Strategies for Improving Enrollment and Maximizing Cost Savings in Maine's Private Health Insurance Premium Program (PHIP)

September 2008

Prepared for the Office of MaineCare Services by
Katie Rosingana
Kimberley Fox

Muskie School of Public Service
University of Southern Maine

Table of Contents

Overview

The purpose of this brief is to identify best practices in states with successful Health Insurance Premium Payment (HIPP) programs[1] to inform the expansion of Maine's Private Health Insurance Premium (PHIP) Benefit as required under Maine Public Law 2007, Chapter 240 and Public Law, Chapter 448, LD 1746.

Statement of Problem

Under Chapter 448, LD 1746 of the Maine Public Laws 2007, the Office of MaineCare Services was mandated to maximize enrollment in PHIP by "establishing procedures to identify families or individuals with access to other public or private insurance coverage and educating members and employers about the purpose and benefits of the program." The law further mandates that if a MaineCare member or family member or person is deemed eligible for employer-sponsored health insurance it is considered a "qualifying event" and the insurer and employer must allow the family or individual to enroll without regard to any enrollment season restrictions. The fiscal note attached to this legislation estimated sizeable savings as a result of these changes.

Accordingly, the current state budget (Maine Public Law 2007, Chapter 240), assumes aggressive savings from the PHIP Benefit for this biennial budget cycle. Through the expansion of the PHIP program, the Office of MaineCare Services (OMS) was expected to save $1.9 million in State Fiscal Year (SFY) 2007-2008, and $4.3 million in SFY 2008-2009. Funding for four new positions for the PHIP program in SFY 2007-2008 and two new positions in SFY 2008-2009 are included in this budget bill.[2]

Given relatively low PHIP enrollment and current savings, OMS commissioned the Muskie School of Public Service to investigate other states' methodologies for estimating program savings and determining cost-effectiveness as well as strategies for increasing enrollment.

Current Practice in Maine PHIP

Enrollment in PHIP is currently voluntary in Maine. To identify MaineCare members who are working that may have access to employer-sponsored insurance (ESI), PHIP Benefit program administrators link MaineCare enrollment data with the state's department of labor database and send out SWICA (State Wage Information Collection Agency) letters to MaineCare enrollees that are employed for 32 hours or more per week (approximately 13,000 in 2008). The response rate to these letters has been low, and has not increased PHIP enrollment substantially. Provision of SWICA information is voluntary, and the state lacks the resources to send follow-up letters and or phone calls to SWICA letter recipients. In addition to SWICA letters, the state also promotes PHIP

[1] Authorized under Section 1906 of the Social Security Act, Health Insurance Premium Payment (HIPP) programs subsidize enrollment in employer-sponsored private health insurance for Medicaid-eligible individuals—and their families—who have access to such coverage and for whom it is cost-effective. Individual state programs may have specific state names (e.g. Maine's PHIP or Rhode Island's RIte SHARE) but throughout this report we will largely use the general terminology of HIPP.

[2] In SFY 2007-2008, MaineCare added the budgeted four new positions to the PHIP unit- and has chosen not to fill the two new positions budgeted for 2008-2009.

through brochures distributed to regional intake offices and other locations. The PHIP Benefit unit receives phone calls from members, eligibility workers or outside providers inquiring about the program. The PHIP staff person conducts a quick "straight-face" test to assess if the case is likely to be cost-effective. If so, an application is sent out to the member, who in turn completes and mails it back to OMS.

Once information on the employer plan benefits is provided, the state assesses cost-effectiveness, as described in more detail below. If there is any estimated savings, the case is approved and premium payments begin. Historically, OMS reviewed ongoing cases for cost-effectiveness on a quarterly basis, but has recently changed this to an annual review. As of February 2008, only 337 individuals (in 189 cases/households) of approximately 188,000 MaineCare non-dual eligible adult and child members (or less than .2%) were enrolled in the PHIP Benefit program.[3]

Best Practices in Other States and Lessons for Maine

The state of Maine's PHIP Benefit program faces two challenges – low enrollment and relatively low total and per person cost-savings resulting from shifting individuals from MaineCare to private insurance. To identify best practices for improving enrollment and maximizing cost-savings, we contacted other states with successful HIPP programs. State selection criteria included program size as measured by total HIPP enrollment and the percentage of Medicaid enrollees enrolled in HIPP, reported levels of total cost-savings and savings per case, whether the program operates under 1906 authority,[4] and preferably states operating in a non-managed care environment similar to Maine.

Based on a literature and document review of HIPP programs and consultation with staff at OMS, we identified 4 states (Iowa, Missouri, Pennsylvania, and Texas) that met our criteria. We contacted these states by phone and email and were able to speak with program directors in 3 out of the 4 states. Texas, which utilizes a private subcontractor to administer its HIPP program, did not respond to our repeated attempts to contact them. Thus, we also contacted and interviewed program directors in Rhode Island, a Medicaid managed care state. Rhode Island's RIte Share HIPP program has one of the highest enrollment rates in the country and thus may still have important lessons for Maine. Table 1 compares Maine and selected states on key HIPP program indicators.

