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OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

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A Medicaid Buy-in Program Would Increase Health Care Access for the Uninsured But Also Increase State Costs

at a glance

A potential Medicaid buy-in program would allow people not currently eligible for Medicaid services to participate by paying monthly premiums and co-payments. Implementing a buy-in program could improve health care access for some of the 2.7 million uninsured Floridians. However, the cost to the state could be substantial, depending on the number of people covered, the benefits package, and financing mechanisms. Because most of those uninsured have incomes below 200% of the federal poverty level, they would likely be able to afford only modest premium payments. In addition, the state has limited options to finance a buy-in program within existing available resources.

Redesigning the current medically needy program into a buy-in program could be beneficial to some participants and to the state. However, other medically needy individuals who might qualify could potentially lose their safety net. The large pool of potential buy-in participants and the upcoming implementation of Medicare Part D make estimating the size and costs for a medically needy buy-in program problematic at this time.

Scope

As required by Chapter 2005-133, *Laws of Florida,* OPPAGA reviewed Medicaid buy-in programs and options in other states to answer three questions.

- How have states used Medicaid buy-in programs to increase health care access for uninsured individuals?
- Could a buy-in program increase health care access for uninsured Floridians and at what cost?
- Would it be feasible for Florida to redesign the Medically Needy Program as a buy-in program?

Background

In 2004, an estimated 2.7 million or 19.2% of Florida's citizens did not have health insurance. Most uninsured Floridians live in households where at least one person is employed. However, these working individuals lack insurance because their employers do not offer insurance, the workers are not eligible, or the families cannot afford to pay for insurance coverage. [1]

Lack of medical insurance in Florida has significant consequences for both individuals and the state. Uninsured individuals often forego routine preventive and non-emergency medical care and may delay receiving care until their health is compromised, resulting in conditions that are costly to treat. These poor health outcomes burden the state's health care delivery system,

[1] Individuals not eligible for employer-sponsored insurance are generally part-time or contract workers.

pressure safety net hospitals, and increase the amount of uncompensated care costs.[2] Florida participates in two federal-state partnerships to improve the health status and access to medical care of individuals who might otherwise go without needed medical care. First, the state's Medicaid program, authorized under Title XIX of the Social Security Act, provides health care services to low-income persons who meet federal and state eligibility requirements. Medicaid mainly serves low-income families with children, elderly persons who need long-term care services, and persons with disabilities. Florida's Legislature also has expanded the state's Medicaid program by extending coverage to several optional groups. For example, Florida provides Medicaid coverage to pregnant women with incomes above 150% and up to 185% of the federal poverty level. In addition, Florida provides Medicaid coverage to medically needy individuals who have high medical bills regardless of their income.

Second, Florida covers children under its KidCare program which is funded by both Medicaid and the state children's health insurance program (SCHIP), authorized under Title XXI of the Social Security Act. Specifically, SCHIP funds programs for children ages 1 to 5 whose family income is between 134% and 200% of the federal poverty level (and not eligible for Medicaid) and children ages 5 to 18 whose family income is up to 200% of the federal poverty level. In addition, SCHIP includes Children's Medical Services that covers children from birth to age 19 who have special health care needs whose family incomes are up to 200% of the federal poverty level. These programs require cost-sharing such as monthly premiums and co-payments for some services.[3] Together, Medicaid and SCHIP pay for medical services for approximately 2.5 million Floridians each month.

In the early 1990s, Florida considered implementing a buy-in program to expand health care coverage for uninsured individuals with incomes up to 250% of the federal poverty level.[4] However, although a waiver was approved by the federal government, the state did not implement the buy-in program because of concerns over costs.

Questions and Answers

How have states used Medicaid buy-in programs to increase health care access for uninsured individuals?

Nineteen states and the District of Columbia have designed new Medicaid options to increase health care access for uninsured individuals who do not usually qualify for Medicaid. (See Appendix A for detailed information about these programs.) These programs typically offer coverage to uninsured parents or caregivers of children enrolled in the state's SCHIP program or to other low-income working age adults. Many are structured as buy-in programs and are similar to private health care insurance plans, in which recipients pay monthly premiums and/or co-pays for a standard set of benefits. Each state determines its program's structure including eligibility requirements, service delivery, cost-sharing mechanisms, and benefit packages.[5]

These buy-in programs must be federally approved through either a regular Medicaid 1115 waiver or a Health Insurance Flexibility and Accountability (HIFA) waiver.[6] Regular 1115 waivers are intended to allow states to pilot or test a program improvement and require formal, independent evaluations. HIFA waivers are intended to encourage states to develop new comprehensive approaches to increase the number of individuals with health insurance coverage. HIFA waivers generally target

[2] The state's safety net hospitals provide the majority of uncompensated health care. These hospitals receive state funds and a fixed amount of federal matching funds which do not increase if uncompensated care increases. Other safety net system providers include county services supported by local taxes and charity care provided through donated professional services.

