

WHO ENROLLS IN OREGON'S PREMIUM ASSISTANCE PROGRAM AND HOW DO THEY FARE?

Premium assistance programs enable States to use funds from Medicaid and the State Children's Health Insurance Program (SCHIP) to subsidize the purchase of employer-sponsored or other private health insurance coverage for eligible low-income families. States can use these programs to promote access to and enrollment in private health insurance. States' use of premium assistance programs has grown in recent years, in part because of greater Federal flexibility in implementing these programs. Yet, little is known about the characteristics of families who enroll in premium assistance programs, their experiences in using the program, and what happens when they disenroll.

This Issue Brief summarizes findings from a Child Health Insurance Research Initiative (CHIRI™) project that compared Oregon SCHIP enrollees with low-income children who enrolled in the Oregon Family Health Insurance Assistance Program (FHIAP)—the State's premium assistance program. In Oregon, eligible families can choose to participate in either FHIAP or SCHIP because the eligibility requirements for both programs are the same. Researchers found:

- Approximately one-fourth of FHIAP and SCHIP families had access to employer-sponsored insurance. As a result, 70 percent of FHIAP families purchased their coverage in the individual market.
- FHIAP and SCHIP enrollees reported similarly high levels of health care access and satisfaction with the programs after enrollment.
- SCHIP enrollees were more likely to be Hispanic and have parents who were less educated and less likely to be employed or speak English than FHIAP enrollees.
- Families who enrolled their child in FHIAP were more likely than their SCHIP counterparts to have prior experience with private health insurance coverage and paying premiums.
- Increases in family income were cited as the main reason for disenrollment from FHIAP and from SCHIP.
- Two-thirds of SCHIP disenrollees and almost half of FHIAP disenrollees who left public insurance became uninsured.



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“Many families who were enrolled in Oregon’s premium assistance program did not have access to employer-sponsored insurance.”

WHAT WAS LEARNED

Researchers conducted surveys in 2002 of families who enrolled their child in either the Oregon premium assistance program (FHIAP) or SCHIP to study the factors that affect parental choice and compare program effects. Although FHIAP and SCHIP differ in several key areas (see text box), the eligibility requirements for the programs are identical.

Most FHIAP Families Obtained Coverage in the Individual Market

Parents of FHIAP enrollees were somewhat more likely to be employed than parents of SCHIP enrollees. However, 70 percent of FHIAP families did not have access to employer-sponsored health insurance and, thus, purchased their coverage in the individual market. Only 50 percent of children enrolled in either program had health insurance coverage at some point in the year prior to

enrollment. Families of enrollees cited the high costs of health insurance as the main reason for the lack of coverage.

FHIAP and SCHIP Enrollees Reported Similar Primary Care Access and Program Satisfaction

Nearly all children in FHIAP and SCHIP reported that they had a regular source of care. FHIAP enrollees were more likely to obtain their care in a physician’s office whereas SCHIP enrollees were more likely to receive their care from clinics or community health centers. Both groups of enrollees rated their health care very highly and were equally satisfied with their health care benefits.

SCHIP enrollees reported higher levels of unmet need for specialty care services than FHIAP enrollees (11 percent versus 4 percent). Enrollees in FHIAP and in SCHIP reported high levels of unmet need for dental care services with the greatest need being

Oregon SCHIP and FHIAP

SCHIP serves Oregon children through the Oregon Health Plan, the State’s Medicaid program. At the time of the study, the Family Health Insurance Assistance Program was a State-funded program initiated in 1998 that provided premium subsidies to families. Families who choose to enroll in FHIAP can use the subsidy to purchase employer-sponsored insurance or buy individual coverage directly from insurers that are certified by the State to participate in the program. Selected program components of SCHIP and FHIAP at the time of the study are compared below.

Component	SCHIP	FHIAP (premium assistance)
Eligibility*	<170% of Federal poverty level	<170% of Federal poverty level
Family coverage	No	Yes
Benefits	Comprehensive – includes EPSDT services	More limited – few with dental coverage
Cost-sharing	None	5-30% of premium plus co-payments and deductibles
Health care delivery system	Capitated managed care plans	Commercial health insurers

Note: 170% of Federal poverty level = \$30,770 for a family of four in 2002.

EPSDT – Early and Periodic Screening, Diagnosis, and Treatment program.

