State Initiatives to Expand Health Insurance

A report prepared for

The Kentucky Council on Development Disabilities

March 1, 2004

Prepared by

Developmental Disabilities Project Team

Martin School of Public Policy and Administration

University of Kentucky

Project Director: Edward T. Jennings, Jr., Ph.D.

Report prepared by: Suzanne Dale

David Shellhorse
State Initiatives to Expand Health Insurance

Executive Summary

States have pursued a variety of options to expand health insurance coverage for their residents. Many of these approaches rely on programs where the federal government shares the costs, like Medicaid and the State Child Health Insurance Program. Others have relied on purely state initiatives. The approaches have included

- Section 1115 waivers under Medicaid
- Health Insurance Flexibility and Accountability (HIFA) Waivers, a special type of Section 1115 waiver
- Health Insurance Premium Payment Programs under Medicaid
- Section 1931 of the Social Security Act
- Transitional Medicaid Assistance under welfare reform
- Employers Buy-In in the State Child Health Insurance Program (SCHIP)
- Full-cost Buy-In for Families in SCHIP
- State-only coverage programs
- State-only high risk pools
- State-only tax incentives

These programs offer diverse ways for states to expand coverage to the uninsured. The report identifies salient features of each option.

Introduction

In 2003, approximately 517,200 Kentuckians did not have health insurance. This group of uninsured makes up about 15% of Kentucky’s population. Most (80%) of the uninsured in Kentucky were in working families, with one family-member working full-time or part time. According to Families U.S.A., the uninsured in Kentucky includes children, young adults, middle-aged adults, and people nearing or at retirement age (Families U.S.A., 2003). The following chart reveals the number of uninsured in Kentucky by age:

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Uninsured</th>
<th>Percent without Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-18</td>
<td>102,300</td>
<td>9.7%</td>
</tr>
<tr>
<td>19-29</td>
<td>181,900</td>
<td>28.9%</td>
</tr>
<tr>
<td>30-49</td>
<td>150,900</td>
<td>12.9%</td>
</tr>
<tr>
<td>50-64</td>
<td>82,200</td>
<td>12.3%</td>
</tr>
<tr>
<td>Total</td>
<td>517,200*</td>
<td></td>
</tr>
</tbody>
</table>

*Total may not add due to rounding
People lack health insurance for a number of reasons: 1) Employer-based coverage is unavailable or unaffordable, 2) People who lose their jobs also lose their health insurance, 3) Buying coverage in the private market is expensive, 4) The state health care safety nets, Medicaid and State Children Health Insurance Programs, leave many people uncovered, especially adults (Families U.S.A., 2003).

Many states have begun to recognize the high costs associated with the uninsured in their boundaries. The uninsured are less likely to than the insured to use cost-saving preventive services like basic screenings and checkups, and they delay care for minor problems until they become major ones with high health and economic costs. The cost of an emergency visit is 3-4 times more expensive than a cost of a regular office visit. When the uninsured turn up in the emergency room, they usually cannot pay for the care they receive. Ultimately, these costs are paid by hospitals, taxpayers in the form of higher taxes, and the insured in the form of higher premiums (Economic Opportunity Institute, 2003). The poor health associated with the lack of insurance also decreases individual work and earning capacity. This, too, adversely affects tax revenues and the economy as a whole.

Therefore, states have searched for ways to expand health insurance coverage to more people of their residents. Typically, states have expanded coverage using Medicaid and the State Children’s Health Insurance programs, both of which are jointly funded by the federal and state governments. States can leverage federal dollars by using these programs and provide more coverage than without federal assistance. However, some states have begun their own initiatives to expand coverage, in absence of federal help. This paper discusses the three ways that states expand coverage: 1). Medicaid, 2). State Children’s Health Insurance Programs, and 3). State Coverage Initiatives.