[3] SCHIP also includes regular Medicaid coverage for children from birth to age 18 whose families have incomes up to 185% of the federal poverty level and for infants under the age of one whose family incomes are between 185% and 200% of the federal poverty level. However, these families are not required to pay premiums.

[4] Chapters 92-33 and 93-129, *Laws of Florida.*

[5] Some states have also provided health care coverage for the uninsured through ticket to work buy-in programs for persons with disabilities, premium assistance programs, reinsurance programs, and high risk pools. For more information, see Appendix B.

[6] These waivers are both authorized under Section 1115 of the Social Security Act and allow states to make changes to their Medicaid or SCHIP programs that are not normally allowed.

individuals with incomes up to 200% of the federal poverty level and encourage states to maximize private insurance options by including premium assistance. [7]

For example, Illinois (through a HIFA waiver) operates a buy-in program for uninsured parents with incomes up to 185% of the federal poverty level whose children receive SCHIP coverage. Enrollees may choose to receive health benefits through the state's Medicaid program, or to participate in a premium assistance option. Cost-sharing, including monthly premiums and co-payments based on income, is required. As of December 2004, the program enrolled 83,545 parents. Illinois funds its buy-in program with both Medicaid and SCHIP dollars. [8]

Some states cover uninsured childless adults as well as parents of children who receive SCHIP or Medicaid benefits. Minnesota's buy-in program, for example, currently serves 101,383 parents and caretakers with children and incomes up to 275% of the federal poverty level, and 30,485 childless adults with incomes up to 175% of the federal poverty level. All participants are required to pay monthly premiums and co-payments based on a sliding scale. Minnesota funds the program with SCHIP dollars. In Fiscal Year 2004, program expenditures totaled $487 million.

However, buy-in programs designed using these waivers, for the most part, have had limited success in increasing health care access for the uninsured. A recent publication issued by the Kaiser Commission on Medicaid and the Uninsured reported that because of fiscal pressures to save money, many states with buy-in programs have capped enrollments, reduced benefits, increased cost-sharing or otherwise limited these programs. [9] For example, in November 2003, Utah closed enrollment for newly eligible parents and other adults into its Primary Care Expansion Network after only 16 months. Rhode Island modified its buy-in program in January 2002 and began charging premiums for families above 150% of the federal poverty level, which resulted in program enrollment declining by 18%.

Could a buy-in program increase health care access for uninsured Floridians and at what cost?

A Medicaid buy-in program could improve health care access for some of the state's 2.7 million uninsured persons. However, depending on the number of people covered, the benefit package, and financing mechanisms, the cost to the state could be substantial. In addition, Florida has limited options to finance a buy-in program within existing available resources. Waiver funding requirements also could constrain the size and scope of a buy-in program.

A Medicaid buy-in program could increase the ability of some uninsured Floridians to access health care, and decrease pressure on Florida's safety net system. The most direct benefit to participants of a Medicaid buy-in program would be increased access to affordable health care. Individuals with affordable health care are more likely to maintain their health by taking advantage of preventive medical care and going to a physician at the onset of illness. This in turn makes it more likely that employed persons can keep their jobs and continue as productive members of the workforce.

A Medicaid buy-in program also could decrease pressure on the state's safety net system, which includes certain hospitals, the county health departments, and federally qualified health care centers. [10] In 2003, safety net hospitals provided $5.7 million in uncompensated care. [11]

[7] Under HIFA, states are encouraged to integrate SCHIP and Medicaid funding with private health insurance options. This includes supporting the increased use of private group health plan premium assistance programs. Through premium assistance programs, the state pays for a portion of the enrollees' employer-sponsored or private insurance.

[8] Illinois' funding for the five-year waiver period is $889.1 million.

[9] Artiga, Samantha and Cindy Mann, "New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity," Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2005.

[10] There is some evidence that prior Medicaid expansions in Florida decreased pressure on safety net hospitals by reducing uncompensated care. For example, studies show that Medicaid expansions to cover pregnant women were associated with reductions in uncompensated care.

[11] Funding for the state's safety net hospitals may be undergoing significant changes as a result of Medicaid reform. Under the plan, the Upper Payment Limit system will be replaced with a new Low Income Pool.

