State Data Series

SHADAC

USING STATE DATA TO INFORM POLICY

State Health Access Data Assistance Center

# The Oklahoma Employer/employee Partnership For Insurance Coverage (O-EPIC):

Issue 7/September 2005

## Using a Premium Assistance Program to Improve Access to Coverage

## INTRODUCTION

Governor Brad Henry and the Oklahoma State Legislature have collaborated to enact legislation to expand access to affordable health insurance for low-income working families. In January 2005, the State of Oklahoma requested a waiver from the Centers for Medicare and Medicaid Services (CMS) to offer a premium assistance program to a group of adults not currently covered under the state's Medicaid or State Children's Health Insurance Program (SCHIP). The waiver has led to the creation of the Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC).

This paper presents a discussion of the advantages and challenges of premium assistance programs, highlighting experiences of other states and describing Oklahoma's premium assistance plan for low-income workers and their spouses. The paper also provides supplemental analyses of the 2004 Oklahoma Health Care Insurance and Access Survey data that identify the potential impact of O-EPIC.[1]

## STATES' EXPERIENCES WITH PREMIUM ASSISTANCE PROGRAMS

***What is a premium assistance program?***

A premium assistance program provides a public subsidy to uninsured individuals to help pay the premium costs of employer-sponsored insurance (ESI).[2] The strategy of premium assistance plans is to leverage employer contributions to reduce state costs of providing coverage to low-income individuals through Medicaid and SCHIP.

There are a number of issues for states to consider when designing premium assistance programs, such as:

- What groups will be eligible to participate?
- Will employers be required to provide a defined package of health benefits?
- Will there be limits on enrollees' cost-sharing?
- If coverage under the employer plan is more expensive to the state than coverage under the state's Medicaid plan, will enrollees be required to enroll in the Medicaid plan?
- What will employers be required to contribute towards the premium costs?
- Will the premium assistance subsidy be paid to employers or employees?

The design of premium assistance programs is greatly influenced by their source of funding. There are three primary sources of funding available to states, including: Medicaid, SCHIP and waivers for Federal Demonstration Projects (i.e., Medicaid Section 1115 waivers and SCHIP Health Insurance Flexibility and Accountability waivers). The premium assistance program requirements for each of these funding sources are summarized in Table 1 on the next page.

**Table 1. Premium Assistance Program Requirements under Medicaid, the State Children's Health Insurance Program (SCHIP), and Federal Demonstration Projects**

| Requirements | **Medicaid** Section 1906 of the Social Security Act, the Health Insurance Premium Payment Program (HIPP) | **State Children's Health Insurance Program (SCHIP)** Title XXI of the Balanced Budget Act of 1997 | **Federal Demonstration Projects** Section 1115 and Health Insurance Flexibility and Accountability (HIFA) Waivers |
|---|---|---|---|
| ***Health Benefits*** | Must provide the same benefits offered in the state's Medicaid program. If it does not, the state must provide "wrap-around" benefits to enrollees to supplement the employer-sponsored coverage. | Must provide the "benchmark" or "Secretary-approved" benefits specified under SCHIP rules. If it does not, the state must provide "wrap-around" benefits to enrollees to supplement the employer-sponsored coverage. | Must provide primary care benefits including immunizations for children. |
| ***Cost-Effectiveness*** | Cost of providing coverage for eligible and non-eligible family members through premium assistance must not exceed cost of providing Medicaid coverage to these family members. | Cost of providing coverage to the entire family through premium assistance must not exceed cost of providing coverage to the children in the family through SCHIP. | Cost of covering all family members through premium assistance must not exceed the cost of covering all family members in a public program. |
| ***Cost-Sharing*** | Employee cost-sharing must be nominal (i.e., not exceed what is allowed for other Medicaid beneficiaries). Children are excluded from cost-sharing. | Cost-sharing for children cannot exceed 5% of family income. Cost-sharing is not allowed for preventive care. | No specific requirements; however, CMS has generally not allowed higher than nominal costs for adults or higher than 5% family income for children. |
| ***Employer Contribution*** | No minimum employer contribution specified. | Must establish a minimum employer contribution and evaluate whether persons are substituting premium assistance coverage for private coverage. | No minimum employer contribution specified. |

Sources: Curtis, R.E., and Neushcler, E. Premium Assistance. *The Future of Children*, 13(1): 214-23; National Academy of State Health Policy and Academy Health. *Premium Assistance Toolbox for States: Assisting States to Develop Premium Assistance Programs.* Internet: http://www.patoolbox/org/index.cfm; Williams, C. *A Snapshot of State Experience Implementing Premium Assistance Programs.* Portland: The National Academy for State Health Policy. April 2003.