Expansions under Medicaid

Medicaid is the nation’s major health care coverage program for the low-income population in the United States. Jointly financed by the federal and state governments, Medicaid covers three primary groups of low-income Americans: the elderly, the disabled, and children and their parents. If a state chooses to participate in Medicaid, federal rules require participating states to ensure a “mandatory” level of coverage to specific groups of people. Beyond the federal minimums, states have flexibility to cover additional “optional” groups or provide “optional” benefits (Kaiser Commission on Medicaid and the Uninsured, July 2001).

If a state wishes to change their Medicaid program in ways that will not meet federal Medicaid rules, that state may apply to the federal government for a waiver. Several states have used waivers to change their delivery system, limit benefits, and increase cost-sharing requirements for beneficiaries. Many states have used Medicaid waivers to expand health insurance coverage to populations that are not considered “mandatory” or “optional” by the federal government. State waiver requests are subject to public review and must be approved by the Department of Health and Human Services (Kaiser Commission on Medicaid and the Uninsured, July 2001).
States have used several waivers to expand health insurance coverage to populations that would not otherwise receive coverage, including couples and childless adults. The newest ways for states to expand coverage through Medicaid are by implementing Section 1115 Waivers and HIFA Waivers.

**Section 1115 Waivers**

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects which, in the judgment of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute (Centers for Medicare and Medicaid Services, 2003). States can submit demonstration proposals that meet “budget neutrality requirements,” meaning that total federal Medicaid expenditures under a waiver can be “no greater than they would have been in the absence of the demonstration for comparable services for the same beneficiaries” (Kaiser Commission on Medicaid and the Uninsured, July 2001).

Waivers are usually approved for a five-year period. States find these waivers attractive because they are the only way through Medicaid and SCHIP to expand coverage to non-mandatory and non-optional groups. The waivers also allow states the opportunity to cap enrollment and begin time-limited programs. Section 1115 demonstration waivers allow states to change provisions of their Medicaid programs and State Children’s Health Insurance Programs, including:

1. Eligibility requirements;
2. The scope of services available;
3. The freedom to choose a provider;
4. A provider's choice to participate in a plan;
5. The method of reimbursing providers; and
6. The statewide application of the program.

Kentucky implemented a Section 1115 waiver when it began the Kentucky Health Care Partnership, a managed care network, in the mid-1990s. Sixteen states have used Section 1115 authority to expand health insurance coverage to such populations as adults under age 65 and families of children on Medicaid (http://www.statecoverage.net/medicaid-1115.htm).

The issue of budget neutrality is one of the draw-backs or the “catch” of expanding coverage through the Section 1115 waivers. Budget neutrality means that in order to cover the costs of insuring new populations, these costs must be off-set by other programmatic changes in Medicaid that lower overall spending. The federal government requires that over the five-year proposed waiver period, the “with waiver” costs (what the federal government will spend under the new waiver) must not be higher than the “without waiver” costs (what the federal government would spending assuming the status quo). It is not necessary for a waiver to be budget neutral every individual year. Some waivers will have deficits in the earlier years, but these costs are offset by savings in later years. According to the Lewin Group, states use four ways to maintain budget neutrality:
(1) **Managed Care Savings:** States can move their Medicaid population into managed care programs in order to expand eligibility.

(2) **Reallocation of Disproportionate Share Hospital (DSH) Funds:** DSH funds are a special part of the Medicaid program which subsidizes certain health care providers who care for a disproportionate share of Medicaid and indigent patients. If more people are covered under Medicaid using the Section 1115 waiver, then the federal government would presumably have to pay less to states in DSH funds, and thereby states could prove budget neutrality.

(3) **Pay Now, Save Later:** Some states have used this strategy to begin HIV Waivers and Family Planning Waivers. The rationale is that if the government pays for cheaper preventative care today, then the government will realize savings in the long-run because less people will show up later who need expensive care under Medicaid.