The cost to the state for a buy-in program depends on the benefits package, cost-sharing mechanisms, and the number of people served. The potential cost of establishing a Medicaid buy-in program would depend on the scope and intent of such a program. Key drivers of potential program costs are the number of uninsured persons who would participate and the scope of medical services to be provided. Some of these costs could be mitigated by establishing cost-sharing requirements, but most participants would likely be unable to pay high premiums or co-payments. The size and scope of a buy-in program would ultimately be constrained by waiver requirements to fund a buy-in program within existing Medicaid resources.

Benefits packages. A buy-in program that provides the same level of benefits as the state's Medicaid or SCHIP programs would have higher costs than a program with a more limited benefits package. Most states that have implemented federally approved buy-in programs offer participants the same level of health benefits as their Medicaid or SCHIP programs. However, some states provide more limited benefits to at least some buy-in participants. For example, in Hawaii, children enrolled in the buy-in program receive the same benefits as regular Medicaid participants, while adults receive reduced benefits equivalent to the benefits that the state mandates employers to cover.

Cost-sharing mechanisms. Buy-in programs generally require enrollees to pay some of the costs of their health care. Most of these programs require at least some participants to pay a monthly premium based on their income and/or co-payments for services received. For example, New Jersey's buy-in program provides health care coverage to parents of children enrolled in SCHIP with incomes up to 200% of the federal poverty level. New Jersey requires parents with incomes over 150% of the federal poverty level to pay monthly premiums and co-payments for medical services; parents with incomes below this level are exempt from these payments. A few states require participants to pay an enrollment fee rather than a premium and/or a deductible before receiving services. For example, Utah requires a $50 enrollment fee for individuals with incomes from 50% to 150% of the federal poverty level.

Individuals served. States that use Medicaid buy-in programs to increase access for the uninsured have typically targeted working age adults who earn up to 200% of the federal poverty level and/or uninsured parents of children who receive health services through SCHIP. As shown in Exhibit 1, approximately 1.14 million uninsured working age adults in Florida have incomes under 200% of the federal poverty level. Most of these uninsured working age adults are employed (63.1%) but cannot afford or do not have access to health insurance. An estimated 112,000 of these individuals are uninsured parents of children who receive SCHIP coverage.

Exhibit 1
In 2004, 1.14 Million of Florida's Uninsured Working Age Adults Had Incomes Below 200% of the Federal Poverty Limit [1]

Percentage of Federal Poverty Level	Number Working Age Uninsured	Cumulative Number Working Age Uninsured	Cumulative Percent
≤ 100	458,525	458.525	24%
101-150	405,653	864,178	46%
151-200	279,082	1,143,260	61%
201-250	181,308	1,324,568	71%
> 250	550,720	1,875,288	100%
Total	**1,875,288**	**1,875,288**	**100%**

[1] Information represents 84% of Florida's uninsured working age adults; information was not sufficient to determine poverty levels of the remaining 16%.

Source: The Agency for Health Care Administration and the Department of Health Services Research, Policy and Management at the University of Florida.

A buy-in program that covers from 25% to 50% of Florida's working age uninsured with incomes under 200% of the federal poverty level could cost between $700 million and $1.4 billion. The number of uninsured who elect to participate in a buy-in program would depend on a number of factors, including program design, the extent to which these persons value health insurance, and their ability to pay premiums or other cost-sharing requirements. Based on the experience of other states, we estimated that between 25% and 50% of Florida's uninsured might elect to participate in a Medicaid buy-in option. Nationwide about 75% of those eligible for Medicaid choose to participate. However, participation in a buy-in program would likely be lower because Medicaid is free except for nominal co-payments while the buy-in program would require additional financial contributions.

Exhibit 2 shows the estimated premium costs if Florida were to offer a buy-in program that covered from 25% to 50% of the state's uninsured working age adults with incomes under 200% of the federal poverty level. The February 2005 Social Services Estimating Conference projected that the average per-member, per-month cost for Medicaid prepaid health plans will be $204 in Fiscal Year 2005-06. At this level, a buy-in program covering one-quarter of these working-age adults would cost $700 million; a program covering one-half of these persons would cost $1.4 billion. [12, 13]

Some of this cost could be mitigated by requiring participants to share in the costs of the program. Cost-sharing can include not only monthly premiums but also require co-payments and deductibles. However, if cost-sharing requirements are set too high, low-income participants may have difficulty staying enrolled or choose not to participate. In addition, high co-payments can result in people avoiding treatment, for example, by not buying needed prescription drugs.

It is unlikely that many uninsured persons could afford the full estimated $204 average per-member monthly cost of the program. In 2004, 61% of uninsured working age adults in Florida had incomes below 200% of the federal poverty level. A recent report by the Kaiser Commission on Medicaid and the Uninsured found that low income families (defined as those below 200% of the federal poverty level) spend $7 out of every $10 for basic living expenses including housing, transportation, and food and thus could afford

[12] These amounts reflect total federal and state cost assuming a Medicaid managed care premium of $204 per member per month.