### *What have other states done?*

It is difficult to give an exact count of the number of states that have implemented premium assistance programs because many states are in different stages of the implementation process. Some states have submitted waiver applications to CMS, some states have received approval from CMS and are implementing their programs, others had their premium assistance programs in place for a long time, while others had premium assistance plans and then dropped them. According to a recent estimate, approximately one-third of all states have implemented premium assistance programs.[3] A majority of premium assistance programs are HIPP programs funded through Medicaid. However, with the introduction of HIFA in 2001, the number of premium assistance programs that are federal demonstration projects has been on the rise. Table 2 provides examples of state premium assistance programs highlighting states' funding source, eligibility groups and number enrolled.

**Table 2. Examples of State Premium Assistance Programs**

| State | Funding Source | Eligibility Groups | Number Enrolled* (as of date) |
|---|---|---|---|
| California | Medicaid | ▪ All Medi-Cal (Medicaid) eligibles<br>▪ Parents/legal guardians of SCHIP children with income up to 200% FPL | 1,001 individuals (6/05) |
| Idaho | Federal Demonstration Project | ▪ Children in families with income up to 185% FPL in Medicaid and SCHIP<br>▪ Small business employees with annual incomes below 195% FPL (program implemented July 1, 2005, enrollment capped at 1000 adults) | 101 individuals (5/05)<br>13 adults, 136 employers (6/05) |
| Illinois† | Federal Demonstration Project | ▪ Children between 133% and 185% FPL Parents up to 38% FPL (anticipated incremental phase-in expansion to parents up to 185% FPL by 2007) | 118 individuals (06/05) |
| Iowa | Medicaid | ▪ All Medicaid eligibles and their family members | 5,715 individuals **(5/05) |
| Maine† | Federal Demonstration Project | ▪ Expand MaineCare's income eligibility for parents up to 200% FPL and childless adults up to 125% FPL; Workers in small businesses up to 300% FPL (anticipated) | 205 individuals (5/05) |
| Maryland | SCHIP | ▪ Families between 200% and 300% FPL | 198 families (6/03) |
| Massachusetts | Medicaid and<br>Federal Demonstration Project | ▪ Families 150% to 200% FPL, under 200% FPL working for small employer | 37,343 individuals (5/05) |
| Missouri | Medicaid | ▪ All Medicaid eligibles | 4,762 individuals (07/03) |
| New Jersey† | Medicaid and Federal Demonstration Project | ▪ All Medicaid eligibles and parents with income between 100 and 133% FPL<br>▪ Parents between 134% and 200% FPL | 725 individuals (6/05) |
| New Mexico | Federal Demonstration Project | ▪ Childless adults and parents of Medicaid and SCHIP children up to 200% FPL | NA (not yet implemented) |
| Oregon† | Federal Demonstration Project and State Funds | ▪ Families up to 185% FPL | 12,012 individuals*** (6/05) |
| Pennsylvania | Medicaid | ▪ All Medicaid eligibles | 22,000 individuals (12/03) |
| Rhode Island | Medicaid | ▪ Families up to 185% FPL, children and pregnant women up to 250% FPL | 5,100 individuals (12/03) |
| Texas | Medicaid | ▪ All Medicaid eligibles | 8,197 individuals (03/04) |
| Utah | Federal Demonstration Project | ▪ Uninsured adults up to 150% FPL | 67 individuals (6/05) |
| Virginia | Medicaid and SCHIP | ▪ Children 133% to 200% FPL | 1,200 individuals (03/04)<br>42 families, 93 children (06/05) |
| Wisconsin | Medicaid and<br>Federal Demonstration Project | ▪ Families up to 185% FPL | 2,056 individuals (5/05) |

Sources: State Coverage Matrix, State Coverage Initiatives: An Initiative of The Robert Wood Johnson Foundation; Kaiser Commission on Medicaid and Uninsured, "Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity;" National Academy for State Health Policy, "A Snapshot of State Experience Implementing Premium Assistance Programs;" the National Conference of State Legislatures, "Summary of Employer Premium Assistance Programs – updated July 14, 2003," and the Urban Institute, "Premium Assistance Programs under SCHIP, Not for the Faint of Heart?"; National Academy for State Health Policy "Premium Assistance Toolbox for States: Program Design" Table 2. http://www.patoolbox.org/index.cfm accessed June 16, 2005; AcademyHealth State Coverage Initiatives, "State of the States 2005".

