percent of the premium was not necessary due to the presence of the cost-effectiveness rule. HCFA officials did not buy this argument but did agree to lower the employer contribution requirement for Mississippi's program to 50 percent of premium.

Most plans in Mississippi also have employee cost-sharing requirements that exceed SCHIP's limits. State officials say that, due to several factors, the employer subsidy program may be so expensive as to violate the cost-effectiveness test under SCHIP. These factors include the general cost of meeting SCHIP requirements, the cost of creating and administering wrap-around benefit packages, and the cost of providing the wrap-around benefits themselves.

Maryland

Maryland state officials plan to subsidize employer coverage as part of an SCHIP coverage expansion. Beginning July 1, 2001, Maryland children whose family income is greater than 200 percent of FPL and at or below 300 percent of poverty will be eligible to enroll in the program. If employer-sponsored coverage meeting federal and state requirements is not available, eligible children will be enrolled directly in a managed care organization offering the same services as currently provided under the state's Medicaid plan (called HealthChoice) for children at or below 200 percent of poverty. For employer-provided health plans to be eligible for subsidization under the program, the benefits must be equivalent to a benchmark plan. Maryland has selected the HMO with the largest commercial, non-Medicaid enrollment in the state as its benchmark plan.

According to a state Medicaid official, some members of the state legislature worried that the decision to subsidize workers with incomes up to 300 percent of the FPL might lead some employers to drop coverage for all workers. In preparing to implement the program, a key issue that has arisen has been how to get employers to participate; many have said that they would not be interested in participating if doing so means the imposition of any additional administrative burdens. This sentiment by employers has been echoed in many other states as well.

Oregon

Discussions between officials from the state of Oregon and HCFA have bogged down regarding how to use SCHIP dollars to fund an employer insurance subsidy program that the state currently operates without any federal money. After the state's comprehensive "pay or play" health reform legislation was repealed in 1995, the state legislature in 1996 voted to create the Family Health Insurance Assistance Program (FHIAP). Under this program, families can obtain subsidies to help them buy either employer-provided or individual health coverage. About 5,500 people are enrolled in FHIAP and more than 15,000 others are on a waiting list. A state official described current efforts to mesh the subsidy program with SCHIP as going through "contortions" to fit employer-sponsored insurance into a Medicaid-like template. State officials are not sure if it is possible to do so.

State officials say that they have encountered two major difficulties in gaining approval from HCFA. One of these is meeting SCHIP's cost-sharing limits. The state is proposing to use an employer purchasing cooperative, which is organized by a business association and offers a choice of three federally qualified HMOs as the vehicle through which to subsidize employer coverage. Proposing a rather creative approach towards bolstering benefit packages to meet federal cost-sharing rules, state officials have suggested that families choosing to enroll in a plan offered by the cooperative be given two insurance cards. One card would carry the name of whichever HMO they chose, while the other card would cover additional costs if the plan fails to meet federal SCHIP cost-sharing requirements. If this approach is rejected, an alternative might be to develop new coverage packages that meet the federal SCHIP cost-sharing requirements; but the disadvantage of this approach is that some employers might object to having to offer different employees different benefit packages (in some instances, for

example, SCHIP-eligible employees would be offered richer benefits than their co-workers).

The second major difficulty the state faces in gaining federal approval has to do with the federal requirement that children that appear to be eligible for Medicaid must apply for that program before applying for SCHIP. According to a state official, leaders of the privately organized purchasing cooperative are leery of routinely asking subsidy applicants to apply for Medicaid because they do not want the purchasing cooperative to develop a reputation for running a Medicaid plan. State officials have proposed that, instead of being told to apply for Medicaid, subsidy applicants would have to be informed that they appear to be eligible for Medicaid and have the right to apply for Medicaid instead of a subsidy for employer-sponsored insurance.

State officials said that, despite the complexity inherent in attempting to mesh the existing state subsidy program with SCHIP, they feel that they must try to do so because thousands of eligible Oregon children remain uninsured. Between 25 percent and 30 percent of children in Oregon who are eligible for Medicaid remain unenrolled and the percentage of unenrolled children is somewhat higher among those eligible for SCHIP, they estimate. About one in three of the state's uninsured children have parents that declined to cover them through employer-sponsored insurance. In many instances employers in the state will pay up to 90 percent of the premium for a worker's coverage but are willing to contribute much less, if anything, toward premiums for dependent coverage. HCFA's fear that enhanced subsidies might crowd out employer coverage is shared at the state level, but state officials think that, if federal rules can be made more flexible, employer-sponsored insurance can be strengthened through SCHIP.

