Discussion Papers

States as Innovators in Low-Income Health Coverage

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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.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia. Publications and database are available free of charge on the Urban Institute' s web site: http://www.urban.org. This paper is one in a series of discussion papers analyzing information from these and other sources.

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I. INTRODUCTION

The majority of nonelderly Americans are covered with health insurance obtained through their own or a family member's employer. Others are insured through solely federally funded programs, such as Medicare or military health programs. A small share purchase private coverage in the individual market. Those remaining without private or fully federally funded insurance must rely on federal-state subsidy, or they are left uninsured. The number of uninsured in a state will depend on, first, how many people are not covered by private insurance or federal health programs and, second, how far states go in developing state-subsidized programs to cover those remaining.

In this paper we examine the extent to which states have been innovative in designing programs to provide health insurance to low-income Americans. Have states functioned as laboratories, with successful innovations being replicated by other states? Or have some states successfully extended coverage while the majority have done little beyond the minimum required to obtain federal matching funds under Medicaid and the State Children's Health Insurance Program (SCHIP)? Can the existing federal-state partnership be relied upon to solve the problem of the uninsured, particularly for those with low incomes?

Following a discussion of the mechanisms available for states to expand coverage, this paper introduces a typology for designating states by the extent of their coverage expansions. The typology divides states into four groups, ranging from most to least innovative. The results show that it is only a minority of states that have seriously attempted to extend coverage beyond what are essentially levels required for Medicaid and SCHIP. These states have used considerable creativity in employing diverse funding streams and have fought many difficult

political battles to achieve what they have. In contrast, the majority of states have done relatively little to expand coverage beyond minimum federal requirements.

We then describe the programs developed by the most innovative states. The concluding discussion highlights differences between those states that have chosen to substantially expand coverage and those who have not. We show that coverage innovations are more likely in states that have higher incomes, higher education levels, larger urban populations, and that are less politically conservative. We additionally demonstrate that the thirteen states in the most innovative group have the highest rates of public coverage and the lowest uninsurance rates, but they also have likely reduced some private coverage. Even in these more innovative states, uninsurence rates for low-income populations remain surprisingly high.

II. STATE EXPANSION MECHANISMS

States have several options for providing health insurance to the uninsured. These include expansions of traditional Medicaid, state Medicaid Section 1115 research and demonstration waiver initiatives, SCHIP coverage expansion for children and recently parents, and exclusively state-funded programs. Legislation enacted in the past several years created new opportunities for states to receive federal matching funds. For Medicaid, Section 1931 of the Social Security Act considerably increased a state's ability to extend Medicaid coverage to both parents and children in low-income, working families. The SCHIP legislation of 1997 gives states generously matched federal dollars for coverage expansion to children and, to some extent, parents (primarily with waivers). States are also using interesting combinations of Section 1115, Section 1931, and SCHIP funding authorities to craft new coverage designs for

children and adults. This section will discuss the coverage expansion mechanisms at a state's disposal.[1]

A. Traditional Medicaid

Medicaid is the federal-state-financed program that provides health coverage to certain low-income populations, including low-income elderly and disabled persons, nondisabled parents (mostly women) and children receiving cash assistance, low-income pregnant women and children, as well as medically needy populations who meet categorical eligibility requirements but have high medical expenses.

Medicaid is an entitlement program. Once eligibility policies have been set, both the federal government and states have an obligation to pay for all eligible beneficiaries. Under the program, the federal government reimburses the state for at least 50 percent of Medicaid's costs.[2] Eligibility for this federal financial participation (FFP) depends on a state's adherence to the federally mandated rules and requirements of Medicaid, including minimum benefit requirements, family composition requirements, and eligibility limitations. Within those requirements, states have a great deal of flexibility.

Medicaid Rules, Requirements, and Structure

Medicaid requires applicants meet categorical eligibility requirements and pass means testing. Historically linked to receipt of cash assistance through Aid to Families with Dependent Children (AFDC) for children and parents or Supplemental Security Income (SSI) for the disabled and elderly, federal law mandates Medicaid coverage for four categories of

[1] This paper builds off of work by Krebs-Carter and Holahan. Melora Krebs-Carter and John Holahan, *State Strategies for Covering Uninsured Adults* (Washington D.C.: The Urban Institute, 2000). *Assessing the New Federalism* Discussion Paper 00-02.

low-income individuals: pregnant women, parents and children, the elderly, and persons with disabilities. To pass Medicaid's means tests, an applicant must have income and assets that fall below the levels specified by the state for that category. These income levels are often very low—as low as approximately 22 percent of the federal poverty level (FPL) for cash recipients in Louisiana.[3]

In addition to the traditional eligibility categories, there are many more groups that states are either now required to or may opt to cover. Beginning in the late 1980s, a series of federal legislative initiatives created a broad "poverty-related" eligibility category for pregnant women, infants, and children with income thresholds significantly higher than the traditional AFDC levels. Coverage of pregnant women, infants, and children up to age 6 was federally mandated to 133 percent of FPL. States were also required to phase-in coverage for older children with family incomes below the poverty level who were born after 1983. In 1988, Section 1902(r)(2) of the Social Security Act enabled states to expand Medicaid coverage to pregnant women, infants, and children at higher income levels by disregarding certain amounts of income or assets. Other optional eligibility categories target small populations, such as the recent extension of eligibility to breast and cervical cancer patients. For both the required and optional groups, the state receives FFP.

States may also develop medically needy programs that are designed to provide coverage for slightly higher-income individuals and people with large health care expenses. Under medically needy programs, states may elect to cover any categorically eligible individual who has an income or asset that are up to one-third higher than the AFDC limit as in

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

[3] Kathleen A. Maloy, Kyle Anne Kenney, Julie Darnell, and Soeurette Cyprien. *Can Medicaid Work for Low-Income Working Families?* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2002).

place on July 16, 1996.[4] Many people, particularly those with chronic health problems or long-term care needs, may also qualify as medically needy through the "spend down" process, in which their medical expenses are deducted from their income or assets in computing eligibility.

Transitional Medical Assistance (TMA) was established in 1988 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. TMA has been relatively underutilized due to the requirement that families had to have been on welfare, the program's time limitations, and the burdensome reporting requirements for both states and recipients.[5]

B. Medicaid Section 1931: Family Coverage

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 also altered Medicaid eligibility criteria, making Medicaid expansions for families more economically feasible to states by "delinking" cash assistance and Medicaid eligibility determinations, thereby 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 and gives states flexibility to establish more liberal eligibility rules to provide Medicaid coverage to families. States can expand Medicaid to higher-income families without also expanding cash assistance programs, giving greater

[4] U.S. House of Representatives, Committee on Ways and Means, *1998 Green Book* (Washington, D.C.: U.S. Government Printing Office, May 19, 1998) 955-6.

[5] Marilyn Ellwood and Kimball Lewis, *On and Off Medicaid: Enrollment Patterns for California and Florida in 1995* (Washington, D.C.: The Urban Institute, 1998). *Assessing the New Federalism* Occasional Paper No. 27.

incentive to provide coverage to more families. However, this category is only available to families (children and parents), so a large number of uninsured adults are still ineligible.

The key provision of Section 1931 is that 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.[6,7] States can also 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 may 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 but is now extended to parents.[8]

As of August 7, 1998, the Department of Health and Human Services also 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. Prior to its elimination, this rule afforded Medicaid eligibility to two-parent families only if the primary wage-earner was incapacitated or worked fewer than 100 hours per month. While some states have had 1115 waivers for this rule, all states now have the option of treating eligible one- and two-parent families equally.[9,10]

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[6] 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.

[7] 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.

[8] Jocelyn Guyer and Cindy 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, 1998).

[9] Ibid.