* Confirmed number enrolled through personal communication with following state contacts: *California:* Department of Health Services (Celine Donaldson); *Idaho:* Access to Health Insurance Program (Patti Campbell); *Illinois: Health Insurance Premium Program* (HIPP) Office; *Maine:* Department of Human Services (Rossi Rowe); *Massachusetts:* Premium Assistance Programs (Nancy Kealey); *New Jersey*: Center for State Health Policy, Rutgers University(Dina Belloff); *Oregon:* Family Health insurance Assistance Program (Craig Kuhn); *Utah*: Children's Health Insurance Program (CHIP) Office (Heidi Weaver); *Virginia:* Virigina Department of Medical Assistance Services (Janice Holmes) and Virginia Department of Health (Kathy Wibberly); *Wisconsin*: BadgerCare (Greg DiMiceli)

**Numbers available online at http://www.dhs.state.ia.us/dhs2005/dhs_homepage/reports_pubs/medicaid_b1/medicaid_b1.html; accessed July 2005

***Numbers available online at http://egov.oregon.gov/IPGB/FHIAP/index.shtml; accessed July 2005.

†Approved waivers to refinance and expand already existing premium assistance programs

*Advantages of Premium Assistance Programs*

Premium assistance programs offer many advantages as a strategy to improve access to health insurance coverage among the working uninsured. The following paragraphs highlight some of these benefits.

- **Leverage private dollars to cover more uninsured persons.** Premium assistance programs are appealing to state policy makers because they provide a mechanism to enhance access to health insurance that does not rely solely on public funds. With the current state budget crisis, policy makers are looking for ways to stretch public dollars. Using private sector dollars allows states to serve more uninsured families with available public funds.[4]

- **Support the private insurance market.** Several states value using the private sector to provide health insurance and want to employ policies that support the private market. Some believe that premium assistance programs have the advantage of discouraging "crowd-out" which is the use of public health coverage by persons with access to private coverage. It is difficult to measure the how premium assistance programs affect crowd-out. Estimates of crowd-out are imprecise because it is difficult to ascertain whether changes in private coverage are directly related to public program expansions (i.e., would the change in private coverage have occurred if the public program did not exist).[5] However, there is some recent evidence that crowd-out is more likely to occur in programs that target families with incomes between 100%-200% of the federal poverty level.[6] A state that uses Medicaid funds for its premium assistance program can combat crowd-out by requiring that applicants enroll in employer-sponsored coverage if it is available.

- **Support self-sufficiency.** Another reason states want to pursue premium assistance programs is that they are consistent with the welfare reform goal of self-sufficiency. As welfare leavers enter the workforce, employment-based coverage can help to strengthen modest income parents' attachment to the labor force. Furthermore, employee-base coverage will remain available for enrollees if they become ineligible for public supports due to increased income.[7]

- **Support employment.** Premium assistance programs also support employment. One of the advantages of premium assistance programs to employers is that they reduce worker turnover. Employees are less likely to look elsewhere for a job when they are provided good benefits. [8]

- **Enroll family members in the same health plan.** Another benefit of premium assistance programs is that children and parents can enroll together in the same plan.[9] Research suggests that states with expanded access to coverage to both children and parents have increased enrollment at greater rates than states that do not offer coverage to parents.[10] Furthermore, premium assistance programs do not carry the same stigma associated with public health programs and may reach families who would otherwise not enroll in Medicaid or SCHIP.[11]

- **Provide a stable source of health coverage.** There is also research that suggests employer-sponsored insurance may provide more stable coverage to low-income children. A recent study found that children who are enrolled in an employer-group plan would keep that coverage longer than children who are enrolled in a public insurance program.[12]

*Disadvantages of Premium Assistance Programs*

While premium assistance programs offer many advantages as a means to improve health insurance coverage, they also have some drawbacks and pose a number of implementation challenges.