[3] Estimate of MaineCare members was provided by Frank Johnson of Office of Information Technology, Maine DHSS, August 21, 2008. It only includes non-dual eligible members with full service RAC codes.
[4] Authorization under Section 1906 of the Social Security Act (42 U.S.C. 1396 e) allows states to offer HIPP programs, subsidizing employer-sponsored enrollment for cost-effective cases. This program is optional for state Medicaid programs.

TABLE 1: Key HIPP Program Indicators in Selected States

State	Program Start Date	HIPP Enrollment	% of Medicaid enrollees in HIPP/PHIP program +	Average # enrollees per case	Medicaid Eligibility ++	Annual Savings FY 07-08
ME	1993	337 enrollees (189 cases)	<.2%	1.8	Children <150% FPL Pregnant ♀ <200% FPL Parents <200% FPL	@$833K
IA	1991	8,000 enrollees (2,137 cases)	1.6%	3.7	Children <133% FPL Pregnant ♀ <200% FPL Parents <84% FPL	$20M
MO	1992	4,500 enrollees (1,000 cases)	.5%	4.5	Children <150% FPL Pregnant ♀ <185% FPL Parents <39% FPL	$3.0M
PA	1994	25,000 enrollees (10,000 cases)	1.9%	2.5	Children <133% FPL Pregnant ♀ <185% FPL Parents < 200% FPL	$87M
RI	2001	7,539 enrollees (2,449 cases)	4.7%	3.1	Children <250% FPL Pregnant ♀<250% FPL Parents <185% FPL	$6.3M

+ Source: For IA, PA, and RI: Don Dickey, "Premium Assistance for Employer-Sponsored Insurance (ESI) Enrollment Experience in Other States," Vermont Legislative Joint Fiscal Office, October 2006. For ME and MO: # of HIPP enrollees as reported by program administrators, divided by the # of total Medicaid enrollees as reported by program administrators (ME) or from 2005 Kaiser Health Facts (MO).

++ Eligibility information from Kaiser State Health Facts: http://www.statehealthfacts.org/medicaid.jsp

Our interviews with HIPP program directors included questions regarding current enrollment and cost savings, recent trends, key strategies for maximizing enrollment (including engagement of providers/employers), and methods for determining cost-effectiveness and calculating program cost savings. The following summarizes the key findings from those interviews.

Key strategies for increasing enrollment

1) **Mandating enrollment in ESI for all Medicaid beneficiaries if cost-effective**. Three out of four of the states mandate enrollment in ESI if the plan is cost-effective. All of these states (PA, IA, RI) indicated that the imposition of the mandate was a key strategy for achieving high enrollment rates. Rhode Island's HIPP program, known as RIte Share, offers a striking example of the impact of a mandate on enrollment. When the RIte Share program was initiated in February 2001, it was a voluntary program. At the end of its first year, there were only 111 enrollees. In January 2002, the state mandated enrollment. One year later Rite Share enrollment had increased to 2,905 or 26 times higher than the prior year. The mandate, combined with efforts to get all health insurance plans offered in the Rhode Island market approved for participation in the program and the use of an aggregate cost-effectiveness test (described below), contributed to continued enrollment increases. RIte Share enrollment as of July 2008 is 7539 (4.7% of Medicaid enrollment).

2) **Developing employer ESI database and engaging employers.** To facilitate enrollment and the process of gathering current information on employer benefits, many state programs have developed detailed databases to track employer benefit packages – including type of insurance available, services covered, cost-sharing requirements, benefit limits, etc. Employer benefit package information is voluntarily provided by employers themselves, through contacts with HIPP staff and/or through health insurers. Rhode Island indicated that it does monthly tape matches between its RiteCare eligibility files and benefit information required from employers for TPL.

   Somet state officials indicated that the employer community was relatively responsive to requests and willing to provide necessary information. Pennsylvania identified their relationship with the employer community as one of their key factors for success. Based on the relationships PA HIPP staff has developed with employers, many employers now contact their division if they think one of their employees may be eligible for HIPP to help get them enrolled.

   However, in annual reports, Rhode Island has cited the lack of a mandate that employers submit health insurance benefits information as a continuing challenge to getting people enrolled. To get this information from health care employers, Rhode Island legislators recently passed Article 17, which amended Chapter 40-8 of the state's General Laws. The legislation mandates the provision of employee benefit information from all Medicaid providers and vendors doing business with the state that employ individuals receiving state medical assistance. Furthermore, Article 17 amended Section 40-6-9.1 of Rhode Island General Laws to include language that mandates all health insurers to provide the state with requested information on members within 14 days of said request.

3) **Automating referral and training caseworkers.** All four states had automated the referral process for their HIPP program through the existing state eligibility system. Every state interviewed indicated that automating referral had significantly helped them in identifying potentially eligible clients and in increasing program enrollment.