[10] States can link their Section 1931 income and resource standards to the consumer price index (CPI), increasing the standards as the CPI increases, and ensuring that inflation does not lead to a gradual reduction of eligibility

C. Medicaid Section 1115 Waivers

Medicaid expansions are also possible through research and demonstration waivers authorized under Section 1115 of the Social Security Act. 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.[11]

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 to expand coverage and still meet the budget neutrality requirements of the waiver. Additionally, section 1115 waivers are the only way states have been able to obtain Medicaid funds to cover childless adults (unless disabled).

In August 2001, the Bush administration introduced a new Section 1115 waiver authority, the Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA), which permits states to scale back benefits for optional eligibility groups and use the savings, as well as other funding such as any unspent SCHIP allotment, to extend coverage. It is too soon to judge the response to this initiative.

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over time. Under this provision, states can also restrict coverage by reducing income standards as low as the standards as of May 1, 1988. 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.

[11] CMS, *1115 Waiver Research and Demonstration Projects*, http://www.hcfa.gov/medicaid/hpg5.htm (accessed October 29, 2001).

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

Established in August 1997 as Title XXI of the Social Security Act, SCHIP 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 allocated over $20 billion to SCHIP over five years in the form of matching grants to states based on the state's share of the nation's low-income and low-income uninsured children.[12] SCHIP allows states to design their own stand-alone program, cover children through Medicaid, or create a program that combines both types of coverage. For SCHIP-enrolled children, states receive an enhanced federal match rate that is 30 percent higher than the Medicaid FFP.

SCHIP legislation affords states flexibility to determine eligibility thresholds. The program targets children with family incomes above Medicaid eligibility levels and below 200 percent of FPL; however, states are not required to expand to this income level and have the option of extending SCHIP coverage to children from families with higher income levels through the use of income and resource disregards. Under Title XXI rules, SCHIP funds cannot be used to provide coverage for children already covered through private insurance or Medicaid, even if their coverage is insufficient or a financial burden.[13]

Until recently, the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration, or HCFA) had restricted use of SCHIP funding for coverage of parents through strict cost-efficacy standards. To qualify for the family coverage "variance," the state had to demonstrate that coverage of parents and children was no more

[12] Genevieve Kenney, Frank Ullman, and Alan Weil, *Three Years into SCHIP: What States Are and Are Not Spending* (Washington, D.C.: The Urban Institute, 2000). *Assessing the New Federalism* Policy Brief A-44.
[13] U.S. General Accounting Office (GAO), *Children's Health Insurance Program: State Implementation Approaches Are Evolving* (Washington, D.C.: GAO). GAO/HEHS-99-165.

costly than if only the children were covered, making parental SCHIP coverage a viable option for only a few states. CMS had also been unwilling to approve Section 1115 waivers that waived these rules and incorporated SCHIP parent funding because they felt that states must first develop successful traditional SCHIP programs before attempting any type of demonstration project.[14] With SCHIP programs entering their second and third years, CMS began accepting SCHIP waiver applications in August of 2000.[15] Thus far, CMS has approved four SCHIP waivers allowing Minnesota, New Jersey, Rhode Island, and Wisconsin to receive the enhanced match rate for parents of SCHIP-enrolled children. Other state waivers are under consideration.[16]

E. State-Funded Initiatives

In addition to federal-state-financed 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 may cap enrollment at any point in order to stay within a budget. The most prominent state-funded program has been Washington State's Basic Health Plan (BHP). Many other 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

[14] Ibid.

[15] CMS, Letter from Timothy M. Westmoreland to State Health Officials, July 31, 2000. http://www.hcfa.gov/init/ch73100.htm (accessed November 1, 2001).

[16] CMS, State Children's Health Insurance Program (SCHIP) *Approved* Section 1115 Demonstration Proposals, http://www.hcfa.gov/init/1115waiv.pdf (accessed February 22, 2002).

York was an exception with its Home Relief program, which has now been incorporated into its Section 1115 demonstration.

III. STATES AS INNOVATORS

States have used the various mechanisms described above, including combinations of them, to achieve their coverage objectives. In order to examine the structure of innovative programs and analyze common characteristics of states by their likelihood to expand coverage, we developed a typology to classify states into four groups. The groups are as follows:

- Group I: States (13) that have covered nonparents to at least 100 percent of FPL. Group I also includes states that have extended coverage of children above 200 percent of FPL and to parents to 150 percent of FPL or above.
- Group II: States (11) that have had a significant coverage expansion for children and/or their parents. These states cover children with income levels above 200 percent of FPL and/or cover parents to at least 100 percent of FPL.
- Group III: States (14) that cover children to 200 percent of FPL through the SCHIP program and, although these states have not extended coverage to parents beyond AFDC levels, they have eliminated the 100-hour rule, thereby covering two-parent, working families.
- Group IV: States (12) that have not extended coverage for children to 200 percent of FPL or have not eliminated the 100-hour rule. These states have not extended coverage to parents beyond AFDC levels.

Table 1 shows how the 50 states are distributed into the four groups, as well as their current eligibility levels for children, parents, and nonparents.

Table 1: States by Groupings with Current Eligibility Levels for Children, Parents, and Nonparents

	Children	*Parents* [a]	*Nonparents*	*Expansion Type*	*100 hour rule elimination?*	*Notes*
Group I						
Arizona	200	200	100	1115/HIFA	Yes	HIFA parent expansion (100-200%) scheduled to begin October 1, 2002.
Connecticut[b]	300	150	—	1931	Yes	At 185% when legislation initially passed, but scaled back to 150% prior to implementation.
Delaware	200	100	100	1115	Yes	
Hawaii	200	200	100	1115	Yes	
Massachusetts[b]	200	200	133	1115	Yes	Other coverage up 400% (Medical Security Plan).
Minnesota[b]	275[c]	275	175	SCHIP 1115	Yes	
New Jersey	350	200	100	SCHIP 1115	Yes	
New York[b]	250	150	100	1115	Yes	
Oregon[b]	170	100	100	1115/SF	Yes	State plans to submit HIFA waiver.
Rhode Island[b]	250	185	—	SCHIP 1115	Yes	
Tennessee	400	400	400	1115	No	Enrollment for adults closed since 1995. Pending waiver will scale back to 250%.
Vermont[b]	300	185	150	1115	Yes	
Washington[b]	250	200	200	SF	Yes	Submitted 1115/HIFA waiver to receive match for state funded populations.
Group II						
California[b]	250	100	—	1931	Yes	State's budget crisis indefinitely delayed SCHIP 1115/HIFA expansion to parents to 200%.
Georgia	235	64	—	—	Yes	
Maine	200	150	—	1931	Yes	
Maryland	300	44	—	—	Yes	
Missouri	300	100,125	—	1115	Yes	Custodial parents up to 100%, non-custodial parents actively paying child support up to 125%.
New Hampshire[b]	300	64	—	—	No	No 100-hour rule elimination; recipient remains eligible to 102%.
New Mexico	235	60	—	—	Yes	
Ohio	200	100	—	1931	Yes	
Pennsylvania[b]	235	68	—	—	Yes	
Utah	200	150	150	HIFA	Yes	Comprehensive care only to TANF families; other adults eligible for only primary care services.
Wisconsin[b]	185	185	—	SCHIP 1115	No	No 100-hour rule elimination for Medicaid, but two parent working families are eligible through BadgerCare; recipient remains eligible to 200% FPL.
Group III						
Alabama	200	31	—	—	Yes	
Alaska	200	82	—	—	Yes	Recipient remains eligible to 124%.
Arkansas	200	22	—	—	Yes	No 100-hour rule elimination for Medicaid; recipient remains eligible to 54%.
Florida	200	33	—	—	Yes	Recipient remains eligible to 68%.
Indiana	200	32	—	—	Yes	Eligibility threshold at 100% for TANF families.
Iowa[b]	200	90	—	—	Yes	
Kansas[b]	200	42	—	—	Yes	Recipient remains eligible to 65%.
Michigan[b]	200	66	—	—	Yes	State plans to submit HIFA waiver.
Mississippi	200	39	—	—	Yes	Recipient remains eligible to 57%.
Nevada	200	59	—	—	Yes	Allows 134% for the first three months of coverage and then eligibility drops to 59%.
North Carolina	200	64	—	—	Yes	
South Dakota	200	68	—	—	Yes	
Texas	200	34	—	—	Yes	Allows 45% for the first four months of coverage and then eligibility drops to 34%.
Virginia	200	32	—	—	Yes	Recipient remains eligible to 47%.
Group IV						
Colorado	185	43	—	—	Yes	
Idaho	150	35	—	—	Yes	
Illinois	185[c]	58	—	—	Yes	Recipient remains eligible to 96%. Pending HIFA waiver.
Kentucky	200	52	—	—	No	100-hour rule applied to applicants only; recipient remains eligible to 77%.
Louisiana	200	22	—	—	No	No 100-hour rule elimination for Medicaid.
Montana[b]	150	71	—	—	Yes	
Nebraska	185	45	—	—	No	No 100-hour rule elimination for Medicaid.
North Dakota	140	89	—	—	Yes	Allows 151% for the first six months of coverage and then eligibility drops to 89%.
Oklahoma	185	50	—	—	No	No 100-hour rule elimination for Medicaid.
South Carolina	150[c]	56	—	—	Yes	
West Virginia	150	46	—	—	No	No 100-hour rule elimination for Medicaid.
Wyoming	133	67	—	—	Yes	