[13] These estimates do not include the costs of administering the buy-in program, including eligibility determination and premium collection. Administrative costs would vary widely depending on program design and other factors. For example, the administrative costs of a program with a limited level of benefits that caps enrollment to a minimal number of persons may be absorbed into current program costs. A program with a rich benefit design and no enrollment limitations would be more costly to administer.

Exhibit 2
It Could Cost Florida From $700 Million to $1.4 Billion to Cover from 25% to 50% of the State's Working Age Adults With Incomes Under 200% of the Federal Poverty Level [1, 2]

Percentage of Federal Poverty Level	Estimated Number of Uninsured Working Age Adults	Estimated Monthly Managed Care Cost	Estimated Cost to Serve 25% of Uninsured	Estimated Cost to Serve 50% of Uninsured
< 100	458,525	$204	$280,617,300	$ 561,234,600
101-150	405,653	204	248,259,636	496,519,272
151-200	279,082	204	170,798,184	341,596,368
Total	**1,143,260**		**$699,675,120**	**$1,399,350,240**

[1] Beyond the per-member/ per-month premium costs of a buy-in program, there would be various other administrative costs for eligibility determination, enrollment, and collection of premiums.

[2] We estimated costs based on assuming participation rates of from 25% to 50% of the number of eligible uninsured working age adults with incomes under 200% of the federal poverty level multiplied by an estimated average annual cost of $2,448, which is $204 for 12 months.

Source: OPPAGA estimates based on the results of Agency for Health Care Administration and University of Florida surveys of Florida's uninsured.

to pay only a modest insurance premium.[14] Establishing a modest premium of up to 15% of the program's cost ($30 per person per month) would generate between $102.9 million to $205.8 million annually. A more narrowly focused and administratively less costly alternative would be to establish a buy-in program for parents whose children receive SCHIP benefits. Based on the SCHIP annual survey, we estimated that approximately 112,000 of these parents are uninsured.[15] The advantage of covering the parents of children who receive SCHIP benefits is that these families have demonstrated a willingness to participate in health insurance programs and, thus, might be more likely to maintain eligibility and program enrollment. In addition, eligibility determination and premium collection systems are already in place for SCHIP.

Waiver funding requirements could constrain the size and scope of a buy-in program. Federal rules require waiver expansions to be carried out within existing Medicaid resources. As a result, the cost of a buy-in program depends on reallocating current funding as well as offsets from cost-sharing requirements. Most states are funding their buy-in programs with unspent SCHIP dollars or a combination of Medicaid and SCHIP funds. States also have the option of using unspent or diverted Disproportionate Share Hospital (DSH) dollars.[16]

Since Florida has a surplus of unspent SCHIP funds, the state could potentially use these dollars to fund a buy-in program.[17] The Agency for Health Care Administration estimates the state will have $407 million in unspent SCHIP funds at the end of Fiscal Year 2005-06. One advantage of using SCHIP funds is that the state receives a higher federal match compared to regular Medicaid. In Fiscal Year 2005-06, the federal SCHIP grant covered 71.22% of program expenditures compared to the 58.89% federal cost share for Medicaid expenditures. Thus, to use these unspent SCHIP dollars the state would have to provide $164.5 million in general revenue. This would enable the state to use $571.5 million in state and federal funds, which would potentially fund two-thirds of the estimated $700-million first-year cost to cover 25% of the uninsured adults under 200% of the federal poverty level. However, the estimated surplus could change depending on new enrollment in the SCHIP program. An unexpected increase in SCHIP enrollment might lead to the state having to cap enrollment if the surplus funds were exhausted.

In addition, the federal government could limit states' use of SCHIP dollars to fund health insurance for adults in the future. According to a recent report by the Government Accountability Office, using SCHIP funds to expand coverage to childless adults may not be consistent with SCHIP's statutory objective to expand health coverage to low-income children.[18] The Government Accountability Office recommended that the federal government deny any pending or future waivers that propose spending SCHIP funds for this purpose.

Would it be feasible for Florida to redesign the Medically Needy Program as a buy-in program?

Although redesigning the current medically needy program into a buy-in program could be beneficial to some participants and to the state, other individuals who might qualify under current criteria could potentially lose their medical safety net. In addition, changes to the federal Medicare program will affect a significant subpopulation of the current medically needy group, making it difficult to estimate buy-in participation and costs.

[14] Artiga, Samantha and Molly O'Malley, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences,* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2005.

