

Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States

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IN BRIEF

Under health reform, 16-20 million beneficiaries will be eligible to enroll in Medicaid. It is critical for Medicaid stakeholders to develop a better understanding of who these beneficiaries are and what their care needs are likely to be. This brief outlines key health reform provisions related to Medicaid expansion and examines existing state programs for low-income childless adults in search of potential insights on the new expansion population. Among the findings suggested by this analysis are:

- The expansion population will include many relatively healthy beneficiaries as well as a significant number of individuals with multiple comorbidities and high levels of likely service utilization.
- Individuals who are below 50 percent of the federal poverty level will have the highest levels of morbidity, including high rates of mental illness and substance abuse.
- Different participation rates among population subsets will drive Medicaid costs; those with more complex needs are likely to enroll first.
- Costs for the expansion population on average are likely to be greater than costs for parents currently enrolled in Medicaid, but less than costs for adults with disabilities.
- States will need partners with experience caring for people with multiple chronic conditions.
- Medicaid must work closely with health insurance exchanges to ensure continuity of care for beneficiaries crossing income thresholds.

Further analysis is necessary to better prepare states for enrolling and serving the expansion population and its various subsets.

The relatively swift culmination of the Congressional health care reform debate may have caught many interested observers by surprise. Most of us were gearing up for the coming “race,” but perhaps not for a cross-country marathon. We knew that Medicaid would be a big part of reform, but the terrain ahead was uncharted. Adding 16-20 million beneficiaries sounded fairly straightforward — until one began to work through the details.

It will be critical for Medicaid stakeholders to determine who exactly these prospective new beneficiaries are and what their health care needs may be. Some national groups have begun to sort out how many new Medicaid beneficiaries there will be and from which income tiers and states most of them will be coming. Others have begun discussing how best to determine eligibility and enroll new beneficiaries in appropriate programs. And some have begun to make projections regarding the health status of the expansion population based on national data sets or individual state experiences.

In this brief, the Center for Health Care Strategies (CHCS) and its partners from Mathematica Policy Research explain why it is critical to clarify who will actually sign up for Medicaid coverage on January 1, 2014. The paper attempts to summarize: (a) what is known about the incoming population, including their health care needs and costs; (b) the outreach and enrollment challenges presented by the expansion population; and (c) the delivery system design questions that need to be answered to adequately address their needs. It draws insights from the experiences of 10 states with existing programs for low-income childless adults* to help guide other states in preparing for the expansion population.

Prior to March 2010, Medicaid was already a significant program with significant responsibilities for covering many of the nation’s most vulnerable citizens — low-income families, people with disabilities and those dually eligible for Medicare

*For the purposes of this brief, “childless” is defined as having no dependent children. Accordingly, the brief refers interchangeably to “childless adults” and “adults without dependent children.”

and Medicaid. Today, it is the nation's foundation for universal coverage and, with expansion, will likely be serving upwards of 80 million Americans after 2014. That is more than a quarter of the U.S. population.

Many of Medicaid's new enrollees will be temporary — churning from uninsured, to Medicaid, to publicly subsidized private insurance, and back again with changes in employment status. The goal should be to keep these individuals insured without discontinuities in coverage and access to care. Other new beneficiaries will be very low-income adults with multiple chronic conditions, including mental illness and substance abuse, that may not meet disability criteria, but which make it unlikely that they will become fully employed. The chances are consequently high that they will become permanent Medicaid enrollees.

The prospect of steady insurance in this new pro-coverage world creates significant incentives and opportunities for all of Medicaid's stakeholders to: increase access, particularly to primary and preventive care; improve quality; and reduce unnecessary expenditures for avoidable hospitalizations and institutionalizations. It is the promise of continuity of coverage and improvement in care that impelled the Robert Wood Johnson Foundation, UnitedHealthcare, and Aetna to support the development of this brief. It is also what makes CHCS and its partners eager to help Medicaid's stakeholders successfully implement health care reform in 2014.

Overview of Relevant Key Provisions of Health Care Reform

Prior to the enactment of federal health care reform in March 2010, most state Medicaid programs did not cover low-income adults without dependent children unless they were disabled or chronically ill. A number of states provided coverage to this population with state-only dollars, however, or under special Medicaid waivers.¹

New options for childless adults. With the enactment of health care reform, new options for Medicaid coverage of low-income adults without dependent children became available, with some new requirements. As of April 1, 2010, states can provide coverage for this population without a special waiver under Medicaid state plans with regular federal matching payments.² Beginning on January 1, 2014, all states must provide coverage under their state plans to childless adults with incomes up to 133 percent of the federal poverty level (FPL), with much higher federal matching payments than are currently available (100 percent in 2014-2016 in most states, phasing down to 90 percent by 2020).³

Regular Medicaid vs. waivers. Relative to the waivers that states have used in the past to cover adults without dependent children, regular Medicaid offers states less flexibility. Waivers (usually Section 1115 demonstration waivers) have allowed states to put ceilings on enrollment, require beneficiary payment of premiums and cost sharing, and limit the services included in the benefit package. In the regular Medicaid program, ceilings on enrollment are not permitted, charging

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premiums to low-income populations is not allowed, and cost sharing is very limited.

Benchmark coverage requirements. For newly enrolled childless adults, Medicaid benefit packages must meet at least “benchmark” standards, which are somewhat lower than regular Medicaid requirements, but are still relatively comprehensive. Benchmark coverage is defined in Section 1937(b) of the Social Security Act as coverage equivalent to the Federal Employees Health Benefit Plan, state employee coverage, coverage offered by the largest non-Medicaid commercial health organization in the state, or “Secretary-approved coverage.” Current benchmark package requirements include inpatient and outpatient hospital services, physician services, lab and x-ray services, prescription drugs, mental health services, well-baby and well-child care, and other appropriate preventive services as designated by the Secretary. Beginning in 2014, benchmark coverage must include at least “essential health benefits,” as defined in health care reform, including prescription drugs and mental health and substance abuse services, and (in managed care plans) mental health parity.⁴ Since the statutory language describing benchmark coverage is relatively general, the Centers for Medicare & Medicaid Services (CMS) will presumably provide more specific guidance for states on the type and level of coverage that will be required.

Analysis of Potential Enrollment, Care Needs, and Costs

Potential enrollment by adults without dependent children in Medicaid in 2014 (and before then for states that choose to start earlier) depends largely on: (1) how many uninsured adults without dependent children are under 133 percent of the FPL; and (2) how many of them choose to enroll (driven in part by state outreach activities).

The likely care needs and costs of this population are difficult to ascertain, since prior service use among most potential enrollees has not been tracked systematically. National surveys can provide a starting point for estimating potential enrollment and care

needs, as they can be used to identify the number of currently uninsured as well as those who may switch to Medicaid if their current insurance is more expensive or less adequate. Surveys can also provide information on the demographics, health care needs, and health care service utilization of potential beneficiaries.⁵ The usefulness of these data, however, is limited by two critical factors: (1) potential underrepresentation of important subpopulations, such as the homeless and institutionalized; and (2) limitations of self-reported data, including underreporting of conditions such as mental illness and substance abuse. In this brief, we instead focus on the experiences of states that have previously covered low-income childless adults to examine the potential care needs and costs of the expansion population. Although data from these existing state programs are not without limitations — e.g., enrollment caps and lower income eligibility thresholds in some programs may limit overall representativeness — these experiences can offer valuable on-the-ground perspective and complement information gleaned from national data sources.

Potential Enrollment

Whereas the overall Medicaid expansion population will include a mix of healthy and chronically ill individuals, several factors make it likely that many of the initial new enrollees will be those with relatively high health care needs and costs:

- **Provider-stimulated enrollment.** Hospitals, emergency rooms, clinics, and other providers who currently serve low-income adults without dependent children will likely make certain that those who are potentially eligible for this expanded Medicaid coverage enroll as soon as possible, provided that Medicaid payment for their services is at least as good as the reimbursement they are currently receiving from other sources. This could lead to relatively high enrollment by low-income adults who currently have significant health care needs.