a. FPL levels for parent coverage estimated by the dollar amount for a family of three. Kathleen A. Maloy, Kyle Anne Kenney, Julie Darnell, and Soeurette Cyprien, *Can Medicaid Work for Low-Income Working Families?* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2002).

b. State has a medically need program with an eligibility level at 60% FPL or higher.

c. State offer coverage at a higher level for infants. Minnesota, 280% FPL. Illinois, 200% FPL. South Carolina, 185% FPL.

We regard Group I states as the real innovators, those that have gone significantly beyond required minimums. The classification approach is based on first, whether the state extends coverage to nonparents, and second, the extent of coverage to parents and children. We argue that coverage of nonparents to 100 percent of FPL or more is the most significant step for three reasons: first, states must either obtain a Section 1115 waiver to receive FFP or solely use state funds; second, coverage of nonparents is not as politically popular as coverage of children and their parents; and third, there are many more uninsured nonparents than parents

and they tend to be more costly on a per-person basis because they are generally older and less likely to be in excellent or very good health.[17] All states that have extended coverage to nonparents are in Group I. Also included are states that have gone to 150 percent of FPL or above for parents, in addition to increasing coverage for children to above 200 percent of FPL. Group I includes several large states, including Massachusetts, New Jersey, and New York.

Group II includes a number of states that have significant expansions in coverage for either children or parents. Georgia, Maryland, Missouri, New Hampshire, and Pennsylvania have all extended coverage above 200 percent of FPL or above for children. Maine, Missouri, Ohio, and Wisconsin have extended coverage for parents to 100 percent of FPL or higher. Utah extended coverage for adults to 150 percent of FPL but only for primary care and preventive sources.

Group III states have reached the target coverage levels established in SCHIP, 200 percent of FPL, and cover two-parent families with incomes below AFDC/TANF levels. This group of states is mostly in the south and west and includes several large states including Florida, Michigan, North Carolina, and Texas. Group IV states have not increased coverage of children to the SCHIP target level and have not gone beyond minimum levels for adults. These states are again mostly in the south and west; most are small states except for Illinois.

In the next section we briefly describe innovations adopted by some of the states in Group I to illustrate the complexity of the coverage initiatives and ingenuity these states have displayed. The states are ordered by population size.

[17] Authors' tabulations from the March 2001 Current Population Survey.

New York

New York provides extensive coverage for low-income populations, including nonparent adults, through a comprehensive Medicaid and SCHIP program. Coverage of children was expanded to 250 percent of FPL under the state's SCHIP program, a program that built upon an older state-funded initiative, Child Health Plus, which began in 1991 and provided a more limited benefit package than Medicaid. The SCHIP program was implemented in April 1998 and by December 1999 it had already enrolled 425,522 children,[18] by far the largest in the U.S.

For many years the state's Home Relief program provided health benefits to very low income nonparent adults. Beginning in 1997, the state received federal Medicaid matching funds for that population through an 1115 waiver. In December 1999, New York legislators approved the Health Care Reform Act of 2000, which created Family Health Plus, a program expanding eligibility to parents with incomes up to 150 percent of FPL and other adults up to 100 percent of FPL. The Family Health Plus 1115 waiver amendment gained CMS approval in June 2001.[19] The benefit package for Family Health Plus is nearly identical to the Child Health Plus package.

[18] New York's SCHIP enrollment has remained fairly constant for several years. By December 2001, California growing enrollment matched New York's. Vernon K. Smith and David M. Rousseau, *SCHIP Program Enrollment: December 2001 Update* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2002).

[19] CMS, *New York Statewide Health Reform Demonstration Fact Sheet*, http://www.hcfa.gov/medicaid/1115/nyfact.htm (accessed November 1, 2001).

Table 2.
New York's Family Health Plus
Family Income as a Percentage of FPL

	Children				Parents	Nonparents
	Infants	*Age 0-5*	*Age 6-16*	*Age 17 and 18*		
Traditional Medicaid	185%	133%	100%	AFDC, ~51%	TANF	
SCHIP-Medicaid				100%		
SCHIP-SSP	250%	250%	250%	250%		
1931 Authority					150%	
1115 Waiver						100%
Premiums	<160%: None; 160-222%: $9/child/month ($27 family max); 223-250%: $15/child/month ($45 family max).[20]				None	None
Cost Sharing	None				None	None

New York also developed a program, "Healthy New York," which has the aim of making health insurance more affordable for small businesses with low-income employees and for low- to moderate-income working uninsured individuals. Rather than providing direct subsidies, Healthy New York attempts to reduce the cost of private insurance by shifting some of the risk of high-cost cases to the state. For certain small firms with many low wage workers and low-income uninsured individuals, the state is establishing two stop-loss funds (one for small group coverage and one for individual coverage) from which health plans will be reimbursed for 90 percent of claims that fall between $30,000 and $100,000.[21]

[20] CMS, *New York's State Fact Sheet*, http://www.hcfa.gov/init/chpfsny.htm (accessed October 29, 2001).
[21] Teresa Coughlin and Amy Westpfahl Lutzky, *Recent Changes in Health Policy in New York* (Washington, D.C.: The Urban Institute, 2002). *Assessing the New Federalism* State Update No. 22.

New Jersey

New Jersey has made significant increases in coverage in the past several years, spurred by the new federal SCHIP funds offered in 1997.[22] Prior to SCHIP funding, New Jersey had limited Medicaid coverage that included AFDC children and parents (approximately 41 percent of FPL[23]) and poverty-related children to 100 percent of FPL for ages 6 through 14. Although the state chose to develop their New Jersey KidCare SCHIP program outside of Medicaid, New Jersey first increased its Medicaid thresholds to 133 percent of FPL for children of all ages so that all children in a family will receive the same type coverage. SCHIP coverage is offered to uninsured children up to 350 percent of FPL, the nation's highest level.[24]

In January 2001, New Jersey was one of the first states to receive an 1115 waiver to use SCHIP funding for coverage of parents.[25] The expansion, now called New Jersey FamilyCare, attempts to create a seamless system for families by providing care through a single program, although funding sources and benefits may vary depending on the enrollee. In anticipation of the waiver, the state had used its Section 1931 authority to begin coverage of parents up to 133 percent of FPL in September of 2000. The SCHIP waiver gives New Jersey the higher SCHIP matching rates for any parent with an SCHIP child. New Jersey FamilyCare provides the Medicaid benefit package for all parents below 133 percent of FPL. Benefits for those earning

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22 Frank Ullman and Randy Bovbjerg, *Recent Changes in Health Policy in New Jersey* (Washington, D.C.: The Urban Institute, 2002). *Assessing the New Federalism* State Update No. 21.

