State Strategies for Covering Uninsured Adults

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Assessing the New Federalism

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states. It focuses primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. Alan Weil is the project director. In collaboration with Child Trends, the project studies changes in family well-being. The project provides timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

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INTRODUCTION

Recent efforts to expand health insurance have focused primarily on children. Medicaid coverage of children and pregnant women has been expanded several times since the late 1980s. More recently the Children's Health Insurance Program (CHIP) has further increased the opportunities for states to expand coverage for children. However, recent data suggest that there are even greater problems of uninsurance among low-income adults. Low-income adults are more likely than children to be covered by employers but much less likely to be covered by public programs. As a result, they are substantially more likely to be uninsured. Recent data from the National Survey of America's Families show that 17 percent of adults at all income levels lacked health insurance, versus 12 percent for children. Below 200 percent of the federal poverty level (FPL), 37 percent of adults lacked insurance versus 21 percent for children.

States have several options to provide health insurance to adults who are uninsured. These include traditional Medicaid, exclusively state-funded programs, and state Medicaid Section 1115 waiver initiatives, which are often used in conjunction with state-funded programs. In addition, a few states have extended coverage to adults in families through CHIP. Medicaid and state-funded programs to insure adults have been in existence for years, but recent legislation has created new opportunities under Medicaid and CHIP to obtain federal matching funds. The most important of these is Section 1931 of the Social Security Act, which considerably increases states' ability to extend Medicaid coverage to both parents and children in low-income families. States are also using interesting combinations of Section 1115, Section 1931, and CHIP funding authorities to craft new designs to cover adults.

In this paper we describe in greater detail all of the available mechanisms that states have to cover low-income adults. We address what states are permitted to do under current law and what several states are currently doing or beginning to implement. Table 1 provides an overview of the state programs to cover adults (those beyond traditional Medicaid), indicating the type of program, the target group of eligibles, and the income level to which coverage is extended. Table 1 shows there is considerable variety in these programs in terms of which adults are targeted, how far up the income distribution states have extended coverage, and what funding approaches have been used. The table also documents that the majority of states (36) have not taken these kinds of steps to cover uninsured adults.

Because of the limitations to these currently available provisions, some federal legislation would probably be necessary to substantially increase coverage for low-income adults. This could take the form of easing the restrictions that now exist for using CHIP funds for working parents, making new matching funds available for state-subsidized insurance programs for low-income adults similar to those now existing for children, or, alternatively, using tax credits for health insurance.

We begin with background information on insurance coverage of adults. The top panel of table 2 shows that 41.5 percent of adults with incomes below 100 percent of the FPL are uninsured, as are 33.5 percent of those with incomes between 100 and 199 percent of the FPL. Because some recent proposals (Vice President Gore, the Clinton administration) would extend coverage to parents, we provide data on insurance coverage of adults with children and adults without children. Of adults with children, 42 percent are uninsured, compared with 41 percent of adults without children. Compared with adults without children, those with children are more

Table 1
State Programs for Covering Adults

State	Program Title	Program Type	Target Eligibility Group*	Income Eligibility Level
California		Section 1931	Adults with children	100% FPL
Connecticut		Section 1931	Adults with children	185% FPL
DC		Section 1931	Adults with children	200% FPL
Delaware	Diamond State Health Plan	Section 1115	Adults	100% FPL
Hawaii	QUEST	Section 1115	Most uninsured adults	100% FPL
Massachusetts	MassHealth Standard	Section 1115	Parents, disabled adults, and unemployed adults	133% FPL
	MassHealth Family Assistance	Section 1115/CHIP	Custodial families and insured individuals	200% FPL
Minnesota	MinnesotaCare	Section 1115	Adults with children	275% FPL
			Adults without children	175% FPL
Missouri	Managed Care Plus	Section 1115/CHIP	Single custodial parents	300% FPL
			Other parents	100% FPL
New York	Families Health Plus	Section 1115/1931	Adults with children	150% FPL
			Adults without children	100% FPL
Oregon	Oregon Health Plan	Section 1115	Adults	100% FPL
	Oregon Family Health Insurance Assistance Program	State-funded	All Oregon residents	170% FPL
Rhode Island	RIteCare	Section 1115/1931	Adults with children	185% FPL
Tennessee	TennCare	Section 1115	Uninsured adults	No income threshold**
Vermont	Vermont Health Access Plan	Section 1115	Uninsured adults	150% FPL
Washington	Basic Health Plan	State-funded	Adults and children	No income threshold***
Wisconsin	BadgerCare	Section 1115/CHIP	Adults with children (applicants)	185% FPL
			Adults with children (recipients)	200% FPL

* Several of these programs are integrated with Medicaid and thus often cover many other individuals. The table focuses on the principal target group of the broader coverage expansion.

**Above 100% FPL, enrollees must pay premiums, deductibles, and copayments.

***Above 200% FPL, enrollees must pay the full premium.

Table 2
Health Insurance Coverage of Nonelderly Adults by Income and Family Type, 1997

All Adults

	Total (millions)	Employer	Medicaid	Other Private	Other Public	Uninsured
< 100%	20.3	21.6%	26.0%	7.4%	3.6%	41.5%
100-199%	27.4	46.9%	7.1%	7.1%	5.5%	33.5%
200-299%	27.8	71.3%	2.4%	5.4%	4.1%	16.9%
300%+	87.3	86.3%	0.4%	5.1%	1.9%	6.2%
Total	162.8	69.1%	5.1%	5.8%	3.1%	17.0%

Adults with Kids

	Total (millions)	Employer	Medicaid	Other Private	Other Public	Uninsured
< 100%	9.4	17.6%	34.9%	3.0%	2.5%	42.0%
100-199%	13.2	53.6%	7.4%	4.1%	4.0%	31.0%
200-299%	12.6	79.5%	2.0%	3.4%	3.4%	11.8%
300%+	28.6	91.1%	0.4%	3.5%	1.5%	3.5%
Total	63.8	70.2%	7.2%	3.5%	2.5%	16.5%

Adults without Kids

	Total (millions)	Employer	Medicaid	Other Private	Other Public	Uninsured
< 100%	10.9	25.1%	18.3%	11.1%	4.6%	41.0%
100-199%	14.2	40.7%	6.8%	9.9%	6.8%	35.8%
200-299%	15.2	64.4%	2.7%	7.0%	4.7%	21.2%
300%+	58.8	84.0%	0.4%	5.9%	2.2%	7.5%
Total	99.1	68.3%	3.7%	7.2%	3.5%	17.3%

Source: Urban Institute tabulations from the National Survey of America's Families (NSAF), 1997.

likely to be covered by Medicaid and less likely to have employer-sponsored insurance or private nongroup coverage. The likelihood of being uninsured declines as income increases. But because the uninsurance rates for those below 200 percent of the FPL are so high, almost two-thirds of the uninsured are below 200 percent of the FPL.

Table 3 shows the distribution of insurance coverage by various characteristics—age, family work status, race/ethnicity, and state. The percent of adults who lack insurance is highest for those between the ages of 19 and 34 and lowest for those ages 55 to 64. However, almost one-quarter of those low-income adults ages 55 to 64 lack health insurance.

Table 3 shows that uninsurance rates are over 35 percent for low-income adults who are in families with at least one worker. Almost two-thirds of uninsured low-income adults (11.5 million) are in families with at least one full-time worker (by contrast, only 29.9 percent of adults in families with no worker lack health insurance) because many are eligible for Medicaid.

Health insurance coverage varies by race and ethnicity. While only 31.5 percent of white non-Hispanics are uninsured, white non-Hispanics make up about half of the low-income uninsured population (8.7 million out of 17.6 million). The highest rate of uninsurance is among Hispanics, among whom 52.6 percent of adults with incomes below 200 percent of the FPL are uninsured. Low-income black non-Hispanics have an uninsurance rate of 34.1 percent.

Finally, uninsurance rates vary among states. This is largely because of the variations in employer-sponsored coverage. The rate of employer-sponsored coverage for low-income adults ranges from a low of 29.1 percent in California to 51.4 percent in Wisconsin. Medicaid and other public coverage offset low rates of employer-sponsored coverage to some degree. Public

Table 3
Health Insurance Coverage of Low Income* Adults by Age, Family Work Status, Race/Ethnicity, and State, 1997