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As 2014 approaches, better understanding the health needs of newly eligible beneficiaries will enable states to:

- (1) design appropriate benefit packages and delivery systems;
- (2) allocate sufficient resources and set adequate rates; and
- (3) develop effective outreach and enrollment strategies.

- **Retroactive eligibility in Medicaid.** New Medicaid enrollees can obtain retroactive coverage for up to three months prior to the date they apply, provided they would otherwise have been eligible during that period. This retroactive enrollment frequently occurs when individuals without Medicaid coverage receive services in hospitals and emergency rooms. This is because hospitals can obtain reimbursement they might otherwise not receive by helping patients enroll retroactively in Medicaid. Those who enroll in Medicaid under these circumstances are likely to have relatively high health care needs.
- **Limited applicability of tax penalties for lack of insurance coverage.** The tax penalties that will enforce the individual mandate for health insurance coverage beginning in 2014 will only apply to those with gross incomes above the income tax filing threshold (\$9,350 for single filers under age 65 in 2009). In addition, the maximum penalty in 2014 will be only \$95.⁶ This may not be enough to induce healthy low-income adults to enroll in Medicaid, especially if they know they can get retroactive coverage if they need health care.
- **Transfers from state-funded health care programs.** About 20 states currently operate state-funded general assistance or other programs that provide some health care services to low-income childless adults.⁷ These states will presumably shift adults covered by these alternative coverage programs to Medicaid in 2014, if not before. Again, these programs tend to attract relatively high-need, high-cost patients.

Care Needs

As 2014 approaches, better understanding of the health needs of newly eligible beneficiaries will enable states to: (1) design appropriate benefit packages and delivery systems; (2) allocate sufficient resources and set adequate rates; and (3) develop effective outreach and enrollment strategies. As with existing covered populations, newly eligible beneficiaries will likely comprise multiple

subgroups, including variations in income level, employment status, and physical and behavioral health needs. Following are lessons from Oregon and Maine's past coverage expansion experiences that shed light on the potential range and extent of health needs of the newly eligible populations.

Oregon

Oregon extended coverage via an 1115 waiver to all residents up to 100 percent of the FPL beginning in 1994 through the Oregon Health Plan. Although the program covered adults with and without children using the same eligibility standards and benefit packages, the two groups were distinguished in order to track differences in demographic characteristic, health needs, and utilization. As illustrated in a 2000 study by Susan Haber and colleagues, the childless adult population had more complex health needs and higher utilization than the adults with children.⁸ Following is a summary of key comparisons between the two populations:

- **Income levels.** Adults without children had significantly lower incomes, with 75 percent earning \$6,000 or less vs. 46 percent of adults with children.
- **Employment status.** Childless adults were significantly less likely to be employed, with 41 percent reporting that either they or their spouse was employed vs. 75 percent of those with children.
- **Self-reported health status.** Adults without children reported significantly poorer health status than those with children across physical health, mental health, and disability domains. More than one-third reported that a disability prevented them from working vs. 11 percent of adults with children.
- **Utilization.** Childless adults had greater utilization across all categories of service, including more than twice as many inpatient admissions, twice as many emergency room visits, more than three times as many mental health/substance

abuse-related visits, and 30 percent more evaluation and management visits.

- **Pent-up demand.** Childless adults were significantly more likely than those with children to cite the need to pay for a current medical condition (49 vs. 25 percent) as the most important reason for having insurance. And, whereas all beneficiaries eligible for Oregon’s extended coverage tended to use services most intensively during the initial month of eligibility, adults without children used proportionately more services in the first month compared to those with children.

Maine

Since 2002, Maine has covered childless adults up to 100 percent of the FPL through an 1115 waiver under MaineCare, the state Medicaid and CHIP program. The waiver covers inpatient and outpatient hospital services, physician care, prescription drugs, mental health and substance abuse treatment services, lab and x-rays, and medical transportation. The most recent evaluation of the program covers a seven-year period through September 2009.⁹ Although it does not provide comparative data for adults with children, the review highlights some relevant findings:

- **Mental health/substance abuse prevalence.** Mental health and substance abuse diagnoses account for four of the top 10, and nine of the top 20 most costly diagnoses.
- **High-cost populations.** The top five percent of beneficiaries by cost accounted for 44 percent of total expenditures, and the top 10 percent accounted for 60 percent. High-cost beneficiaries (defined as those with more than \$10,000 in total annual paid claims) were more likely to be enrolled for all 12 months than the overall waiver population (68 vs. 42 percent). Over the program’s first six years, high-cost beneficiaries were enrolled for an average of 33 months — indicating that the majority of these individuals were not new to the program and that most were long-term enrollees.

Service and Care Management Needs

Taken together, these data suggest that the expansion population is likely to include a considerable proportion of very low-income, non-working adults with multiple, chronic health needs – including complex populations that more closely resemble current Supplemental Security Income (SSI) beneficiaries than the relatively healthier and lower-cost Temporary Assistance for Needy Families (TANF) population. The Oregon experience suggests that the lowest-income subset of the expansion population will likely be overrepresented among newly eligible enrollees. In addition, these individuals will typically have a higher burden of illness and more complex care needs than their counterparts with incomes closer to the 133 percent of the FPL threshold. Importantly, these care needs will likely include a high prevalence of mental illness and substance abuse. This is further supported by data from Pennsylvania’s General Assistance population, which indicate mental illness and substance abuse prevalence rates of 53 and 36 percent, respectively.¹⁰

Finally, the suggestion from Maine that the more complex, higher need subset of the expansion population will have lower churn rates and lengthier periods of enrollment has broad implications ranging from program budgeting to care management system design. In particular, the long-term nature of this enrollment suggests both a need and an opportunity to help these beneficiaries better manage their illnesses, thereby improving health outcomes and reducing costs.

Costs

The potential costs of covering low-income childless adults are of immediate concern to states that are planning to extend Medicaid coverage before 2014. This is because they will be required to pay the current state share of those costs prior to 2014. The federal government will pay 100 percent of the costs in 2014-2016 in most states, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and subsequent years. In states that are planning to cover low-income childless adults in full-risk managed

care arrangements, estimates of the potential costs will be critical for setting appropriate capitated rates.

One way of assessing the potential costs of the low-income childless adult population is to look at the experience in states that have expanded coverage to childless adults with Medicaid 1115 waivers or state-only funding. We reviewed this experience in several other states in addition to Oregon and Maine, including Arizona, Indiana, Minnesota, New York, Pennsylvania, Washington, and Wisconsin. To the extent possible, we tried to compare per-member per-month (PMPM) costs for childless adults to those of: (1) non-disabled adults in Medicaid (usually TANF parents); and (2) disabled (ABD/SSI) adults. Table 1 summarizes the results of this analysis (see page 13). More details on these state programs are in Table 2, which summarizes key program design features for each state (see pages 14-16).

Comparisons between childless adults and other populations are not straightforward in most states. This is partly because benefit packages for individuals in childless adult programs are typically more limited than the benefits in the regular Medicaid program; income ceilings sometimes differ; and rate-setting methodologies can also differ. There are also ceilings on enrollment in most current childless adult programs, which can result in a higher-need mix of enrollees. Nonetheless, cost differences within states for different populations can be used to provide a general indication of what to expect with the expansion population. Below is a summary of state experiences:

- **Arizona** offers the best comparison of the states reviewed. The state has been covering low-income childless adults since 2001, providing the same benefit package that is available to other Medicaid beneficiaries, with no ceiling on enrollment. For calendar year 2010, the projected average annual costs for childless adults are about halfway between those of SSI/disabled and TANF adults:¹¹ Childless adults, \$7,361;

SSI/disabled adults, \$9,428; TANF adults age 45+, \$5,305.