23 Kathleen A. Maloy, Kyle Anne Kenney, Julie Darnell, and Soeurette Cyprien. *Can Medicaid Work for Low-Income Working Families?* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2002).

24 Donna Cohen Ross and Laura Cox, *Making It Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2000).

25 CMS, *State Children's Health Insurance Program (SCHIP)* Approved *Section 1115 Demonstration Proposals*, http://www.hcfa.gov/init/chpwvrsd.pdf (accessed August 6, 2001).

over 133 percent are based upon private insurance benchmarks and cost-sharing is based on family income. Premium contributions are required at family incomes above 150 percent of FPL and the premium contribution rises with income.

New Jersey also has gone beyond most other states in allowing childless adults to qualify for coverage under FamilyCare, even though the funding is only through state dollars with no federal match. Childless adults with income below 50 percent of FPL are eligible for Medicaid-like benefits and childless adults between 50 percent and 100 percent of FPL are eligible for a somewhat less comprehensive package. Just months after implementation, FamilyCare surpassed enrollment expectations.[26] On September 1, 2001, the state ceased accepting new applications from childless adults.

Table 3.
NJ FamilyCare
Family Income as a Percentage of FPL

	Children				**Parents**	**Nonparents**	**Pregnant Women**
	Infants	*Age 1-6*	*Age 6-17*	*Age 17 and 18*			
Traditional Medicaid	185%	133%	100%	~41%	TANF, ~41%		185%
SCHIP-Medicaid			133%	133%			
SCHIP-SSP	350%	350%	350%	350%			
SCHIP-1115 waiver					200%		200%
State-Only Funding						100%	
Premiums	<150%: none; 151-200%: $15 per family per month; 201-250%: $30 per family per month; 251-300%: $60 per family per month; 301-350%: $100 per family per month.				$25 for the 1st adult, $10 more for the 2nd per month.	None	None
Cost Sharing	$5-$35				$5-$35	None	None

Notes: For families with incomes between 151 and 200 percent of FPL, the maximum family premium is $50 per month. Emergency Department visits are the most expensive copay. There is also some cost sharing for outpatient prescription drugs.

[26] Frank Ullman and Randy Bovbjerg, *Recent Changes in Health Policy in New Jersey* (Washington, D.C.: The Urban Institute, 2002). *Assessing the New Federalism* State Update No. 21.

Massachusetts

Massachusetts has developed a broad, comprehensive program funded through a Medicaid Section 1115 waiver and SCHIP. It combines both a public program expansion and employer and employee subsidies. Known as MassHealth, the program has several components, with different funding sources, but is largely seamless to the beneficiary. The first and largest component is MassHealth Standard, which includes traditional Medicaid as well as a Medicaid expansion that covers pregnant women and infants up to 200 percent of FPL, children ages 1 to 18 up to 150 percent of FPL, and parents and disabled adults up to 133 percent of FPL. All but pregnant women and people with disabled are enrolled in Medicaid managed care plans. The second component is the MassHealth CommonHealth program, which covers a small number of very expensive disabled children and adults who are not eligible for MassHealth Standard.

The third component, Family Assistance, is the second largest component of MassHealth, but has less than 10 percent as many enrollees as Standard. Most assistance takes the form of Standard-like coverage for children in families at 150-200 percent of FPL, above the Standard ceiling. Those who do not have access to employer-sponsored insurance (ESI) get coverage directly from the state; the smaller share who have access to ESI get that coverage, but have almost all of their premiums paid by the state. In each case, the families make a small monthly contribution to premium (table 4). The more innovative, newer, and smaller parts of Family Assistance apply to low-income parents and nonparents with access to qualified ESI from a qualified small employer (under 50 full-time employees). These provisions were implemented slowly, in phases, as the state learned how to interface with the complexities of private markets. Qualifying employers can receive up to $1,000 a year per qualifying low-

income enrollee by offering comprehensive ESI and paying half the premium. Qualified low-income enrollees (up to 200 percent of FPL) have their premium share paid, again except for a small monthly contribution, which is larger for adults than for children.

MassHealth Basic is the fourth component of the MassHealth program and provides a fairly comprehensive set of medical services to chronically unemployed individuals with incomes below 133 percent of FPL who have no health insurance. MassHealth Buy-In is the fifth component of the program and provides premium assistance to the chronically unemployed with incomes below 133 percent of FPL who have health insurance for which they pay a premium.

In a recent expansion to its Section 1115 waiver, Massachusetts increased MassHealth eligibility to cover persons living with HIV before onset of AIDS, under age 65, and up to 200 percent of FPL. Beyond MassHealth, the state also runs a Children's Medical Security Plan of limited coverage for basic services to otherwise uninsured children under age 19, as well as a Medical Security Plan for adults eligible for unemployment compensation with family incomes up to 400 percent of FPL that provides managed care coverage or contributions to COBRA continuation of ESI, with cost sharing and annual limits.

In addition to all these insurance programs, the state funds two large programs of managed care for the otherwise uninsured run by the state's two biggest safety net hospital systems, as well as a large uncompensated care pool to pay for charity care at all hospitals and community health centers, which are near-entitlements run somewhat like insurance in Massachusetts.

Table 4.
MassHealth Standard, Family Assistance, and Basic
Family Income as a Percentage of FPL

	Children			Parents	Nonparents	Pregnant Women
	Infants	*Age 1-16*	*Age 17 and 18*			
Traditional Medicaid	185%	133%	AFDC, ~86%	TANF		185%
SCHIP-Medicaid		150%	150%			200%
SCHIP-SSP	200%	200%	200%			
MassHealth Family Assistance[a]				200%[c]	200%[c]	
MassHealth Basic[b]					133%	
Type of Coverage	Medicaid and SCHIP: MassHealth (Medicaid Managed Care); MassHealth Family Assistance: State-approved ESI; MassHealth Basic: Reduced benefit package, adult day and foster care, hospice, nursing facility, and non-emergency transportation services are not covered.					
Premiums	Medicaid:None; SCHIP: $10 per month for each child, family maximum of $30 per month; MassHealth Family Assistance: Any cost not paid by their employer and the state; MassHealth Basic: None.					
Cost Sharing	Medicaid and SCHIP: None; MassHealth Family Assistance: Any cost not paid by their employer and the state; MassHealth Basic: None.					

Notes: The state receives the Medicaid FFP for MassHealth Family Assistance and MassHealth Basic enrollees.

a. Childless adults must work for a qualified employer. 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. MassHealth Family Assistance is also available to children in families under 200 percent of FPL who do not meet SCHIP requirement or whose family has access to state-approved ESI.

b. Mass Health Basic is available only to chronically unemployed individuals.

c. Parents and nonparents not eligible for MassHealth Family Assistance are eligible for the state program for the uninsured.

Washington

In 1993, **Washington** passed health care reform legislation intended to create universal coverage through expanded Medicaid eligibility for children to 200 percent of FPL and pregnant women to 185 percent of FPL, a state-subsidized health insurance program (the Basic Health Plan, BHP), an employer mandate, and insurance market reforms. 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.[27]

The BHP allows adults, including nonparents, and children to buy health insurance through the state with a benefit package comparable to most employer-sponsored insurance plans. The intent of the BHP was to offer coverage both to individuals and through employers. For individuals, subsidized coverage was to be available for adults and families with incomes below 200 percent of FPL. Those with incomes above 200 percent were to be able to join by paying the full premium. Today, the subsidized portion of BHP is strong, enrolling about 130,000 people; however, employer-purchased BHP and the non-subsidized program have not faired as well.