- **Impact is limited by number of low-wage workers with access to employer-sponsored coverage.** One of the criticisms of premium assistance plans is that a limited number of low-wage workers have access to ESI. One study found that only 41% of workers with income below the poverty level were eligible for ESI.[13] Other reports have found that enrollment in state premium assistance programs is modest in most states.[14] The potential impact of premium assistance programs may be limited if few low-income workers in the state have access to ESI.
- **Administratively burdensome and large upfront expense.** Another downside to implementing premium assistance programs is that they are administratively burdensome and require a substantial upfront investment of resources that may not be returned to the state in cost-savings in the short-term.[15] To implement a premium assistance program, states will likely need to hire and train new staff and create an administrative system to run the program. Program administration activities include: maintaining a database of employer health plan information, building employer and client relationships for outreach, determining applicant eligibility, verifying enrollment in employer health plans, providing subsidy payments, and reimbursing employee cost-sharing obligations. If a program is funded through Medicaid or SCHIP, the cost-effectiveness of employer health plans also needs to be assessed.
- **Employer data is difficult to obtain.** Premium assistance programs require that states obtain information on what health benefits employers offer, as well as which employees are eligible for coverage and what employees are expected to contribute towards the premium. Obtaining this information from employers can be labor-intensive, time-consuming and inefficient. States that have attempted to contact employers directly for this information have reported high levels of employer non-response and poor cooperation, as well as insufficient information.[16] Employers are required by law to supply benefits information at an employee's request and several states have found that requiring enrollees to obtain benefits information during the application process is a less expensive and more effective approach to obtaining this information.
- **Some employer benefits packages do not meet Medicaid and/or SCHIP program requirements.** If a premium assistance program is funded through Medicaid or SCHIP, the state must invest in assessing the comprehensiveness of employer health plans. Few employer plans provide the comprehensive package of benefits that public programs provide.[17] If employer plans do not offer the same benefits as the Medicaid program or meet the SCHIP standard benefits package, the state must provide wrap-around benefits. Oftentimes states will provide wrap-around benefits on a fee-for-service basis by providing enrollees with a separate Medicaid card to use for services not covered by their employer's plan. The problem with this approach is that many employer health plans have a network of providers that may or may not accept Medicaid clients, so enrollees may have to go outside the network they know and trust to obtain services. As an alternative strategy, states can choose to subsidize employers' private policies with equal or greater degrees of benefits; however, this introduces the administrative burden of obtaining and housing more data on employer health plans.
- **Employer policies on enrollment can lead to delays in coverage.** Another challenge of premium assistance plans is that many employers only allow employees to enroll for coverage once a year during an "open enrollment" period. This can be problematic for premium assistance programs and lead to people's premium assistance being put on hold or pending status. The employee must be on public coverage while waiting to enroll. This can be addressed by changing the definition of a "qualifying event" in state insurance law. However, it will still be an issue for firms that self-insure because they are exempt from state regulation due to ERISA.[18]

*Lessons Learned from States' Experiences*
States have employed a number of different strategies to make the implementation of their premium assistance programs a success. The following paragraphs summarize lessons learned from states' experiences.

**Consider outsourcing administrative functions of the premium assistance program to supplement state staffing resources and obtain expertise that is not available within the state system.**[19]

- Massachusetts has a contracted insurance investigator who evaluates employer-sponsored plans and enters insurance information into a database system to determine premium assistance eligibility. Massachusetts also contracts billing and payment functions, customer service, and accounts receivable collection.
- Rhode Island hires a contractor to handle cost-effectiveness tests and family eligibility for premium assistance, employer recruitment and retention, customer services and enrollment, and payment of claims.

**Consider amortizing program start-up costs over a period of years to decrease the burden of initial investments in the program.** [20]

- Based on the recommendations of an actuarial consultant, New Jersey amortized its premium assistance program costs over a five-year period to spread out start-up costs over a reasonable amount of time.

**Take steps to simplify the administration of the cost-effectiveness test.**[21]

- Iowa has reduced the burden of administering the cost-effectiveness test by automatically considering employer coverage cost-effective when the employee premium is very low (i.e., $50 or less for single coverage and $100 or less for family coverage) or when coverage is provided to a pregnant woman.

**Establish relationships with employers. Collaboration is important.**[22]

- States with premium assistance programs agree that establishing positive ongoing relationships with employers is critical to the program's success. Some states have included employers in their advisory groups to obtain their input on program design and many states engage in a number of outreach and education activities with employers to keep them informed and engaged in the program.
- Massachusetts and Texas both send promotional materials to employers about their premium assistance programs.
- Oregon uses insurance marketing professionals to market their program to employers.