   Staff training and internal operational changes concerning the intake process helped Pennsylvania increase enrollment. Even after automating HIPP referral by adding 3 questions to the eligibility system that trigger letters to enrollees (i.e. whether person was employed, whether they lost their job in last 30 days, and whether anyone in the family is seriously ill or pregnant), PA still found that self-reported employment information provided by the applicant and/or entered by the case worker, often underestimated employment and provided insufficient HIPP referrals. In high volume counties, Pennsylvania modified its operational policy so that each person enrolling in Medicaid received a follow-up letter from the state's HIPP program whether or not the person reported being employed, which increased enrollment in those regions.

Eligibility workers in Rhode Island are also asked to fill in the applicant's employer on the Medicaid application. This was initially a manual process where workers typed the employer into a blank field, but is now automated, complete with drop-down list of all employers in the database that the intake worker can choose from.

Iowa also reported that implementing the automatic referral process made it easier for clients and local county intake workers. Iowa eligibility workers at the county level refer every case that is employed to the state's HIPP program, which sends a letter to the Medicaid recipient. State HIPP administrators in Iowa encourage strong working relationships and frequent communication between HIPP workers and Medicaid workers in the field.

4) **Targeting families; higher income eligibility groups.** While none of the states explicitly indicated that they were targeting groups as a strategy, all selected HIPP programs had much higher member per case ratios than Maine (see Table 1). Rhode Island officials specifically indicated that a key lesson that they had learned was that it is rarely cost-effective to enroll in a child-only ESI plan. They have obtained their largest savings when the whole family or at least more than just than one child is eligible. Other states also averaged at least 2 or 3 family members per case, suggesting that in expanding its PHIP program, Maine may want to target outreach to families where one or more child or parent is enrolled in MaineCare to yield the greatest cost savings.

   Rhode Island, which was the only state able to supply enrollment data by income, also reported that very few persons/families under 100% FPL were eligible; their largest enrollment was among families with incomes 100%-185% FPL that were more likely to be employed and have access to health insurance. Looking more closely at numbers supplied by Rhode Island, we found that 1,932 Rhode Island Rite Share enrollees are under 100% FPL, which comprises about 25% of program enrollment, while 4,939 enrollees have incomes between 100%-185% FPL; this is approximately 65% of Rite Share enrollment. This suggests that Maine may want to target outreach or referral letters to Medicaid enrollees with household incomes above 100% FPL.

Strategies for measuring cost-effectiveness

Maine's cost-effectiveness test for the PHIP program requires the employee's share of the employer-based health insurance premium plus the deductible be less than the average annual cost of all eligible MaineCare family members plus PHIP administrative. Average MaineCare costs are calculated by age and gender and exclude some high-cost users.[5] Maine does not currently require a minimum employer contribution or a minimum benefit or benchmark plan. Rather, if the state saves $1 beyond its average Medicaid and

[5]During the process of researching and writing this report, OMS began using RAC codes to assess average annual member cost for their PHIP cost-effectiveness test.

administrative costs, the case is approved, the individual is enrolled in PHIP, and premium payments are sent to members. As required under Medicaid law, the state also pays for wrap-around benefits not available through employer-sponsored coverage, but these costs are not factored into the cost-effectiveness calculation. OMS reviews ongoing cases for cost-effectiveness on a quarterly basis.[6]

While all the states that we spoke to generally employed a similar approach, there were some differences in how average Medicaid costs are calculated which resulted in variation in average Medicaid costs by state**.**

Other key differences between Maine's methodology for determining cost-effectiveness in its PHIP program and other state HIPP programs that may affect the number of cases likely to qualify include:

1) **Automating the cost-effectiveness calculation in the employer database.** In addition to creating detailed databases of employer health benefit plans, most states have integrated a cost-effectiveness calculator into this system that allows them to isolate the specific benefits covered and apply a cost estimate for similar services covered for the enrollees peer group in Medicaid in the prior year. The database then automatically compares the ESI costs with Medicaid and determines if it is cost-effective. All of the states indicated that these databases took some time to develop but significantly reduced administrative time/costs over time. Pennsylvania, Iowa and Rhode Island all indicated that they would be willing to share their databases and/or work with Maine PHIP to help them adapt it for their program if requested. None of the states we spoke with had minimum employer contributions or minimum benchmark plan requirements. However, through their cost-effectiveness automation process, several states were able to isolate the costs of services covered and not covered by the plan, which effectively achieves a benchmark based on cost-effectiveness. This ultimately ensures higher cost-savings (and less wrap costs) by conducting the cost-comparison at the service-level.