CONCLUSION

Given the considerable hurdles that states must overcome, it seems unlikely that they will be able to cover a significant number of uninsured children through programs accessing SCHIP funds to subsidize job-based health coverage. Although states have focused much criticism on HCFA for its interpretation of the SCHIP's crowd-out provisions, many of the barriers to the growth of these programs appear to be erected by the BBA statute itself. And many other barriers are presented by the dynamic nature of employment-based coverage and the inherent complexities of merging government and private insurance programs. The law contains almost contradictory

elements because it seeks to provide health coverage to uninsured people with incomes higher than those eligible for Medicaid without inducing both employers and employees currently paying for coverage to drop it. That is a fine line for state officials to walk when attempting to implement a complex program.

There is little doubt that HCFA has some discretion and could take steps to make the subsidy programs easier to implement and administer (for example, by relaxing the 60 percent employer contribution requirement). But it appears probable that interpreting the law as flexibly as possible, which many states are clamoring for, would go only so far and that the growth of such subsidy programs would remain inherently limited under the current statute.

Yet the importance of such efforts should not be underestimated. Despite the limits and contradictions inherent in using SCHIP to subsidize employer coverage, state experiments that attempt to do so may generate a great deal of valuable experience and practical knowledge. Developing on-the-ground experience on how to mesh government subsidies with employer coverage would take on new importance should Congress at some point consider expanding efforts to subsidize health coverage for working Americans in a more comprehensive and systematic way.

ENDNOTES

1. A HCFA official interviewed during the preparation of this article said the agency was attempting to issue the final regulations by September 2000.
2. Health Care Financing Administration (HCFA), "State Child Health; Implementing Regulations for the State Children's Health Insurance Program," proposed rules, *Federal Register*, 64, no. 215 (November 8, 1999).
3. Because of considerable turn-over in SCHIP, an estimate of people currently enrolled in SCHIP would be considerably lower than the 2 million figure of people enrolled at some point during the year.
4. HCFA, "The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998–September 30, 1999," 2: accessed May 4, 2000, at <http://www.hcfa.gov/init/enroll99.pdf>, 2.
5. The BBA appropriated \$24 billion over five years and \$40 billion over 10 years to help states expand children's health insurance.
6. For more information on this aspect of SCHIP, see Richard Hegner, "The State CHIP: How Much Latitude Do the States Really Have?" Issue Brief No. 725, National Health Policy Forum, George Washington University, October 1, 1998; see also Sara Rosenbaum, Kay Johnson, Colleen Sonosky, Anne Markus, and Chris DeGraw, "The Children's Hour: The State Children's Health Insurance Program," *Health Affairs*, January/February 1998, 76-77.
7. HCFA, "State Child Health," 60962.
8. Institute for Health Policy Solutions (IHPS) and National Governors' Association (NSA), "Coordinating State Children's Health Insurance Coverage: Design and Implementation of Premium Assistance Programs," summary of conference, October 5, 1999, Washington, D.C. This document provides a good summary of early experiences under premium subsidy programs and identifies many of the issues that have arisen.
9. The state matching rate under SCHIP is 30 percent less than the historic state Medicaid rate. Thus, if a state's current rate is 50 percent under Medicaid, it drops to 35 percent under SCHIP. The federal matching rate for SCHIP is capped at 85 percent of total program costs; thus, state matching requirements range between 15 and 35 percent, compared to 23 to 50 percent for Medicaid.
SCHIP offers states the option of covering uninsured children with family incomes up to 200 percent of the federal poverty level (FPL), using capped federal funds with a significantly higher federal matching rate than for Medicaid. For states whose Medicaid eligibility levels already exceeded 150 percent of the FPL, eligibility limits under SCHIP may exceed those levels by as much as 50 percentage points. As a result, some states have chosen SCHIP eligibility standards as high as 300 percent of the FPL.
10. Catherine Hoffman and Alan Schlobohm, "Uninsured in America: A Chart Book," second edition, Kaiser Commission on Medicaid and the Uninsured, Washington, D.C., May 2000, 101. Data taken from Table 17 (entitled "Characteristics of Uninsured Children [Less than Age 19], 1998") are Urban Institute estimates based on March 1999 Current Population Survey.
11. Providers participating in Medicaid must accept Medicaid payment rates as payment in full. States must make additional payments to qualified hospitals that provide inpatient services to a disproportionate number of Medicaid recipients and/or to other low-income or uninsured persons under what is known as the "disproportionate share hospital" (DSH) adjustment. Excessive use of the DSH adjustment resulted in rapidly increasing federal expenditures for Medicaid. However, under legislation passed in 1991, 1993, and again within the BBA, the state allotments for payments to DSH hospitals have become increasingly limited. (See Mary Onnis Waid, "Brief Summaries of Medicare and Medicaid, Title XVIII and Title XIX of the Social Security Act," Health Care Financing Administration; accessed May 23, 2000, at <http://www.hcfa.gov/medicare/ormedmed.htm>.)
12. Waid, "Brief Summaries of Medicare and Medicaid."