**Minimize demands on employers to maximize participation.**[23]

- States should not ask employers to do more than supply basic information about their health benefits and employees' share of premiums. If the task of providing information is too burdensome for employers they will be discouraged from participating.
- In Iowa, all applications are sent to the state's "benefits plan library" to find information on employers' health plan offerings. This avoids having to contact the employer on multiple occasions for plan information. If the employer's information is not available in the database, the employee is asked to request the information from his/her employer.[24]

**Using fee-for-service payment for wrap-around benefits can minimize administrative hassles.** [25]

- Iowa, Wisconsin, Virginia, Rhode Island, and New Jersey all use fee-for-service Medicaid to provide wrap-around benefits to premium assistance enrollees. These plans appear to run smoothly without too much administrative burden.

**Pay premium subsidies directly to families as opposed to employers.**[26]

- In Oregon and Illinois, subsidy payments are sent directly to families. This decreases the administrative burden on the state by minimizing the amount of interaction between the state and employers. It also decreases the amount of administrative burden on employers. If the subsidy went to employers, they would have to update their payroll systems to track premium contributions and workers' health insurance payroll deductions.

## OKLAHOMA'S PREMIUM ASSISTANCE PLAN

***The Oklahoma Employer/employee Partnership for Insurance Coverage (O-EPIC)***

The HIFA waiver establishes a premium assistance program for low-income workers with incomes at or below 185% poverty and working for small firms with 25 or fewer employees. The program will be available to full-time, part-time and self-employed workers. The program will also be available to small employers that currently offer coverage.[27]

O-EPIC will provide a "safety net" option to eligible workers whose employers are not eligible or are unwilling to participate. This safety net option will allow individuals to buy into a public health plan offered by the state.

Employers will be required to pay 25% of the cost of the premium while employees will be responsible for up to 15% of the cost, as long as the 15% does not exceed 3% of the employee's annual household income. The state will cover the remaining costs. The funding for the program will come from a new tobacco tax that took effect January 1, 2005, as well as federal funds through a HIFA waiver.

O-EPIC also includes a special provision to meet the health insurance needs of disabled workers. O-EPIC will offer premium assistance to working disabled persons who are ineligible for Medicaid due to their employment earnings.

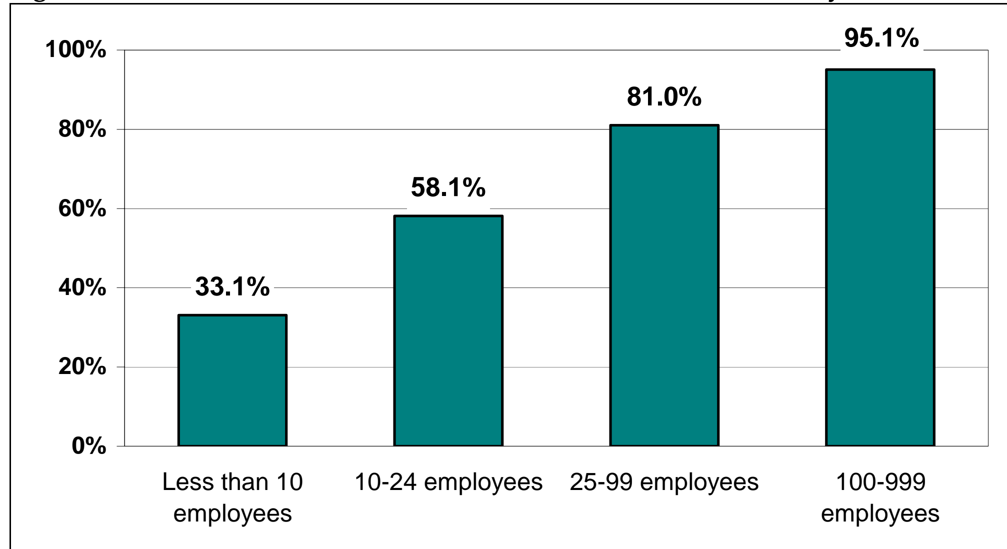
## OKLAHOMA'S WORKING UNINSURED POPULATION

The following charts display information on Oklahoma's working uninsured population, elucidating the potential reach of Oklahoma's premium assistance program.