2) **Alternative methods for estimating Medicaid costs.** While all states compared the cost of buying into ESI insurance compared to the average Medicaid cost, their methods for determining average Medicaid cost varied. States with managed care have capitated rates similar to private insurance products (i.e. child-only, single and family coverage) to compare with the employer plan premiums and deductibles. (Rhode Island, Pennsylvania in some counties). Rhode Island also factors in the ESI costs of non-covered plan services in their cost-effectiveness test such as coinsurance/co-pays and deductibles, as well as services not covered under the commercial plan that are covered by Rite Care, like transportation, and child birth education classes. (See ATTACHMENT A, Rhode Island Cost Effectiveness Calculator). In addition to age and gender, other states also factor in county of residence and Medicaid eligibility group to assess comparative peer

[6] After the first draft of this report was submitted (March 2008), OMS changed their case-by-case cost-effectiveness review schedule from quarterly to annually.

group costs. Iowa and Pennsylvania also factor in institutional status, and exclude Medicare. While Pennsylvania excludes users with 14 high-cost diagnoses, the other states do not exclude high-cost users from their Medicaid average cost estimates. Inclusion of high cost users in average Medicaid cost categories increases estimated average Medicaid costs and likely results in more people being determined eligible. This could also potentially over-inflate individual cost experience resulting in lower or even negative savings in individual cases.

3) **Conducting aggregate cost-effectiveness test at the employer level annually.** One state -- Rhode Island – has elected to conduct aggregate cost-effectiveness tests by the employer. They determine if the employer single coverage, child-only, or family coverage is cost-effective rather than assessing cost-effectiveness for each applying individual/family, which they have found to reduce administrative burden. On a company-by-company basis they will assess whether the employers' health plan is cost effective through their automated database; usually this information is garnered from a previous employee application. Rite Share administrators will contact the employer to assess if the employee(s) applying for medical assistance works full-time, is not on a probationary period, and is eligible for ESI, The program generates letters to all RiteCare enrollees that are employed by that company congratulating them as being eligible for RiteShare, state that they are mandated to participate, and ask them to enroll. RIte Share also only reassesses cost-effectiveness annually, as ESI products renew**.** For people employed by employers not in the database, program administrators send a form to both employee and employer requesting insurance information, which is then usually provided by employee.

4) **Administrative costs/ staffing.**
All states deduct the administrative costs for administering the program to determine cost effectiveness, although most acknowledged their estimates for assessing administrative costs were relatively rough. We also found wide variation across states in the HIPP staffing levels and staff case ratios for these programs ranging from 143 cases per staff in Iowa to nearly 350 cases per staff in Rhode Island.

Factors contributing to higher program savings in other states

As shown in Table 2, other states are achieving much higher aggregate annual cost savings than Maine, driven in large part by higher HIPP enrollment in these states. The factors that appear to be contributing to other states higher HIPP cost savings are 1) higher enrollment 2) higher estimated Medicaid costs per HIPP case and/or enrollee; and 3) lower ESI premiums, or a combination of these factors. Overall program savings may also be higher because other states tend to enroll larger families of at least 2 or more that yield greater savings.

TABLE 2: HIPP Program Savings Estimates*

State	Reported Annual Aggregate Savings, State Fiscal Year 07-08	Average Monthly Medicaid Cost	Average Monthly ESI Premium Paid through HIPP, PMPM	Enrollees	Savings/ Enrollee
ME	$833K	@$206	@$121	337	$2472
IA	$20M	@$257	@$63	8,000	$2511
MO	$3M	@132	@$ 77	4,500	$667
PA	$87M	@$421	@$131	25,000	$3480
RI	$ 9M	@$212	@$114	7,539	$1194

PMPM = per member per month

** Note: Aggregate savings are based on self-report from PHIP program directors for FY 2007 with the exception of RI, which was estimated from total enrollment and reported savings of $1.2 million for every 1,000 enrolled. Maine figures are from MaineCare report of net savings of PHIP members based on RAC code, July 30, 2008. Average Monthly Medicaid costs are based on numbers provided by the state (RI, and IA/per case) or were backed into from reported program savings and total or average ESI premiums paid.*

Based on our analysis, the most likely explanation for wide variation in state average cost savings estimates is due to some differences in how Medicaid cost savings estimates were arrived at by each state. For example, Iowa, which estimated that it saved $20 million in 2006, uses a very gross formula to develop its estimates. Iowa's program savings estimates are derived from multiplying every Medicaid $1 spent by a factor of 3.3. The factor of 3.3 was arrived at from a survey of employer plans several years ago that determined that, on average, employers paid approximately two thirds of their ESI premiums on behalf of employees. This is a similar methodology that was employed in developing the anticipated cost savings from LD 1746 in Maine, and captures contributions by employers rather than savings to Medicaid. Iowa also did a gross comparison of its enrollees on TPL with those not on TPL and found a similar ratio of 3:1, which they feel further validates their cost-savings estimates.

