
Using Medicaid/SCHIP to Insure Working Families: The Massachusetts Experience

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Massachusetts was the first State to implement a premium subsidy program for employer-sponsored health insurance, using both Medicaid and State Children's Health Insurance Program (SCHIP) funding. The Insurance Partnership (IP) provides subsidies directly to small employers, and the Premium Assistance Program provides subsidies to their low-income employees. Approximately 3,500 small firms currently participate, most of them offering health insurance coverage for the first time. Approximately 10,000 adults and children are covered through the program, the majority of whom had been uninsured prior to enrolling. Massachusetts' successful experience with premium subsidies offers important lessons for other States wishing to implement similar programs.

INTRODUCTION

While the majority of working Americans and their families obtain health insurance coverage through their employers, policymakers have become increasingly aware of the large numbers of workers without insurance. The 2000 Census indicates that there are approximately 24 million individuals in the U.S. who work full-time, yet do not have health insurance for themselves or their families (Hoffman and Schlobohm, 2000). Workers in the bottom of the pay scale are far less likely to receive employer-

sponsored health insurance coverage than those at the top. Just over one-half (56 percent) of these working uninsured individuals earn less than 200 percent of the Federal poverty level (FPL) (Hoffman and Schlobohm, 2000), or less than \$35,304 for a family of four in 2001 dollars.

Researchers have identified a number of reasons why employers may not offer health insurance coverage to their employees, and why, when offered, the employee may not take up the offer (Blumberg and Nichols, 2001; Gabel et al., 2000, 2001; Silow-Carroll, Waldman, and Meyer, 2001; Thorpe and Florence, 2000). The inability to afford the high cost of health insurance premiums is consistently cited as a major factor for both employers and employees. For this reason, there has been a growing interest on the part of Federal and State policymakers in the use of premium subsidies for employer-sponsored health insurance.

In this article, we describe the innovative program Massachusetts has designed to subsidize both small employers and their employees, using Medicaid and SCHIP funding. First, however, we review the various mechanisms States may use to provide premium assistance through either Medicaid or SCHIP. When measured in terms of enrollment, these mechanisms have had limited success, if they are even tried at all. This experience provides a context within which to evaluate the Massachusetts strategy. We limit the discussion to State approaches that rely on Federal (Medicaid or SCHIP) sources of funding. States also may use their own

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funds to subsidize health insurance premiums for low-income individuals. One of the most successful examples of this is Oregon's Family Health Insurance Assistance Program. This program has consistently enrolled the maximum number of people for which it has funding, and maintains a long waiting list.

ALTERNATIVE APPROACHES FOR PREMIUM ASSISTANCE

The Health Insurance Premium Payment (HIPP) program was enacted into law as part of the Omnibus Budget Reconciliation Act of 1990. Under the HIPP program, States could use their Medicaid funds to pay premiums for employer-sponsored health insurance on behalf of Medicaid-eligible individuals and their families. Congress had hoped that HIPP would expand employment-based coverage, save money for the States, and keep families together in the same insurance plan. To date, only six States have implemented HIPP plans, and even the most aggressive of these States have enrolled only small numbers of Medicaid recipients. The U.S. General Accounting Office (1997) identified several barriers to enrollment in HIPP plans. First, State Medicaid programs have difficulty identifying potential enrollees, i.e., Medicaid-eligibles with access to employer-sponsored health insurance. Second, employers may not cooperate with the State's request for information on health insurance coverage. Third, health plans often only have limited time periods during which employees may enroll, making it difficult for them to obtain coverage at the time they become Medicaid-eligible.

Another barrier to use of HIPP was the belief of some State officials that, given the very low Medicaid income eligibility thresholds, most Medicaid recipients

would not have access to employer-sponsored insurance (Tollen, 1999). Under the Personal Responsibility and Work Opportunity Act of 1996, however, Congress unlinked Medicaid and welfare eligibility. States were allowed to raise the income and assets thresholds for Medicaid-only eligibility, thus increasing the likelihood that working families would qualify. While 30 states have extended eligibility thus far in response to this legislation, they generally have not sought to use the HIPP plan option.