	Employer			Other Private			Medicaid/State			Other Public			Uninsured		
	Number	Percent	(S.E.)	Number	Percent	(S.E.)	Number	Percent	(S.E.)	Number	Percent	(S.E.)	Number	Percent	(S.E.)
All Low-Income Adults	17,337,046	36.2%	(0.7)	3,497,517	7.3%	(0.4)	7,199,383	15.0%	(0.6)	2,228,937	4.7%	(0.3)	17,603,701	36.8%	(0.7)
Age															
19-34	7,860,000	33.7%	(0.9)	1,554,557	6.7%	(0.5)	3,524,226	15.1%	(0.7)	635,820	2.7%	(0.3)	9,728,231	41.7%	(1.0)
35-54	7,193,286	39.3%	(1.1)	1,139,614	6.2%	(0.6)	2,712,292	14.8%	(0.8)	849,258	4.6%	(0.5)	6,415,241	35.0%	(1.1)
55-64	2,283,759	36.5%	(2.0)	803,346	12.8%	(1.3)	962,865	15.4%	(1.2)	743,860	11.9%	(1.4)	1,460,229	23.3%	(1.7)
Family Work Status															
2 or More Full-Time Workers	3,444,736	50.8%	(2.1)	349,165	5.2%	(0.9)	293,400	4.3%	(0.8)	188,782	2.8%	(0.8)	2,499,868	36.9%	(2.0)
1 Full-Time Worker	10,427,673	45.4%	(1.1)	1,386,346	6.0%	(0.6)	1,421,212	6.2%	(0.4)	738,929	3.2%	(0.3)	9,015,374	39.2%	(1.1)
1 or More Part-Time Workers	1,340,112	23.7%	(1.8)	606,785	10.8%	(1.3)	1,073,186	19.0%	(1.6)	261,401	4.6%	(0.9)	2,361,962	41.9%	(2.2)
No Workers	2,121,548	17.0%	(1.1)	1,154,810	9.3%	(1.0)	4,411,585	35.4%	(1.4)	1,039,825	8.4%	(0.8)	3,718,782	29.9%	(1.2)
Race/Ethnicity															
White Non-Hispanic	11,327,191	40.9%	(0.9)	2,650,156	9.6%	(0.6)	3,609,602	13.0%	(0.7)	1,429,520	5.2%	(0.4)	8,709,910	31.4%	(0.9)
Black Non-Hispanic	2,621,501	32.4%	(1.7)	357,736	4.4%	(0.9)	1,914,576	23.6%	(1.3)	445,085	5.5%	(0.7)	2,761,732	34.1%	(1.4)
Other Non-Hispanic	639,843	28.4%	(3.0)	213,339	9.5%	(1.7)	339,130	15.1%	(2.2)	82,783	3.7%	(1.3)	975,042	43.3%	(2.8)
Hispanic	2,748,511	28.1%	(1.3)	276,286	2.8%	(0.7)	1,336,076	13.6%	(0.8)	271,550	2.8%	(0.6)	5,157,016	52.7%	(1.5)
State															
Alabama	374,365	39.5%	(1.6)	65,206	6.9%	(1.2)	121,957	12.9%	(1.3)	48,277	5.1%	(0.7)	337,769	35.6%	(1.7)
California	2,033,193	29.2%	(1.6)	412,748	5.9%	(1.0)	1,227,503	17.6%	(1.2)	248,414	3.6%	(0.6)	3,043,091	43.7%	(1.6)
Colorado	252,305	39.3%	(1.8)	54,471	8.5%	(0.8)	59,580	9.3%	(0.9)	31,435	4.9%	(0.7)	244,790	38.1%	(1.7)
Florida	1,006,380	34.6%	(2.3)	281,806	9.7%	(1.2)	305,588	10.5%	(1.0)	170,020	5.8%	(0.9)	1,143,508	39.3%	(2.2)
Massachusetts	268,422	36.0%	(2.2)	62,542	8.4%	(1.1)	156,369	21.0%	(1.4)	30,685	4.1%	(0.7)	227,026	30.5%	(1.9)
Michigan	639,509	45.1%	(1.8)	72,000	5.1%	(0.9)	265,868	18.8%	(1.4)	39,085	2.8%	(0.6)	400,676	28.3%	(1.4)
Minnesota	262,254	43.8%	(2.3)	61,483	10.3%	(1.1)	137,646	23.0%	(1.6)	13,769	2.3%	(0.6)	123,993	20.7%	(1.8)
Mississippi	246,406	36.6%	(1.6)	29,861	4.4%	(0.6)	107,730	16.0%	(1.3)	41,100	6.1%	(0.7)	247,788	36.8%	(1.4)
New Jersey	400,241	41.1%	(2.3)	52,112	5.4%	(0.7)	152,836	15.7%	(1.4)	39,104	4.0%	(0.8)	328,872	33.8%	(2.0)
New York	1,044,949	31.7%	(1.7)	210,561	6.4%	(1.1)	772,181	23.4%	(1.6)	114,796	3.5%	(0.5)	1,158,494	35.1%	(1.8)
Texas	1,348,060	31.9%	(1.5)	163,844	3.9%	(0.7)	461,108	10.9%	(0.9)	132,031	3.1%	(0.6)	2,114,692	50.1%	(1.6)
Washington	337,732	35.1%	(1.5)	83,136	8.6%	(0.9)	179,638	18.7%	(1.1)	66,611	6.9%	(0.8)	295,114	30.7%	(1.4)
Wisconsin	357,904	51.4%	(1.7)	46,900	6.7%	(0.7)	74,539	10.7%	(0.7)	25,610	3.7%	(0.5)	191,419	27.5%	(1.4)

*Low-income is defined as below 200% of the FPL.

Source: Urban Institute tabulations from the National Survey of America's Families (NSAF), 1997.

programs cover more than 20 percent of low-income adults in states such as Massachusetts (21.0 percent), Minnesota (22.9 percent), and New York (23.4 percent), but coverage is substantially lower in other states such as Colorado (9.2 percent) and Texas (11.0 percent). The result is that the rate of uninsurance varies from a low of 20.7 percent in Minnesota and 27.4 percent in Wisconsin to highs of 43.8 percent in California and 49.9 percent in Texas.

Data in table 4 suggest that the lack of health insurance has significant consequences. The table divides low-income adults into those with children and those without. The former, in principle, might be reached through public policies that extended coverage to low-income children covered by Medicaid or CHIP. After controlling for several covariates, uninsured low-income adults with children are significantly more likely than those who are insured to be in only fair or poor health (23.8 versus 17.7 percent), to lack a usual source of care or rely on an emergency room (37.8 versus 16.6 percent), to lack confidence in their access to care (23.8 versus 7.2 percent), and to have unmet needs for medical care or surgery (14.6 versus 7.2 percent).

Table 4 also shows that uninsured low-income adults without children are more likely than those who are insured to lack a usual source of care (45.4 versus 20.2 percent), to lack confidence in their ability to gain access to care (28.7 percent versus 12.8 percent), to have unmet needs for medical care or surgery (15.2 versus 8.6 percent) or prescription drugs (9.9 versus 5.5 percent), and to be dissatisfied with the quality of care they are receiving (15.4 versus 10.7 percent).

Table 4
Low-Income Adults' Health Status, Access, Confidence, and Satisfaction, by Insurance Status — US — 1997

	With Children		*Without Children*	
	Insured	**Uninsured**	**Insured**	**Uninsured**
Fair/Poor Health Status	17.7% *	23.8%	24.0% *	30.0%
No Usual Source of Care/ER	16.6% *	37.8%	20.2% *	45.4%
Not Confident in Access to Care	10.6% *	23.8%	12.8% *	28.7%
Unmet Medical Need	7.2% *	14.6%	8.6% *	15.2%
Unmet Prescription Drug Need	5.9% *	8.9%	5.5% *	9.9%
Not Satisfied with Quality of Care	11.3%	13.6%	10.7% *	15.4%
Any Doctor/Health Professional Visit	73.2% *	51.6%	73.6% *	49.6%

* is significantly different from Uninsured at the 0.01 level.
Regression-adjusted estimates control for age, race, marital status, full-time/part-time work status, poverty, health status, and limiting condition.

Source: Urban Institute tabulations from the National Survey of America's Families (NSAF), 1997.

STATE STRATEGIES FOR COVERING UNINSURED ADULTS

1. Traditional Medicaid

Medicaid is the federal-state-financed program that provides health coverage to certain low-income people, many of whom are adults. It has traditionally provided coverage to low-income elderly and disabled persons, to nondisabled parents (mostly women) and children receiving cash assistance, to low-income pregnant women and children, as well as to others who meet categorical eligibility requirements but have higher income, i.e., the medically needy. Medicaid is an entitlement program, so that once eligibility policies have been set, both the federal government and states have an obligation to pay for all eligible beneficiaries. Under Medicaid, states partner fiscally with the federal government through the Federal Medical Assistance Percentage (FMAP), under which states receive at least 50 percent of the costs of Medicaid from the federal government.[1] In order to be eligible for federal financial participation (FFP), states must follow the federally mandated rules and requirements of Medicaid, which include minimum benefit requirements, family composition requirements, and eligibility limitations. Within those requirements, states have a great deal of flexibility.

Medicaid Rules, Requirements, and Structure

Federal law mandates eligibility for four categories of low-income adults: pregnant women, parents, the elderly, and persons with disabilities. These categories are historically linked to receipt of cash assistance through Aid to Families with Dependent Children (AFDC) for parents and Supplemental Security Income (SSI) for the disabled and the elderly. In addition,

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[1] States' FMAP rates range from 50 percent to 77 percent and are based on per capita income in the state.

eligibility is based on four other financial and nonfinancial requirements, which break down into financial and nonfinancial determinants. Financial determinants include limits on income and resources (assets and savings) while nonfinancial determinants include the categorical eligibility provisions described above, as well as residency and immigration status. The federal government mandates certain elements of these requirements but leaves other elements up to the states. For example, individual eligibility must be redetermined annually, but states have the option to conduct eligibility redeterminations more than once a year.

In order to be eligible, individuals must meet the requirements as specified in their state's Medicaid plan. Assuming they fall into one of the eligibility categories and meet residency and immigration status requirements, applicants must also have income and assets that fall below the levels specified by the state for that category. In addition to the traditional eligibility categories, there are many more groups for which states can receive FFP. Many of these are optional or targeted to small populations, but a series of legislative initiatives beginning in the late 1980s created a broad "poverty-related" eligibility category for pregnant women and infants with a significantly higher federally mandated income threshold of 133 percent of the FPL.

When welfare reform replaced AFDC with Temporary Assistance for Needy Families (TANF) in 1996, it also severed the link between cash assistance and Medicaid. The AFDC-related Medicaid eligibility category was replaced with a new family coverage category called Section 1931, which will be discussed in more detail later in the paper. Section 1931 effectively extended Section 1902(r)(2) of the Social Security Act, a 1988 legislative initiative that enabled states to expand Medicaid coverage to children and pregnant women through income and asset disregards to all family members.

Medically Needy Programs

A majority of states have developed medically needy programs, which are designed to provide coverage for slightly higher-income individuals and/or people with large health care expenses. Under medically needy programs, states may elect to cover children and their parents (and other groups such as the aged and disabled) who have incomes or assets that are higher than the AFDC limits—now Section 1931 (up to one-third higher). Many people, particularly those with chronic health problems or long-term care needs, may qualify as medically needy through the "spend down" process, in which their medical expenses are deducted from their income or assets in computing eligibility. Since the maximum medically needy income limit is only slightly higher than the AFDC limit, this program has limited potential to provide additional coverage for low-income adults; in most cases, medically needy programs have income limits below 70 percent of the FPL (see Bruen et al. 1999). While medically needy programs are fairly widespread, it is hard to determine the total number of beneficiaries because of the difficulty in distinguishing medically needy beneficiaries from other non-cash-assistance beneficiaries. However, most Medicaid recipients not receiving coverage through traditional cash-assistance pathways (AFDC/TANF or SSI) and the poverty-related categories are medically needy beneficiaries, and states spend a substantial amount of money providing Medicaid to these individuals.

Transitional Medicaid Assistance

Transitional Medicaid Assistance (TMA) was established to prevent families who become ineligible for welfare due to an increase in earnings from immediately losing Medicaid. If a family loses its Medicaid eligibility due to wages, TMA will provide coverage for 6 months

without regard to income and for 12 months with an income test. Some states have extended TMA coverage beyond 12 months and/or eliminated the income test. Because it is designed explicitly to help those leaving welfare, TMA has limited potential to provide coverage for low-income adults and families in general. First of all, childless adults are not eligible. Second, families had to have been on welfare (or, more precisely, participating in Medicaid under Sec. 1931 AFDC-related eligibility) for three of the six preceding months, so that families must apply very soon after losing their earlier coverage. Families also have to be quite poor (below the AFDC standard) initially, in order to qualify, so that families who have been working steadily in low-wage jobs will often not qualify. Finally, TMA is time-limited and has burdensome reporting requirements for both states and recipients. Earlier studies (Ellwood and Lewis 1999; Kaplan 1997) have shown that transitional Medicaid is relatively underutilized because of limitations like those discussed.