Differences in private health insurance premium prices and/or the required employee share of those premiums also appear to be a factor. According to national data, Maine private health insurance premiums for both single and family coverage and employee contributions toward these premiums are above the national average. In fact, employee contributions by Mainers for family coverage rank fourth highest in the country.[7] Compared to HIPP programs in other states, Maine's average employee share of the ESI premium paid by PHIP (estimated by the program administrator to be $121 per member)

[7] Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2005 Medical Expenditure Survey Panel- Insurance Component, 2005.

was second to Pennsylvania, with the other states reporting lower ESI average employee shares. (Table 2)

In contrast to Iowa, both Rhode Island and Pennsylvania use a very detailed method for determining its savings (both state-specific and state/federal) essentially replicating the per-case cost-effectiveness test methodology for the program as a whole. (See Table 3.) Rhode Island estimates Medicaid costs avoided using the state's capitation rate for managed care plans, plus risk-share, stop-loss and other plan payments. They then subtract the premiums paid for ESI as well as supplementary payments for any co-payments, deductibles, and services exceeding the benefit maximum under ESI and Rite Share administrative costs to determine net savings. Rhode Island assumes annual savings of $1 million for every 1,000 enrollees enrolled for a full year; this assumption does not include administration costs. Pennsylvania's savings suggest that they aggregate the calculated FFS Medicaid costs avoided from the automated cost-effectiveness test and subtract ESI premiums and deductibles and administrative costs.

TABLE 3: Other State Cost Effectiveness Formulas

State	Average Medicaid costs	Employer plan costs	Admin Costs/# Staff/ Staff Per Case	Savings/Loss Requirement
IA	Average Medicaid expenditures for services covered under the plan from the prior fiscal year by age (8 groups), sex, eligibility group, institutional status, Medicare status. Do not exclude high cost users. Adjusts by factor of 1.6 to higher prices paid by employers	Premium and Deductible	$50/person annually; 15 staff; @ 143 cases per staff	$5/mo per household
MO	Average Medicaid expenditures for services covered under the plan from prior fiscal year by age, gender, county, eligibility group. Do not exclude high cost users.	Premium and deductible	NA	Any savings
PA	For managed care counties, blended capitation rates (updated annually) excluding pregnancy. For FFS, average Medicaid expenditures for ESI covered services from prior fiscal year by age (6 groups), eligibility group, and county. Excludes 65+, all spend-down, long term care, other insurance paid. Also excludes 14 high-cost diagnoses from average.	Premium and deductible Also consider policy service limits, % or fixed copays, and dollar limitations in comparing Medicaid average # of services, cost per service, and cost per client.	Calculated yearly based on admin costs at the end of the prior fiscal year. Subtract this amount from yearly savings./ 50 staff (41 caseworkers)/ @244 cases per staffperson	$1 /mo.
RI	Weighted average composite capitation rate by age/gender adjusted by actuarial "withholds" developed to accommodate benefit differences in commercial plans. Converted to 4 rate tiers of Individual, Applicant and Spouse, Applicant and Children, and Applicant, Spouse, and Children.	Premiums, deductibles, copays, benefit limits.	@ $200/enrollee annually; Subtracted from yearly savings/ 7 staff/ @350 cases per staff	Cost effectiveness is achieved when the combined cost of the employee share of the premiums and withholds is less than the cost of enrollment.

Other Maine-specific considerations

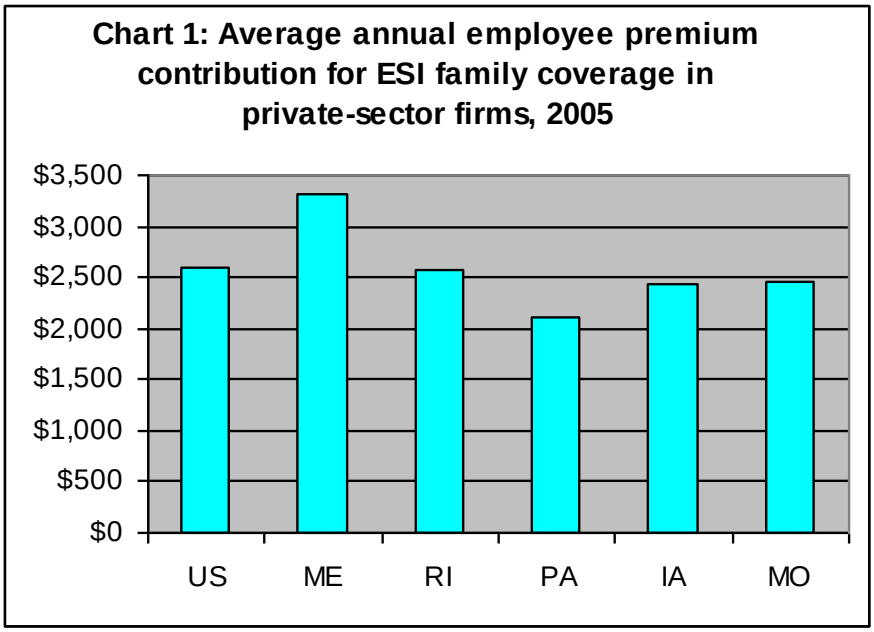
While Maine may be able to learn from the experience of other states and adopt practices of more successful programs that could enhance enrollment, it is important to understand differences in states and state programs that contribute to higher enrollment in Medicaid ESI premium buy-in programs that may not exist in Maine. These factors may include whether the program is targeted to higher income or lower income persons; the rate at which employers offer health insurance coverage to individuals and families in the state; the rate of employees eligible for such coverage and the breadth and depth of coverage offered including the average employer contribution for health insurance coverage.