(4) **Controlling Enrollments, Benefits, and Cost-Sharing:** States can impose enrollment caps and cost-sharing on expansive groups and optional groups in order to maintain budget neutrality. Cost-sharing includes requiring recipients to pay deductibles, copayments, and premium contributions. States can also eliminate coverage for low-priority treatments and use this money to expand coverage to other groups (Milligan, C., The Lewin Group, May 2001)

### Health Insurance Flexibility and Accountability (HIFA) Waivers

HIFA waivers are actually a type of Section 1115 waivers that began in 2001. The new waivers developed out of an initiative by the National Governor’s Association, which asked the federal government to grant states broader flexibility in designing benefits and imposing cost-sharing requirements under Medicaid and SCHIP. The governors stated that gaining eligibility under traditional Section 1115 authority was cumbersome and limiting. States were also attracted to the idea of covering more people at lower costs (State Coverage Initiatives, August 2002).

According to the CMS, the primary goal of the HIFA demonstration initiative is “to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources.” The Bush Administration puts a particular emphasis on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the Federal poverty level (FPL) (Centers for Medicare and Medicaid Services, 2003). By 2003, at least eight states had implemented HIFA waivers ([http://www.statecoverage.net/hifa.htm](http://www.statecoverage.net/hifa.htm)).

HIFA waivers allow states to do the following:

- **Limit Enrollment:** Enrollment can be controlled on either an expenditure or enrollment basis in response to budgetary changes.
• **Implement cost-sharing requirements:** States can impose cost-sharing requirements on optional groups and expansive groups (i.e. single adults and couples) provided that expenditures attributable to children do not exceed 5% of family income.

• **Have Flexibility in Benefit Design:** States can re-design benefit packages for optional and expansive groups. Benefit design for optional group is more limited than that for expansive groups.

• **Expand Coverage to Single Adults and Couples:** Some states have covered these populations using state-only dollars. HIFA allows states to leverage these programs in order to expand coverage.

• **Participate in Employer-Sponsored Insurance:** HIFA emphasizes state coordination with private health insurance coverage, through premium assistance for the purchase of Employer-Sponsored Insurance (ESI). CMS is most likely to approve HIFA applications that offer expanded coverage through ESI, and the federal government encourages all state applicants to include ESI in their waiver applications (State Coverage Initiative, 2002).

Beyond Section 1115 and HIFA Waivers, states have used other ways to expand health insurance coverage to uninsured populations. These initiatives include the Health Insurance Premium Payment Program, and expansions using Section 1931 Waivers and Transitional Medicaid Assistance.

**Health Insurance Premium Payment Program (HIPP)**

Since the early 1990s, eleven states have expanded health insurance coverage by beginning Health Insurance Premium Payment programs. These programs are Medicaid programs that pay for the cost of health insurance premiums, coinsurances, and deductibles. HIPP programs pay for health insurance for Medicaid-eligible persons who have access to employer-based insurance when it is proven cost-effective for the state to do so (http://www.statecoverage.net/hipp.htm).

**Section 1931**

At least 27 states have used Section 1931 of the Social Security Act to expand Medicaid eligibility to low-income populations. Section 1931 was established due to the passage of Temporary Assistance for Needy Families (TANF) in 1996. Under the old welfare laws, the majority of Medicaid beneficiaries became eligible for the program when they enrolled in Aid to Families with Dependent Children (AFDC). Passage of TANF delinked Medicaid and cash assistance, creating a new eligibility category which is based on state AFDC eligibility standards in effect on July 16, 1996. Section 1931 requires states to cover those families with incomes below the 1996 AFDC income limits, regardless of whether they receive cash assistance. Section 1931 also gives states greater flexibility to extend eligibility to more low-income families using any of three different mechanisms:
(1) income disregards;
(2) asset disregards,
(3) increasing income and asset limits by as much as the increase in inflation since July 1996
(http://www.statecoverage.net/medicaid-1931.htm).

Section 1931 is not a waiver program, and therefore, states using this authority to expand
coverage do not have to prove budget neutrality.