The Health Insurance Premium Payment Program

Section 1906 of the Social Security Act established the Health Insurance Premium Payment (HIPP) program, which allows states to use Medicaid funds to subsidize employer sponsored insurance (ESI) for entire families who have access to insurance through their employer when it is cost-effective to do so. States may use Medicaid funds to pay for all cost-sharing elements of ESI for Medicaid-eligible individuals who have access to ESI when it is cost-effective to do so. In addition, states must pay premiums, but not deductibles or copayments of ESI, for non-Medicaid-eligible family members when it is necessary to do so in order to cost-effectively cover Medicaid-eligible family members. In this case, cost effectiveness means that states may not spend more to subsidize ESI coverage for an individual than they would have

spent to provide coverage to similar individuals under the state Medicaid program.[2] States must provide wraparound benefits and cost-sharing fill-ins to bring ESI coverage up to Medicaid standards, since few ESI plans match Medicaid's rich benefits and minimal cost-sharing. (These expenditures are considered in the cost-effectiveness test.)

HIPP programs often cover individuals with costly medical conditions because these populations are more likely to meet cost-efficacy requirements and are more likely to result in significant cost savings to the state if they are enrolled in an ESI program.[3] In 1997, a GAO study found that only 18 states had implemented a HIPP program, and only three (Iowa, Pennsylvania, and Texas) had implemented programs of any size. The number of enrollees in HIPP in these three states, along with estimated budgetary savings, is shown in table 5. In each case HIPP enrollment was less than 1 percent of program enrollment. HIPP was also used in Wisconsin as a means of using Medicaid funding to pay for family coverage for families whose ESI plan met HIPP specifications but not CHIP specifications (described below). These programs have remained small primarily because most Medicaid-eligibles are not employed and do not have access to ESI.[4]

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[2] Tollen, Laura, *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States*. Washington, D.C.: Institute for Health Policy Solutions.

[3] U.S. General Accounting Office (GAO). 1997b. Medicaid: Three States' Experiences in Buying Employer-Based Health Insurance. Letter Report, GAO/HEHS-97-159. Washington, D.C.: GAO.

[4] Tollen, *op. cit.* In addition, Medicaid eligibles may not report access to ESI because they fear it will prevent them from receiving benefits, and employers may not respond to states' requests for health plan information. Finally, HIPP was designed to be used in a fee-for-service environment and becomes much more administratively complex in a managed care environment under capitation. In addition, cost-efficacy is harder to establish for two reasons. First, the cost of Medicaid managed care is significantly less than the cost of Medicaid under FFS, so the cost of purchasing employer-based insurance may or not be less than the cost of contracting with a managed care plan. Second, while HIPP plans mainly enroll families, they also enroll individuals with expensive medical conditions. Because cost-efficacy is often determined based on beneficiaries' past medical expenses, the added cost of treating these individuals was considered under FFS but is not considered in managed care's system of universal capitation rates for group members. See U.S. General Accounting Office (GAO). 1997b. Medicaid: Three States'

Table 5
State HIPP Program Enrollment and Estimated Savings, 1996

	Number of Enrollees	Percentage of State Medicaid Population	Estimated Budgetary Savings	Estimated Savings as a Percentage of Medicaid Expenditures
Iowa	2,504	0.8%	$2.4 million	0.2%
Pennsylvania	4,700	0.3%	$9.7 million	0.2%
Texas	5,507	0.2%	$4.6 million	0.1%

Source: U.S. General Accounting Office (GAO). 1997b. Medicaid: Three States' Experiences in Buying Employer-Based Health Insurance. Letter Report, GAO/HEHS-97-159. Washington, D.C.: GAO.

2. State-Funded Initiatives

In addition to federally funded programs, states have always had the option to create entirely state-funded programs to cover uninsured adults. State-funded programs give states complete freedom and flexibility to design the programs as they wish. They can cover adults with or without children, there are no minimum benefit requirements, and they can cap enrollment at any point in order to stay within a budget. Many states have General Assistance programs to provide services (including limited health insurance coverage) to adults with very low incomes, including those not traditionally eligible for Medicaid or cash assistance. However, these programs are generally small and help only the very poor. New York was an exception with a large Home Relief program, which has now been incorporated into its Section 1115 demonstration.

In general, exclusively state funded-programs have not had a substantial impact on expanding coverage because states have to fund the entire program. Washington's Basic Health Plan is the only major program funded primarily with state funds, but other states have taken

Experiences in Buying Employer-Based Health Insurance. Letter Report, GAO/HEHS-97-159. Washington, D.C.: GAO.

incremental steps on their own to help uninsured adults. Arizona, Michigan, and New Jersey have small programs that provide temporary coverage or premium assistance. Until it obtained a Medicaid waiver to help cover some of these populations, Massachusetts covered the chronically unemployed up to 133 percent of the FPL; the short-term unemployed to 400 percent of the FPL; the disabled; and outpatient care for children with state funds. Like Massachusetts, Minnesota and Oregon have obtained Medicaid demonstration waivers and are using state funds in conjunction with federal funds in order to bolster their reform efforts and achieve broader coverage expansion. These programs will be discussed in a later section of the paper.

Washington (Basic Health Plan)

In 1993, Washington passed health care reform legislation intended to create universal coverage through expanded Medicaid eligibility for children and pregnant women, a state-subsidized health insurance program (the Basic Health Plan), an employer mandate, and insurance market reforms. The Basic Health Plan (BHP) allows adults and children to buy health insurance through the state. Individuals and families with incomes below 200 percent of the FPL are subsidized; those with incomes above 200 percent can join by paying the full premium (table 6). The employer mandate and universal coverage elements were repealed in 1995, but the state's basic commitment to providing affordable health insurance to low-income individuals and families has not changed, as evidenced by the coverage network created by Medicaid, the BHP, and a multitude of smaller programs designed to fill in the "gaps" left by these programs.[5]

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[5] Nichols, L., et al. *Health Policy for Low-Income People in Washington* (Washington, D.C.: The Urban Institute, November 1997).

Table 6
Washington State's Basic Health Plan

	Children (under 19)	Pregnant Women	Uninsured Adults and Children
Eligibility	200% FPL	185% FPL	No income threshold, but enrollees must be Washington residents, not eligible for Medicare, and not institutionalized; full premiums above 200% FPL.
Enrollment*	80,536 BHP+		130,479 Reduced Premium 7,149 Full Premium
Crowd-Out Provisions	None	None	None
Premiums	None	None	1. Reduced premiums on sliding scale for individuals with income <200%FPL 2. Full age-adjusted premiums for individuals with income >200% FPL
Cost-Sharing	No cost-sharing	No cost-sharing	Copayments for prescription drugs and many outpatient and inpatient services, which are dependent on level (reduced or full) of premium contribution.
Funding	FFP (Medicaid)	FFP (Medicaid)	State

* Numbers as of July 1999, http://www.wa.gov/hca/Basic.htm.

The Basic Health Plan was designed to support participation in ESI by subsidizing the employee's share of the premium, but the vast majority of enrollees are not enrolled in employer-sponsored insurance. The state had hoped that BHP would encourage employers to offer ESI by making it affordable to both employers and employees, but some hypothesize that the availability of highly subsidized insurance to individuals without employee sponsorship has "crowded out" ESI participation in BHP. Washington was relying on employer contributions to reduce the cost of the program; the state exhausted appropriated funds and subsequently capped enrollment.

In addition, Washington is currently experiencing both a revenue shortfall and a crisis in the individual insurance market. Initiative 695, which gave all households in Washington a tax break, also reduced government revenues and left many state programs, including BHP, in financial distress. In addition, the majority of private carriers have withdrawn from the individual market in some regions; as a result, many high-risk individuals attempted to join BHP.

Because of the state's budget problems and the adverse selection in BHP, enrollment of full-premium (unsubsidized) beneficiaries has been capped since January 1st. High-risk individuals' only options are the state's expensive high-risk pool. However, enrollment in BHP is still open for uninsured adults and children with income below 200 percent of the FPL. The state legislature is working to come up with a solution that will encourage private carriers to reenter the individual market. There are no plans to reopen enrollment in full-premium BHP this legislative session.[6]

Washington has not sought federal support for its Basic Health Plan (except for children) and has only recently received federal approval for a CHIP plan that will raise Medicaid eligibility for children to 250 percent of the FPL.[7] The benefit package offered by the Basic Health Plan is not as comprehensive as Medicaid, but it is comparable to most ESI plans. Washington has created a program called BHP+, which offers children the full Medicaid benefit package. In order to create seamless family coverage, Washington enrolls Medicaid-eligible children in BHP+ if their parents are enrolled in BHP. Medicaid pays the premiums of children in BHP+. Washington values its autonomy from federal rules and regulations and has shown a willingness to use state funds in order to maintain that independence.[8]

3. Medicaid Section 1115 Waivers

For states seeking federal financial help, Medicaid expansions are possible through research and demonstration waivers authorized under Section 1115 of the Social Security Act.

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[6] Turner, J. "State Won't Be Cities' Savior If I-695 Passes," *The News Tribune,* October 24, 1999; "An Insurance Crisis Made in Olympia," *The News Tribune*, September 5, 1999.

[7] http://www.hcfa.gov/init/chpfswa.htm.

While these waivers have been available for years, gaining federal approval became easier in late 1993 after the Clinton administration implemented policies that streamlined the process. As a result of this policy change, many states have used Medicaid as a testing ground for health care reform under the authority of Section 1115.

In order to test innovative policy initiatives, states may apply for waivers of many of Medicaid's requirements. Federal rules require that 1115 waivers meet budget neutrality requirements, undergo a formal evaluation, and last no more than five years without being renewed. For a demonstration to be budget neutral, it must not cost more than the Medicaid program would have cost over the course of its duration.[9] Section 1115 waiver authority can be used to expand Medicaid to include nondisabled adults without children and to waive financing rules, allowing states to funnel Medicaid-related funds like disproportionate share hospital (DSH) payments and managed care savings into Medicaid expansions.