For example, of the four other states that we spoke with (RI, IA, PA, and MO) income eligibility varied significantly within the state Medicaid programs. Rhode Island, which has the highest percent of its Medicaid population enrolled, also has increased its Medicaid income eligibility levels to 185% FPL. Higher income persons are more likely to have access to ESI.

Based on national survey data of employers, Maine employers are less likely to offer health insurance coverage than the national average. As many as 40% of Maine's workers are estimated to be part-time or seasonal employees that are less likely to be offered coverage[8] and Maine employees are more likely to face waiting periods for coverage than employees in other states.[9] Fewer Maine employees work in firms that offer coverage or are eligible for ESI than nationally, so the likelihood that MaineCare members may not have access to insurance at all is higher. Although PHIP members in Maine's ESI employee premiums average $121 PMPM, national surveys suggest that statewide, Maine has among the highest annual premium employee contributions (@$275 PMPM) for private employer-sponsored insurance in the country – higher than the national average and than all of the selected HIPP states (Chart 1).

[8] Based on analysis of most recent 3 years of Current Population Survey data conducted for the Governor's Office of Health Policy and Finance.

[9] Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2005 Medical Expenditure Survey Panel- Insurance Component, 2005.



Source: Agency for Healthcare Research and Quality, center for Financing, Access and Cost Trends, 2005 Medical Expenditure Panel Survey – Insurance Component.

MaineCare also has a fairly aggressive third party liability program (TPL) that seeks to maximize Medicaid revenues by ensuring it is the payer of last resort. According to the third party liability unit, 90% of non-dual eligible MaineCare members with TPL (@17,000) currently have comprehensive health insurance through their employer. The state saves a significant amount of money on their TPL program, ensuring that Medicaid only pays for services not covered by the primary payer.

TPL is much more cost-effective than PHIP because the state does not contribute anything toward the employer-sponsored insurance premium but only pays for wrap services. In PHIP, the state pays both the employee portion of the premium (if determined cost-effective) and the wrap services. To the degree that the state actively promotes its PHIP program, it could have a detrimental effect on ESI TPL coverage. Significant expansion of PHIP, mandating enrollment, or publicizing that the state will help pay for employer-sponsored insurance premiums for Medicaid enrollees, could have the unintended result that some individuals or employers that currently are paying for ESI for Medicaid enrollees may drop or reduce that coverage in order to get state premium subsidies through PHIP.

Other states did not identify loss of 'self pay' TPL as a problem encountered as a result of mandating. Rhode Island did not specifically track the impact on TPL, but said that a large share of their TPL coverage for children was through non-custodial parents not residing in the household that would not be eligible for premium assistance. They also indicated that to the extent that they were paying the full capitated rate to managed care companies to provide wrap services for RiteCare enrollees with TPL, it would be more cost-effective for them to only pay premium and wrap services under RIte Share. Both

Pennsylvania and Iowa also indicated that the number of ESI 'self pay' TPL cases represented relatively few if any cases. In Pennsylvania, unless there is a special condition (catastrophic illness) they do not enroll them into the HIPP unless the enrollee specifically states that they are discontinuing coverage due to hardship.

Recommendations

Mandating Enrollment: Benefits and Concerns

Based on other states' experience, imposing a mandate was the most effective strategy identified for increasing program enrollment in HIPP programs. Mandating enrollment in Maine's PHIP, coupled with strong enforcement for those that do not provide requested information, could potentially triple PHIP enrollment after three months based on Rhode Island's experience.

However, given the level of ESI TPL already identified among MaineCare members, a mandate may not be the most cost effective strategy for the MaineCare program. Other states interviewed did not appear to have as high rates of ESI self-pay and thus were at less risk of assuming the employee's cost of these premiums as a result of a mandate. At minimum Maine should conduct a cost/benefit analysis of imposing a mandate. Such an analysis should consider whether the potential savings that the state is likely to achieve by enrolling all MaineCare members eligible but not enrolled in cost-effective ESI plans exceeds the additional costs that will be incurred by the state to pay the employee share of premiums for MaineCare members with TPL.

While some states indicated that employers supported their programs once in place, others reported initial employer resistance to a mandate. Rhode Island created a Business Advisory Committee of employers and trade associations during the planning stage of their RI Share program. In response to their concerns, RI elected to buy- in to existing employer plans rather than creating a separate RiteShare insurance product as initially considered. They also designed the mandate so that the onus was on RiteCare members to enroll in ESI if eligible rather than involving employers. Even with these accommodations, employers still opposed the mandate. RI pursued the mandate despite employer opposition, in order to maintain fiscal viability of the Rite Care program, to discourage crowd-out of private coverage, and to maximize public dollars while ensuring continued coverage for low-income beneficiaries. Before imposing a mandate, Maine should consider the trade-offs of achieving some Medicaid savings through maximizing ESI (if identified through a cost/benefit analysis) and creating an adversarial relationship with the business community.