[15] As of November 2005, there were 223,107 children enrolled in Healthy Kids, MediKids, and Children's Medical Services, the programs where parents pay all or part of a subsidized premium depending on their income. A 2004 survey showed that 51% of Healthy Kids families, 40% of MediKids families, and 49% of Childrens Medical Services families were uninsured.

[16] Disproportionate Share Hospital Funds are used to provide supplemental support to safety net hospitals.

[17] Disproportionate Share Hospital funds would not be a viable option for funding a buy-in program as Florida typically uses all of these funds to help support safety net hospitals.

[18] U.S. General Accounting Office, *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns*, GAO-02-817, July 2002.

A buy-in option could be beneficial to persons with long-term health care needs but could leave individuals faced with unexpected illnesses or accidents without a safety net. The Medically Needy Program currently assists individuals and families with high medical expenses who do not qualify for regular Medicaid because their incomes are too high. [19] The program allows these individuals and their families to qualify for Medicaid coverage in any given month by demonstrating they have incurred health care expenses at a predetermined level (known as a share of cost). Once that cost share is met, the individual or family becomes eligible for Medicaid for the remainder of the month. For example, to qualify for Medicaid in a given month, a single individual must incur medical expenses that consume all but $200 of his/her monthly income.

Florida's medically needy individuals typically fall into one of two categories. The first category includes persons with chronic conditions that result in ongoing high medical costs. Individuals in this category generally are aged or disabled. A buy-in option would likely be well received by this group as their medical needs are more predictable, and it would eliminate their need to reapply each month.

The second category of medically needy persons include those who have short-term or unexpected illnesses or accidents. Individuals in this category tend to include families with children or non-citizens who are legal residents and need emergency medical treatment. A buy-in option would limit these individual's access to program services. Currently, participants can access the Medically Needy Program at any point in a month in which they qualify. [20] Under a buy-in program, eligible participants would need to enroll and pay monthly premiums prior to receiving services. Many of the individuals who typically use the medically needy program have low incomes and may choose not to enroll.

In August 2005, 85% of the families with children who accessed the Medically Needy Program had incomes lower than 100% of the federal poverty level. If the state's Medically Needy Program was changed to a buy-in, low-income families that did not enroll and were faced with unforeseen catastrophic illnesses or accidents would have no source of assistance for high medical bills and would have to rely on uncompensated care.

A Medicaid buy-in program would benefit the state as it would ensure that all participants pay a portion of their medical expenses. Although the intent of Medicaid is to not pay any expenses that meet a medically needy individual's share of costs, the state sometimes does. This occurs when individuals submit medical bills that exceed their share of costs. Because Medicaid's current payment system is unable to split single bills to apportion the share of the bill that the state and the participant should pay, the state will pay the entire bill if it exceeds the participant's share of costs. [21] For example, if an individual with a required $500 share of costs submits a bill for $700, Medicaid will pay the entire $700 and approve Medicaid eligibility for the rest of the month. However, if this individual submits a bill for $400, Medicaid will not pay any of the bill but will apply the $400 towards the individual's share of costs. The individual would need to submit additional bills that exceed his/her remaining share of costs before becoming Medicaid eligible for the month.

A buy-in program potentially would eliminate the share of cost requirement. Instead, all participants would pay some of the cost of their care. Essentially, by requiring premiums, the state would recover some portion of the costs to serve this population. However, given the low incomes of many currently served by the program, most people would be able to pay only nominal premiums.

[19] To qualify for the Medically Needy Program, individuals must be categorically eligible for Medicaid but have incomes that exceed financial eligibility. Thus, the program serves families with children, pregnant women, elders, and persons with disabilities.

[20] Coverage is also extended three months retroactively.

[21] However, Florida's new Medicaid fiscal agent contract, which goes into effect in 2007, requires the vender to propose a solution.

Despite these potential advantages, a buy-in program could be costly. If the state created a buy-in program that was open to all persons currently enrolled in the Medically Needy Program, up to 300,000 individuals could potentially enroll. While only about 30,000 medically needy participants incur medical bills sufficient to meet their share of cost in any given month, over 300,000 persons are enrolled in the program and nearly 100,000 people receive services at some point during the year (the remainder do not incur sufficiently costly medical bills to cover their share of cost and receive Medicaid coverage). Thus, a large number of persons could participate in the buy-in program, making its costs similarly large.