In 1997, passage of Title XXI of the Social Security Act establishing SCHIP heralded renewed interest in premium assistance on the part of States. As part of the SCHIP legislation, States could seek Federal approval to use SCHIP dollars (and the enhanced Federal match rate) to subsidize employer-sponsored insurance premiums. Employer-sponsored plans were required to meet various Federal criteria regarding benefit package and cost-sharing limitations, and employers were required to contribute at least 60 percent toward the cost of the premium.¹ In addition, State applicants must demonstrate that subsidizing employer-sponsored insurance is cost-effective, i.e., that the cost of the subsidy is no more than what it otherwise would have cost Medicaid to cover the children in the family.

To date, six States have gained approval to use SCHIP dollars for premium assistance: Maryland, Massachusetts, Mississippi, New Jersey, Virginia, and Wisconsin. Massachusetts is unique from the other five States in adopting a two-pronged approach, offering premium assistance not only to low-income workers but also to small employers. Together, these subsidies

¹ This latter requirement was relaxed and now, States must merely set a minimum contribution level for employers with CMS approval.

are intended to increase the number of employers offering health insurance coverage, as well as the number of employees accepting that coverage. This article presents the first ever assessment of the Massachusetts program. Because Massachusetts was the first of these six States to implement its premium assistance program, its experience may provide important lessons for other States.

METHODS

This descriptive policy report relies on a mix of case study interviews and program enrollment data. Interviews were conducted with a wide range of stakeholders, including Massachusetts Medicaid program staff, eligibility and enrollment workers, State contractors, outreach workers, and advocates. These stakeholders reported on the program's design, goals, implementation, and problems encountered. Information on the characteristics of employers and employees, and their health insurance coverage was obtained from a unique data base developed by the State to track enrollment in its subsidy programs.

OVERVIEW OF PREMIUM ASSISTANCE PROGRAMS

Massachusetts established two separate, but interrelated, programs to administer these subsidies: the Insurance Partnership for small employers and the premium assistance component of the Family Assistance Program for low-income employees and their families. We describe the design and financing of each of these programs, followed by a discussion of their implementation and current enrollment. Both of the programs were designed under the authority of the State's 1115 Medicaid waiver.

Insurance Partnership

In designing the IP, Massachusetts hoped not only to encourage some employers to offer health insurance for the first time, but also to encourage other employers to maintain their current contributions to existing policies. In other words, the employer subsidy was intended to help combat crowd-out by encouraging employees to either retain existing insurance coverage, or to offer health insurance for the first time.

To qualify for IP subsidies, employers must meet the following criteria:

- Employ 50 or fewer full-time workers.
- Offer health insurance that meets the State basic benefit level, i.e., the benefit package required of all small group health insurers in the State.
- Pay at least 50 percent of the total premium.
- Employ workers who are enrolled in the premium assistance program.
- Be willing to adjust the employee's payroll withholding for health insurance coverage to reflect the premium assistance payment made by the State on behalf of that employee.

The employer subsidies are fixed amounts established by the State legislature: \$400 annually for an individual policy, \$800 for a couples or dual policy, and \$1,000 for a family policy. The subsidies are paid directly to the IP participating employer for each qualified employee. (Qualified employees are those enrolled in the premium assistance program.) How well do these subsidies help defray the cost of health insurance? A typical family policy for the largest health care plan in Massachusetts cost \$8,712 in 2001. An employer with the minimum 50-percent contribution would be responsible for paying \$4,356. The IP payment then would reduce the employer's share by \$1,000 or 23 percent.

The State receives Federal Medicaid matching payments for employer subsidies only for those employers offering health insurance coverage for the first time. State-only funds are used to pay subsidies for all other employers. These would include not only employers who simply maintain coverage, but also those who upgrade existing policies.

Premium Assistance Program

Massachusetts had already planned to implement a premium subsidy program as part of its 1115 Medicaid waiver, when the SCHIP legislation was passed. The State decided to use its SCHIP funding to expand eligibility for children up to 200 percent of the FPL through its existing MassHealth programs. (MassHealth is the name that Massachusetts has given to its Medicaid and SCHIP programs in an effort to minimize the stigma that may deter some people from applying for benefits.) These programs included: (1) MassHealth Standard, the standard Medicaid package offered by the State, (2) CommonHealth, for persons with disabilities regardless of income, and (3) the premium assistance program. The SCHIP rules for funding employer-sponsored insurance required that the State rethink its strategy for implementing the premium assistance program in order to be able to use SCHIP dollars.

The State had designed their program to require that at least 50 percent of the premium be paid by employers. However, Federal SCHIP rules had required that employers contribute at least 60 percent toward the cost of premiums.² Because Massachusetts' original 1115 Medicaid waiver request had included a 50-percent employer premium contribution, CMS agreed to lower the employer requirement and still permit matching at the SCHIP rate.