Section 1115 waiver authority has been used most often by states to institute a mandatory Medicaid managed care program by waiving specific benefit requirements and freedom of choice rules of Medicaid. This has enabled states to move beneficiaries from fee-for-service to managed care, creating cost-savings that have made it possible for some states to expand coverage and still meet the budget neutrality requirements of the waiver. However, approval of an 1115 waiver is not guaranteed, especially for a waiver that creates comprehensive reform, and can take months (or years). While the Health Care Financing Administration (HCFA) evaluates each waiver individually, experience shows that it will waive Medicaid's rules on cost-sharing and benefits

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[8] Nichols, L., et al. *Health Policy for Low-Income People in Washington* (Washington, D.C.: The Urban Institute, November 1997).
[9] HCFA Fact Sheet, *Medicaid Waivers*, at http://www.hcfa.gov/medicaid/obs7.htm.

and allow a state to cap enrollment if the new program expands coverage and applies the policies for which it needed a waiver to higher-income families.[10]

Because of changes made by the Balanced Budget Act of 1997 (BBA) that allowed states to impose mandatory Medicaid managed care programs without a waiver, 1115 waiver applications have declined in recent years. At this point many of the savings that enabled states to expand coverage have already been achieved through a shift of beneficiaries to managed care. Also, states' health policy efforts have concentrated on planning and designing CHIP programs.

Expansions to Adults under Section 1115 Waiver Authority

Delaware, Hawaii, Minnesota, Oregon, and Tennessee have all used Section 1115 waivers to expand coverage; the last three of these have combined the Medicaid expansions with existing state-funded programs. In addition to these four states, there are four others (Massachusetts, Rhode Island, Vermont, and Wisconsin) that have expanded Medicaid coverage to adults with an 1115 waiver. However, these states' 1115 programs are more complex and involve at least one additional expansion, so they will be discussed separately.

Delaware. The Diamond State Health Plan is a Section 1115 waiver that was approved by HCFA in 1995 and expanded coverage to children and adults through savings achieved by a mandatory Medicaid managed care program.[11] All adults (with or without children) and children with incomes up to 100 percent of the FPL are eligible for Medicaid coverage without any cost-sharing through the waiver. An existing 1115 waiver, which insured children up to 100 percent of

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[10] Guyer, J., and C. Mann, *A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families* (Washington, D.C.: Center on Budget and Policy Priorities, July 1999).
[11] Individuals receiving long-term care or eligible for Medicare as well as Medicaid are excluded from the program.

the FPL, and the state general assistance program were folded into the Diamond State Health Plan. In addition, Delaware expanded Medicaid to 133 percent of the FPL for children through age 6 and has a CHIP program that insures children under age 19 in families with incomes up to 200 percent of the FPL by enrolling them in the Diamond State Health Plan. However, CHIP enrollees with family incomes above 100 percent of the FPL do pay a sliding-scale monthly premium, unlike Medicaid Diamond State Health Plan enrollees.[12]

Hawaii. The Hawaii QUEST (Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided to public clients) program is a unique Section 1115 waiver demonstration. As summarized in table 7, it builds on Hawaii's employer mandate to create near-universal coverage and creates a public health care purchasing pool for the beneficiaries of three public programs (Medicaid, General Assistance (GA), and the State Health Insurance Program (SHIP)). This pool is used to purchase health care from capitated managed care plans, which serve private patients as well. There is also a program that offers health insurance coverage through QUEST at full-premium cost to individuals who fall between eligibility levels and 300 percent of the FPL.

[12] Delaware Healthy Children Program Fact Sheet at http://www.hcfa.gov/init/chpfsde.htm.

Table 7
Hawaii's QUEST Program

	Children	Pregnant Women	One-Parent Families	GA* Eligibles	SHIP** Population
Eligibility (% of FPL)	Infants: 185% 1-6 yrs: 133% >6 yrs: 100%	185%	100%	100%	100%
Crowd-Out Provisions	Beneficiaries must not be enrolled in or have access to a health insurance plan provided by their employer.				
Cost-Sharing	50% of premium for self-employed individuals, with copayments for some outpatient services, prescriptions, and medical equipment				
Funding	FFP (Medicaid)				

Notes:
* Single adults and childless couples.
** Unemployed individuals, part-time workers, spouses and children of low-income workers, and self-employed and seasonal workers.

Originally extending coverage to 300 percent of the FPL, QUEST eligibility was restricted to 100 percent of the FPL on January 1, 1998, in order to reduce expenditures. Pregnant women and young children are eligible at higher income levels. In addition, in 1996, the asset test was reinstated and enrollment for all but those eligible for Medicaid under the pre-waiver rules was capped at 125,000 enrollees. Along with these rules, the legislation created a program called QUEST-Net, which acts as a safety net for individuals and families who become ineligible for QUEST or Medicaid because of changes to asset or income tests. Only those who were eligible for QUEST before the eligibility changes may be eligible for QUEST-Net. It has subsidized premiums for children and adults and offers the full QUEST package to children but a limited benefit package for adults. In addition, Hawaii has a small CHIP program that covers children between the ages of 1 and 6 from 133 percent to 185 percent of the FPL through a Medicaid expansion; for these children, the state receives the higher CHIP matching rate.

Minnesota. As part of its 1992 comprehensive state health care reform initiatives, Minnesota created a publicly sponsored health insurance program that targets the low-income

population. The program—called MinnesotaCare—provides a basic benefit package, i.e., primary care and limited hospitalization coverage, to uninsured families and single adults and to childless couples who meet income eligibility guidelines. Adults with children can qualify if their family income is less than 275 percent of the FPL; for childless couples and single adults, the income threshold is 175 percent of the FPL (see table 8). The program is funded with state taxes (including provider taxes), enrollee premiums, and copayments. Monthly premiums are based on family size and income. In addition to meeting income standards, eligible beneficiaries cannot have access to employer-sponsored health insurance. MinnesotaCare recipients are enrolled in managed care plans.

Some populations are now eligible for both Medicaid and MinnesotaCare and have the option to join either (the state will get FFP regardless of which program the beneficiary chooses). These groups are pregnant women and infants up to age 2 with incomes up to 175 percent of the FPL, children ages 2 to 5 with incomes up to 133 percent of the FPL, children ages 6 to 13 with incomes up to 100 percent of the FPL, and children ages 14 to 20 with incomes up to AFDC/TANF levels. Children who fall above these income thresholds but below 275 percent of the FPL must enroll in MinnesotaCare (unless they enter Medicaid as a medically needy person by spending down).

Table 8
Minnesota's Minnesota Care

Minnesota Care	Adults with Children	Adults without Children and Childless Couples
Eligibility	275% FPL	175% FPL
Other Requirements	State residency	State residency[1]
Enrollment[2]	38,440	12,363
Crowd-Out Provisions[3]	Yes	Yes
Cost-Sharing[4]	Copayments and premiums of 1.5%-8.8% of gross income	Copayments and premiums of 1.5%-8.8% of gross income
Funding Source[5]	State	State

Notes:
1. Adults without children must have lived in Minnesota for at least six months.
2. MinnesotaCare Enrollment Reference Sheet at http://www.dhs.state.mn.us.hlthcare.
3. Sexton, Jennifer, *MinnesotaCare and "Crowding-Out"* (Washington, D.C.: Institute for Health Policy Solutions, September 1998). Crowd-out provisions include the following requirements for eligibility:
    (a) Recipients must not have access to ESI in which the employer pays more than 50%. In addition, recipients are ineligible if their employer has dropped coverage in the past 18 months.
    (b) Recipients must have been uninsured for at least the past four months.
4. *Ibid.*
5. ANF State Report on Minnesota.

Minnesota has been attempting to gain an 1115 waiver of Title XXI (CHIP) so that it can receive the enhanced FFP matching rate to cover the children it currently covers under MinnesotaCare. However, it has been stymied by the law's requirement that states use CHIP funds to expand coverage beyond its current eligibility levels instead of subsidizing existing programs. In addition, HCFA has prohibited 1115 waiver proposals for Title XXI from states that have not received approval for a general CHIP plan. In order to gain time to develop a new proposal, Minnesota created a small CHIP program that expanded Medicaid to 280 percent of the FPL for infants under the age of 2. This expansion covered fewer than 15 children, but it will prevent other states from receiving Minnesota's CHIP allotment.[13]

[13] Minnesota's Federal Medical Assistance Waivers at http://www.dhs.state.mn.us/hlthcare/Waivers/federal.htm.

Oregon. Starting in 1994, Oregon implemented comprehensive reform through the Oregon Health Plan (OHP), an 1115 waiver that expanded Medicaid to cover individuals up to 100 percent of the FPL through mandatory managed care and a health services prioritization list that limited benefits ("rationing"). The state also proposed a play-or-pay employer mandate, which violated ERISA, but the state legislature assumed that Congress would grant a waiver. However, authority was never granted, and the mandate was repealed in 1996. In addition, legislation was passed in 1995 that restricted the expansion by imposing an asset test, requiring three months of income information, and imposing premiums on all newly eligible beneficiaries who had been brought in through the expansion.[14] Oregon also created a CHIP program in 1998 that expanded Medicaid to cover children from birth to age 6 with incomes between 133 and 170 percent of the FPL and to children from age 6 to age 19 with incomes between 100 and 170 percent of the FPL. Adults are eligible for OHP up to 100 percent of the FPL, but some are now required to pay premiums (see table 9).[15]

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[14] Sparer, M., *Health Policy for Low-Income People in Oregon* (Washington, DC: The Urban Institute, September 1999).
[15] Oregon CHIP Fact Sheet at http://www.hcfa.gov/init/chpfsor.htm.

Table 9
The Oregon Health Plan (OHP)

	Adults	**Children under 6**	**Children between 6 and 18**
Eligibility	100% FPL	170% FPL	170% FPL
Other Requirements	$5,000 liquid asset test (excluding house or car)	$5,000 liquid asset test (not house or car)	$5,000 liquid asset test (not house or car)
Enrollment*	227,415	8,799	234,806
Crowd-Out Provisions	None	None	None
Premiums	$6-$28 monthly premiums for nonpregnant adults who are eligible because of the expansions; none for pregnant and previously eligible adults	None	None
Funding	FFP (Medicaid)	<133% FPL—FFP (Medicaid) 133-170% FPL—FFP (CHIP)	<100% FPL—FFP (Medicaid) 100-170% FPL—FFP (CHIP)

Note:
* Includes transitional Medicaid.