By allowing employers to purchase affordable insurance with the BHP, state officials hoped many small business owners would offer coverage through this option. However, the availability of highly subsidized insurance to individuals without employee sponsorship discouraged employer-sponsored 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 at approximately 133,000 people in 1996. Budget shortfalls projected in the 2001-2003 biennium further reduced enrollment to 125,000.[28]

The non-subsidized or "full premium" part of BHP has essentially collapsed. Because of adverse selection, premiums rose sharply and dramatically reduced enrollment. Adverse selection also struck the individual market where the state had mandated guaranteed issue and

[27] Len Nichols, et. al., *Health Policy for Low-Income People in Washington* (Washington, D.C.: The Urban Institute, 1997). *Assessing the New Federalism* State Report.
[28] John Holahan and Mary Beth Pohl, *Recent Changes in Health Policy in Washington* (Washington, D.C.: The Urban Institute, 2002). *Assessing the New Federalism* State Update No. 24.

controlled premium levels. As insurers pulled out of the individual market, many high-risk individuals attempted to join BHP, further exacerbating its cost problems. Today unsubsidized BHP is available only in a few counties.

Children are eligible for Medicaid with family incomes up to 200 percent of FPL. For families in the BHP, the state creates seamless family coverage by allowing the children to enroll in the same health plan as the state-funded parents; however, children receive a Medicaid benefit package and do not pay the BHP premiums and cost-sharing. If families are not enrolled in BHP, children are enrolled directly in Medicaid. The state was also reluctant to initiate an SCHIP program, feeling it was penalized by not receiving the enhanced SCHIP match for its early coverage expansions to children. After pressure from advocates and the federal government, Washington began a very small SCHIP program that provides insurance for children with family incomes between 200 and 250 percent of FPL.[29]

Table 5.
Washington's Healthy Options and Basic Health Plan
Family Income as a Percentage of FPL

	Children	Parents	Nonparents	Pregnant Women
Traditional Medicaid (Healthy Options or BHP+)	200%	TANF		185%
SCHIP-SSP	250%			
State-Only Funding		200%	200%	200%
Premiums	None	Sliding scale premiums.		None
Cost Sharing	None	Copayments for prescription drugs and many outpatient and inpatient services, which are dependent on level (reduced or full) of premium contribution.		None

[29] Based on a site visit conducted October 11, 2000 as part of the Urban Institute's SCHIP evaluation *Assessing the New Federalism* project.

Tennessee

In 1994, **Tennessee** embarked on a broad coverage expansion of Medicaid, attempting to increase Medicaid coverage by about 50 percent with little additional new money. In response to projected annual 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 expand Medicaid to include the uninsured and "medically uninsurable," a high-risk group who meet the state's medical underwriting standards. 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 expanded coverage to over 400,000 previously uninsured individuals. With expenses higher than anticipated, enrollment was frozen in 1995 at 1.3 million beneficiaries and left open only to Medicaid eligibles and the medically uninsurable.

By 2000, TennCare faced impending collapse. The state temporarily froze entry of the medically uninsurable because of high costs and a fear that insurance companies were rejecting the chronically ill because they knew that TennCare would cover them. TennCare also faced deteriorating relations with plans and providers due to low capitation rates, and many of the largest plans threatened to withdraw from TennCare. The fundamental problem was 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 given the likelihood of considerable adverse selection into the program.[30]

With program costs continuing to increase and the state facing recession, Governor Sundquist developed a modified 1115 waiver that was submitted to CMS in February 2002. The waiver would restructure and constrict TennCare, decreasing enrollment by an estimated 180,000. TennCare's three parts—TennCare Medicaid, TennCare Standard, and TennCare Assist—target separate populations and have different benefit packages and cost sharing.

Residents who were Medicaid-eligible by the 1993 state plan (pre-TennCare) and uninsured women with breast and cervical cancer are TennCare Medicaid-eligible. TennCare Standard has four groups. Following the original waiver, residents deemed medically uninsurable are eligible regardless of income. Secondly, state residents with family incomes under 250 percent of FPL who do not have access to group insurance are eligible. The waiver specifically reserves the ability of the General Assembly to revise downward this income ceiling. The modified TennCare waiver additionally grandfathers two groups—Medicare eligibles who receive prescription drugs through TennCare and children with family incomes under 200 percent of FPL regardless of group insurance availability. Aside from these two populations, no other TennCare members are grandfathered into the modified program; those not meeting the new criteria will be disenrolled (anticipated to start in July 2002). Following CMS approval, the state hopes to implement Modified TennCare in January 2003. The state projects the initiation of TennCare Assist, a premium assistance program for those with family

[30] Christopher Conover and Hester Davies, *The Role of TennCare in Health Policy for Low-Income People in Tennessee* (Washington, D.C.: The Urban Institute, 2000). *Assessing the New Federalism* Occasional Paper No. 33.

incomes below 250 percent of FPL, in January 1994. The program would be available to those with access to group insurance and will help in paying premiums.[31]

Table 6.
Income Eligibility Thresholds for the *Proposed* Modified TennCare
Family Income as a Percentage of FPL

	Children				Pregnant Women	Parents	Nonparents	Medically Uninsurable[a]
	Infants	*Age 1-6*	*Age 1-15*	*Age 15-19*				
TennCare Medicaid	185%	133%	100%	TANF	185%	TANF		
TennCare - Standard	<250% and without access to group insurance.							No income ceiling
TennCare - Assist	<250% and with access to group insurance.							
Premiums	Medicaid eligible: None; Non-Medicaid beneficiaries: sliding scale based on income and family.							
Cost Sharing	- All beneficiaries: No cost-sharing for preventative services; - Medicaid eligible: None; - Non-Medicaid beneficiaries: $25 emergency room[b], $5 for primary care services, $15 Specialists, $5 generic/$15 brand name prescription drugs, $100 hospital admission.							

Notes:
a. Determined as "medically uninsurable" by state underwritting standards.
b. Waived if the patient is admitted.

Arizona

Arizona received a HIFA waiver that will allow them to use Title XXI funds to cover childless adults below 100 percent of FPL and parents between 100 percent and 200 percent of FPL. This extends the state's current Medicaid Section 1115 waiver which has extended coverage to parents to 100 percent of FPL. Arizona has a separate SCHIP program that covers children to 200 percent of FPL. The new waiver provides the higher SCHIP matching rate for the childless adults below 100 percent of FPL, and when implemented, for parents between 100 percent and 200 percent of FPL. The program will be funded through the state's SCHIP

[31] TennCare, *TennCare Program Design and Waiver Modifications, State of Tennessee, Don Sundquist. Submitted to Secretary Tommy Thompson, Department of Health and Human Services, February 12*, 2002, http://www.state.tn.us/tenncare/waiver2-11.pdf (accessed February 21, 2002).

allotment. Expenditures under the HIFA amendment will be limited to available SCHIP funds and if these are exhausted, coverage of childless adults will use Title XIX funds as part of the state's Section 1115 waiver. If Arizona does not implement the expanded coverage for parents to 200 percent of FPL, the state will only receive the Title XIX matching rate for childless adults.

Minnesota

Minnesota boasts one of the nation's most expansive publicly funded health insurance programs. As part of its 1992 comprehensive state health care reform initiatives, Minnesota created a state-funded health insurance program, MinnesotaCare, which targeted the low-income population. MinnesotaCare supplements the state's Medicaid program, a program which began moving enrolled populations to managed care through a Section 1115 Medicaid competition demonstration as early as 1985.[32] Originally, MinnesotaCare provided a basic benefit package of primary care services only to parents and children under 185 percent of FPL with funding through cigarette taxes, health care provider taxes, and enrollee premiums.[33] Numerous income threshold expansions occurred, and today, between Medicaid and MinnesotaCare, parents and children are eligible up to 275 percent of FPL and childless adults to 175 percent. The benefit package was also extended to include inpatient coverage and the

[32] Stephanie Kendall and Sharon Long, *Recent Changes in Health Policy in Minnesota* (Washington, D.C.: The Urban Institute, 2002). *Assessing the New Federalism* State Update No. 19.
[33] MinnesotaCare, *A Brief History of MinnesotaCare*, http://www.dhs.state.mn.us/hlthcare/AsstProg/mncare/history.htm (accessed August 9, 2001).

program was converted from fee-for-service to managed care. Monthly premiums are based on family size and income.[34]