- **Indiana** has been covering low-income childless adults in its Healthy Indiana Plan since January 2008. Originally, Indiana assumed that the costs of this population would be similar to those of non-disabled adult parents in Medicaid. However, costs for childless adults for the first year were substantially higher than those of non-disabled adult parents, and while costs have leveled off a bit, they remain significantly higher.¹² As reported in Table 1, inpatient hospital and prescription drug use for childless adults is twice as high as that of non-disabled adults in Medicaid. Indiana reached the enrollment cap for childless adults in its Healthy Indiana Plan waiver within its first year. CMS allowed the state to lift the enrollment ceiling and enrollment reopened in 2009. After health care reform passed in March, the state closed new enrollment for childless adults and has no plans to allow additional enrollment, due in part to the high cost of these enrollees.
- **Maine's** coverage of childless adults under 100 percent of the FPL has a benefit package that is more limited than regular Medicaid coverage. The average PMPM cost for childless adults in this waiver in 2008 was \$406.¹³ For comparison, the average monthly expenditure for TANF adults in 2007 was \$143, and for SSI/disabled adults it was \$1,003.¹⁴
- **Minnesota** also covers childless adults and non-disabled parents in its MinnesotaCare Basic Plus One and Plus Two programs. As shown in Table 1, the monthly capitated rates for Plus One childless adults age 50 and over are about one-third higher than those for Plus Two parents of the same age, despite the fact that the Plus One program has stricter limits on the use of hospital services.¹⁵ This is roughly comparable to the Arizona experience, where the childless adult costs are about 40 percent higher than the non-disabled adult costs. The rates for those in Minnesota's General Assistance

Medical Care (GAMC) program are even higher — about 25 percent above the Plus One childless adult rates — even though the benefit package is more limited than the Plus One and Plus Two benefit packages.

- **New York** covers low-income childless adults and parents through its state-funded Family Health Plus program and through a state-funded portion of its Medicaid program. As shown in Table 1, the PMPM costs for childless adults in the Family Health Plus program are about the same as those for parents, but the costs for childless adults on Medicaid who are also receiving cash assistance are almost four times higher. These cash assistance recipients have incomes that are below 78 percent of the FPL, while Family Health Plus childless adults are covered up to 100 percent of the FPL and parents are covered up to 150 percent of the FPL.¹⁶
- **Oregon** covers low-income childless adults and parents in its Oregon Health Plan Standard program. As shown in Table 1, the PMPM cost for childless adults in 2010 was more than twice as high as the cost for parents.¹⁷
- **Pennsylvania** covers childless adults up to 200 percent of the FPL in its state-funded adultBasic program, which has relatively low costs to the state (\$290 per person per month in 2009) because enrollee premiums and insurance plan subsidies cover part of the cost. Pennsylvania also has a General Assistance (GA) program that covers childless adults up to about 30 percent of the FPL. For the year ending in March 2010, PMPM costs for enrollees in the GA program averaged \$840 for adults with lower incomes receiving cash assistance, and \$505 for adults not receiving cash assistance. The comparable Medicaid PMPM costs were \$388 for TANF adults and \$1,717 for SSI disabled adults.¹⁸
- **Washington** covers childless adults in both its Basic Health program and its General Assistance-Unemployable (GA-U) program (now called Disability Lifeline). In the Basic

Health program, the average PMPM rate in 2009 was \$248. Despite a more limited benefit package, the average PMPM in the GA-U/Disability Lifeline program was \$570 in 2009.¹⁹ The Disability Lifeline program covers a very low-income population (below 38 percent of the FPL).

- **Wisconsin** covers childless adults in its BadgerCare Plus Core Plan, and parents in its BadgerCare Plus Standard Plan, both up to 200 percent of the FPL. For adult males age 45 and over in 2010, an illustrative PMPM rate from one of the participating health plans for childless adults in the Core Plan was \$224, somewhat below the \$262 rate for adult parents in that age group in the Standard Plan. The Standard Plan benefit package is broader, however, and beneficiary cost sharing in the Core Plan is higher. For comparison, the PMPM rate for the SSI disabled Medicaid population in the 45 and over age group was \$1,435. Wisconsin also has a General Assistance Medical Program that covers childless adults. The state's General Assistance PMPM rate for adult males over 45 was \$412 for 2010.²⁰

To supplement our analysis of the rates for childless adults in these states, we also discussed the issue with Sandra Hunt of PricewaterhouseCoopers, Oregon's long-time Medicaid actuary and a consultant to Wisconsin on its BadgerCare Plus low-income childless adult program. She estimated that — if benefit packages were comparable — the costs for low-income childless adults would be approximately halfway between those of non-disabled and disabled adults, supporting the Arizona experience.²¹

Implications for Budgeting, Rate Setting, and Risk Adjustment

State experiences in covering childless adults in Medicaid and various state-funded programs suggest that the childless adult population is unlikely to have the same costs and care needs as the non-disabled adults currently covered by Medicaid, most of whom are relatively healthy parents of young children. Some of the newly enrolled childless

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adults may look similar to these Medicaid parents, but a large portion of the initial enrollees are likely to have substantially higher costs and care needs.

Fee-for-service budgeting. For states that plan to cover newly enrolled childless adults in fee-for-service Medicaid beginning in 2014, it may be prudent to assume for budget planning purposes that the average costs for this population will be somewhere between those of non-disabled and disabled adults already covered by Medicaid. Since the federal government will be paying 100 percent of these costs in 2014-2016, these program costs will not have to be covered in state budgets in those years. Beginning in 2017, the federal share for this population drops to 95 percent, and declines over time to 90 percent for 2020 and subsequent years. This should give states sufficient time to determine the likely program budget costs for this population before they have to begin covering a significant portion of these costs themselves. Based on the experience of the states we reviewed, initial average costs may decline as: (a) accumulated unmet needs are addressed; (b) better care management systems are put in place; and (c) healthier adults begin to enroll.

Capitated managed care rates. For states that plan to cover the expansion population under capitated managed care programs, it may be appropriate to establish one or more new rate categories for newly enrolled childless adults. While the federal government will be paying most of the program costs for this population, it is important that payments to managed care organizations reflect their anticipated costs, since health plans may not be willing to cover this population if they do not view the capitated payments as adequate. For states that set rates primarily on the basis of age, sex, and eligibility category, an eligibility category approximately halfway between adult parents and SSI/disabled in terms of PMPM costs might be an appropriate starting point. For states that already cover the SSI/disabled population in capitated managed care programs, and that use a diagnosis-based risk adjustment system like the Chronic Disability Payment System (CDPS), that system should

be sufficient to deal with the diverse care needs and costs of the newly enrolled childless adult population.

As with other newly enrolled Medicaid beneficiaries who do not have a claims history to build into a diagnosis-based risk adjustment system, an initial health screening questionnaire could be used to help establish initial rates, with further refinement occurring after there is a year or so of claims history. Since most states will have limited or no historical data on service use and costs for childless adults when setting initial rates in 2014, there will inevitably be some uncertainty in determining appropriate rates. Accordingly, states may want to consider various ways of sharing the risk with managed care organizations during the first year or two of coverage, including partial capitation, risk corridors, and individual stop-loss arrangements. States could also contract with health plans on an administrative services only (ASO) basis for the first year or so, with the state (actually the federal government) remaining at risk for all health care service costs during that period.