²As noted earlier, CMS has since relaxed the 60 percent employer contribution requirement. States must still require some minimum contribution level, however.

The State had also designed their premium assistance program to require that employer-sponsored health insurance coverage meet the State's basic benefit level, i.e., the small group market standard as defined by the Division of Insurance. However, Federal SCHIP rules mandate that States cover minimum benefits as defined in a specified benchmark benefit plan. Massachusetts' benchmark benefit plan is defined as that of the State's largest health maintenance organization (HMO), a benefit package that State officials describe as considerably richer than most small employers would be willing to purchase.³ CMS would not agree to relax the benchmark requirement for SCHIP funding of premium assistance. Instead, the agency required the State to monitor two separate benefit levels for the premium assistance program, one for Medicaid and one for SCHIP.

To receive premium assistance, the individual must have a gross family income less than or equal to 200 percent of FPL, and be employed by a qualified small employer participating in the IP. The latter requirement means that the health insurance offered meets the basic benefit level and that the employer contributes at least one-half of the premium cost. The program also provides premium assistance to eligible children and their parents who do not work for IP employers. This article focuses on those individuals receiving premium assistance for coverage through an IP participating employer only.⁴

The size of the premium subsidy varies as a function of family income and whether the employee has children. Some individuals

³Some individuals and families receiving premium assistance may have qualified for MassHealth Standard (traditional Medicaid). In these cases, MassHealth provides wrap-around coverage for Medicaid services not included in the employer-sponsored insurance plan, as well as for payment of any deductibles or copayments.

⁴Approximately 2,300 children and their parents receive premium assistance outside the IP. Most of these parents work for large employers that are not eligible to participate in the IP.

must contribute toward the cost of their premiums. (Employers are responsible for doing this through a payroll deduction.) Adults with children who have family incomes between 150 and 200 percent of FPL are responsible for a monthly premium of \$10 per child, up to a maximum of \$30 per family. Adults without children with incomes between 100 and 200 percent of FPL are responsible for \$25 per covered adult. The subsidy is equal to the premium cost less the employer contribution and any amounts paid by individuals. Families with incomes below 150 percent of FPL, and childless adults with incomes below 100 percent of FPL, are not required to pay a portion of their premium.

The State receives a Federal match for the premium subsidies provided to all individuals enrolled in the premium assistance program. The enhanced SCHIP rate is used for those who meet all of the following criteria:

- Coverage is for a family with children (as opposed to a married couple or a single adult).
- The employer's health insurance policy meets the Federal benchmark benefit level and the cost-effectiveness test.
- The child was uninsured at time of enrollment in the program.

Premium assistance for all others is matched at the Medicaid rate. Families need not be uninsured at the time of enrollment in order to receive premium assistance through Medicaid.

IMPLEMENTATION AND CURRENT STATUS

Insurance Partnership

Because the State had no experience in working with employers, the Division of Medical Assistance recognized early on that outside help would be needed to administer the program on their behalf.

The State decided to launch the IP in two phases. Under the first phase, the State contracted with billing and enrollment intermediaries (BEIs) to enroll eligible employers. BEIs are health insurance brokers for small businesses and are registered with the State's Division of Insurance. BEIs perform all administrative activities associated with health insurance for their client firms, including plan enrollment and billing and collection of premiums on behalf of insurance plans. The State perceived these BEIs as natural vehicles to identify small employers, particularly those with fewer than 10 employees.

Under the second phase, the State contracted with a single vendor to administer the program for employers who do not use a BEI to purchase health insurance. Both the BEIs and this vendor perform similar functions for the State. They are responsible for marketing the IP to potentially eligible employers, managing all aspects of the employer enrollment process, and disbursing premium payments. (The latter include both the IP payment to employers and the premium subsidy to employees.)

There are some differences, however, regarding billing and payment responsibilities between BEIs and the single vendor. These differences reflect pre-IP insurance payment arrangements and were intended to not disrupt existing business practices. BEIs receive premium payments from the State, and then pay the health insurance plans directly on behalf of their employer clients, just as they do for their employers' non-subsidized workers. This approach has the additional advantage of avoiding any potential cash flow problems for BEI clients (who tend to be among the smaller firms). The vendor for non-BEI employers receives premium payments from the State and then pays the employers. The employers in turn then pay their premiums to

Table 1
Growth in Number of Massachusetts Employers Participating in the Insurance Partnership, by Size of Firm: Selected Time Periods

Firm Size ¹	Employer Participation			
	June 1999	June 2000	March 2001	October 2001
Total	160	1,311	2,304	3,498
1	108	892	1,502	2,316
2-5	31	266	445	659
6-9	7	35	84	114
10-50	14	118	273	409

¹ Number of employees.