***What proportion of Oklahoma's firms offer health insurance coverage, by size of firm?***

As shown in Figure 1, smaller firms in Oklahoma have lower health insurance coverage offer rates than large firms. The offer rate among firms with less than 10 employees is 33.1% and for firms with 10-24 employees the offer rate is 58.1%. However the offer rate among firms with 25-99 employees is 81.0% and for firms with over 100 employees the offer rate is 95.1%. This suggests that workers in small firms have the most difficulty accessing employer-sponsored coverage and that there is much room for improvement in offer rates among small firms. Of the approximately 51,000 small firms (fewer than 25 employees) in Oklahoma that meet the eligibility requirements for O-EPIC, less than half (approximately 19,000) currently offers health coverage.[28]

**Figure 1. Percent of Oklahoma Firms that Offer Health Insurance by Firm Size**

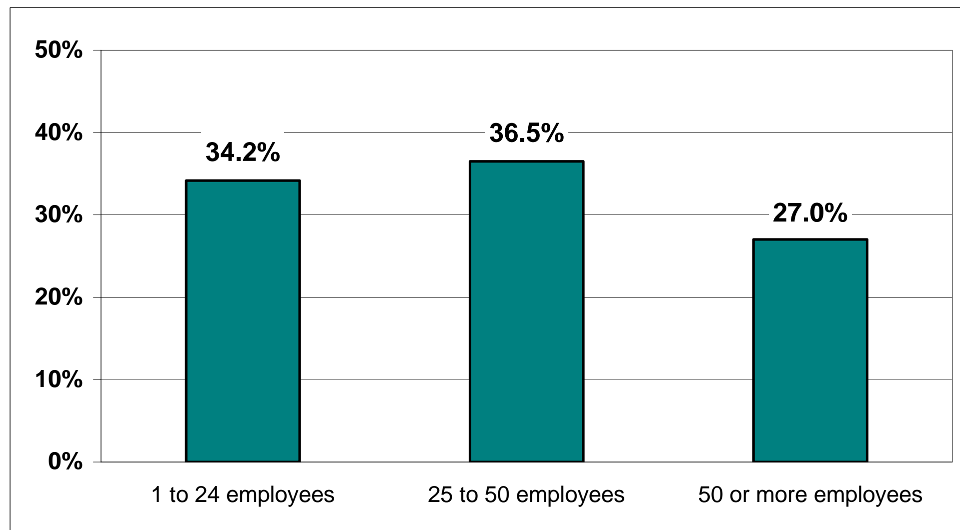



Source: Agency for Healthcare Research and Quality, Center for Financing Access and Cost Trends. 2002 Medical Expenditure Panel Survey-Insurance Component.

***What proportion of workers in small firms are low-income (below 185% FPL)?***

The O-EPIC income eligibility requirement for workers is that their income be less than 185% of the Federal Poverty Level (FPL). Approximately one third (34.2%) of workers in small firms with less than 25 employees and 36.5% of workers in firms with 25 to 50 employees have incomes that fall below 185% of poverty. Using estimates of the number of private-sector employees by firm size from the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey Insurance Component, the number of workers in small firms (less than 25 employees) that meet O-EPIC's income eligibility requirements is approximately 89,000.[29]

**Figure 2. Percent of Workers in Small Firms with Incomes below 185% FPL**

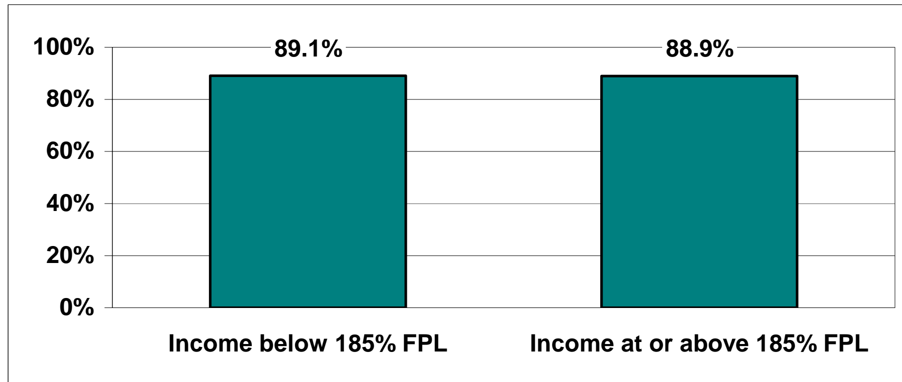



Source: State Health Access Data Assistance Center. *2004 Oklahoma Health Care Insurance and Access Survey, Prepared for the Oklahoma Health Care Authority.* Minneapolis: University of Minnesota. 2005.

***What percent of uninsured low-income workers express an interest in obtaining coverage through a public program?***

Most uninsured workers in Oklahoma express an interest in obtaining coverage through a public program regardless of income. Approximately 90% of both uninsured workers with incomes below 185% of poverty as well as those with incomes above 185% of poverty express an interest in obtaining coverage through a public program. This suggests that a majority of uninsured workers, irrespective of income, would be willing to participate in a state-sponsored health coverage program.