Delivery System Design

Given the diversity of health care needs among the low-income childless adults likely to enroll in Medicaid in 2014 or before, states should begin now to consider how best to serve them, including benefit packages, provider networks, and care coordination services. This section examines how a number of states have addressed these issues in providing coverage for low-income childless adults. As noted earlier, both regular Medicaid and benchmark benefit packages are fairly comprehensive, so states will generally not have as many benefit design options as found in the current waiver and state-funded programs for childless adults. However, the adequacy of provider networks will be a critical issue, especially given the substantial behavioral health service needs of many low-income childless adults. Substantial care coordination resources may also be needed, given the prevalence of multimorbidity, relatively low education levels, and relative

lack of experience of many low-income childless adults in navigating the health care system. These network adequacy and care coordination issues will need to be considered as states make decisions about using capitated managed care arrangements, primary care case management programs, or fee-for-service for newly enrolled childless adults.

Profiles of Existing State Programs

Table 2 summarizes key program features as well as experiences from 10 states that offer coverage for low-income childless adults with state dollars or under special Medicaid waivers. Table 2 includes Vermont, as well as the nine states included in Table 1 and discussed in the previous section.²²

Insurance Access Requirements

All the current programs reviewed require that adults have no other access to insurance, but the amount of time they must be without insurance varies. At 12 months, Wisconsin and Vermont require the longest period of uninsurance. Indiana requires a six-month uninsured period, Minnesota requires four-months, and Pennsylvania requires only 90 days except if a participant or spouse has lost coverage due to loss of a job. As discussed earlier, this requirement of a prior period of uninsurance generally cannot be applied in the regular Medicaid program without a special waiver.

Delivery Models

Eight of the 10 states researched use capitated managed care plans to deliver care to the childless adult population (all but Maine and Vermont, which do not use capitated managed care in their underlying Medicaid programs). In each of the eight states, the managed care plans serving low-income childless adults all have relationships with the state through existing Medicaid managed care programs. Maine and Vermont both use their existing non-capitated care management programs. In the future, other states might also want to consider building on their underlying delivery system approach for serving this new population.

Care Management Approaches

Indiana. Indiana administers a questionnaire at the time of application for the Healthy Indiana Plan to identify participants with medical conditions that require more care. Participants who self-identify as having at least one of the identified conditions (i.e., internal cancers, HIV/AIDS, hemophilia, aplastic anemia, or organ transplants),²³ are placed in the Enhanced Services Plan (ESP) in the state's fee-for-service program (not in a pre-paid, capitated plan). ESP participants can access the same primary care providers as other fee-for-service Medicaid or Healthy Indiana Plan participants, but the state contracts with the Indiana Comprehensive Health Insurance Association, the organization that operates the state's high-risk pool,²⁴ to process ESP claims and provide information to beneficiaries regarding managing chronic conditions and appropriate preventive care. Indiana also uses a health savings account to encourage individuals who do not participate in ESP to receive recommended preventive services.

Wisconsin and Maine. Participants in Wisconsin's BadgerCare Plus Plan must also complete a health needs assessment form as part of the application process so the state can match participants to managed care plans that can meet their health care needs. The program also requires that participants receive a physical examination in their first year of participation.²⁵ Maine has contracted with a care management firm (Schaller Anderson/Aetna) since 2007 to serve beneficiaries who are identified as chronically ill, e.g., those with multiple chronic conditions, high inpatient or ED use, care/service coordination needs, and/or poly-pharmacy issues.

Benefit Packages

Seven of the 10 states provide a package of benefits to the childless population that is less comprehensive than the regular Medicaid benefit package. All states cover preventive care, inpatient and emergency care, and prescription drugs (see Table 2). All states except Pennsylvania provide some mental health and substance abuse services in these

FOR MORE INFORMATION

The profiles of existing state programs discussed in this section draw from interviews as well as a review of publicly available literature. For summaries of the state programs profiled in this section and Table 2, visit www.chcs.org/MedicaidExpansion.

more limited benefit packages. Arizona and Vermont provide the same level of benefits as Medicaid. Minnesota excludes only medical transportation for its MinnesotaCare Basic Plus One population and otherwise provides the Medicaid benefit package, including dental and vision coverage.²⁶ There are 10 percent copayments and a \$10,000 annual limit on inpatient hospital stays in the Basic Plus One program; these fees do not apply in the regular Medicaid program. Pennsylvania requires adult Basic participants to share in the costs of the program through premiums, copayments, and coinsurance with an annual limit on all coinsurance set at \$1,000. Inpatient hospital stays are limited to two per year. New York state residents in Family Health Plus receive a benefits package that is similar to Medicaid, limiting only carved-out services and the duration of some chemical dependence benefits.

Oregon is the only other state that provides access to dental and vision, but it is limited. Oregon has a unique process for defining covered benefits, using a governor-appointed group of physicians and consumers (called the Oregon Health Services Commission) to create a “prioritized list” of health services that are covered under each Oregon Health Plan package. The childless adult package, Oregon Health Plan — Standard (OHP-S),²⁷ includes all of the services listed in Table 2, but limits access to acupuncture, dental, hospital care, medical equipment and supplies, medical transportation, and vision. It excludes coverage for hearing aids and hearing aid exams, home health, naturopathy, occupational therapy, physical therapy, private duty nursing, and speech therapy — all of which are included in the Medicaid benefits package.²⁸

Indiana provides access to services that are equivalent to those available through the state’s traditional Medicaid program, but services outside of what are considered preventive services are subject to deductibles, and payment for them can be drawn from a health savings account, called a Personal Wellness Responsibility (POWER) account. Services through the Basic Health Plan in

Washington are comprehensive, but some, such as hospital, mental health, chemical dependency, and chiropractic services, are subject to co-insurance requirements.

Considerations for States

These state experiences with covering low-income childless adults suggest a variety of options for covering the Medicaid expansion population. Some considerations for states are briefly summarized below.

Delivery Models

States that are already covering Medicaid populations in capitated managed care arrangements will likely want to include newly enrolled childless adults in these arrangements. However, if capitated managed care programs have covered only relatively healthy TANF children and adult parents and not the SSI/disabled population, it would be unwise to assume that the managed care organizations (MCOs) serving the TANF population will be able to address the more complex care needs that newly enrolled childless adults are likely to have. If a state already covers the SSI/disabled Medicaid population in capitated managed care, it should be easier to accommodate newly enrolled childless adults in these same MCOs.

In considering delivery system options, states may want to cover the newly enrolled childless adult population in the same way that SSI/disabled beneficiaries are currently covered in the state. If managed care is available but optional for the SSI/disabled population, childless adults could be given the same options. If managed care is mandatory for the SSI/disabled population, and the track record of Medicaid MCOs in serving this population has been good, the same mandatory enrollment requirement could be extended to childless adults.

Relationship to Health Insurance Exchanges

States will also have to consider how newly enrolled childless adults will be incorporated into the new health insurance exchanges that will be in place in 2014. For childless adults

with incomes substantially below 100 percent of the FPL, it is likely that relatively few of them will obtain jobs that will afford them private insurance. Thus, Medicaid will probably remain their sole coverage choice and relationships between Medicaid and the exchange will likely not be significant.

For those at income levels closer to 133 percent of the FPL, however, a portion may have private insurance options available at various times, so continuity across Medicaid and exchange-driven private insurance will be important. In determining the relationships between Medicaid and the exchanges, states may want to consider this higher-income portion of the newly enrolled childless adult population in the same way that higher-income adults in other parts of Medicaid and CHIP are considered. It will be important, for example, to try to include health plans that serve both Medicaid and commercial populations in the exchanges so childless adults do not have to change plans if they lose Medicaid coverage. It will also be important to include provisions to maintain continuity of care for those leaving and returning to Medicaid, to the extent possible.

Care Management Resources Needed

As described earlier, many newly enrolled adults are likely to have multiple chronic health needs, including mental illness and substance abuse. In the absence of effective care management and care coordination, these beneficiaries may either face insufficient access to needed preventive services or potentially duplicative or adversely interacting treatments. Either path could result in poor health outcomes, otherwise preventable hospitalizations, and high levels of medical expenditures.