**Transitional Medicaid Assistance (TMA)**

Congress created Transitional Medicaid Assistance under the 1988 Family Support Act
(FSA). FSA required states to extend Medicaid coverage for up to 12 months to families who
lost their AFDC eligibility because of increased earnings. Under these provisions, individuals
could access TMA if they received welfare benefits and were eligible for Medicaid in at least
three of the six months prior to entering the job. The welfare reform act of 1996 extended the
states' obligation to provide TMA and provides for the continuation of Medicaid benefits for
families that have increased their earnings in excess of the state's July 16, 1996 AFDC income
and family composition standards. Eligible families are those who were receiving Medicaid
benefits while receiving cash assistance under Temporary Assistance for Needy Families
(TANF) based on those eligibility standards. Six states have expanded health insurance in their
state by extending the timeframe to receive TMA benefits: four states have a 24 month
expiration date while two states provide benefits for up to 18 months
(http://www.statecoverage.net/ma.htm).

**Expansions under State Children’s Health Insurance Programs**

The Balanced Budget Act of 1997 created a new children's health insurance program
called the State Children's Health Insurance Program (SCHIP). This program gave permission to
each state offer health insurance for children up to age 19, who are not already insured and
whose families earn up to 200 percent of the poverty level. SCHIP is a state administered
program, and each state sets its own guidelines regarding eligibility and services (Centers for
Medicare and Medicaid, 2003).

Several states have expanded health insurance to more people using their SCHIP
program. At least 15 states have raised the income threshold above 200 percent of the federal
poverty level for SCHIP eligibility. States have also begun using Section 1115 or HIFA waivers
(as detailed above) in connection with their SCHIP programs to expand health insurance
coverage. Other expansion initiatives under SCHIP include Employer Buy-In and Full-Cost Buy-
In.

**Employer Buy-In**

State *employer buy-in programs* utilize SCHIP funding to provide premium assistance to
families that are covered through employer-based insurance. In order to gain approval from the
federal government to implement an employer buy-in system under their SCHIP programs, states must demonstrate that premium assistance will be given to employer plans that meet SCHIP requirements, including benefit standards, enrollee cost-sharing limits, and minimum employer premium contribution levels. States must also demonstrate that providing premium assistance to families who pay into private insurance plans (via their employers) is more cost-effective than the cost of covering individuals directly through state SCHIP programs.

While six states have created employer buy-in programs based around SCHIP funding, only five gone through with implementation: Maryland, Massachusetts, Rhode Island, Virginia, and Wisconsin. Only the state of Mississippi has created such a program without finalizing the implementation process. Eligibility limits of these programs range from 185% of the Federal Poverty Level in Wisconsin to 300% of the federal poverty level in Maryland (http://www.statecoverage.net/employer.htm).

**Full Cost Buy-In**

State full cost buy-in programs allow higher-income families to purchase coverage for their children through their SCHIP programs at the full premium price (with no state subsidy). Connecticut’s SCHIP Husky Program, for instance, has three components: “Husky A” for traditional low-income families, “Husky B” for higher-income families, and “Husky Plus”, for higher-income families who have children with physical, developmental, behavioral, or emotional disabilities (http://www.huskyhealth.com/index.html). Along with Connecticut, only three other states utilize a full cost buy-in system: North Carolina, New York, and Florida. New York was the first state to implement this type of program in 1991, and eligibility rates in these four programs range from 200% of the federal poverty level in North Carolina to 300% of the federal poverty level in Connecticut.

**Expansions under State-Only Initiatives**

In the absence of federal support, many states have taken initiative to create their own healthcare expansion programs that are independent of larger federal programs such as SCHIP and Medicaid. In fact, forty-three states have implemented at least one state-only healthcare expansion program for their uninsured populations. There are three broad categories of the state-only initiative: coverage programs, high risk pools, and tax incentives.