Finally, Maine program officials raised concerns about mandating participation in PHIP for the SCHIP population.[10] As allowable under federal law Title XXI, Maine opted to expand its Medicaid program and maintain a separate SCHIP program; thus, some

[10]Added February 2009: See ATTACHMENT B for summary of the Premium Assistance provisions in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law No. 111-3, signed by President Obama on 2/4/09. These provisions may address some of the concerns discussed in this report.

MaineCare families and/or children are covered under Medicaid expansion and some are covered under Title XXI/SCHIP, referred to in Maine as CubCare. For low-income families covered under SCHIP, federal law states that children cannot be "covered under a group health plan or under health insurance coverage."[11] Given this fact, Maine officials were concerned that a PHIP mandate would be problematic for the CubCare population, which covers approximately 8,200 children in Maine.[12]

The RI Share program mandate applies to both members that are eligible for Medicaid and SCHIP match. According to RI officials, families who are eligible but not enrolled in ESI do not meet the SCHIP exclusion of "covered under a group health plan or under health insurance" because they are not covered by a plan at the time of enrollment. Under the Special Terms and Conditions (STCs) of the RI's Section 1115 waiver, SCHIP-eligible individuals can be enrolled in RIte Share upon redetermination even if they have ESI upon initial application. In addition, Title XXI regulation (Section 457.1010) allows states to purchase family coverage including targeted low-income children if it is cost effective to do so; similar to the Title XIX HIPP benefit.[13] If Maine does elect to mandate PHIP in both MaineCare and CubCare at minimum it would require a Title XXI State Plan amendment.

Should Maine elect to mandate PHIP, there would need to be changes in eligibility processes and data collection as well as increased training of case workers. In the event that Maine chooses this course, other states may be able to provide guidance for how these new responsibilities could be integrated into caseworkers' existing requirements.

Targeting Outreach

With or without a mandate, Maine should target its PHIP outreach and/or enforcement efforts toward those most likely to have coverage (i.e. Medicaid expansion families) and households where more than one person is Medicaid eligible that are more likely to be cost-effective. By focusing on families, some states have not only saved the state Medicaid program money but by helping in the purchase of ESI family coverage have helped get coverage for non-Medicaid family members who otherwise would have been uninsured. In fact, half of Iowa's HIPP enrollees are not Medicaid eligible.

Operational and Systems Updates

Another strategy that requires greater consideration is Rhode Island's strategy of conducting cost-effectiveness tests at the employer rather than individual/family level. This may be more difficult in a non-managed care state, but worthy of further discussion. At minimum, focusing PHIP outreach/enforcement on MaineCare enrollees employed by large employers is likely to yield large economies of scale and reduced administrative burden of gathering information on multiple small employers.

[11] See Title XXI at CFR 457.310(b)(2)(ii).
[12] From Maine DHHS Office of Integrated Access and Support, Monthly Eligibility Report, data run June 2008.
[13] Email from Linda Schumacher, Office of MaineCare Services, July 10, 2008.

Building the systems to support automated referral through the eligibility system and developing a ESI database linked to claims data that can automate the cost-effectiveness determination process is likely to also yield large administrative efficiencies and facilitate faster enrollment of those eligible. While building an entirely new employer data system would take time, several PHIP states volunteered to share their data systems with Maine which could significantly reduce up-front database development time and costs.

Based on the other states experience, automation and linking PHIP referrals and cost-effectiveness tests with Medicaid eligibility and claims systems is crucial to program success. Such a policy change will require commitment by OMS leadership external to the PHIP unit (e.g.. eligibility and IT). However, given current planning around transfer of MaineCare's claims processing to UNYSIS, now may be an opportune time to raise PHIP automation issues in light of the fairly large savings potential.

ATTACHMENT A

RIte Share Cost Effectiveness Calculator

Principals and Concept

Various market surveys have indicated that employers contribute between 35% and 50% of an employee's health plan premium for a family coverage. The State's RIte Share program allows DHS to reduce the State's cost of providing health coverage to certain segments of the RIte Care population who have access to an employer-sponsored health insurance plan (ESI), by keeping them under the ESI and paying the employee share of the premium, known as the cost-effectiveness "number."

The cost-effectiveness "number" refers to the RIte Share subsidy threshold amounts used in enrolling RIte Care eligible members into an ESI. The cost-effectiveness number represents the maximum amount of payment DHS can make towards the employee share of the ESI premium, pay for benefits which must be made available to the eligible member but which are not covered by the ESI plan, and still have a financial result that is positive for DHS and pass the cost effectiveness test set by CMS.

Every 12 to 18 months, a RIte Share savings analysis is refreshed to verify that the cost-effectiveness "numbers" generated by the model discussed above is, in the aggregate, cost-effective per the CMS test. That is, the total expenditures on ESI premium subsidy amounts and RIte Care-type benefits not covered by ESI are less than or equal to what the expenditures would have been under RIte Care (including capitation, risk share, stop-loss, etc.) had the eligible members been enrolled in the RIte Care Program.