In addition to OHP and CHIP, Oregon offers a Family Health Insurance Assistance Program (FHIAP) financed with state funds. Enacted in August 1997 to help low-income individuals purchase private insurance, it originally offered subsidies for families with incomes up to 200 percent of the FPL, but state regulators capped it at 170 percent of the FPL because the program has been more costly than expected (see table 10). The $23.7 million allocated was supposed to cover 15,000-17,000 Oregonians from 1997 to 1999, but recent predictions have estimated the cost of subsidizing insurance for 15,000 from 1999 to 2001 at $50 to $60 million. As a result, the state has created a waiting list for new applications and will cap enrollment at 7,000 persons. However, Oregon hopes to be able to use CHIP funds to pay for families who enroll in FHIAP, but the program does not meet the minimum-benefit, crowd-out, or cost-sharing

standards mandated by Title XXI.[16] The state is currently in the process of developing a strategy to comply with these standards in order to receive federal funding for FHIAP.[17]

Table 10
Oregon's Family Health Insurance Assistance Program (FHIAP)

	All Oregon residents who are qualified U.S. residents
Eligibility	170% FPL
Other Requirements	• There is a $10,000 asset test. • Beneficiaries cannot be eligible for or receiving Medicare. • FHIAP will not subsidize insurance for adults who do not have their children enrolled in Medicaid or FHIAP.
Enrollment (as of 11/98)	• 1,153 enrolled (state officials expect 7,000 by late 1999) • 4,191 shopping for coverage* • 2,124 applications under review
Benefits	Benefit package varies by carrier. These is no minimum package, as the state relies on the generous subsidy as an incentive for people to choose plans with adequate coverage.
Crowd-Out Provisions	Cannot have had insurance (other than Medicaid) during the previous six months
Premiums	• 5% of employee share of the premium cost for individuals with income <125% FPL. • 10% of employee share of the premium cost for individuals with income 125-150% FPL. • 30% of employee share of the premium cost for individuals with income 150-170% FPL.
Funding	State-funded (allocation of $23.7 million of tobacco tax revenue for 1997-1999)

Note:
*These individuals have received certificates of eligibility and are actively seeking coverage.

Beneficiaries with access to ESI in which the employer makes any contribution to the cost of insurance must purchase the plan offered by their employer, unless they missed the open enrollment period. These beneficiaries and all others without access to ESI may choose and purchase individual coverage from any certified carrier. Medicaid- and CHIP-eligible individuals may enroll in FHIAP whether or not they have access to ESI.[18]

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[16] Sparer, M., *Health Policy for Low-Income People in Oregon* (Washington, D.C.: The Urban Institute, September 1999).
[17] Sexton, J., *An Overview of the Oregon Family Health Insurance Assistance Program* (Washington, D.C.: The Institute for Health Policy Solutions, December 1998).
[18]Sexton, J., *An Overview of the Oregon Family Health Insurance Assistance Program* (Washington, D.C.: The Institute for Health Policy Solutions, December 1998).

Tennessee. In response to projected annual financial losses of half a billion dollars and potential losses of federal DSH funding, Tennessee developed a Section 1115 waiver to move all Medicaid recipients into managed care and create near-universal coverage by expanding to include the uninsured and medically uninsurable. Starting in January 1994, all individuals without access to insurance, including those not usually categorically eligible for Medicaid, were permitted to enroll in the TennCare plan by paying an income-related premium. By pooling all state, federal, and local funds dedicated to providing care to low-income populations and requiring cost-sharing by those individuals with incomes above the federal poverty level, Tennessee devised a means of covering over 400,000 previously uninsured individuals. Because expenses were higher than anticipated, enrollment was frozen in 1995 at 1.3 million beneficiaries and left open only to Medicaid eligibles and the medically uninsurable. Making use of the enhanced federal match under CHIP, the TennCare program reopened in 1997 to dislocated workers and children, and over 30,000 more beneficiaries have entered the program. However, there are no plans to reopen enrollment to the general uninsured, and the state temporarily froze entry of the medically uninsurable this year because of high costs and a fear that insurance companies were rejecting the chronically ill because they knew that TennCare would cover them.

Table 11
Tennessee's TennCare Program

	Medicaid Eligibles	Medically "Uninsurable"	Uninsured
Eligibility	• 54% FPL for AFDC eligibles • 185% FPL for pregnant women and infants • 23% FPL for medically needy	Must prove uninsurability by enclosing a letter of denial from a licensed insurance company in Tennessee	All individuals not eligible for Medicaid and without access to ESI (directly or as a dependent), or a government program such as Medicare as of July 1, 1994 (10 months before enrollment began).
Enrollment	883,000 Open enrollment	108,000 Temporarily frozen in 1999	309,000 Frozen in 1995 , reopened in 1997 for children[1] and dislocated workers[2] only
Crowd-Out Provisions	None	None	Initial 10 month look-back period
Premiums	None	1. None for beneficiaries with income <100% FPL 2. Graduated up to 100% of premium costs for beneficiaries with income of 400% FPL 3. Additional premiums for medically uninsurable beneficiaries only: • 13.5% above premium cost for uninsurable beneficiaries with income between 400% and 750% FPL; and • 21.7% above premium cost for uninsurable beneficiaries with income >750% FPL	
Cost-Sharing: Deductibles and Copayments	None, except a $25 copayment for non-emergency use of emergency services	1. None for beneficiaries with income <100% FPL 2. $250 deductible for individuals, $500 for families 3. Cost-sharing capped at 10% of income and is on a graduated scale for beneficiaries, with income between 100% and 200% FPL (2% for 101-119% FPL, 4% for 120-139% FPL, etc.) 4. Full co-payments and deductibles for beneficiaries above 200% FPL, but total cost-sharing (excluding premiums) is capped at $1,000 for individuals, $2,000 for families 5. No cost-sharing for preventive services 6. No deductibles for children, and copayments limited to 2% of income 7. $25 copayment for non-emergency use of emergency services	
Funding	FFP[3] (Medicaid) as well as public and private funds	FFP[3] (Medicaid) as well as public and private funds	FFP[3] (Medicaid) for adults, FFP (CHIP) for children as well as public and private funds allocated to low-income patients

Notes:
1. Made possible by CHIP funds, which were made available for these children through a technical revision by Congress because TN had frozen enrollment due to financial strain.
2. Workers must have lost access to insurance due to a bona fide business or plant closing.
3. In order to meet budget neutrality requirements of the Section 1115 waiver, a global budget was placed on federal financial participation.

TennCare has also faced serious problems because its capitation rates to managed care plans have been very low, causing serious problems for and deteriorating relations with plans and

providers. In April 1999, the state took over operation of the third-largest plan, and in December the largest plan—Blue Cross-Blue Shield of Tennessee—announced it would withdraw from TennCare on July 1, 2000. The fundamental problem is that there was never enough new money to finance a roughly 50 percent increase in coverage while paying rates that plans and providers would find acceptable, particularly if the allegations of considerable adverse selection into the program are true.[19]

4. State Options under the State Children's Health Insurance Program

Established as Title XXI of the Social Security Act in August 1997, the State Children's Health Insurance Program (CHIP) was designed to reduce the number of uninsured children by expanding coverage to children in low-income families who did not qualify for Medicaid. The Balanced Budget Act of 1997 (BBA) allocated over $20 billion to CHIP over five years in the form of grants to states based on the state's share of the nation's uninsured children. States must provide a match to the federal funds, but the federal match rate is significantly higher (30 percent) than it is under Medicaid. Although states have the option of extending CHIP coverage to children from families with higher income levels, the program targets children in families with incomes above Medicaid eligibility levels and below 200 percent of the FPL. However, under Title XXI rules, CHIP funds cannot be used to provide coverage for children already covered through private insurance or Medicaid, even if their coverage is insufficient or unaffordable.[20]

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[19] Conover, C., and H. Davies, *The Role of TennCare in Health Policy for Low-Income People in Tennessee* (Washington, D.C.: The Urban Institute, February 2000).
[20] U.S. General Accounting Office (GAO). 1999b. Children's Health Insurance Program: State Implementation Approaches Are Evolving. Letter Report, GAO/HEHS-99-165. Washington, D.C.: GAO.

CHIP allows states to design their own stand-alone program, cover children through Medicaid, or create a program that combines both types of coverage. While Section 1115 waiver authority applies to CHIP, HCFA has not accepted applications because they feel that states must first develop successful traditional CHIP programs before attempting any type of demonstration project.[21] CHIP does allow for a family coverage "variance," which grants states the authority to cover parents with CHIP funds if their plans meet cost-efficacy standards (explained below), prevent crowd-out (substitution of CHIP coverage for private or Medicaid coverage), and meet certain benefit and cost-sharing standards mandated under Title XXI. However, these and other requirements make it very difficult for states to use CHIP funds to cover adults in eligible families. Only Massachusetts, Missouri, and Wisconsin have been successful in designing and implementing programs that are able to use Title XXI to provide family coverage—and only then in combination with Medicaid or state-funded programs.[22] These combination strategies will be described in the final section of the paper.

In order to create an CHIP program that extends coverage to adults, states must design programs that are cost-effective.

Cost-Efficacy. Under the family coverage variance, the cost of insuring an entire CHIP-eligible family must be less than or equal to the cost of insuring just the CHIP-eligible children in the family. Because of this requirement, some amount of additional funding is generally necessary. States have only been able to use CHIP funding to cover families by using CHIP funds in employer buy-in programs, which subsidize a family's contribution to employer-sponsored

[21] U.S. General Accounting Office (GAO). 1999b. Children's Health Insurance Program: State Implementation Approaches Are Evolving. Letter Report, GAO/HEHS-99-165. Washington, D.C.: GAO.

insurance (ESI). States have also created family coverage by extending already existing 1115 waivers to fund adults with Medicaid funds and children with CHIP funds.[23]

Crowd-Out. If a program uses CHIP funds to buy in to ESI, it must abide by the guidelines outlined by HCFA in its February 13, 1998, letter to state officials.[24] This letter suggests that states take the following measures or employ measures that are "substantially equivalent" in order to limit the potential for the displacement of private coverage, or "crowd-out," to occur:

- Children receiving subsidized ESI must not have been insured under an ESI program for at least six months;
- For CHIP funds to be used to subsidize ESI, the employer must contribute at least 60 percent of the cost of family coverage (some states have been able to reduce this to 50 percent);
- The ESI subsidization payment (premiums, cost-sharing, and benefit wraparound) may not exceed the cost of enrolling the child in the state's non-ESI buy-in CHIP coverage;[25]
- For CHIP funds to be used to subsidize ESI, the family must apply for and receive the highest premium contribution available from the employer; and
- States must collect information in order to monitor the degree to which substitution is occurring.[26]

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[22] Cohan, S., *State Tools to Provide Family Health Insurance Coverage* (Washington, D.C.: National Governors' Association, January 1999).

[23] U.S. General Accounting Office (GAO). 1999b. Children's Health Insurance Program: State Implementation Approaches Are Evolving. Letter Report, GAO/HEHS-99-165. Washington, D.C.: GAO.

[24] http://www.hcfa.gov/init/chsub213.htm.