Changes to the federal Medicare program could significantly reduce the number of current medically needy with long-term health care needs. Medicare Part D, which goes into effect on January 1, 2006, will reduce the medically needy eligibility of a large number of persons. Medicare Part D will pay for prescription drugs for "dual eligible" individuals who receive both Medicare and Medicaid benefits. Many of Florida's medically needy are dual eligibles with high ongoing prescription drug costs. These persons may no longer be eligible for medically needy services once Medicare starts paying these costs. In August 2005, approximately 18,850 (or 60%) of the medically needy who received Medicaid assistance were dual eligibles.

As a result, the implementation of Medicare Part D could significantly reduce the number of medically needy persons with established long-term medical needs. In the absence of knowledge about how Part D will affect the Medically Needy Program, it is difficult to predict how many would participate in a buy-in option. The people who would remain medically needy eligible would be families with children who access the program because of an unanticipated catastrophic event. These families, many of whom are young and healthy, may choose not enroll in a buy-in program because they do not see an immediate need to do so.

The large pool of potential buy-in participants and changes from Medicare Part D make estimating the size and costs for a medically needy buy-in program problematic at this time. As a result, the Legislature may wish to delay consideration of a medically needy buy-in until the state has more experience with how Medicare Part D affects enrollment in the Medically Needy Program.

Appendix A

1115 Waiver Programs Covering Non-Medicaid Eligible Individuals[22]

States can use regular Section 1115 or Health Insurance Flexibility and Accountability (HIFA) waivers to expand coverage to non-Medicaid eligible individuals. Nineteen states and the District of Columbia have developed such programs. These programs typically offer coverage to uninsured parents or caregivers of children enrolled in the state children's health insurance program (SCHIP) or to other low-income working age adults. Table A-1 provides information about these programs, including the name of the program, the initial date of waiver approval, the funding source(s), the populations covered, the type of participant cost-sharing required, and the benefits packages offered under the program.

Table A-1
Nineteen States and the District of Columbia Have Developed Programs to Expand Insurance Coverage to Non-Medicaid Eligible Groups Using Either Regular 1115 or Health Insurance Flexibility and Accountability (HIFA) Waivers

State	Waiver Authority	Name of Program	Initial Date of Approval	Funding Source(s)	Populations Covered	Cost-Sharing	Benefits Package
Arizona [1]	HIFA	AHCCCS	September 2001	Reallocated SCHIP and Disproportionate Share Hospital (DSH) funds	Childless adults with incomes up to 100% of the federal poverty level (FPL) and SCHIP/Medicaid Parents with incomes from 100-200% of the FPL	Premiums and co-payments based on income (same as existing Medicaid/SCHIP cost-sharing)	Same as SCHIP
California	HIFA	California Parental Coverage Expansion	January 2001	Reallocated SCHIP funds/tobacco settlement funds	SCHIP and Medicaid Parents with incomes under 200% of the FPL	Premiums and co-payments based on income, premium assistance option	Similar to SCHIP
Colorado	HIFA	CHP+	September 2002	Reallocated SCHIP funds	Uninsured pregnant women with incomes at or below 185% of the FPL	Premiums and co-payments similar to SCHIP requirements	Prenatal benefit package
District of Columbia	1115	Waiver for Childless Adults	March 2002	Medicaid	Childless adults age 50-64 with incomes at or below 50% of the FPL	None	Same as Medicaid
Hawaii	1115	QUEST	July 1993	Reallocated SCHIP, Medicaid	Non-categorical adults with incomes at or below 100% of the FPL and adults with incomes below 300% of the FPL who lose Medicaid eligibility	Premiums, co-payments, and deductibles based on income	Limited Medicaid
Illinois	HIFA	Family Care	September 2002	Medicaid and reallocated SCHIP funds	SCHIP Parents with incomes up to 185% of the FPL	Same as Medicaid/SCHIP, depending on income, premium assistance option	Same as Medicaid

[22] The waivers are authorized under Section 1115 of the Social Security Act and allow states to make changes to their Mediciad or SCHIP programs that are not normally allowed.