Methodology

1. A weighted average composite capitation rate is developed from the various RIte Care age/gender capitation cells. This is then used to set the threshold for the decision as to whether family members are to be enrolled in RIte Care or Rite Share (i.e., in the employer sponsored coverage).

2. Actuarial values are developed to accommodate benefit differences between the various commercial plans (ESI) which are present in the marketplace and the RIte Care benefits (e.g. such as deductibles, point of service co-pays, or benefit limits) . These values are used to calculate "withholds" and adjusted composite capitation rates (net of the withholds) from the composite capitation rate developed in step 1.

3. Since commercial premiums are delivered in various rate tiers, such as Individual, Applicant & Spouse, Applicant & Child(ren), and Applicant, Spouse & Children, the adjusted composite capitation rates calculated in step 2 are converted to the various rate tiers present in a RIte Share applicant's ESI. The resulting numbers are known as cost-effectiveness numbers.

4. A determination is then made by the Employer Contact Unit (ECU) at DHS to enroll a potential applicant in RIte Share. The determination is driven by whether the resulting cost-effectiveness number developed in step 3 for the ESI under consideration is sufficient to cover the employee share of the ESI premium. That is, it is determined that it will be less costly for the State to enroll the potential applicant in RIte Share than to enroll them in RIte Care.

5. The withholds which were developed in step 2 are used to fill the gaps in benefits between the ESI and RIte Care (e.g., where appropriate, to cover the cost of deductibles). Cost effectiveness is achieved when the combined cost of the employee share of the ESI premium and the "withholds" is less than the cost of enrollment in RIte Care. This step also complies with CMS's cost-effectiveness requirements.

Cost-Effectiveness Verification

Periodically, every 12 to 18 months, a RIte Share savings analysis will be performed to verify that the cost-effectiveness "numbers" generated by the model discussed above is, in the aggregate, cost-effective per the CMS test. That is, the total expenditures on ESI premium subsidy amounts and RIte Care-type benefits not covered by ESI are less than or equal to what the expenditures would have been under RIte Care (including capitation, risk share, stop-loss, etc.) had the eligible members been enrolled in the RIte Care Program.

ATTACHMENT B

Premium Assistance in CHIPRA 2009
Source: Center for Children and Families, Georgetown University Health Policy Institute

Over the years, states have sought ways to better coordinate public and private coverage, including the implementation of premium assistance programs (when a state subsidizes employer coverage with public dollars). CHIPRA includes new rules and options for states implementing these programs.

- **New options for CHIP and Medicaid.** The law reduces barriers for states to provide subsidies for the purchase of employer-sponsored coverage (ESI) by allowing states to include the cost of covering parents in assessing the cost-effectiveness of providing premium subsidies to CHIP-eligible children. (The law also creates a new child-only Medicaid premium assistance option that is similar to the existing Medicaid premium assistance program.) States must also include administrative costs in the cost-effectiveness test when comparing the cost of subsidizing ESI versus direct coverage.

  Coverage that can be subsidized must meet some conditions: 1) employers must contribute 40 percent of the cost; 2) the benefit package must meet an actuarial equivalency test to the CHIP coverage or children are eligible for supplemental benefits and cost-sharing protections; and 3) subsidies may not be used to purchase high deductible plans and/or benefits provided under flexible health spending accounts. Participation must be voluntary and children must be permitted to "opt-out" by moving back into direct coverage at the end of any month. Waiting periods are not required, but states that otherwise have waiting periods in their CHIP programs must apply those same waiting periods to their premium assistance programs.

- **Coordination between Public and Private Coverage.** The law amends federal Employee Retirement Income Security Act (ERISA) law to promote coordination between public and private coverage by establishing that both the loss or gain of Medicaid or CHIP coverage counts as a "qualifying event" for the purposes of being able to enroll in employer-sponsored coverage. These provisions are intended to do two things: 1) in the case of a family that loses its Medicaid or CHIP coverage because its employment situation improves and the family is over-income, the family can sign up for their employer-sponsored coverage without having to wait for the open enrollment period and experiencing a gap in coverage; and 2) in the case of a child that becomes eligible for Medicaid or CHIP and has access to ESI which the state wishes to subsidize through a premium assistance option, the family may sign up immediately and not have to wait for the open enrollment period. Employers must also share information about their benefits packages at state request to allow states to assess cost effectiveness and the need for supplemented services.

The law also encourages outreach on premium assistance by lifting the 10 percent cap on non-benefit expenditures under CHIP to 11.25 percent if the money is used for this purpose, authorizes the development of model notices about premium assistance for employers by the federal government, and establishes a working group to develop these notices and identify impediments to the effective coordination of public and private coverage. In addition, the law mandates the GAO to conduct a study on state premium assistance programs by January 2010.

- **New "Buy-in" Option.** CHIP gives states the option to establish a purchasing pool for employers with fewer than 250 employees and at least one employee who is CHIP-eligible or has a CHIP eligible child and/or families wishing to purchase coverage. The purchasing pool must offer at least two CHIP benchmark or benchmark-equivalent products. States can provide CHIP-funded subsidies for premium costs for those eligible for CHIP.