[25] Under the "substantial equivalent" clause, some states have been able to negotiate for a 50 percent minimum employer contribution.

[26] Tollen, Laura, *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States* (Washington, D.C.: Institute for Health Policy Solutions).

Cost-Sharing and Benefit Requirements. If the ESI plan does not meet the benefit standards mandated by Title XXI, the state must provide a wraparound program. In addition, if the ESI plan does not meet Title XXI's cost-sharing standards, the state must provide cost-sharing fill-ins that do not require beneficiaries to incur out-of-pocket expenses above the Title XXI limits for cost-sharing, even if they will be retrospectively reimbursed.[27]

5. Medicaid Section 1931: Family Coverage

Recent legislation altered Medicaid eligibility criteria, making Medicaid expansions for families more economically feasible to states. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) reformed the welfare system, replacing AFDC with Temporary Assistance for Needy Families (TANF). It restricted welfare eligibility rules and "delinked" cash assistance and Medicaid eligibility determinations, creating a category of individuals eligible only for Medicaid. This category was created by federal law under Section 1931 of the Social Security Act and sets mandatory minimum rules as well as giving states flexibility to establish more liberal eligibility rules to provide Medicaid coverage to families. This category is only available to families, so a large number of uninsured adults are still ineligible. However, because states can expand Medicaid to higher-income beneficiaries without also expanding cash-assistance programs, there is a greater incentive to provide coverage to more families. In addition, an allocation of $500 million was provided for states to draw from to help cover the higher costs of administering Medicaid eligibility created by the delinking of Medicaid and welfare eligibility and the creating of Section 1931.

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[27] Tollen, Laura, *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States* (Washington, D.C.: Institute for Health Policy Solutions).

In order to be eligible under Section 1931, families must meet income and resource requirements, have a dependent child living with them, and meet the pre-reform AFDC deprivation requirement. The deprivation requirement stipulates that "a child must be living with a parent or other relative and deprived of parental support or care by the death, absence, incapacity or unemployment of a parent."[28] States have the option to waive parts of this requirement, effectively treating single-parent and two-parent families equally.

In addition to standard Medicaid rules such as TMA eligibility, states must follow the following rules and policies under Section 1931:

- *Maintaining eligibility*: States must provide coverage to families that have income and resources that would have qualified them for AFDC under the state's welfare plan effective as of July 16, 1996.[29]
- *Statewide consistency and recipient/applicant equality*: States' eligibility policies and standards must be consistent throughout the state and must treat applicants and current recipients equally, with the exception of earned income disregards, which can be applied differently to applicants and recipients.

[28]Welfare Reform Fact Sheet #1, *Link between Medicaid and Temporary Assistance for Needy Families (TANF)*, available at http://www.hcfa.gov/medicaid/wrfs1.htm.

[29] Section 1931 does give states flexibility to use lower income standards as long as they do not go below the standards in place on May 1, 1988.

In addition, states have the following options to expand coverage:

- *Income and asset disregards*: States can create "less restrictive methodologies" for counting income and resources in determining eligibility. As long as a state's rules for determining countable income do not cause anyone who would otherwise be eligible to lose coverage, states can disregard earnings or assets of families without limit and without any need for a waiver. This option is similar to the 1902(r)(2) flexibility granted to states to expand coverage to children and pregnant women under the "poverty-level" categories.[30]

- *Expand coverage to two-parent families*: As of August 7, 1998, DHHS eliminated the mandatory "100-hour rule," granting states the option to change family composition rules to expand coverage to low-income adults in two-parent families, regardless of the employment status of the parents. This rule only afforded Medicaid eligibility if the primary wage-earner was incapacitated or worked fewer than 100 hours per month. While many states have had 1115 waivers for this rule, all states now have the option of treating eligible one- and two-parent families equally.[31]

- *Adjust standards for inflation and continue AFDC waivers*. States can link their Section 1931 income and resource standards to the consumer price index, increasing the standards as the CPI increases, and ensuring that inflation doesn't lead to a gradual reduction of eligibility over time. Under this provision, states can also restrict coverage by reducing income standards as low as the standards as of May 1, 1988.[32] In addition, states can continue to use income, resource, and family composition rules established by AFDC waivers to determine Medicaid eligibility permanently, even if the waiver is no longer being used under TANF or has expired.[33]

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[30] Guyer, J., and C. Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Coverage to Low-Income Working Parents* (Washington, D.C.: Center on Budget and Policy Priorities, August 1998).

[31] Guyer, J., and C. Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Coverage to Low-Income Working Parents* (Washington, D.C.: Center on Budget and Policy Priorities, August 1998).

[32] Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World, 3/22/99, at http://www.hcfa.gov/medicaid/wrefhmpg.htm.

[33] However, the waiver must have been submitted before August 22, 1996, and must have been approved before July 1, 1997. In addition, provisions established by expired AFDC waivers that are more restrictive than the Medicaid provisions established under Section 1931 cannot be used to determine Medicaid eligibility after they have expired. From: Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World, 3/22/99, at http://www.hcfa.gov/medicaid/wrefhmpg.htm.

CHIP and Section 1931

Because Section 1931 is intended for families, Medicaid expansions under this "family coverage category" must include all members of a family, including dependent children. This creates a problem for states that are insuring children under CHIP by enrolling them in a separate state children's health plan. States cannot create a special Medicaid eligibility category for these children's parents under Section 1931. However, states may cover both parents and children under Section 1931 by moving the children into their Medicaid program and expanding family coverage through 1931. Section 1931 does not present a problem for the states that are insuring children under CHIP by enrolling them in Medicaid. These states can expand Medicaid for both parents and children and still obtain the enhanced CHIP federal match rate for children covered under this expansion.[34] States with combination programs will be able to use Section 1931 authority to expand Medicaid to families up to the level of the Medicaid expansion segment of their CHIP plan, but will not be able to extend beyond that unless they are willing to extend their CHIP Medicaid expansion as well.[35]

Comprehensive Section 1931 Expansions

Six states have passed legislation that expands Medicaid coverage to higher income levels by eliminating the asset test and employing less restrictive methodologies for counting income. Two of these states, Wisconsin and Rhode Island, have used Section 1931 in the context of an 1115 waiver and will be discussed fully in the next section of this paper. New York will also be

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[34] These funds can only be claimed for uninsured children who would not have qualified for Medicaid according to the eligibility rules of the state as of March 31, 1997.

[35] Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World, 3/22/99, at http://www.hcfa.gov/medicaid/wrefhmpg.htm.

discussed in the next section because it plans to use Section 1931 in the context of an existing 1115 waiver. California[36] and Connecticut[37] recently enacted legislation to expand coverage under Section 1931 but have not yet implemented the policy. In order to meet the statutory requirements of the enacted legislation, state officials are considering expansions under the authority of Section 1931.

Connecticut intends to expand coverage to adults in families up to 185 percent of the FPL. This group will include the children covered under Husky A (the state's CHIP Medicaid expansion) and their parents. Parents of children enrolled in Husky B (the state's non-Medicaid CHIP expansion) will not be covered.[38] California is planning a similar strategy to enroll parents and children up to 100 percent of the FPL using Section 1931 and a CHIP Medicaid expansion. Parents of children in the Healthy Families program, which is a state-funded program covering children up to 250 percent of the FPL, will not be covered by the Section 1931 expansion.

The District of Columbia created a program called DC Healthy Families in October 1998, which expands coverage to families with incomes up to 200 percent of the FPL. This program builds on DC's CHIP program, DC Healthy Kids, a Medicaid expansion for children in families with incomes up to 200 percent of the FPL.[39] Table 12 summarizes the provisions that these five states have enacted under Section 1931 to expand Medicaid coverage:

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[36] 1999 Budget Highlights at http://www.dof.ca.gov/html/BUDGT9-0/FinlOverview.pdf.
[37] Summary of Public Acts passed on July 1, 1999, at http://www.cga.state.ct.us/olr/EXTRA/july1laws.htm.
[38] Personal communication with Dan Buckson at CT Medicaid Institute, (860) 424-5336.
[39] Guyer, J., and C. Mann, *Employed but Not Insured: A State-by State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance* (Washington, D.C.: Center on Budget and Policy Priorities, March 1999).

Table 12
Section 1931 Provisions for Expanding Medicaid Coverage to Higher Income Levels in Six States

	Asset Test	Two-Parent Families	Income Level	CHIP Program	Status
California	Yes, $3,150	Yes	100% FPL	100% FPL, Medicaid Expansion 250% FPL State Program (Healthy Families)	Passed, not yet implemented
Connecticut	Yes, $3,000	Yes	185% FPL	185% FPL, Medicaid Expansion 300% FPL, State Program (Husky B)	Passed, not yet implemented
D.C.	No	Yes	200% FPL	200% FPL, Medicaid Expansion	Implemented
New York	Yes, $3,000	Yes	150% FPL	133% FPL, Medicaid Expansion 230% FPL, State Program (Child Health Plus)	Passed, not yet implemented
Rhode Island	No	Yes	185% FPL	300% FPL, Medicaid Expansion, beneficiaries with incomes above 185% FPL pay premiums	Implemented under 1115
Wisconsin	No	Yes	185% FPL*	185% FPL, Medicaid Expansion, beneficiaries with incomes above 150% FPL pay premiums	Implemented under 1115

Note:
* Families already enrolled may stay enrolled until income exceeds 200% of the FPL.

Incremental Section 1931 Expansions

Several states have made more modest expansions by disregarding some earnings and assets using Section 1931. Maine has extended Medicaid to single parents up to 100 percent of the FPL but has not repealed the 100-hour rule, so coverage for two-parent families is limited.[40] New York has also created an earnings disregard for families already receiving Medicaid that is adjusted annually to maintain eligibility for families with incomes of up to 100 percent of the FPL.[41] Pennsylvania has a similar policy that disregards 50 percent of earned income for families

[40] Guyer, J., and C. Mann, *Employed but Not Insured: A State-by State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance* (Washington, D.C.: Center on Budget and Policy Priorities, March 1999).

[41] Guyer, J., and C. Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Coverage to Low-Income Working Parents* (Washington, D.C.: Center on Budget and Policy Priorities, August 1998).

receiving Medicaid under Section 1931.[42] Michigan, North Carolina, and Ohio have created a time-limited income disregard that allows for 12 months of additional coverage under TMA for families with earnings up to 100 percent of the FPL. North Carolina has also employed a less restrictive methodology that does not count $2,000 of otherwise countable income, effectively creating a resource test of $3,000, and Oklahoma and Ohio have eliminated the resource test entirely using the flexibility allowed under Section 1931.[43]

6. Combination Approaches

Several states have expanded coverage using multiple approaches. In order to close as many of the gaps in insurance coverage as possible, six states have used different programs and funding sources. The most common of these is a comprehensive Medicaid 1115 waiver program with a CHIP add-on to cover children, which is being used by Massachusetts, Missouri, New York, Rhode Island, Vermont, and Wisconsin.