**Figure 3. Percent of Uninsured Low-Income Workers Interested in Public Coverage**

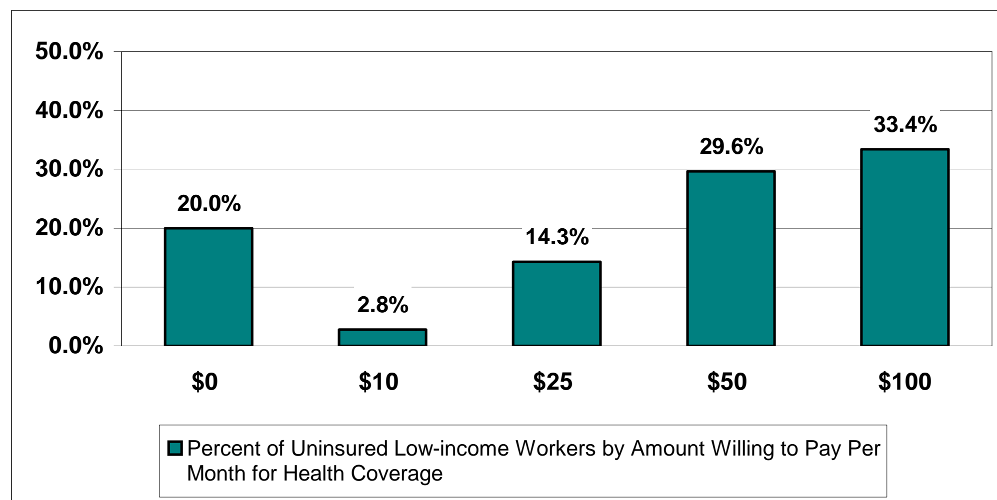



Source: State Health Access Data Assistance Center. *2004 Oklahoma Health Care Insurance and Access Survey, Prepared for the Oklahoma Health Care Authority.* Minneapolis: University of Minnesota. 2005.

***How many uninsured low-income workers indicate they would be willing to pay for coverage?***

The Oklahoma Health Care Insurance and Access Survey asked individuals who had reported being without coverage whether or not they would be willing to pay for health insurance. The figure below displays the results of this question for individuals with incomes at or below 185% of poverty. Approximately 20% indicated unwillingness to pay for insurance coverage; however, 33.0% of low-income uninsured respondents said they would be willing to pay $100 per month for coverage. An additional 29.6% reported willingness to pay $50 per month. There is some debate in the literature as to the accuracy of willingness to pay measures. While some may argue this survey item is not a reliable measure of the exact amount the uninsured would be willing to pay, the results suggest that the uninsured would be willing to pay some amount for coverage. These findings suggest strategies involving subsidies for coverage may be a promising means of helping Oklahomans who are willing to pay for coverage but cannot afford 100% of health insurance costs.

**Figure 4. Uninsured Low-Income Workers Willingness to Pay for Health Insurance**




Source: State Health Access Data Assistance Center. *2004 Oklahoma Health Care Insurance and Access Survey, Prepared for the Oklahoma Health Care Authority.* Minneapolis: University of Minnesota. 2005.

## CONCLUSIONS

Premium assistance programs are increasingly being used by states as a strategy to expand individuals' access to employer-sponsored coverage. The major appeal of this policy strategy is that it has the potential to reduce the costs of providing low-income individuals coverage through Medicaid and SCHIP by leveraging employer contributions.

The analyses presented in this report suggest that Oklahomans who work in small firms are the least likely to be offered employer-sponsored coverage, that low-income workers in small firms represent a large proportion of the working population, and that they are not averse to obtaining coverage through a public program or to paying some amount for their health insurance coverage. All of these findings suggest that the impact of the O-EPIC premium assistance program could be far-reaching and produce significant improvements in the rates of health insurance coverage among Oklahomans.

A major benefit of O-EPIC is that it expresses one of the core values of Oklahoma policy makers by creating a public-private initiative to address the problem of the uninsured. O-EPIC will have a consistent source of funding through the new state tobacco tax and federal funding, as well as private dollars through expansions in coverage through the private market.