* Oregon raised the eligibility for SCHIP and FHIAP from 170 percent to 185 percent of the Federal poverty level in 2002 after this study was conducted.



among enrollees in FHIAP. Barriers to obtaining dental care were attributed to high costs and lack of dental coverage in the health plan (FHIAP enrollees), and a lack of participating dentists in the program (SCHIP enrollees).

Over Half of FHIAP Families Thought They Were Ineligible for SCHIP

Applications for both SCHIP and FHIAP advise applicants that they may be eligible for either program. When asked if they had heard of the other program, nearly all of FHIAP parents (96 percent) knew about SCHIP; many of them (47 percent) had been previously enrolled in the program. In contrast, only 14 percent of SCHIP parents had heard of FHIAP. When FHIAP families were asked why they chose FHIAP instead of SCHIP, 52 percent of families were under the mistaken impression that their child was ineligible for SCHIP. Other major reasons for why families chose FHIAP over SCHIP included a preference for private rather than public insurance coverage (16 percent), a desire to cover the entire family (16 percent), and a wish to keep their current health plan or doctor (7 percent).

Prior Insurance Experience, Education Level, and Employment Were Factors in Program Enrollment

Families with more highly educated parents and those in which at least one parent was employed were significantly more likely to enroll in FHIAP than SCHIP. Parents' prior experience with paying premiums and belief that health insurance protects against future health care needs also made it more likely for them to enroll their child in FHIAP. A greater proportion of SCHIP families were Hispanic compared with FHIAP enrollees (29 percent versus 8 percent). Moreover, Hispanic parents who did not speak English were much less likely to enroll their children in FHIAP than non-Hispanic parents who spoke English. The child's health status, including the presence of a special health care need, was not a factor in program enrollment.

A Significant Proportion of Public Insurance Disenrollees Became Uninsured

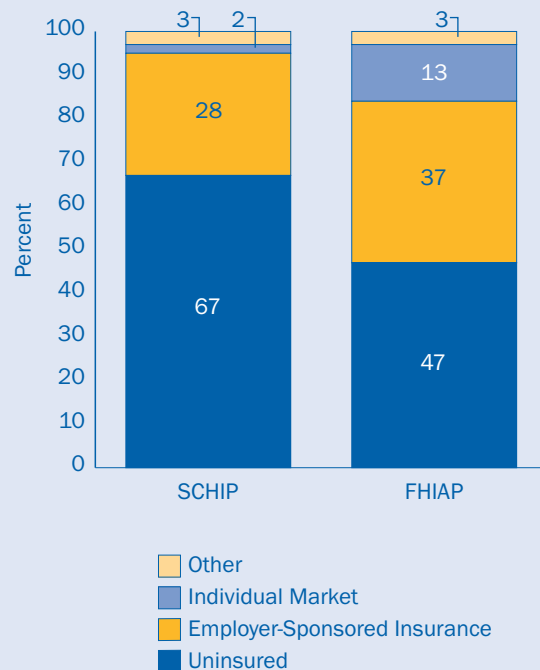
Over half of low-income children who disenrolled from FHIAP and SCHIP no longer qualified for the

program. An increase in income was the primary reason for disenrollment reported by families who reapplied for either program (80 percent and 67 percent of SCHIP and FHIAP disenrollees, respectively).

FHIAP children who disenrolled from public insurance were more likely to have health insurance coverage than those leaving SCHIP. However, almost half of FHIAP disenrollees became uninsured after leaving public insurance (see Figure 1). Among SCHIP disenrollees, more than two-thirds became uninsured.

Over one-third of FHIAP disenrollees and over one-fourth of SCHIP disenrollees obtained employer-sponsored insurance after leaving the programs. A smaller proportion of disenrollees in both programs obtained coverage through the individual market. Two-thirds of public insurance disenrollees who had to pay a premium for their insurance said it was a moderate or big hardship.

Figure 1. Children's Insurance Status After Public Insurance Disenrollment



“Premium assistance and SCHIP did not guarantee a bridge to unsubsidized private health insurance coverage—many low-income families were unable to afford coverage despite increases in family income.”



CONCLUSION

Until recently, few States offered premium assistance programs, in part because low-income families have limited access to employer-sponsored insurance and in part because such programs are complex to administer. Since the Health Insurance Flexibility and Accountability (HIFA) demonstration began, however, implementing premium assistance programs has become somewhat simpler. However, lack of employer-sponsored coverage options for low-income workers remains a key barrier to implementing these programs in many States.