Massachusetts (MassHealth). The MassHealth Section 1115 waiver is a broad, comprehensive program that has several components, which are described in the charts below. MassHealth Standard, a Medicaid expansion that covers pregnant women and infants up to 200 percent of the FPL, children ages 1 to 18 up to 150 percent of the FPL, and parents and disabled adults up to 133 percent of the FPL, is the largest component. All but pregnant women and the disabled are enrolled in Medicaid managed care plans. The second component is the

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[42] Guyer, J., and C. Mann, *Taking the Next Step: States Can Now Take Advantage of Federal Medicaid Matching Funds to Expand Health Coverage to Low-Income Working Parents* (Washington, D.C.: Center on Budget and Policy Priorities, August 1998).

[43] Guyer, J., and C. Mann, *Employed but Not Insured: A State-by State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance* (Washington, D.C.: Center on Budget and Policy Priorities, March 1999).

MassHealth CommonHealth program, which covers disabled children and disabled adults who are not eligible for MassHealth Standard.

The third component is MassHealth Family Assistance, a complex program that provides premium assistance to families with access to state-approved ESI and allows families without access to ESI to purchase MassHealth coverage for their children. State-approved ESI meets certain benchmark benefit standards. MassBasic is the fourth component of the MassHealth program and provides a fairly comprehensive set of medical services to chronically unemployed individuals who have no health insurance. MassHealth Buy-In is the fifth component of the program and provides premium assistance to the chronically unemployed who have health insurance for which they pay a premium.

In addition to these programs, Massachusetts also has a program for pregnant women (MassHealth Prenatal) and an emergency health services program for certain individuals who are ineligible for other services because of their immigration status (MassHealth Limited).

Table 13
The MassHealth Comprehensive Program to Expand Coverage through Multiple Sources in Massachusetts

MassHealth Standard	Pregnant Women and Infants	Children (Ages 1–18)	Parents	Disabled Adults
Eligibility	200% FPL	150% FPL	133% FPL	133% FPL
Enrollment	684,017			
Crowd-Out Provisions	None			
Premiums	None			
Type of Coverage	MassHealth (Medicaid Managed Care)			
Cost-Sharing	None			
Funding	Medicaid and CHIP FFP/State			

MassHealth CommonHealth	Disabled Children (<18)	Disabled Adults (18-64)*
Eligibility	No upper income limit, cannot be eligible for MassHealth Standard	
Enrollment	8,469	
Crowd-Out Provisions	None	
Premiums	Based on monthly income, family size, and other health insurance.	
Type of Coverage	MassHealth (Medicaid Managed Care)	
Cost-Sharing**	One-time deductible for certain higher-income disabled adults; deductible is based on medical expenses and is equal to the excess income above a monthly income standard over a six-month period.	
Funding	Medicaid and CHIP FFP/State	

* Must be working at least 40 hours per month or have been employed at least 240 hours in the preceding six months. If unemployed or working less than 40 hours a month, the applicant must meet the one-time deductible.
** For example, for a family of two with a monthly income of $1,270, the income standard is $670 and the excess income is $600. The deductible is then $3,600 ($600 x 6 months). To meet the deductible, families must show medical bills (these bills may not be covered by other health insurance) or bills for the cost of health insurance.

Table 13 (*continued*)
The MassHealth Comprehensive Program to Expand Coverage through Multiple Sources in Massachusetts

MassHealth Family Assistance	Custodial Families with Children under Age 19 without Access to ESI	Custodial Families with Children under Age 19 with Access to ESI That Meets CHIP's Requirements.	Custodial Families with Children under Age 19 with Access to ESI That Does Not Meet CHIP's Requirements.	Individuals without Children Who Work for a Qualified Employer*
Eligibility	200% FPL	200% FPL	200% FPL	200% FPL
Enrollment	24,689			
Other Requirements	Must be under 65 and ineligible for MassHealth Standard or CommonHealth	1. Must be under 65 and ineligible for MassHealth Standard or CommonHealth 2. If you have access to ESI, it must meet the standards set by the state 3. Have an employer who pays at least 50% of your health insurance premium 4. Must contribute to the cost of their employer-sponsored health insurance premium 5. The policyholder must be a member of your family		
Premiums	$10 per month for each eligible child, with a $30 maximum monthly total for a family**		Family is responsible for all costs not paid by their employer and the state****	$25 per month for each covered adult**
Type of Coverage	MassHealth coverage for children only***	State-approved ESI coverage that also meets CHIP's requirements	State-approved ESI coverage	State-approved ESI coverage
Cost-Sharing	None	None	Family is responsible for all costs not paid by their employer and the state****	None
Funding	Medicaid/CHIP FFP/State	Employer/Medicaid/ CHIP FFP/State	Employer/Medicaid FFP/State/Family	Employer/ Medicaid FFP

Notes:
* To be qualified, an employer must: 1) have 50 or fewer employees, 2) contribute at least half the cost of the health insurance premium for benchmark coverage, 3) purchase health insurance from an approved billing and enrollment intermediary, 4) participate in the Insurance Partnership, a financial incentive program to encourage small businesses to offer health insurance to their employees. Self-employed individuals can also meet the requirements to become qualified employers.
** In some situations, both families and individuals may have to pay more.
***The MassHealth package offered to children does not include non-emergency transportation, day habilitation, personal care, private nursing, or nursing facility services.
****Massachusetts only contributes the amount that it would cost to enroll the children in the family in MassHealth.

Massachusetts folded its CHIP allotment into the MassHealth Family Assistance program, a preexisting program. The fact that MassHealth Family Assistance was approved and implemented is the primary reason that Massachusetts is the only state (other than Wisconsin)

that has been able to use the CHIP family coverage variance. Because of the different rules associated with Medicaid and CHIP, the state designed a three-tier program to provide coverage to these families.

- Uninsured families that do not have access to ESI contribute 1 to 2 percent of gross income for their children to participate in a state program that provides benefits similar to those covered under Medicaid and is funded through the CHIP enhanced federal match. Parents do not receive coverage.
- Families that have access to ESI that meets CHIP's requirements contribute 1 to 2 percent of gross income to ESI premiums, and the state uses CHIP funds to cover any remaining premium costs. The entire family receives coverage.
- For families that are already insured or have access to ESI that does not meet CHIP's requirements, the state contributes the amount it would cost to enroll the children in the state program; the family is responsible for any additional charges. Through its 1115 waiver and HIPP program, the state receives the Medicaid match rate for its costs in subsidizing ESI in this situation. This situation is more flexible because it does not have the benefit, cost-efficacy, and anti-substitution requirements of CHIP. The entire family receives coverage.[44]

[44]U.S. General Accounting Office (GAO). 1999b. Children's Health Insurance Program: State Implementation Approaches Are Evolving. Letter Report, GAO/HEHS-99-165. Washington, D.C.: GAO; Tollen, Laura, *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States* (Washington, D.C.: Institute for Health Policy Solutions).

Table 13 (*continued*)
The MassHealth Comprehensive Program to Expand Coverage through Multiple Sources in Massachusetts

MassHealth Basic	Individuals under the age of 65 who: 1. Have not worked for more than a year or have worked but not earned enough to collect unemployment benefits 2. Are not eligible for unemployment benefits 3. Do not have health insurance
Eligibility	133% FPL
Enrollment	56,881
Other Requirements	1. Must not be a student who can get health insurance through his/her academic institution 2. Must not be married to a person who works more than 100 hours per month
Premiums	None
Type of Coverage	MassHealth Basic*
Cost-Sharing	None
Funding	Medicaid FFP

Note:
*Adult day and foster care, hospice, nursing facility, and non-emergency transportation services are not covered.

MassHealth Buy-In	Individuals under the age of 65 with health insurance for which they pay the premium who: 1. Have not worked for more than a year or have worked but not earned enough to collect unemployment benefits 2. Are not eligible for unemployment benefits
Eligibility	133% FPL
Enrollment	166
Other Requirements	1. Must not be a student who can get health insurance through his/her academic institution 2. Must not be married to a person who works more than 100 hours per month
Premiums	MassHealth Buy-In will pay for all or part of your premium
Type of Coverage	Coverage provided by your private insurance plan
Cost-Sharing	MassHealth Buy-In will pay for all or part of your premium
Funding	Medicaid FFP

Missouri. The Managed Care Plus (MC+) program covers children up to 300 percent of the FPL and uninsured custodial parents up to 100 percent of the FPL through CHIP and an 1115 wavier. Coverage is also available, through an 1115 waiver, to uninsured noncustodial parents up to 125 percent of the FPL who are current in their child support payments. From a beneficiary's point of view, Missouri has created one seamless program to cover entire families, although the funding comes from two separate streams (Medicaid and CHIP). Essentially, children are covered under CHIP at the higher CHIP matching rates; the parents are covered under the 1115

waiver at Medicaid matching rates. However, the state disproportionate share cap was reduced by the full amount of the Title XXI allotments. HCFA classifies MC+ as two separate programs and insisted on approving the 1115 waiver and the CHIP program separately.[45] Coverage for parents transitioning off welfare is limited to two years under the waiver, although parents can continue their coverage by paying the entire premium. The state and federal government would not play a financial role in continuance of coverage for these parents transitioning off welfare.[46] Coverage for uninsured postpartum women is for an additional two years beyond the 60 days postpartum and includes a limited benefit package related to family planning and gynecological services.

[45] U.S. General Accounting Office (GAO). 1999b. Children's Health Insurance Program: State Implementation Approaches Are Evolving. Letter Report, GAO/HEHS-99-165. Washington, D.C.: GAO.
[46] Missouri Statewide Health Reform Demonstration Fact Sheet at www.hcfa.gov/medicaid/mofact.htm.