SOURCE: Commonwealth of Massachusetts, Insurance Partnership data base: Data from the Division of Medical Assistance, October 2001.

their insurance plan. In this way, participating employers do not need to alter the way they do business with their insurers.⁵

The IP was launched in February 1999 for those employers using a BEI to purchase health insurance. There is general consensus by all stakeholders that IP implementation got off to a slow start, with employers signing up in fewer numbers than expected. At the outset, there was considerable confusion and misunderstanding about the nature of the IP, with some insurance brokers perceiving it as a new entity that could take business away from them. There was also limited marketing of the program at this time. Five months into the program, only 160 employers had enrolled in the IP (Table 1).

The State rolled out the second phase of the IP in January 2000 with their use of the outside contractor to enroll employers who did not purchase health insurance through a BEI. At the same time, the State launched an extensive media campaign, using television, radio, newspapers, and billboards. The campaign was conducted in both English and Spanish, and was targeted to employees, rather than employers. The State believed that employees constituted a larger potentially eligible audience than the employers themselves.

⁵There is one change that all employers must make, however. They must amend their employees' payroll deductions to take into account the State's premium assistance payment.

As shown in Table 1, the number of employers participating in the IP has increased steadily over time. By June 2000, the number of employers had increased almost tenfold to 1,311. The State's initial media campaign had coincided with unprecedented premium rate increases in spring 2000 for the small group market. As a result, more small employers began seeking assistance with health insurance costs, either through their own BEIs or through the State contractor. Today, approximately 3,500 employers participate in the IP. IP payments to these employers cover almost 10,000 individuals. Of these employers, the vast majority (2,694, or 77 percent) are offering health insurance for the first time.

Since its inception, the IP has been dominated by the self-employed. The self-employed have consistently represented about two-thirds of all employers participating in the IP (Table 1). Since the self-employed individual is both employer and employee, he/she may qualify for both IP and Family Assistance program premium payments. This makes the IP particularly attractive for those low-income self-employed who otherwise could not afford health insurance premiums.

The health insurance policies purchased through the IP are fairly evenly divided between individual policies (49 percent) and family policies (42 percent) (Table 2).

Table 2
Number of Health Insurance Policies
Purchased, by Type of Policy: Massachusetts

Type of Policy	Number of Policies
Total	4,350
Individual	2,157
Family	1,849
Couple	241
Dual	103

SOURCE: Commonwealth of Massachusetts, Insurance Partnership data base: Data from the Division of Medical Assistance, October 2001.

The remainder are either couples or dual (one parent, one child) policies. There are no differences in the type of policy purchased by employer size (data not shown).

Almost one-half of the employers who participate in the IP are in the services industry (Table 3). The industry classifications are based on standard industrial classification codes (U.S. Department of Labor, 2002). These include such businesses as beauty shops, car repair shops, building cleaning services, day care centers, and graphic design and other business support services. Among the larger firms (11-50 employees) are also a number of businesses providing individual and family social services. About one-sixth of IP participants are in construction. Typically, these are general contractors, painters, plumbers, and electricians. Another one-sixth of firms are in retail trade. These are more likely to be employers with 2-9 employees, and tend to be small stores and restaurants. Although only 10 percent of employers overall are in manufacturing, almost one-third of the largest firms are involved in manufacturing, such as plastic products and machine parts.

IP employers are located throughout the State. Compared with other small Massachusetts businesses, they are disproportionately located in the rural western part of the State (15 percent of IP participants, compared with 6 percent of all small firms), and less likely to be in Boston (27 percent of IP firms, compared with 47

percent of all small employers, data not shown). We suspect that there are relatively more eligible workers in the western part of the State, because of lower average wages, especially compared with the Boston area.