This CHIRI™ study is instructive to States considering premium assistance programs. First, it shows that low-income families will enroll their child in premium assistance programs even without access to employer-sponsored coverage if the State offers the option of purchasing individual coverage. However, providing individual coverage through this route is expensive; as a result, Oregon limits enrollment in individual health plans. As of January 2007, over 7,000 families were on a FHIAP waiting list for an application for individual coverage.

Second, many private health insurance plans do not cover dental services. FHIAP enrollees were more likely to report unmet need for dental care.

Third, premium assistance programs may not reach and appeal similarly to all groups of low-income families. For example, Hispanic families were more likely to enroll in SCHIP. This finding may reflect the provider networks associated with SCHIP versus FHIAP. Safety net providers (e.g., community health centers) typically provide on-site interpreters and other culturally sensitive services, making services more accessible for Hispanic and other non-English speaking families. These providers are often not part of private insurance networks. Additionally, the difference between enrollees in the two programs may reflect variations in outreach and enrollment strategies as well as in processes of communicating with applicants about their program options.

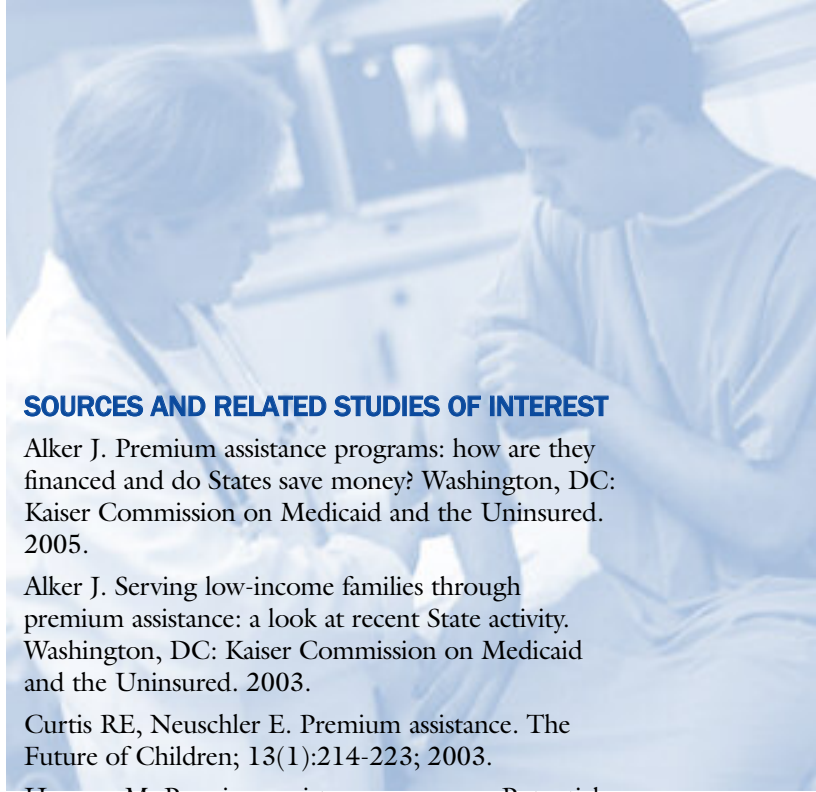
Finally, and perhaps most importantly, FHIAP disenrollees from public insurance were only slightly

POLICY IMPLICATIONS

This CHIRI™ study provides State policymakers with several strategies to consider when designing and implementing premium assistance programs for low-income children and families. These strategies include the following:

- Consider how low-income families who do not have access to employer-sponsored insurance might be covered under a premium assistance program, such as allowing families to purchase individual coverage.
- Consider the affordability of private coverage for low-income families when setting eligibility limits for premium assistance programs. Even when employer-sponsored insurance for children is available, substantial coinsurance (e.g., copayments) is often required.
- Educate families about their options for all relevant public insurance programs in multilingual program outreach and enrollment materials. Materials might include information on the importance of health insurance, how it works, and how to effectively participate in private insurance programs.
- Encourage private health insurance plans participating in premium assistance programs to tailor programs and services to Hispanic and non-English speaking enrollees.

less likely to be uninsured than SCHIP disenrollees. Many policymakers view premium assistance programs as a strategy for encouraging participation in private health insurance markets and promoting transitions to employer-sponsored health insurance. However, this CHIRI™ study found that many low-income families were unable to maintain private insurance coverage when they no longer received premium subsidies, despite increases in income. Over 85 percent of disenrolled families in the study reported that they would have kept their children in SCHIP or FHIAP if possible.