Table 14
Missouri's Managed Care Plus (MC+) Program

<table>
<tr><th>MC+[47]</th><th>Children (under 19) MC+ for Kids</th><th>Parents Transitioning off TANF</th><th>Uninsured Custodial Parents</th><th>Uninsured Noncustodial Parents*</th><th>Uninsured Postpartum Women</th></tr>
<tr><td>Eligibility</td><td>300% FPL</td><td>300% FPL</td><td>100% FPL</td><td>125% FPL*</td><td>No income test</td></tr>
<tr><td>Benefits</td><td>Full Medicaid benefit package except for non-emergency medical transportation</td><td colspan="2">State Employee Package**</td><td colspan="2">Women's Health Services (limited)***</td></tr>
<tr><td>Crowd-Out Provisions</td><td colspan="3">1. 6 mos. of uninsurance
2. No access to affordable health care insurance for children with family incomes less than 225% FPL****</td><td colspan="2">None</td></tr>
<tr><td>Premiums</td><td colspan="3">None up to 225% FPL
$68/mo. Premiums for families with incomes from 226 to 300% FPL. Total cost-sharing cannot be more that 5% of income.</td><td colspan="2">None</td></tr>
<tr><td>Cost-Sharing</td><td colspan="3">None up to 185% FPL; $5 for professional visits for children with family incomes between 186 and 225%, $10 for provider visits and $5 for prescriptions with a maximum of 5% of income (including premiums) for families from 185 to 300% FPL</td><td colspan="2">None</td></tr>
<tr><td>Funding</td><td>CHIP FMAP</td><td>Medicaid FMAP</td><td>Medicaid FMAP</td><td>Medicaid FMAP</td><td>Medicaid FMAP</td></tr>
</table>

Notes:
*To be eligible, noncustodial parents must be current in child support payments or participating in Missouri's Parent's Fair Share Program. Uninsured parents actively participating in the Fair Share Program are eligible for this program.
**This package is similar to a commercial package and does not include non-emergency transportation.
***Women's health services include: Department of Health and Human Services--approved methods of contraception; pap test; pelvic exam; sexually transmitted disease testing and treatment; family planning counseling/education on various methods of birth control; drugs, supplies, and devices related to the women's health services described above when they are prescribed by a physician or advanced practice nurse.
****Affordable health care insurance is defined such that premiums cannot be greater than $90/month.

New York. In December 1999, New York signed into law the Health Care Reform Act of 2000, which created Family Health Plus. Family Health Plus targets parents with incomes up to 150% of the FPL and other adults up to 100% of the FPL. It is likely to be implemented as a Medicaid expansion through the state's existing 1115 waiver, assuming HCFA approval. The expansion for parents will be implemented under the authority of Section 1931, and childless adults will be covered through an amendment to the state's 1115 waiver. The benefit package

will be almost identical to covered benefits in the Child Health Plus program, a managed care program that covers hospital and physician services, laboratory services, mental health and substance abuse, vision, speech and hearing services, and prescription drugs. New York plans to phase it in gradually, beginning in January 2001.[48]

Rhode Island. In November 1998, Rhode Island expanded RIteCare, the state's section 1115 Medicaid Managed care program. Using the flexibility created by Section 1931, it used its waiver to extend Medicaid coverage to families with children with countable income up to 185 percent of the FPL. By arguing that it would have gone to 185 percent of the FPL under Section 1931, it created a higher baseline for budget neutrality calculations under the waiver. This extended Medicaid to some, but not all, parents of children covered under Medicaid because Rhode Island had already extended Medicaid coverage to children up to 300 percent of the FPL using CHIP funds. Rhode Island's waiver is distinct from most 1115 waivers because coverage expansion has been achieved through the flexibility granted by Section 1931, not through cost savings from the shift of beneficiaries from fee-for-service to managed care.[49] Rhode Island could have used Section 1931 to expand coverage, but it chose to use 1115 waiver authority because it already had an existing 1115 waiver. There is no resource test, and one- and two-parent families are eligible for coverage.[50]

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[47] Missouri Statewide Health Reform Demonstration Fact Sheet at www.hcfa.gov/medicaid/mofact.htm.
[48] Silverman, G., *State's New Health Care Reform Law Seen as National Leader for Access Issue,* Bureau of National Affairs, Vol. 8, No. 6, 2000.
[49] Guyer, J., and C. Mann, *Employed but Not Insured: A State-by State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance* (Washington, D.C.: Center on Budget and Policy Priorities, March 1999).
[50] Guyer, J., and C. Mann, *Employed but Not Insured: A State-by State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance* (Washington, D.C.: Center on Budget and Policy Priorities, March 1999).

Vermont. The Vermont Health Access Plan (VHAP) is a Section 1115 mandatory Medicaid managed care program that has enabled Vermont to expand coverage to all uninsured adults not otherwise eligible for Medicaid up to 150 percent of the FPL. Vermont has a preexisting program, Dr. Dynasaur, which used a federal-state Medicaid expansion to cover all children in families with incomes below 225 percent of the FPL. Vermont attempted to use the CHIP family coverage variance as a way to expand coverage to children living in families with incomes up to 300 percent of the FPL and uninsured parents and caretaker relatives with income between 150 and 185 percent of the FPL. However, Vermont withdrew its application because of difficulties experienced during HCFA's approval process. HCFA signaled that it was unlikely to approve the application under CHIP, but that the state could cover the same group by using 1115 waiver authority. Vermont has since used CHIP to expand coverage to children up to 300 percent of the FPL and has received a Section 1115 Medicaid waiver amendment that covers uninsured parents and caretaker relatives up to 185 percent of the FPL. Like Rhode Island's program, this could have been achieved using Section 1931, but Vermont chose to use 1115 authority because it knew that HCFA was likely to approve the expansion, and it already had an 1115 program in place and wanted to enroll newly covered individuals in VHAP.[51]

Wisconsin (BadgerCare). Wisconsin has used a Section 1115 waiver to expand Medicaid to working families beyond traditional AFDC and poverty-related groups. The BadgerCare program uses a combination of CHIP funds and Medicaid funds to cover entire families up to 185 percent of the FPL with an ESI subsidy program or a public insurance

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[51] Cohan, S., *State Tools to Provide Family Health Insurance Coverage* (Washington, D.C.: National Governors' Association, January 1999); U.S. General Accounting Office (GAO). 1999b. Children's Health Insurance Program: State Implementation Approaches Are Evolving. Letter Report, GAO/HEHS-99-165. Washington, D.C.: GAO.

program. A cost-efficacy determination is made in order to determine which funding source and program will be used to provide family coverage. There are three sources:

- **CHIP:** When the cost of insuring the entire family through ESI coverage is no greater than the cost of insuring the eligible children under CHIP, it meets Title XXI cost-efficacy requirements, and enhanced federal match CHIP funds are used to cover the whole family in the ESI subsidy program.
- **Medicaid:** When the cost of insuring the family does not meet Title XXI cost-efficacy requirements, but does meet Medicaid cost-efficacy requirements through HIPP (the cost of insuring all members of the family through ESI coverage, including those ineligible for Medicaid, is no greater than the cost of insuring just eligible members under Medicaid), federal matching funds (at Medicaid rates) are used to cover the whole family in the ESI subsidy program.
- **Combination:** If requirements are not met for either CHIP or Medicaid, the family is enrolled in the public program, and CHIP funds at the enhanced matching rate are used to cover the children while Medicaid funds are used to cover the adults.[52]

Table 15
Wisconsin (BadgerCare) Program

BadgerCare	Applicants		Recipients	
	Adults with Children	**Children**	**Adults with Children**	**Children**
Eligibility	185% FPL	185% FPL	200% FPL	200% FPL
Other Requirements	Wisconsin residency and U.S. citizenship or qualified alien status			
Crowd-Out Provisions	1. Families cannot currently have coverage or have been covered in the last six months 2. Families cannot have access to or have had access to ESI during the past 18 months in which the employer pays 80% of more of the cost of family coverage			
Premiums	No premiums for beneficiaries with family incomes below 150% FPL Premiums of no more than 3% of income for beneficiaries with family incomes above 150% FPL			
Cost-Sharing	No copayments or deductibles for any beneficiaries			
Funding	Medicaid FFP	CHIP FFP (in most cases)	Medicaid FFP	CHIP FFP (in most cases)

52 Tollen, Laura, *Purchasing Private Health Insurance through Government Health Care Programs: A Guide for States* (Washington, D.C.: Institute for Health Policy Solutions).

Wisconsin treats applicants and recipients differently, in that new applicants must have family income below 185 percent of the FPL but can stay in the program if they obtain work as long as family income remains below 200 percent of the FPL.

7. Conclusions

This paper has described the efforts that several states have made to expand coverage to low-income adults. All told, 14 states and the District of Columbia have made significant efforts to expand coverage beyond what is allowed by traditional Medicaid. The state of Washington developed a large, fully state-funded program. Delaware, Hawaii, Minnesota, Oregon, Tennessee, and Vermont used Section 1115 waivers to significantly expand coverage. These 1115 expansions extended coverage to adults without children as well as to parents. California, Connecticut, and the District of Columbia have used the new Section 1931 authority to expand coverage for entire families. Massachusetts, Missouri, and Wisconsin have used their Section 1115 waivers, together with new authorities allowed through CHIP, to extend coverage to adults. New York and Rhode Island have combined Section 1931 and Section 1115 waivers to extend coverage to parents of Medicaid-eligible children (and in the case of New York, to other adults as well).

These 14 states (and the District of Columbia) have made important advances in extending coverage to low-income adults. It is noteworthy that 36 states have not made such efforts. This perhaps reflects the fact that all existing ways of extending coverage have their limitations. Extending coverage through waivers is limited because states must demonstrate budget neutrality, that is, that the cost of the expanded coverage would be no more than if the expansion had not occurred. Several years ago, when states had high levels of disproportionate

share hospital payments and operated fee-for-service programs, it was easier to use the DSH funds and the projected savings from managed care to make the case for budget neutrality. With constraints on federal DSH payments and with states having already adopted managed care plans, demonstrating budget neutrality is more difficult. Finally, the length and uncertainty of the wavier process can be discouraging to states.

States can clearly extend coverage on their own and would be free from any federal constraints. Such efforts would be fully funded with state dollars, with no federal assistance. Extending coverage to adults through the CHIP family variance provisions also requires proof of cost-effectiveness, that is, that it is no more expensive to cover the parents than it would have been to cover just the child in the state's CHIP program. Finally, states have an opportunity through Section 1931 to extend coverage to parents at existing Medicaid matching rates. Thus far, there has been relatively little interest on the part of the majority of states for using these provisions for broad, comprehensive expansions.

Vice President Gore and, more recently, President Clinton have proposed increasing matching rates to states that extend coverage to parents of Medicaid- or CHIP-enrolled children. It is difficult to know how states would respond, but in any event this would still only extend coverage to parents. Thus, it seems that the problems of low-income uninsured adults will only be solved if more extensive measures are taken. Such efforts would include extending direct subsidies or refundable tax credits to low-income adults. Such efforts pose many difficult problems, not the least of which is a large increase in public expenditures. The data presented in the beginning of the paper showing high uninsurance rates for low-income adults, together with

evidence that the uninsured are in worse health, suggest there is a need to confront these difficulties.

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