Premium Assistance Program

Implementation of the premium assistance program posed special challenges for the State with regards to outreach and eligibility. Community-based outreach workers were less familiar with private health insurance (as opposed to traditional Medicaid), and initially experienced difficulty in explaining the premium subsidy to potentially eligible low-income workers. The actual process of eligibility determination also proved to be considerably more complicated for this population. The traditional MassHealth program uses a gross income test and requires relatively little documentation (e.g., two payroll stubs with other information self-declared). However, many applicants for premium assistance are self-employed, and hence have no payroll stubs. In these cases, MassHealth defines income as net income and requires income tax returns for documentation. State Medicaid staff had no experience in dealing with tax returns, and required training from the regional Internal Revenue Service office.

These challenges, along with the slow startup of the IP, has meant that the number of individuals receiving premium assistance also grew more slowly than originally projected. After the first 5 months of the program, only 451 people were covered by the program. A year later (June 2000), this number had grown almost ninefold to 3,668, and has grown steadily ever since. As of October 2001, a total of 9,760 individuals have health insurance coverage through this program. Despite this rapid

Table 3
Percent Distribution of Massachusetts Employers Participating in the Insurance Partnership, by Standard Industry Classification (SIC)

SIC Division	Employer Firm Size				All Firms
	1	2-5	6-9	11-50	
	Percent Distribution				
Agriculture, Forestry, and Fishing	5.8	4.9	4.7	1.6	5.1
Mining	0.1	0.1	1.3	0.0	0.2
Construction	18.0	9.4	4.7	2.9	14.1
Manufacturing	6.6	6.8	14.8	29.9	9.7
Transportation, Communications, Electric, Gas, and Sanitary Services	3.4	4.0	4.0	4.2	3.6
Wholesale Trade	2.0	2.9	5.4	3.9	2.5
Retail Trade	13.0	30.8	25.5	16.8	17.2
Finance, Insurance, and Real Estate Services	4.2	4.3	5.4	3.4	4.2
	47.0	36.8	34.2	37.3	43.4

NOTE: Percentages sum to 100 percent by column.

SOURCE: Commonwealth of Massachusetts, Insurance Partnership data base: Data from the Division of Medical Assistance, October 2001.

Table 4
Number and Percent of Massachusetts Adults and Children Receiving Premium Assistance, by Prior Insurance Status

Insurance Status	Adults		Children		Total	
	N	Percent	N	Percent	N	Percent
Total	6,163	100.0	3,597	100.0	9,760	100.0
Previously Uninsured	4,311	69.9	2,504	69.6	6,815	69.8
Previously Insured	1,852	30.1	1,093	30.4	2,945	30.2

SOURCE: Commonwealth of Massachusetts, Insurance Partnership data base: Data from the Division of Medical Assistance, October 2001.

Table 5
Percent Distribution of Massachusetts Adults and Children Receiving Premium Assistance, by Eligibility Categories

Eligibility Category	Adults	Children
	Percent Distribution	
Premium Assistance	55.6	40.0
MassHealth Standard	24.0	59.5
SCHIP (Title XXI)	0.0	0.0
CommonHealth	0.2	0.5
Covered by Default	20.2	0.0

NOTES: SCHIP is State Children's Health Insurance Program. Columns sum to 100 percent.

SOURCE: Commonwealth of Massachusetts, Insurance Partnership data base: Data from the Division of Medical Assistance, October 2001.

rate of growth, absolute enrollment in the program has fallen short of the State's initial projections. The reasons for this are unclear, but some observers believe that the 200 percent of FPL income limit is too low, especially in urban Massachusetts with its high cost of living.

Almost two-thirds (63 percent) of those covered through the premium assistance program are adults (Table 4), including

both parents (55 percent of all adults, data not shown) and those without children (45 percent). The majority of those receiving premium assistance (~70 percent) had been uninsured prior to enrolling in the program. Children were as likely to have been uninsured prior to enrollment as adults.

Table 5 compares adults and children, based on their eligibility for the premium assistance program. A surprising number,

24 percent of adults and 60 percent of children, are eligible for traditional Medicaid (MassHealth Standard), but receive premium assistance because they have access to employer-sponsored insurance. All of these adults are parents, as childless adults without disabilities are not eligible for MassHealth Standard (only for premium assistance, and then only if they work for a qualified employer). A small proportion of eligibles qualified through Common Health, the State's Medicaid program for adults and children with disabilities. Despite the large number of children who previously had been uninsured, none of them currently qualify through SCHIP.⁶ State officials blame the SCHIP benchmark benefit level as being too rich a package for small employers. The benchmark benefit service that is most often missing from employers' health plans is skilled nursing care, a service that MassHealth staff believe would be rarely needed by SCHIP children and their families. For this reason, the State has submitted a State plan amendment that (if approved by CMS) would allow MassHealth to redefine its SCHIP benchmark benefit level as the basic benefit level currently being used for its premium assistance program.