Given this picture, states should determine how best to implement effective care management strategies for this population, which will likely include individuals who are less connected to existing social service structures than current SSI beneficiaries and thus may have a range of unmet needs related to housing, employment, transportation and interactions with the criminal justice system

that will likely need to be considered along with issues related to health status. Following are core elements that states might want to consider for care management programs for these new beneficiaries:

- Stratification and triage by risk/need;
- Integration of health services, including in particular physical and behavioral health;
- Coordination with social services, including housing, employment, and transportation among others;
- Designated “health homes” and personalized care plans;
- Consumer engagement strategies;
- Provider engagement strategies;
- Exchange of relevant health information across stakeholders, including consumers;
- Performance measurement and accountability; and
- Financial incentives aligned with quality care.

There are a number of opportunities enacted through health care reform for states to receive enhanced federal support for the design and implementation of effective care management programs. These include planning grants and enhanced federal match for the development of health homes and grants to support the development of community health teams, among others. In addition, the newly established Center for Medicare and Medicaid Innovation within CMS will be funding a number of demonstrations and pilot programs over the next decade, many of which are likely relevant to addressing the care needs of the expansion population.²⁹ As states prepare for 2014, these opportunities could help build the infrastructure that will be critical to managing care and controlling costs for this population, particularly as state match kicks in beginning in 2017.

Treatment Capacity Needed

The likelihood that many newly eligible adults who enroll in 2014 will have multiple chronic health needs has important implications for ensuring sufficient access to care. Based on the experience of states that have previously expanded coverage to

States should consider how to implement effective care management strategies for this population, which will likely include individuals who are less connected to existing social services than current SSI beneficiaries and thus may have a range of unmet needs.

Further analysis is needed to help states design delivery systems that will most effectively manage the needs of new beneficiaries.

childless adults, states may expect high levels of demand for primary and specialty care services, particularly in the initial months following enrollment.

For primary care, increased payment rates to 100 percent of Medicare rates in 2013-2014 may help increase access in the initial period of expansion.³⁰ However, if states revert to pre-2013 payment rates once enhanced federal funding ends in 2015, primary care access could become a more critical issue in the absence of other efforts to increase capacity.

The data suggesting high prevalence of mental illness and substance abuse among the expansion population suggests that capacity constraints may pose a similar if not more pressing issue with regard to behavioral health treatment. Related to this, there is reason to believe that the criminal justice system may become an active source of Medicaid enrollment post-expansion, particularly for the subset of offenders with charges related to substance abuse. As cited in a recently released report, 65 percent of all U.S. inmates meet medical criteria for drug and/or alcohol addiction, and alcohol and other drugs are involved in 85 percent of all reported crimes.³¹ Given that many of these offenders may become newly eligible for Medicaid in 2014 once they leave the criminal justice system, the availability of community-based substance abuse treatment will be critical. Moreover, the high prevalence of co-occurring substance abuse and mental illness would suggest that access to substance abuse treatment would likely identify substantial need for mental health treatment among the criminal justice population as well. Accordingly, state Medicaid agencies might consider partnering with colleagues in state and local criminal justice systems to determine how to most effectively meet the demand for services among this segment of the expansion population.

Conclusion and Next Steps

As discussed above, the experience covering low-income childless adults among the 10 states included in this brief suggests that a

meaningful subset of the expansion population will have a complex range of health needs, including high rates of mental illness and substance abuse. Moreover, in the absence of aggressive outreach efforts, a number of factors are likely to contribute to adverse selection, making it more likely that newly eligible individuals with existing health care needs are more likely to enroll.

In designing delivery systems to address the needs of the expansion population, states should consider the experience of potential contractors in managing complex populations, as well as the ability to offer products in both Medicaid and the health insurance exchange to ensure continuity of care for individuals whose eligibility may fluctuate. States may also want to consider developing risk-sharing arrangements with contracting health plans in the initial years of expansion while understanding of the health and cost profile of these new beneficiaries builds. Also critical will be the assurance of adequate access to treatment to address the multiple and complex needs that are likely to be common among a substantial subset of these new beneficiaries.

The experience of states that have previously expanded coverage provides a rich source of data for further analysis of the issues considered in this brief. For example, future inquiries might explore:

- Segmentation of morbidity and cost profiles by factors including income level, age and employment status;
- Implications of varying degrees of state outreach efforts and enrollment practices on participation rates;
- Influence of participation rates on overall morbidity and cost levels; and,
- Analyses of demographics, health needs, and costs by year following coverage expansion.

Such future analyses should provide data to help states design delivery and payment systems that most effectively meet the needs of the expansion population and assure appropriate resource allocation.

Table 1: Costs of Coverage for Low-Income Childless Adults in Selected States

	Childless Adult Costs Compared to Other Medicaid Populations	Income Limit	Benefit Package	Beneficiary Cost Sharing	Diagnoses/Care Needs	Ceiling on Enrollment
Arizona	<ul style="list-style-type: none"> ▪ CY 2010 projected annual costs: <ul style="list-style-type: none"> » Childless adults: \$7,361 » SSI/disabled adults: \$9,428 » Non-disabled adults age 45+: \$5,305 	110 FPL	Same as Medicaid	Higher than Medicaid	NA	No
Indiana	<ul style="list-style-type: none"> ▪ Inpatient hospital and Rx drug use twice as high as non-disabled adults in Medicaid ▪ ER costs lower due to high copays 	200 FPL	Similar to Medicaid	Higher than Medicaid	Higher prevalence of heart disease, diabetes	Yes
Maine	<ul style="list-style-type: none"> ▪ PMPM childless adults in waiver: \$406 (FFY 2008) ▪ TANF adults: \$143 (FFY 2007) ▪ SSI/disabled: \$1,003 (FFY 2007) 	100 FPL	Less than Medicaid	Same as Medicaid	High prevalence of smoking, substance abuse, depression, diabetes	Yes
Minnesota	<ul style="list-style-type: none"> ▪ Illustrative PMPM capitated rates, 50+ male (2010): <ul style="list-style-type: none"> » Minnesota-Care (MC) Basic Plus One childless adult: \$640; Basic Plus Two parent: \$482 » General Assistance Medical Care (GAMC): \$806 	MC: 250 FPL GAMC: 75 FPL	MC: Same as Medicaid GAMC: Less than Medicaid	Higher than Medicaid	GAMC: High prevalence of mental health, substance abuse, and chronic physical illness diagnoses	Yes
New York	<ul style="list-style-type: none"> ▪ Family Health Plus (FHP) PMPM: <ul style="list-style-type: none"> » Childless adults: \$291 » Parents: \$288 ▪ Medicaid childless adults PMPM: <ul style="list-style-type: none"> » Cash assistance, \$1,140 » Non-cash assistance, \$521 	FHP: 100 FPL Medicaid: 78 FPL	Less than Medicaid	Higher than Medicaid	Severity of illness (case mix index) <ul style="list-style-type: none"> ▪ Family Health Plus: Childless adults: 1.15; Parents: 0.91 ▪ Medicaid childless adults: cash: 2.23; Non-cash 1.31 	Yes
Oregon	<ul style="list-style-type: none"> ▪ Oregon Health Plan Standard PMPM (2010): <ul style="list-style-type: none"> » Adults and couples: \$679 » Families: \$329 	100 FPL	Less than Medicaid	Higher than Medicaid	NA	Yes
Pennsylvania	<ul style="list-style-type: none"> ▪ adultBasic: per month state cost (reduced by employee premiums and insurance plan subsidies): \$290 ▪ General Assistance (GA): <ul style="list-style-type: none"> » Cash assistance: \$840; » Non-cash assistance: \$505 ▪ Average PMPM in Medicaid/related programs (09-10): <ul style="list-style-type: none"> ▪ SSI Adults: \$1,717 ▪ TANF Adults: \$388 	adultBasic: 200 FPL GA: 30 FPL	adultBasic and GA: Less than Medicaid	adultBasic and GA: Higher than Medicaid	High prevalence of mental illness in GA Cash and SSI adult populations	Yes
Washington	<ul style="list-style-type: none"> ▪ Basic Health Plan (BHP) adults (2009): <ul style="list-style-type: none"> » PMPM: \$248 » Disability Lifeline (General Assistance-Unemployable [GA-U]) PMPM: \$570 	BHP: 200 FPL GA-U: 38 FPL	Basic Health Plan: Similar to Medicaid Disability Lifeline (GA-U): Less than Medicaid	Higher than Medicaid	NA	Yes
Wisconsin	<ul style="list-style-type: none"> ▪ Illustrative PMPM rates for 45+ male (2010) <ul style="list-style-type: none"> » BadgerCare Plus Core Plan childless adult: \$224 » General Assistance Medical Programs (GAMP) childless adult: \$412 » BadgerCare Plus Standard adult parent: \$262 » SSI Medicaid only: \$1,435 	200 FPL	Less than Medicaid	Higher than Medicaid	NA	Yes