Through an 1115 waiver, the funding streams for MinnesotaCare have also changed to include Medicaid matching funds for children in 1992 and parents as of 1999. Some children and parents are eligible for both Medicaid and MinnesotaCare and beneficiaries may join either. The state, however, receives the federal Medicaid match regardless of which program the beneficiary chooses to enroll. The groups eligible for either Medicaid or MinnesotaCare are pregnant women and infants up to age 2 with incomes up to 275 percent of FPL, children ages 2 to 5 with incomes up to 133 percent of FPL, children age 6 to 13 with incomes up to 100 percent of FPL, and children age 14 to 20 with incomes up to AFDC/TANF levels (~58 percent of FPL). Children who fall above these income thresholds but below 275 percent of FPL must enroll in MinnesotaCare. Parents must pay premiums for MinnesotaCare-enrolled children but they receive the Medicaid benefit package and the state receives federal matching funds.[35]

Due to the vast coverage expansions prior to SCHIP, the state was stymied by SCHIP's requirement that funds must expand coverage beyond its current eligibility levels, not simply subsidize existing programs. Minnesota's SCHIP coverage for children is limited to infants under the age of 2 between 275 and 280 percent of FPL. While this did little to provide a real increase in coverage, it did prevent other states from receiving Minnesota's SCHIP allotment.[36] In June 2001, CMS approved Minnesota's SCHIP 1115 demonstration waiver and

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[34] CMS, *Minnesota Health Reform Demonstrations*, http://www.hcfa.gov/medicaid/1115/mnfact.htm (accessed August 9, 2001).
[35] Stephanie Kendall and Sharon Long, *Recent Changes in Health Policy in Minnesota* (Washington, D.C.: The Urban Institute, 2002). *Assessing the New Federalism* State Update No. 19.
[36] MinnesotaCare, *Minnesota's Federal Medical Assistance Waivers*, http://www.dhs.state.mn.us/hlthcare/Waivers/federal.htm (accessed August 9, 2001).

the state now receives the enhanced SCHIP match for parents between 100 and 200 percent of FPL.[37]

Table 7.
Income Eligibility Thresholds, Cost Sharing, and Premiums for Minnesota Medicaid and MinnesotaCare Program
Family Income as a Percentage of FPL

	Children			Parents	Nonparents	Pregnant Women
	< Age 2	*Age 2-5*	*Age 6-17*			
Traditional Medicaid[a]	275%	133%	100%	~70%		275%
MinnesotaCare with FFP		275%	275%	70-100%, 200-275%		
MinnesotaCare without FFP					175%	
SCHIP	280%			100-200%		
Premiums	Traditional Medicaid: None; MinnesotaCare: Scaled to income					

Note:
a. Most groups eligible for Medicaid may opt to enroll in MinnesotaCare.

Oregon

In 1994, **Oregon** adopted the Oregon Health Plan (OHP), a major set of reforms developed under an 1115 waiver that expanded Medicaid to cover both parent and nonparent adults up to 100 percent of FPL through mandatory managed care. Oregon's approach is most notable for its call to trade off benefits for expanded coverage. The state developed a health services prioritization list of approved diagnosis/treatment pairs that it would cover as funds permitted. State officials believed that by limiting covered services, more of its population would receive some benefits. Oregon's SCHIP program, beginning in 1998, expanded

[37] CMS, *HHS Approves Minnesota Plan to Insure Parents in SCHIP, Medicaid,* http://www.hcfa.gov/init/061301mn.htm (accessed August 9, 2001).

Medicaid to cover children from birth to age 6 with incomes between 133 and 170 percent of FPL and to children from age 6 to 19 with incomes between 100 and 170 percent of FPL.[38]

Supplementing Oregon Health Plan and SCHIP, Oregon created the Family Health Insurance Assistance Program to offer subsidizes for low-income families for purchasing insurance through their employers. Enacted in August 1997, the fully state-funded program originally offered assistance for families with incomes up to 200 percent of FPL, but state officials quickly reduced eligibility to 170 percent and capped enrollment at 7,000 due to higher than expected costs.[39] In summer of 2001, the Oregon legislature approved expansion of OHP to all individuals with family incomes under 185 percent of FPL. The state will apply to extend its Section 1115 waiver (or apply for a HIFA waiver) and obtain federal matching funds for the newly covered adults. It is proposing a reduced benefit package, with more cost sharing, for adults above 100 percent of FPL. The extension would absorb the current Family Health Insurance Assistance Program and eliminate the current waiting list.

Table 8.
The Oregon Health Plan and The Family Health Insurance Assistance Program
Family Income as a Percentage of FPL

	Children		**Parents**	**Nonparents**
	Age 0-6	*Age 6-18*		
Traditional Medicaid	133%	100%	TANF, ~78%	
Medicaid Waiver			100%	100%
SCHIP-SSP	170%	170%		
FHIAP			170%	170%
Premiums	None		Traditional Medicaid and pregnant women: none; Other Medicaid: $6-$28 monthly premiums; FHIAP: 5-30% of the employee share of the premium cost.	
Cost Sharing	None		None	

[38] CMS, *Oregon CHIP Fact Sheet*, http://www.hcfa.gov/init/chpfsor.htm (accessed August 10, 2001).
[39] Michael S. Sparer, *Health Policy for Low-Income People in Oregon* (Washington, D.C.: The Urban Institute, 1999). *Assessing the New Federalism* Occasional Paper No. 31.

Connecticut

Connecticut's HUSKY program provides public health insurance coverage for children and their parents. HUSKY/A is a Medicaid program covering children up to 185 percent of FPL. HUSKY/B is an SCHIP program separate from Medicaid which effectively provides coverage for children up to 300 percent of FPL. Coverage for parents is provided through Section 1931 authority and extends to parents with a HUSKY/A enrolled child if the family income is less than 150 percent of FPL. Because this is an expansion under Section 1931 parents are enrolled in Medicaid and there is no cost sharing. Connecticut intended to expand coverage to parents up to 185 percent of FPL in January 2001, making all parents with HUSKY/A children eligible. However, due to budget constraints the expansion to 185 percent of FPL was reduced to 150 percent prior to implementation.

Hawaii

Hawaii was one of the original pioneers in coverage expansion efforts, though some of its program has been sharply curtailed. The Hawaii QUEST program, enacted in August 1994, was originally intended to build on Hawaii's employer mandate to create near-universal coverage. It was a public health care purchasing pool for the beneficiaries of three public programs (Medicaid, General Assistance [GA], and the State Health Insurance Program [SHIP]). The program has covered children and adults, including parents and nonparents, and care is purchased 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 FPL. The employer mandate, the only one in the nation to receive an ERISA preemption, remains intact.

Since the enactment of QUEST, there have been several program contractions to reduce expenditures. 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. Coverage for adults was reduced from 300 percent of FPL to 100 percent on January 1, 1998. In 1999, Hawaii enacted a small SCHIP program covering infants from 185 to 200 percent of FPL, children age 1 through 5 from 133 percent to 200 percent, and older children between 100 and 200 percent. SCHIP coverage is through a Medicaid expansion, but for these children the state receives the higher SCHIP matching rate.

Table 9.
Income Eligibility Thresholds for Hawaii's QUEST program
Family Income as a Percentage of FPL

	Children				Parents	Nonparents	Pregnant Women
	Infants	*Age 1-6*	*Age 6-17*	*Age 17 and 18*			
Traditional Medicaid	185%	133%	100%	100%	100%		185%
SCHIP-Medicaid	200%	200%	200%	200%			
State-Only Funding						100%	
Benefits	Standard MCO benefits, including full dental care for individual under age 21.						
Premiums	If self-employed and <100% FPL, pay 50% of monthly premium.						
Cost Sharing	Some beneficiaries required to pay $7/visit.						

Note: Income tests are applied for non-pregnant adults.