Over one-half of adults (55.6 percent) and 40 percent of children are eligible for premium assistance only, i.e., their incomes are too high for traditional Medicaid and/or they do not have children. Of particular interest is the number of adults covered by default (20 percent). These are typically spouses of employees eligible for premium assistance only. They are not considered MassHealth eligible, and do not appear on State eligibility files, but receive coverage through their spouse's policy. There are no children covered by default, as children living in fami-

⁶There are some children who are SCHIP-eligible among those Family Assistance program participants who work for large employers. The number is very small, however ($n=38$).

lies with incomes below 200 percent of FPL are always considered MassHealth eligible in their own right.

CONCLUSIONS AND POLICY IMPLICATIONS

Massachusetts has broken new ground with its twin premium subsidy programs. It was the first State to gain CMS approval to use both SCHIP and Medicaid dollars to help families pay premiums for employer-sponsored health insurance, although actually using SCHIP funds has proven difficult. It is also the only State to use Medicaid dollars to help pay for employers' contributions to health insurance coverage. Enrollment of both employers and employees has increased steadily since the two programs began almost 3 years ago, although the numbers lag behind the State's original projections. Nevertheless, approximately 3,500 small employers participate, providing coverage to almost 10,000 adults and children. The vast majority (70 percent) had been uninsured prior to enrolling in the premium assistance program, suggesting that the program has been instrumental in reducing the State's uninsurance rate. While the State had hoped to fund these programs using both Medicaid and SCHIP dollars, they have effectively been financed by Medicaid alone. None of the otherwise eligible children had access to an employer-sponsored plan that met the SCHIP benchmark benefit level. As noted earlier, Massachusetts has submitted a State plan amendment that, if approved by CMS, would substitute an alternative benchmark benefit level that will be more compatible with those insurance plans offered by small employers.

The Massachusetts experience can help provide lessons for other States that are interested in subsidizing employer-sponsored insurance. The flexibility of the 1115

Medicaid waiver has enabled the State to implement and test innovative approaches. While the State has expressed some disappointment with the lower than expected enrollment figures to date, enrollment exceeds that of similar programs elsewhere. Wisconsin introduced a Medicaid and SCHIP premium subsidy as part of its BadgerCare 1115 Medicaid waiver in 1999.⁷ Based on the most recent available statistics (July 2001), only 32 families had gotten subsidies through this program (Schneider, 2001). Difficulties cited by BadgerCare officials include difficulties obtaining information on access to employer-sponsored insurance, unavailability of family coverage for some employees, and limited cooperation by employers. These are similar problems to those identified by the U.S. General Accounting Office (1997) in evaluating HIPP plans. In fact, BadgerCare uses the HIPP model to operate its premium subsidy program. MassHealth, on the other hand, does not.

BadgerCare also requires employees to have been uninsured for 3 months, and to have had no employer-sponsored insurance for 6 months. By contrast, the premium assistance program has no look-back provision, and 30 percent of participants had previously been insured when they enrolled in the program. Massachusetts officials note that many of these already insured individuals might not have been able to continue to afford premium payments, absent the subsidy, especially after the substantial rate increases of spring 2000.

Unlike BadgerCare and other State Medicaid and SCHIP programs with premium subsidies, MassHealth provides sub-

sidies to employers as well. It is likely that the IP employer subsidy has been instrumental in the success of the premium assistance program. While the size of this subsidy is relatively small, it may still encourage employers to adopt or expand health insurance coverage, as their low-income employees will now be eligible to receive their subsidy and hence afford their share of the coverage. For the self-employed, the combined IP and employee subsidies greatly reduce the total cost burden of their premiums. The employer subsidy may also encourage enrollment in the premium assistance program. Employers participating in the IP have a vested interest in the program, and may want to make sure that all potentially eligible new employees are aware of the premium subsidy. Thus, a relatively small investment in employer subsidies may have a disproportionate impact on reducing the number of uninsured workers and their dependents.

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⁷In addition to Massachusetts and Wisconsin, four other states also have CMS approval to subsidize employer-sponsored insurance. Mississippi's program was never implemented and is on hold indefinitely. The other three programs were implemented in summer 2001, and enrollment statistics are not yet available.

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