NA = Not available

SOURCES: Sources for cost and other information included in this table are cited in footnotes in the text of the report and in Appendix B available at www.chcs.org/MedicaidExpansion. Note that the information comes from a variety of different sources, usually state-specific, and is therefore not necessarily consistent across states.

Table 2: Low-income Childless Adult Coverage Programs from Selected States

	Program Name	Implemented	Income Limit	Authority/Financing	Expenditures	Enrollment Numbers
Arizona	Proposition 204	2001	110 FPL	1115; tobacco tax; general fund	Approximately \$1.2 billion in state general fund and tobacco tax dollars in 2011	211,305 (3/2010)
Indiana	Healthy Indiana	2008	200 FPL	1115; cigarette tax; DSH funds; member/employer contributions	Under \$570 million (FY 2009)	37,568 (2008); 46,460 (2009)
Maine	MaineCare	2002	100 FPL	1115; DSH	\$73 million (FY 2006); \$103.5 million (FY 2007); \$90.3 million (FY 2008)	18,350 (FY 2006); 24,069 (FY 2007); 18,519 with 10,800 wait-listed (FY 2008)
Minnesota	MinnesotaCare Basic Plus One; General Assistance Medical Care (GAMC)	1999	250 FPL (GAMC:75 FPL)	1115; both Basic Plus One and GAMC are state-only funded: 2% provider tax, 1% tax on health plans	\$526 million for all MinnesotaCare programs (FY 2009) averaging \$372 PMPM; \$463 million (FY 2008) averaging \$337 PMPM	Basic Plus One: 41,147 (2008); 47,655 (2009), after GAMC was scaled back
New York	Family Health Plus; State-only Medicaid	2001	100 FPL (FHP); 78 FPL (Medicaid)	1115; state and local general funds	\$424 million for all adults (FY 2008-2009); Spending for 2009-2010 is forecasted at almost \$382 million. The forecast for 2010-2011 is over \$417 million and \$509 million for 2011-2012.	383,000 adults (2009), including parents and childless adults with 600,000 slots authorized under legislation
Oregon	Oregon Health Plan (OHP) Standard /OHP2	1994/2003	100 FPL	1115; hospital tax taken as a percentage of net revenue; tobacco tax; no general fund \$	\$962 million (2009-2011 biennium) projection for families and childless adults	25,000 parents and childless adults (2/2010); 30,000 new slots opened in 5/2010, with target of 60,000 by 6/2011; 14,838 childless adults (2005-2007 biennium)
Pennsylvania	adultBasic; General Assistance	2002	200 FPL (aB); 30 FPL (GA)	State-only \$; tobacco settlement; non-profit insurers community benefit obligation; \$30 monthly premium	\$157 million (2009); \$171.8 million (2008); \$156.3 million (2007); \$160.6 million (2006)	adultBasic: 45,927 (7/2010); 45,461 (2009); 52,319 (2008); 46,663 (2007)
Vermont	Health Access Plan	1994	150 FPL	1115	\$110.8 (FY 2009); \$89.9 million (FY 2008); \$79.8 million (FY 2007). 2010 projection is \$119.7 million.	36,010 (4/2010); 27,592 (2009); 24,771(2008); 22,404 (2007)
Washington	Basic Health Plan; General Assistance-Unemployable (Disability Lifeline)	1987	200 FPL (BHP); 38 FPL (GA)	State-only \$; tobacco tax	\$337 million appropriated (2009-2011 biennial budget) represented a 43% cut from the previous allocation. General Assistance: \$167 million allocated in the 2009-2011 biennium.	37,269 (2009); 31,175 (2008). Program has grown each year, nearly doubling in the past 5 years; 66,000 slots with waitlist over 100,000 (5/2010)
Wisconsin	BadgerCare Plus Core Plan	2009	200 FPL	1115; DSH hospital tax	Full budget numbers are currently unavailable given the program is less than one year old.	60,614 with over 30,000 waitlisted (04/2010); 54,000 slots originally planned

DSH = Disproportionate share hospital payments
 ESI = Employer-sponsored insurance

SOURCES: The sources for the information in this table are listed in Appendix B available at www.chcs.org/MedicaidExpansion.

Table 2: Low-income Childless Adult Coverage Programs from Selected States (continued)

	Care Management/Plans	Innovative Approaches for Care Management	Other Eligibility
Arizona	Pre-paid, capitated health plan/ Plan choice depends on MCO service areas		
Indiana	Pre-paid, capitated health plans: Anthem, MDWise, Enhanced Service Plan (ESP) for chronic conditions	Application asks about health needs; health savings account (HSA) and deductibles are used to encourage preventive service use; claims processing and information provided for people with multiple chronic conditions through the ESP.	<ul style="list-style-type: none"> Open to custodial and non-custodial adults. Non-custodial adults are capped at 36,500. Participants must pay into an HSA and have been uninsured for previous 6 months.
Maine	Primary care case management program	Schaller Anderson/Aetna provides care management services	<ul style="list-style-type: none"> Participants have to meet asset and income guidelines.
Minnesota	MinnesotaCare: Prepaid health plan/ Plan choice depends on MCO service areas GAMC: Hospital care		<ul style="list-style-type: none"> MinnesotaCare: no ESI with more than half paid for; no insurance w/in 4 months; asset test. GAMC: asset test; not eligible for other programs; live in MN for 30 days.
New York	Pre-paid, capitated health plans/ Plan choice depends on MCO service areas; no carve-outs		<ul style="list-style-type: none"> Residents of New York must be citizens or qualified aliens and cannot have access to 'equivalent' health care coverage or insurance.
Oregon	Pre-paid, capitated health plan/ Plan choice depends on MCO Service areas		<ul style="list-style-type: none"> There are work-related requirements for some participants and must participate in FHIAP (subsidy program) if have access to ESI. Participants are disenrolled for at least 6 months if they cannot pay premiums.
Pennsylvania	Pre-paid, capitated health plan/ Plan choice depends on MCO service areas		<ul style="list-style-type: none"> Participants must be uninsured for 90 days prior to enrollment, unless they have lost coverage because of recent unemployment. They must also be a resident of the state for 90 days and have U.S. citizenship or permanent legal status.
Vermont	PC plus: FFS, care managed by a primary care provider		<ul style="list-style-type: none"> Participants must be uninsured for 12 months, with exceptions, or carry insurance that covers only hospital care or only doctors' visits. Those with ESI access participate in a variation of the program.
Washington	Pre-paid, capitated health plan/ plan choice depends on MCO service areas GAU: participants enroll in the Community Health Plan of Washington (managed care organization); services must be medically necessary and ordered by the primary care provider	BHP: Use of deductibles and co-insurance for certain services	<ul style="list-style-type: none"> Slots open on a first-come, first-served basis to state residents who are not eligible for Medicaid/care, not institutionalized, or not full-time students on a student visa. General assistance: asset test; not eligible for other programs, or awaiting SSI receipt.
Wisconsin	Pre-paid, capitated health plan/ Plan choice depends on MCO service areas; 16 plans	Before MCO selection, an applicant must fill out a health needs assessment.	<ul style="list-style-type: none"> Residents with legal status must be uninsured for the previous 12 months and have no access to ESI or any other program.