Rhode Island

Rhode Island implemented its RIteCare program in August 1994 under an 1115 waiver. In addition to moving its existing Medicaid enrollees into managed care, the waiver also expanded access to uninsured pregnant women and young children (under the age of 6) up

to 250 percent of FPL. After two expansions of the original waiver, by May 1997 RIteCare covered all uninsured pregnant women and children up to 250 percent of FPL with a full Medicaid benefit package. When SCHIP funding became available, the state received the increased match for children in the most recent expansion group—the 8- to 18-year-olds up to 250 percent of FPL. In November 1998, Rhode Island extended its 1115 waiver to expand coverage to parents earning less than 185 percent of FPL. In January 2001, Rhode Island's 1115 SCHIP demonstration waiver allowed the state to claim an enhanced SCHIP match for parents with family incomes between 100 and 185 percent of FPL and pregnant women between 185 and 250 percent of FPL. Due to concerns that employers might decrease coverage in response to the generosity of RIteCare, the state passed comprehensive legislation in 2000 that created RIteShare, a premium assistance program for families with access to employer-sponsored coverage. To date, enrollment in the program in the RIteShare program is quite low.

Delaware

Delaware created the Diamond Health State Plan (DHSP) in 1996 using a Section 1115 waiver.[40] This waiver allowed the state to use the savings generated by the managed care delivery system to expand Medicaid coverage for low-income parents and nonparents up to 100 percent of FPL. In 1999, Delaware further extended coverage for children by incorporating an SCHIP component, the Delaware Healthy Children Program, into the Diamond State Health Plan. Healthy Children provides coverage for Medicaid-ineligible children with family

[40] Melora Krebs-Carter and John Holahan, *State Strategies for Covering Uninsured Adults* (Washington, D.C.: The Urban Institute, 2001). *Assessing the New Federalism* Discussion Paper 00-02.

incomes up to 200 percent of FPL through a managed care plan.[41] Although Delaware chose to develop its SCHIP program outside of Medicaid, the Diamond State Health Plan links the two and the state employs a combined application form. Healthy Children has a monthly premium corresponding to family income.

Vermont

Utilizing Medicaid poverty-related expansions, SCHIP funding, and an 1115 waiver, **Vermont** has created a comprehensive program for most low-income children and adults. In 1989, a new program, Dr. Dynasaur, provided Medicaid access to children under the age of six in families earning less than 225 percent of FPL. In 1992, children's coverage was extended to all children under age 18. With the availability of SCHIP funds, Vermont created a separate SCHIP program, also under the name Dr. Dynasaur, for all children up to 300 percent of FPL. While the state's SCHIP children receive the higher federal match, the Medicaid and SCHIP programs appear seamless to the beneficiary with a common applications and identical program cards. The benefits, their delivery system through contracted managed care organizations, and providers are also the same. For adults, the Vermont Health Access Plan (VHAP), a Section 1115 mandatory Medicaid managed care waiver implemented in 1996, enabled Vermont to expand coverage to all uninsured adults not otherwise eligible for Medicaid up to 150 percent of FPL. In 1999, the state amended the 1115 waiver to extended eligibility to parents and caretaker relatives up to 185 percent of FPL.

[41] Delaware Title XXI Program Fact Sheet (Healthy Children), http://www.hcfa.gov/init/chpfsde.htm (accessed August 30, 2001).

IV. DISCUSSION

In the previous section we discussed a typology for dividing states into four groups ranging from most to least innovative and then described the coverage expansions crafted by a number of the most innovative states. This section utilizes the typology to examine differences in key characteristics of states by their innovation group. Table 10 shows differences in incomes, education, urbanicity, political preferences, and federal matching rates under Medicaid.

The more innovative Group I states clearly have higher per capita incomes than states in the other three groups. Eligibility expansions are less likely as per capita incomes decline. Similarly, the percent of a state's population below twice the federal poverty level is lowest in Groups I and II (27 percent) and highest in Groups III and IV (30 and 32 percent respectively). Income per low-income person ranges from $88,922 in Group I to $62,179 in Group IV. Consistent with their higher incomes, states in Group I have lowest federal matching rate (0.546) while states in Group IV have the highest (.659).

Table 10: State Demographics By Generosity Groupings

	State Group			
	I	II	III	IV
Income per Capita	$23,600	$22,188	$20,616	$19,756
Percent <200% FPL	27%	27%	30%	32%
Income per Low-Income Person	$88,922	$85,124	$69,489	$62,179
Percent College-Educated (Bachelor's)	27%	26%	23%	21%
Percent Urban	80%	75%	65%	57%
Percent Gore/Nader Vote	58%	50%	45%	41%
Average FMAP	0.546	0.594	0.614	0.659

Source: Urban Institute, tabulations of the March 2001 CPS and 2002 FMAP.

Table 11: Coverage Characteristics by Generosity Groupings

	State Group			
	I	II	III	IV
Total Population				
Gap Rate	22.5%	21.5%	23.4%	24.9%
Medicaid and State Coverage Relative to Population	9.8%	7.8%	7.6%	8.2%
Medicaid and State Coverage Relative to Gap	43.6%	37.1%	31.9%	32.9%
Uninsured Rate	12.7%	13.7%	15.8%	16.7%
Total Low-Income Population (<200% FPL)				
Gap Rate	53.3%	50.9%	49.8%	51.9%
Medicaid and State Coverage Relative to Population	29.6%	24.6%	21.2%	21.8%
Medicaid and State Coverage Relative to Gap	55.6%	48.7%	41.9%	42.3%
Uninsured Rate	23.7%	26.3%	28.6%	30.1%
Low-Income Children (<200% FPL)				
Gap Rate	55.0%	52.2%	52.5%	55.8%
Medicaid and State Coverage Relative to Population	39.8%	35.6%	31.9%	34.6%
Medicaid and State Coverage Relative to Gap	72.5%	68.7%	59.8%	62.8%
Uninsured Rate	15.2%	16.6%	20.6%	21.2%
Low-Income Adults (<200% FPL)				
Gap Rate	51.9%	49.9%	47.7%	49.1%
Medicaid and State Coverage Relative to Population	22.0%	16.8%	13.1%	13.3%
Medicaid and State Coverage Relative to Gap	42.5%	34.1%	27.2%	27.2%
Uninsured Rate	29.9%	33.1%	34.6%	35.8%

Source: Urban Institute, tabulations of the March 2001 CPS.

The percent of the population with a college education is highest in Groups I and II and lowest in Groups III and IV. Similarly, Groups I and II states have much higher urban populations than do Group III states. which in turn are more urban than Group IV states. States in Groups I and II are more politically liberal as indicated by the percent of voters supporting Gore or Nader in the November 2000 election, 58 percent and 50 percent respectively, versus 45 and 41 percent in Groups III and IV. Thus, states in Group I have higher incomes, higher education levels, are more urban, less politically conservative, but have lower federal matching rates. It seems clear that the higher matching rates available to states in Groups III and IV are not sufficient to offset lower incomes or prevailing political philosophy.

Table 11 summarizes the impact of the coverage expansions adopted by each of the four groups of states using the concept of the "coverage gap" developed by Spillman.[42] The gap is defined as the percentage of a state's population not covered by private insurance, Medicare, or CHAMPUS—the notion being that it is this gap population that would be uninsured if not for Medicaid or other state subsidized insurance.

The table shows the gap rates for the total nonelderly population, all nonelderly low-income indivduals, low-income children, and nonelderly low-income adults, followed by Medicaid and state coverage as a share of the low-income population. Next, we calculate the population covered by Medicaid or state subsidized insurance divided by the gap. These two rates together determine the uninsurance rate. The smaller the gap and the greater the Medicaid-state coverage relative to the gap, the lower the state's uninsurance rate.