Oklahoma has engaged in a number of activities in the past year to develop relationships with employers and encourage their participation in the program, including: a series of focus groups with business leaders across the state to discuss ideas to improve access to coverage, and recruiting representatives from the business community to participate on the Oklahoma Health Care Authority's Health Coverage Advisory Board. Based on the experience of other states, these activities are likely to promote the success of Oklahoma's premium assistance program.

Oklahoma currently plans to pay the premium assistance subsidy directly to employers. Other states have found this approach is too burdensome to employers who must change their payroll systems to accommodate the program. Should this become an issue for Oklahoma, policy makers should consider making subsidy payments directly to families.

Lastly, O-EPIC has provided Oklahoma with an opportunity to serve as a leader in innovation through its special provisions for disabled workers. This groundbreaking program will provide a unique opportunity for Oklahoma as well as other states to learn whether premium assistance programs hold promise as a means to improve access to coverage among this special needs population.

## NOTES

[1] State Health Access Data Assistance Center. The 2004 Oklahoma Health Care Insurance and Access Survey: Select Results. Minneapolis: University of Minnesota. April 2005.

[1]Although most states only subsidize employer-sponsored insurance, Oregon does subsidize individual insurance policies.

[3] Bonney, J. *Making Medicaid Work for the 21st Century, Issue Brief #2, Options for Premium Assistance Programs*. Portland: National Academy for State Health Policy. November 2004.

[4] Neuschler, E. and Curtis, R. *Premium Assistance: What works? What doesn't?* Washington, DC: Institute for Health Policy Solutions. April 2003.

[5] Williams, C., Davidson, G., Blewett, L.A., Call, K.T. *Public Program Crowd-Out of Private Coverage: What Are the Issues? Policy Brief No.5.* Princeton: The Robert Wood Johnson Foundation Synthesis Project. June 2004.

[6] Cunningham, P.J., Reschovsky, J.D., and Hadley, J. *SCHIP, Medicaid Expansions Lead to Shifts in Children's Coverage, Issue Brief No. 59.* Washington, DC: Center for Studying Health System Change.

[7] Neuschler and Curtis, 2003.

[8] Neuschler and Curtis, 2003.

[9] Bonney, 2004.

[10] Ku, L, and Broaddus, M. *The Importance of Family-Based Insurance Expansions: New Research Findings About State Health Reforms.* Washington, DC: Center for Budget and Policy Priorities. September 2000.

[11] National Academy of State Health Policy and Academy Health. *Premium Assistance Toolbox for States: Assisting States to Develop Premium Assistance Programs.* 2004. Internet: http://www.patoolbox/org/index.cfm.

[12] Marquis, M.S., and Kapur, K. (2003). Employment Transitions and Continuity of Health Insurance: Implications for Premium Assistance Programs. *Health Affairs*, 22(5): 198-209.

[13] Garret, B., Nichols, L., and Greenman, E. *Workers without Health Insurance: Who Are They and How Can Policy Reach Them?* Washington, DC: Community Voices. May 1, 2001.

[14] Williams, C. *A Snapshot of State Experience Implementing Premium Assistance Programs*. Portland: National Academy for State Health Policy. April 2003.

[15] National Academy of State Health Policy and Academy Health, 2004.

[16] Williams 2003.

[17] Neuschler and Curtis, 2003.

[18] Ibid.

[19] National Academy for State Health Policy and Academy Health, 2004.

[20] Ibid.

[21] Williams 2003.

[22] Ibid.

[23] Neuschler and Curtis, 2003.

[24] Williams 2003.

[25] Ibid.

[26] National Academy of State Health Policy and Academy Health, 2004.

[27] Oklahoma Health Care Authority. *Proposal to Offer Affordable Health Coverage to Low-Income Families, Submitted to the Centers for Medicaid and Medicare Services (CMS) as an 1115a/HIFA Waiver Amendment*. January 2005.

[28] Agency for Healthcare Research and Quality, Center for Financing Access and Cost Trends. 2002 Medical Expenditure Panel Survey-Insurance Component. Table II.A.1 Number of private-sector establishments by firm size and State: United States, 2002.

[29] We emphasize that this is a rough estimate based on data from two different surveys; the rate and average family size comes from the 2004 Oklahoma Health Care Insurance and Access Survey, while the count of employees comes from the 2002 Medical Expenditure Panel Survey-Insurance Component. Agency for Healthcare Research and Quality, Center for Financing Access and Cost Trends. 2002 Medical Expenditure Panel Survey-Insurance Component. Table II.B.1 Number of private-sector employees by firm size and State: United States, 2002.