DSH = Disproportionate share hospital payments

ESI = Employer-sponsored insurance

SOURCES: The sources for the information in this table are listed in Appendix B available at www.chcs.org/MedicaidExpansion.

Table 2: Low-income Childless Adult Coverage Programs from Selected States (continued)

	Benefit Packages	Health Care Reform
Arizona	<ul style="list-style-type: none"> Same as Medicaid; Includes mental health and substance abuse treatment. 	<ul style="list-style-type: none"> Eligible for the phased-in higher match rate beginning in 2014 for current coverage of childless adults below any enrollment caps that may be in place.
Indiana	<ul style="list-style-type: none"> Similar to Medicaid, but care outside of preventive care is subject to a deductible and/or drawn from a HSA. Includes mental health and substance abuse treatment. 	<ul style="list-style-type: none"> HIP enrollment for childless adults has been frozen. No other firm plans to date.
Maine	<ul style="list-style-type: none"> Less than Medicaid; Includes limited outpatient mental health and substance abuse treatment. 	<ul style="list-style-type: none"> Eligible for the higher phased-in match rate beginning in 2014 for current coverage of childless adults below any enrollment caps that may be in place.
Minnesota	<ul style="list-style-type: none"> MinnesotaCare: same as Medicaid except excludes medical transportation; includes vision, limited dental, mental health, substance abuse, subject to annual limits and copay. GAMC: hospital care provided by designated hospitals including doctors visits, emergency care, hospital stays, prescription drugs. 	<ul style="list-style-type: none"> Eliminated the GMAC. Governor can apply for coverage of GMAC people under Medicaid, but Gov. Pawlenty says unlikely to happen. Basic Plus One not affected.
New York	<ul style="list-style-type: none"> FH Plus benefit package is similar to Medicaid, but excludes long-term care services, non-prescription medications, and non-emergency transportation with no wrap-around fee-for-service provisions. Some services are subject to co-payments. Medicaid administers the prescription benefit. Mental health and substance abuse coverage subject to benefit limits. 	<ul style="list-style-type: none"> Eligible for the phased-in higher match rate beginning in 2014 for current coverage of childless adults below any enrollment caps that may be in place.
Oregon	<ul style="list-style-type: none"> OHP Standard limits hospital benefit to emergent and urgent conditions, and also excludes or limits certain optional Medicaid benefits. Outpatient mental health and substance abuse are included. 	<ul style="list-style-type: none"> Proceed with expanded enrollment as planned and prepare for 2014 changes. The Oregon Health Care Authority established in the executive branch in 2009 is charged with implementing health care reform.
Pennsylvania	<ul style="list-style-type: none"> adultBasic: hospitalization (max of two stays per year); primary and specialty care services; emergency services; diagnostics; maternity care; rehabilitation; skilled care. All services require co-payments, some also requiring coinsurance. Mental health and substance abuse are not covered. 	<ul style="list-style-type: none"> Program is set to expire in December 2010. Legislation pending as of 6/29/10 to establish a Health Insurance Reform Implementation Authority.
Vermont	<ul style="list-style-type: none"> Same as Medicaid; Includes mental health and substance abuse treatment. 	<ul style="list-style-type: none"> Eligible for the higher phased-in match rate beginning in 2014 for current coverage of childless adults below any enrollment caps that may be in place.
Washington	<ul style="list-style-type: none"> BHP: Comprehensive services, some with cost sharing: Physician visits; Hospital Care; Emergency Care; Prescription Drugs. GA-U: Provides medically necessary benefits, including substance abuse and mental health treatment. 	<ul style="list-style-type: none"> Washington submitted an 1115 waiver to start using new Medicaid funds to pay for Basic Health Plan and General Assistance starting in 2011; anyone can enroll in the full-buy in program: Washington Health Plan.
Wisconsin	<ul style="list-style-type: none"> Services with co-payments varying by income level: Chiropractic; Doctor visits; Hospital visits; ER; ambulance; Emergency Dental; Prescription drugs; DME, medical supplies, dialysis; Podiatry; Home health; Hospice; Psychiatrist visits; Physician services for substance abuse. 	<ul style="list-style-type: none"> Those on the waitlist will be covered by BadgerCare Basic plan, using some federal money. Below benchmark levels of care, premium is \$130, in 2014, will be fully Medicaid eligible.

DSH = Disproportionate share hospital payments

ESI = Employer-sponsored insurance

SOURCES: The sources for the information in this table are listed in Appendix B available at www.chcs.org/MedicaidExpansion.