STUDY METHODOLOGY

This CHIRI™ Issue Brief is based on a study of children age 17 and younger who were randomly selected from administrative enrollment files for FHIAP and SCHIP (one child per family). Because of FHIAP's small enrollment size, its sample was comprised of all families enrolled in the program. Telephone interviews were conducted in English and in Spanish in 2002 with the adult in the household most knowledgeable about the child's health insurance, usually the child's mother. Researchers achieved similar response rates for FHIAP (339 children) and SCHIP (1,206 children) (59 and 53 percent, respectively). Primary reasons for non-response were inability to locate the family due to disconnected phone lines, lack of a forwarding address, and other difficulties in contacting families.

Two groups were sampled from each program: 1) currently enrolled children, and 2) children who had been disenrolled for a minimum of 2 and a maximum of 4 months at the time the sample was drawn. The minimum time frame was set to allow time for those families who forget to re-enroll when the eligibility period expires but then quickly reapply when they realize that coverage has lapsed. The maximum time period was identified to ensure that families could more easily recall their child's experience while enrolled in the program.

Multivariate analyses were used to examine the differences between parents who enrolled their children in FHIAP versus those who enrolled their children in SCHIP. Multivariate analyses were also used to determine whether there were systematic differences in several outcome areas (insurance coverage, type of coverage, premium requirement, financial hardship, interest in remaining enrolled in the program, usual source of care, service use, and unmet needs) between children who disenrolled from SCHIP and FHIAP, after controlling for child and parental characteristics.

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For More Information

More information on CHIRI™ projects can be found at www.ahrq.gov/chiri/. Let us know how you use CHIRI™ research findings by contacting chiri@ahrq.gov. Topics of future CHIRI™ Issue Briefs include:

- Could medical providers improve low-income children's access to dental care?
- What is the impact of public insurance program design on provider availability and enrollees' use of care?
- What role does SCHIP play in the patchwork insurance system for children?

ABOUT CHIRI™

The Child Health Insurance Research Initiative (CHIRI™) is an effort to supply policymakers with information to help them improve access to, and the quality of, health care for low-income children. Nine studies of public child health insurance programs and health care delivery systems were funded in the fall of 1999 by the Agency for Healthcare Research and Quality (AHRQ), The David and Lucile Packard Foundation, and the Health Resources and Services Administration (HRSA). These studies seek to uncover which health insurance and delivery features work best for low-income children, particularly minority children and those with special health care needs. The CHIRI™ project "Medicaid SCHIP vs. Premium Subsidy: Oregon's Health Insurance Alternatives for Low-Income Children" (Principal Investigator: Janet B. Mitchell, RTI International) contributed to this Issue Brief.

CHIRI™ FUNDERS

The Agency for Healthcare Research and Quality, part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to essential services. AHRQ sponsors and conducts research that provides evidence-based information on health care outcomes; quality; and cost, use, and access.

The David and Lucile Packard Foundation is a private family foundation that provides grants in a number of program areas, including children, families and communities, population, and conservation and science.

The Health Resources and Services Administration, also part of the U.S. Department of Health and Human Services, directs national health programs that provide access to quality health care to underserved and vulnerable populations. HRSA also promotes appropriate health professions workforce supply, training and education.

Credits: This CHIRI™ Issue Brief was written by Karen VanLandeghem, Cindy Brach, Jennie Bonney, and Lisa Kretz based on articles by Janet B. Mitchell, Susan G. Haber, and Sonja Hoover. See "Premium subsidy programs: who enrolls and how do they fare?" *Health Affairs*, 24(5):1344-1355, September/October 2005; and "What happens to children who lose public health insurance coverage?" *Medical Care Research and Review*, 63(5): 623-635, October 2006.

Suggested Citation: VanLandeghem K, Brach C, Bonney J, Kretz L. Who enrolls in Oregon's premium assistance program and how do they fare? CHIRI™ Issue Brief No. 6. Rockville, MD: Agency for Healthcare Research and Quality. March 2007. AHRQ Pub. No. 07-0022.