13. According to Waid (see 11 above): the following displays the mandatory Medicaid "categorically needy" eligibility groups for which federal matching funds are provided:

- Individuals are generally eligible for Medicaid if they meet the requirements for the AFDC program that were in effect in their State on July 16, 1996, or—at State option—more liberal criteria;
- Children under age six whose family income is at or below 133% of the Federal poverty level (FPL);
- Pregnant women whose family income is below 133% of the FPL (services to women are limited to: those related to pregnancy, complications of pregnancy, delivery and postpartum care);
- SSI recipients in most States (some States use more restrictive Medicaid eligibility requirements that pre-date SSI);
- Recipients of adoption or foster care assistance under Title IV of the Social Security Act;
- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time);
- All children born after September 30, 1983, who are under age 19, in families with incomes at or below the FPL. (This phases in coverage, so that by the year 2002, all such poor children under age 19 will be covered); and
- Certain Medicare beneficiaries (described later).

States also have the *option* of providing Medicaid coverage for other "categorically related" groups. These optional groups share the characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined. The broadest optional groups for which States will receive Federal matching funds for coverage under the Medicaid program include:

- Infants up to age one and pregnant women not covered under the mandatory [groups] whose family income is no more than 185% of the FPL (the percentage amount is set by each State);
- Children under age 21 who meet what were the AFDC income and resources requirements in effect in their State on July 16, 1996 (even though they do not meet the mandatory eligibility requirements);
- Institutionalized individuals eligible under a "special income level" (...set by each State—up to 300% of the SSI Federal benefits rate);
- Individuals who would be eligible if institutionalized, but who are receiving care under home and community-based services waivers;

- Certain aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the FPL;
- Recipients of State supplementary income payments;
- Certain working and disabled persons with family income less than 250% of FPL who would qualify for SSI if they did not work;
- TB-infected persons who would be financially eligible for Medicaid at the SSI income level if they were within a Medicaid-covered category (however, coverage is limited to TB-related ambulatory services and TB drugs);
- "Optional targeted low-income children" included within the Children's Health Insurance Program (CHIP) established by the Balanced Budget Act of 1997 (BBA); and
- "Medically needy" persons (described below).

The Medically Needy (MN) program allows States the option to extend Medicaid eligibility to additional qualified persons. These persons would be eligible for Medicaid under one of the mandatory or optional groups, except that their income and/or resources are above the eligibility level set by their State. Persons may qualify immediately, or may "spend-down" by incurring medical expenses that reduce their income to or below their State's MN income level.

14. HCFA, "Annual Enrollment Report," 8.

15. Jocelyn Guyer and Cindy Mann, "Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Working Parents through Medicaid," Center on Budget and Policy Priorities, Washington, D.C., revised August 19, 1998.

16. IHPS and NGA, "Coordinating State Children's Health Insurance Coverage," 12.

17. The 60 percent minimum employer contribution rule is standard proposed under HCFA's interpretation of the law's intent to prevent "crowd-out" of employer coverage. The contribution requirement is not specifically mentioned in the law itself, but rather in HCFA's proposed regulations.

18. General Accounting Office, "Children's Health Insurance Program: State Implementation Approaches Are Evolving," GAO/HEHS-99-65, May 1999, 87-89.

19. Christopher Rowland, "Officials Rethinking Rite Care's Mission," *Providence Journal*, May 21, 2000.

20. K. L. Hanson, "Is Insurance Enough? The Link between Parents' and Children's Health Care Revisited," *Inquiry*, 35 (Fall 1998): 294-302.

21. Stephen H. Long and Susan Marquis, "Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997," *Health Affairs*, 18:6 (November/December 1999).