Surprisingly, there is not a great deal of difference in the gaps across the four groups of states. As displayed in table 11, there are essentially no differences for the total population, because these are largely driven by higher income groups most of whom have employer-sponsored coverage in all states. For the low-income population the gaps are actually slightly higher in Group I than in the other states (private and federal coverage rates are lower).[43] The data on the ratio of Medicaid and state coverage to the population and to the gap show that states in Group I cover a higher share of their populations and a higher share of those in the gap. The Medicaid-state coverage ratios descend across each of the four coverage groups. This is true whether we look at the entire low-income population, low-income children, or low-

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[42] Spillman, Brenda C., Adults Without Health Insurance: Do State Politics Matter?, *Health Affairs*, Volume 19, July/August 2000.

[43] Elsewhere (John Holahan, *Variations Among States in Health Insurance Coverage and Medical Spending: How Much is Too Much?* Urban Institute Discussion Paper 02-08), we have shown that, for low-income populations employer sponsored insurance is negatively related to insurance rates. When states are grouped by

income adults. For example, if we look at the low-income population, Group I states cover 29.6 percent of their low-income population and 55.6 percent of those in the gap while Group IV states cover 21.8 percent of their low-income population and 42.3 percent of those in the gap. Of low-income adults, Medicaid and state subsidized insurance cover 22.0 percent of their low-income population and 42.5 percent of those in the gap in Group I states versus 13.3 percent of the population and 27.2 percent in Group IV states. With all state groups having nearly the same gap rate, it is the greater coverage expansions in Group I that yields the lower uninsurance rates than in Groups III and IV. Group II states have similar uninsurance rates to Group I states; this happens because they have smaller gaps to begin with, as well as smaller Medicaid and state/coverage rates, resulting in comparable uninsurance. Uninsurance rates in Groups III and IV are virtually identical and somewhat higher than states in Group I and II.

The higher gap rates in Group I states may reflect, in part, a substitute of public for private coverage. That is, Medicaid-state coverage of the low-income population is not greater because private coverage is lower, but rather private coverage is lower because of the availability of public coverage. Table 12 presents the same data with the population divided into three groups. The first two are below 200 percent of FPL and between 200 and 300 percent of FPL, the groups most affected by coverage initiatives. Data on the population with incomes 300 percent of FPL and above, a group largely independent of the impact of differences in Medicaid/state policy, are also shown. The data on the latter group show that the private/federal coverage rates are virtually identical, again because high-income people tend to have employer-sponsored insurance everywhere. But the data on the two lower income groups show that while Group I states have greater public coverage and lower uninsurance rates than

the extent of state coverage expansions, that relationship seems to disappear. That is a function of the diverse characteristics of the innovative states and the displacement effect discussed in the paper.

Table 12: Coverage Characteristics by Income and Generosity Groupings

	INCOMES <200% FPL		INCOMES 200-300% FPL		INCOMES 300%+ FPL	
	State Group		State Group		State Group	
	I	II-IV	I	II-IV	I	II-IV
Portion of the Population						
Private/Federal Coverage	46.7%	49.2%	78.6%	79.7%	91.7%	91.4%
Medicaid and State/Pop	29.6%	22.4%	7.1%	3.5%	1.3%	1.1%
Uninsured Rate	23.7%	28.4%	14.3%	16.8%	7.0%	7.5%
Portion of Children						
Private/Federal Coverage	45.0%	46.5%	82.5%	81.6%	93.8%	93.4%
Medicaid and State/Pop	39.8%	33.9%	9.9%	6.5%	2.6%	2.2%
Uninsured Rate	15.2%	19.6%	7.6%	11.9%	3.6%	4.4%
Portion of Adults						
Private/Federal Coverage	48.2%	51.2%	76.6%	78.7%	90.9%	90.8%
Medicaid and State/Pop	21.9%	14.2%	5.7%	2.0%	0.9%	0.7%
Uninsured Rate	29.9%	34.6%	17.7%	19.3%	8.2%	8.5%

Source: Urban Institute, tabulations of the March 2001 CPS.

other states, they also have lower rates of private/federal coverage. Unfortunately, we do not know what the private/federal coverage rates in the Group I states would have been in the absence of the public initiatives. The data, however, do suggest that not all of the public coverage initiatives result in lower uninsurance rates; some may be displacing private coverage, consistent with existing research evidence.

In this paper we have attempted to provide a fair amount of detail on coverage expansion efforts of the leading states. The detail is provided to show the many innovative ways in which these states have used various funding streams to expand coverage. They include combinations of traditional Medicaid research and demonstration waivers, use of liberal income disregards, the SCHIP program and SCHIP waivers, and state-funded programs. These states deserve considerable credit. They have no doubt overcome serious political and budgetary obstacles to achieve what they have. The broader picture that emerges, however, is not encouraging. If the key question is whether we can rely upon the current set of federal-state

partnerships to expand coverage to the nation's low-income uninsured, the answer is probably no.

The number of innovative states is fairly limited and includes those in Group I and, to a much lesser extent, Group II. This means that thirteen states or so have taken advantage of existing federal law, or established their own programs, to extend coverage in significant ways. Even in the Group I states, uninsured rates average 13 percent for the total population. About one-quarter of the low-income populations and almost one-third of low-income adults in these states lack health insurance. The initiatives in Group I states result in an increase in coverage (fewer uninsured) of about 3 to 5 percent of the low-income population but also result in some displacement of private coverage. Those who leave private coverage are no doubt better off. They are very low-income people who are now paying less and/or receiving better coverage. So while these innovative states have clearly made progress, there remains much to be done. The remaining 37 states have done little beyond what is required by current law. These states have uninsured rates that average about 16 percent with about 30 percent of their low-income population uninsured and 35 percent of their low-income adults without insurance.

Clearly, for the majority of these states the federal-state partnership is not working. The reasons the partnership has not worked are complex. For several states, state incomes and wealth limit available resources. In many states, health care for the low-income population is a low budget priority relative to, say, education and transportation. Others may believe that coverage should be expanded in the private market, that directly providing services through public hospitals and clinics is sufficient for the uninsured, and that expanded public coverage will crowd out private coverage. Finally, the structure of federal programs, particularly Medicaid, makes it hard to cover childless adults. Research and demonstration waivers, which

are subject to budget neutrality limits under Medicaid, are needed to receive federal matching funds. Also, some states allege that the benefit package and cost-sharing requirements of Medicaid cause the program to be prohibitively expensive.

It is possible that the current system can be transformed into one that can achieve broader coverage. More flexibility in Medicaid allowing states to cover low-income childless adults would help. Perhaps allowing more flexibility in establishing benefit packages and cost sharing would encourage states to go further. However, it seems unlikely that the new HIFA initiative—that allows states more flexibility to reduce coverage of optional services and use the savings to expand coverage—is likely to make much difference. There is simply too little money in existing optional services to generate savings that would allow states to extend coverage in any significant way.

Higher federal matching rates as proposed by the National Governor's Association and by Holahan, Nichols, and Blumberg[44] are probably essential if a federal state system is to work. The NGA proposal would provide states with much higher matching rates than under Medicaid for optional populations and allow the states considerable flexibility in program design. It includes no coverage expansion requirement, but provides strong incentives by states to do so. Holahan, Nichols, and Blumberg propose to provide states with higher matching rates for all existing Medicaid spending IF they agree to extend coverage to those below 250 percent of FPL as well as all those with above average health care costs. Either proposal would allow states to substantially expand coverage with little new state expenditures.

Clearly, the response to the State Children's Health Insurance Program makes one optimistic that states may react positively to higher matching rates and more control over

[44] John F. Holahan, Nicholas, L., Blumberg, L. Expanding Health Insurance Coverage. *Covering America: Real Remedies for the Uninsured*, Economic and Social Research Institute, June 2001.

program design. If coverage could be expanded to adults at higher income levels under similar terms states may respond favorably. But the problems with disproportionate share hospital payments and upper payment limit programs, initiatives in which states have leveraged considerable federal money with relatively little state matching funds, give one caution in extending the current system. These arrangements have introduced new inequities in federal-state financing arrangements and have greatly increased tensions between the federal government and the states. It may well be that serious consideration needs to be given to simply making insurance coverage for low-income Americans a federal responsibility.