State	Waiver Authority	Name of Program	Initial Date of Approval	Funding Source(s)	Populations Covered	Cost-Sharing	Benefits Package
Maine	HIFA	Maine Care	September 2002	Redirected DSH payments	Childless adults with incomes at or below 125% of the FPL	Co-payments same as required by Medicaid	Same as Medicaid
Massachusetts	1115	MassHealth	April 1995	Medicaid and redirected DSH payments	Eight different eligibility groups, including parents and childless adults with incomes at or below 133% of the FPL (those under 200% of the FPL are eligible for premium assistance), long-term unemployed at or below 100% of the FPL, and emergency services to undocumented immigrants	Premiums and co-payments based on income, premium assistance option	Similar to Medicaid
Michigan	HIFA	Adults Benefit Waiver	January 2004	Reallocated SCHIP funds	Childless adults with incomes at or below 35% of the FPL	Co-payments are required only for some services and prescription drugs	Same as SCHIP
Minnesota	1115	MinnesotaCare [2]	June 2001	Reallocated SCHIP funds	Medicaid and SCHIP parents with incomes up to 275% of the FPL; childless adults up to 175% of the FPL	Premiums and co-payments based on income	Same as Medicaid
Montana	1115	Medicaid for Able-Bodied Adults	January 2004	Reallocated SCHIP funds	Parents/Caretakers of dependant children, aged 21-64 and not pregnant/disabled, with incomes at or below 185% of the FPL	Same as Medicaid, depending on income	Limited Medicaid package
New Jersey	HIFA	Parent Service Package	January 2003	Reallocated SCHIP funds (Medicaid funds used if allotment insufficient)	SCHIP Parents with incomes at or below 200% of the FPL	Premiums and co-payments required for those above 150% of the FPL, premium assistance option	Same as SCHIP
New Mexico	HIFA	NM State Coverage Initiative	August 2002	Reallocated SCHIP funds	SCHIP and Medicaid parents and childless adults with incomes up to 200% of the FPL	Premiums required only for those over 100% of the FPL, co-pays required for all enrolled	Similar/Limited Medicaid
New York	1115	Family Health Plus	July 1997	Medicaid and redirected DSH payments	Childless adults at or below 100% of the FPL and parents at or below 150% of the FPL	None	Same as Medicaid fee-for-service plan
Oregon	HIFA	OHP-2	October 2002	Reallocated SCHIP funds	SCHIP and Medicaid parents and childless adults with incomes up to 185% of the FPL	Premiums and co-payments based on income, premium assistance option	Two beneficiary levels: (1) full Medicaid/SCHIP and (2) reduced benefits
Rhode Island	1115	RIteCare	November 1993	Medicaid	Parents with incomes up to 185% of the FPL	Premiums based on income, premium assistance option	Same as Medicaid
Tennessee [3]	1115	TennCare	May 2002	Medicaid	See footnote		

State	Waiver Authority	Name of Program	Initial Date of Approval	Funding Source(s)	Populations Covered	Cost-Sharing	Benefits Package
Utah	1115	Primary Care	February 2002	Medicaid	Adults with incomes up to 150% of the FPL	Enrollment fees, co-payments, and/or co-insurance based on income, premium assistance option	Similar/Limited Medicaid
Vermont	1115	VT Health Access Plan	July 1995	Medicaid and redirected DSH payments	Medicaid parents with incomes up to 185% FPL; other adults with incomes up to 150% of the FPL.	Enrollment fees, premiums and co-payments based on income	Same as Medicaid
Wisconsin	1115	BadgerCare	January 1999	Medicaid and reallocated SCHIP funds	Custodial parents and spouses with incomes at or below 200%of the FPL	Families with incomes over 150% of the FPL must pay a 5% premium, no co-pays or deductibles, premium assistance option	Same as Medicaid

[1] This table details states using waivers for expansion populations only. Some states have active 1115 waivers, however, are using these waivers for purposes other than expanding Medicaid coverage to previously ineligible groups. Therefore, the 1115 waiver programs for these states are not detailed in this table.

[2] When the original MinnesotaCare program was implemented in the early 1990s, it did not receive federal funding; it was a solely state-funded program. The program has since evolved into its current form as a federal waiver program that uses federal SCHIP dollars as indicated in the table.

[3] TennCare began as an ambitious statewide program to decrease the number of uninsured in the state. The state established different benefit levels for Medicaid eligibles and the expansion population; however, a Tennessee advocacy group brought suit against the state. Consequently, the state agreed in federal court not to implement different benefit packages and to keep benefits intact. More people became eligible for the program than the state projected; and, as a result, Tennessee was given federal approval to disenroll 323,000 individuals in the optional and expansion groups.

Appendix B

Additional State Strategies for Addressing the Uninsured

States have implemented a variety of strategies to address their uninsured populations. Some common strategies that states have used to expand coverage include those discussed below. [23]

Ticket to Work. Under the Balanced Budget Act of 1997 or the Ticket to Work and Work Incentives Improvement Act of 1999 some states have established buy-in programs for persons with disabilities. These programs provide incentives for persons with disabilities to continue working without the fear of losing Medicaid coverage if they earn too much income. Twenty-six states participate in work incentive buy-in programs. For example, Pennsylvania's Ticket-to-Work program uses Medicaid dollars to cover working individuals with disabilities and incomes up to 250% of the federal poverty level. Participants are required to pay premiums and co-payments based on a sliding income scale.