**State-Only Coverage Programs**

Some states provide direct health insurance coverage or premium assistance for private coverage through programs that are state-designed and state-funded. Of the eleven states that offer such coverage programs, six states plus the District of Columbia offer direct coverage for a variety of different eligibility populations:
<table>
<thead>
<tr>
<th>State</th>
<th>Eligibility Population</th>
<th>State</th>
<th>Eligibility Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>D.C.</td>
<td>Uninsured Residents less than 200% of the federal poverty level</td>
<td>Pennsylvania</td>
<td>Adults 19-64, ineligible for Medicaid, and less than 200% FPL</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Under 19 uninsured who do not qualify for &quot;MassHealth&quot;</td>
<td>Virginia</td>
<td>Residents under 300% FPL and who have life-threatening illness</td>
</tr>
<tr>
<td>Michigan</td>
<td>Families less than or equal to 180% of federal poverty level</td>
<td>Washington</td>
<td>Uninsured adults under 200% FPL</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Adults 21+ who are less than or equal to 175% FPL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other states provide coverage programs in the forms of either reinsurance (New York and Louisiana for uninsured workers) or employer buy-in (Oregon and Rhode Island). ([http://www.statecoverage.net/coverageprogram.htm](http://www.statecoverage.net/coverageprogram.htm))

**State-Only High-Risk Pools**

High-risk health insurance plans called "risk pools" have become an important safety net for individuals who are denied health insurance because of a medical condition. More than 250,000 enrollees in the 31 states which operate high-risk pools have been provided with comprehensive insurance protection since the first pools were started in Connecticut and Minnesota in 1976. This type of system provides a vehicle for individuals who, because of their physical condition, are unable to purchase health insurance at any price ([http://www.healthinsurance.org/riskpoolinfo.html](http://www.healthinsurance.org/riskpoolinfo.html)). There are three broad individual eligibility requirements for high-risk pools:

1. People who have been denied coverage in the private market due to a chronic illness or condition;
2. People who have found they can only access restricted coverage;
3. People who have found coverage that costs more (higher premiums) than what is available from the pool ([http://www.statecoverage.net/highrisk.htm](http://www.statecoverage.net/highrisk.htm)).

High-risk pools are state-created, nonprofit associations that typically funded through assessments on insurers and government revenue. According to healthinsurance.org, however, most state high-risk pools do not require tax dollars for their operational purposes ([http://www.healthinsurance.org/riskpoolinfo.html](http://www.healthinsurance.org/riskpoolinfo.html)). They serve as temporary stopping point for individuals who are denied health insurance for medical reasons, and often help individuals fill gaps in their insurance coverage.
State-Only Tax Incentives

Many states offer tax reductions and/or credits to individuals who purchase health care for themselves, their families, or their employees. A tax incentive is a credit or a deduction that reduces the cost of purchasing health insurance through a reduction in an individual's tax payments. Tax credits are amounts subtracted from the income tax liability itself, unlike deductions, which merely reduce adjusted gross income or taxable income. Tax credits may be refundable or non-refundable. Most tax credits are non-refundable, meaning that if a taxpayer's credit exceeds his/her income tax liability, the taxpayer does not receive the difference as a refund. However, with a refundable tax credit, taxpayers whose credits exceed their income tax liabilities receive the difference in the form of a tax refund (http://www.statecoverage.net/tax.htm).

Of the seventeen states that offer health insurance-based tax incentives, fourteen of them offer standard tax deductions to individuals and their dependents that account for 100% of premium expenditures. The remaining three states—Maine, North Carolina, and Kansas—offer various forms of tax credits:

<table>
<thead>
<tr>
<th>State</th>
<th>Eligibility Population</th>
<th>Credit</th>
<th>Credit Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine</td>
<td>Small Employers with less than 5 Low-income Employees</td>
<td>Credit</td>
<td>Lower of: $125 per employee with dependent coverage; or 20% of dependent premiums</td>
</tr>
</tbody>
</table>
| North Carolina | Individual, Spouse, Dependents             | Refundable Credit | $300 (<225% FPL)  
|              |                                             |                 | $100 (>225% FPL)                                                  |
| Kansas       | Small Employers                            | Refundable Credit | $35 per eligible employee per month                                |