Premium Assistance. Premium assistance programs can be implemented under a Medicaid waiver, the Health Insurance Premium Payment program, or some other mechanism. [24] Through premium assistance programs, the state pays for a portion of the enrollees' employer-sponsored or private insurance. Rhode Island's premium assistance program serves children and pregnant women up to 250% of the federal poverty level and parents with incomes up to 185% of the federal poverty level, and requires cost-sharing. Many states have found that premium assistance programs are costly and cumbersome to administer and enrollment in the programs has been lower than expected. While federal policy requires premium assistance programs to be cost-effective, a recent report suggests that the Centers for Medicare and Medicaid Services is not closely monitoring whether these programs are saving money. [25]

Reinsurance. Reinsurance programs have been implemented to stabilize health insurance markets and to maintain or increase health insurance coverage. A reinsurance program can be used to reduce premiums by shifting some of the expenses for high-cost enrollees to a third party (e.g., a reinsurance carrier, a reinsurance pool, the state). Reinsurance programs are sometimes linked to other strategies to make coverage more affordable, such as purchasing pools and small business insurance products. For example, Healthy New York is a state-subsidized reinsurance mechanism that reimburses participating health plans for 90% of the claims paid between $5,000 and $75,000 on behalf of a member in a calendar year. [26]

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[23] In addition, some states also may operate programs that are entirely state funded (through general revenue, tobacco settlement dollars, etc.). States that operate these types of programs (including Minnesota, New York, Pennsylvania, Washington and the District of Columbia) design their own eligibility and service delivery mechanisms, and may require some form of cost-sharing.

[24] The Health Insurance Premium Payment program was enacted into law as part of the Omnibus Budget Reconciliation Act of 1990. Congress had hoped that this program would expand employment-based coverage, save money for the states, and keep families together in the same insurance plan.

[25] Alker, Joan, *Premium Assistance Programs: How Are They Financed and Do States Save Money?,* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, 2005.

[26] All health maintenance organizations in New York are required to participate in the Healthy New York program.

High Risk Pools. High-risk pools are typically state-created, nonprofit associations that offer health insurance benefits to individuals who are uninsurable in the private market due to chronic or catastrophic pre-existing health problems. [27] Funding for high-risk pools is subsidized primarily through assessments on insurers, service charges or taxes on hospitals, or through state general revenues, although there are many variations on these financing mechanisms. Illinois has a high-risk pool that covers the medically uninsurable and is funded by participant premiums and state general revenue funds. In 2004, premiums for the Illinois high-risk pool were set at 143% of the average premium charged for comparable coverage in the private market.

Group Purchasing Arrangements. Group purchasing arrangements are public or private efforts to allow more than one employer and/or individuals to pool together to collectively purchase health insurance. Such arrangements seek to achieve lower-cost premiums by bringing smaller groups together to achieve the buying power of large groups. Some group purchasing arrangements are established through state legislation or regulation, while others are formed by associations of employers and/or individuals. California's group purchasing arrangement offers affordable combinations of health insurance plans, and allows small businesses and self-employed individuals to buy insurance.

See Table B-1 for a listing of states participating in these types of programs.

[27] High-risk pool participants are typically not categorized as having low-incomes. They are usually uninsurable due to diagnosis, not ability to pay.

Table B-1
Additional Strategies Used by States to Address Health Care Access for the Uninsured

State	Ticket-to-Work	Premium Assistance	Reinsurance	High-Risk Pools	Group Purchasing
Alabama				X	
Alaska	X			X	
Arkansas	X			X	X
Arizona	X		X		
California	X	X		X	X
Colorado				X	
Connecticut	X		X	X	
Florida				X [1]	
Georgia		X			
Idaho			X	X	
Illinois	X	X		X	
Indiana	X			X	
Iowa	X	X		X	
Kansas	X			X	X
Kentucky				X	
Louisiana				X	
Maine	X				
Maryland		X		X	
Massachusetts	X	X	X		
Minnesota	X			X	
Mississippi	X			X	
Missouri	X	X		X	
Montana					X
Nebraska				X	
New Hampshire	X		X	X	
New Jersey	X	X			
New Mexico	X		X	X	X
New York	X	X	X		X
North Dakota				X	
Oklahoma				X	
Oregon	X	X		X	
Pennsylvania	X	X			
Rhode Island		X			
South Carolina	X			X	
South Dakota				X	
Texas		X		X	X
Utah	X	X		X	
Vermont	X				
Virginia		X			
Washington	X			X	
West Virginia				X	X
Wisconsin	X	X		X	X
Wyoming	X			X	
Total	**26**	**16**	**7**	**32**	**9**

[1] Florida's high risk pool is closed to new enrollees.

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