Endnotes

- ¹ For details of this coverage as of late 2009, see Kaiser Commission on Medicaid and the Uninsured, “Where Are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults,” December 2009. Available at: <http://www.kff.org/medicaid/upload/7993.pdf>. Accessed July 19, 2010.
- ² For details on this option, see C. Mann, State Medicaid Director Letter #10-005, “New Option for Coverage of Individuals under Medicaid,” April 10, 2010. Available at: <http://www.cms.gov/smdl/downloads/SMD10005.PDF>. Accessed May 28, 2010.
- ³ 133 percent of the FPL for a single adult is an annual income of \$14,404 in 2010. The ceiling in 2014 is actually 138 percent of the FPL, since federal health care reform uses modified adjusted gross income to define eligibility, which disregards 5 percent of income. In approximately a dozen states that covered low-income childless adults in Medicaid before 2010 (“expansion states”) the federal match for this population is gradually increased beginning in 2014 and does not reach the level of other states until 2019.
- ⁴ Patient Protection and Affordable Care Act (P.L. 111-148). Sections 2001(c) and 1302(b). See also Kaiser Family Foundation, “Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries.” August 2010. Available at <http://www.kff.org/healthreform/upload/8092.pdf>. Accessed August 11, 2010.
- ⁵ See, for example, Kaiser Family Foundation, “Expanding Medicaid Under Health Reform: A Look at Adults at or Below 133% of Poverty,” April 2010. Available at: <http://www.kff.org/healthreform/upload/8052-02.pdf>. Accessed July 21, 2010. See also J. Holahan and I. Headen, “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL,” Washington, DC: Kaiser Commission on Medicaid and the Uninsured, May 2010. Available at: <http://www.kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf>. Accessed July 21, 2010.
- ⁶ The penalty rises to \$325 in 2015 and \$695 in 2016, but with a ceiling of 2 percent of taxable income in 2015 and 2.5 percent in 2016.
- ⁷ Washington State Institute for Public Policy, “General Assistance Programs for Unemployable Adults,” December 2009. Available at: <http://www.wsipp.wa.gov/rptfiles/09-12-4101.pdf>. Accessed July 16, 2010. See also Kaiser Commission on Medicaid and the Uninsured, “Where are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults,” December 2009.
- ⁸ S.G. Haber, G. Khatutsky and J.B. Mitchell. “Covering Uninsured Adults through Medicaid: Lessons from the Oregon Health Plan.” *Health Care Financing Review*. Winter 2000. Vol 22, Number 2.
- ⁹ N. Anderson and T. Gressani, “MaineCare for Childless Adults Waiver Year 7 Annual Report, October 1, 2008 – September 30, 2009,” Cutler Institute of Health & Social Policy, Muskie School of Public Service, University of Southern Maine, February 23, 2010, Table 2, p. 15.
- ¹⁰ Analysis by the Office of Medical Assistance Programs, Department of Public Welfare. Includes adults receiving cash assistance. Based on paid FFS and encounter claims between 4/1/2008 and 3/31/2010 with the primary diagnosis code between 29000 and 30299 or between 30600 and 31399 for mental illness and primary diagnosis codes between 30300 and 30599 for substance use.
- ¹¹ Based on a September 9, 2009 Acute Care Actuarial Memorandum prepared by W. Marks of the Arizona Health Care Cost Containment System Administration, available at: <http://www.azahcccs.gov/commercial/Downloads/CapitationRates/AcuteCare/AcuteCYE10ActuarialCertification.pdf> See Appendix II on p. 12. Childless adults are the “Prospective non-MED” group, SSI/disabled adults are “SSI w/o Med,” and TANF adults are Title XIX adults age 45 and older. Note that “PPC” (prior period costs) are included in the calculation of projected annual costs shown above; they represent costs incurred in the period prior to enrollment, which may be up to three months. They represent one-time payments for individual enrollees, and they are substantially larger for childless adults than for disabled and non-disabled adults.
- ¹² For details on this early experience in the Healthy Indiana Plan, see R. Damler, “Experience under the Healthy Indiana Plan: The short-term costs challenges of expanding coverage to the uninsured.” Milliman, Inc., August 2009. Available at: <http://publications.milliman.com/research/health-rr/pdfs/experience-under-healthy-indiana.pdf>. Accessed June 18, 2010. A more recent analysis of the Healthy Indiana Plan experience by C. Westover of WellPoint, one of the plans participating in the program, indicated that inpatient hospital and prescription drug utilization for childless adults is approximately halfway between that of adult parents in the Indiana program, and the Medicaid SSI/disabled population in Virginia, another state in which WellPoint participates in the Medicaid program. Unpublished PowerPoint presentation from the 18th Annual Medicaid Managed Care Congress in Baltimore, Maryland, on May 18, 2010.
- ¹³ N. Anderson and T. Gressani, op cit.
- ¹⁴ Centers for Medicare and Medicaid Services, Medicaid Statistical Information System (MSIS), FFY 2007. Data from Maine for FFY 2008 are not yet available in MSIS.
- ¹⁵ Analysis by J. Verdier of 2010 capitation payment rates supplied by J. Wiley of the Minnesota Department of Human Services, March 31, 2010. Note that rates differ by health plan and by geographic area. The illustrative rates shown are metro-area rates from a plan with large Medicaid and related enrollment.
- ¹⁶ D. Frescatore, “New York’s Experience Covering Childless Adults,” June 23, 2010 slide presentation.
- ¹⁷ PricewaterhouseCoopers, “Oregon Health Plan Medicaid Demonstration: Analysis of Calendar Years 2010-2011 Average Costs.” Report Addendum, December 12, 2008, Exhibit 13-E, p. 73. Available at: http://www.oregon.gov/DHS/healthplan/data_pubs/rates-costs/cap-rates/addendum10-11.pdf. Accessed August 8, 2010.
- ¹⁸ Based on data provided to CHCS and Mathematica by B. Buckingham of the Pennsylvania Department of Public Welfare, July 2010.
- ¹⁹ Washington State Department of Social and Health Services data provided to CHCS, July 2010.
- ²⁰ Analysis by J. Verdier of actuarial data provided by J. Johnston and C. Cunningham of the Wisconsin Department of Health Services, April 2010.
- ²¹ J. Verdier telephone conversation with S. Hunt, May 5, 2010.
- ²² We did not include Vermont in Table 1 because we did not have sufficient comparative PMPM cost data to warrant the state’s inclusion.
- ²³ Indiana Family and Social Services Administration. “Enhanced Services Plan – Frequently Asked Questions.” Accessed February 2010 at: http://www.in.gov/fssa/hip/files/ESP_Final_FAQ.pdf
- ²⁴ Indiana Family and Social Services Administration, “Enhanced Services Plan (ESP) Overview.” Accessed May 2010 at: www.indianamedicaid.com/ihcp/ProviderServices/.../HIP_ESP.ppt
- ²⁵ Centers for Medicare and Medicaid Services. “Wisconsin – BadgerCare Plus – Health Insurance for Childless Adults.”
- ²⁶ The General Assistance Medical Care (GAMC) program, which has been scaled back dramatically, covers only very low-income adults in Minnesota, and will reimburse hospitals for care of very low-income childless adults and couples that do not qualify for traditional MinnesotaCare and who cannot afford the

premiums associated with MinnesotaCare Basic Plus One. See: W. Wolfe. "Poor Face Health Care Change." *Minnesota Star Tribune*. May 17, 2010. Accessed at: <http://www.startribune.com/politics/state/94015769.html?page=1&c=y>

²⁷ Centers for Medicare and Medicaid Services. "Oregon Demonstration Fact Sheet." March 30, 2009. Accessed at: <http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp>.

²⁸ Oregon Department of Human Services. "General Rules." February 8, 2010. Accessed at: <http://www.dhs.state.or.us/policy/healthplan/guides/genrules/genrules-sup0210.pdf>

²⁹ See sections 2703, 3021, and 3502 of the Patient Protection and Affordable Care Act for complete descriptions of the health homes, Center for Medicare and Medicaid Innovation, and community health teams provisions, respectively.

³⁰ States will receive 100% federal funding for these increased primary care payment rates in 2013-2014.

³¹ The National Center on Addiction and Substance Abuse at Columbia University. "Behind Bars II: Substance Abuse and America's Prison Population." February 2010. Accessed July 20, 2010 at http://www.casacolumbia.org/templates/publications_reports.aspx.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. Its program priorities are: improving quality and reducing racial and ethnic disparities; integrating care for people with complex and special needs; and building Medicaid leadership and capacity. For more information, visit www.chcs.org.

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Appendices for Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States

This appendix is a supplement to a Center for Health Care Strategies policy brief, *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States*.

To download the policy brief, visit www.chcs.org.

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Appendix A: Summary of Core Program Features from Selected States

Following are summaries of key features of state programs discussed in *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States*, a policy brief coauthored by the Center for Health Care Strategies and Mathematica Policy Research in August 2010. To download the policy brief, visit www.chcs.org.

Arizona residents approved Proposition 204 in 2000, expanding coverage to adults under 110 percent FPL through the state's Medicaid program. CMS authorized this expanded coverage under an amendment to the state's long-standing 1115 waiver. With recent budget constraints, in 2010 the state sought to eliminate the program, but the maintenance-of-effort requirements of health care reform led the state to reverse that decision.

During the Bush administration, states were encouraged to experiment with high-deductible health plans and health savings accounts to cover more people. **Indiana's** 1115 waiver program, called the Healthy Indiana Plan (HIP), incorporates these elements to expand health coverage to adults — both custodial parents and childless adults — up to 200 percent of the FPL.

Voters in **Maine** approved the Dirigo Health Act in 2003 to expand health care coverage to more residents, including childless adults. These adults are covered under the MaineCare program — Maine's Medicaid program — up to 100 percent of the FPL, the lowest Medicaid income threshold among the states we researched. Maine has seen high demand for the program and has cycled through various caps on enrollments since implementing the program.

Minnesota offers MinnesotaCare Basic Plus One to childless adults up to 250 percent of the FPL and the General Assistance Medical Care (GAMC) program to those who are very low-income (below 75 percent of the FPL) and cannot afford the cost-sharing associated with Basic Plus One. The Basic Plus One program has the most generous income eligibility limits among the 10 states we researched while the GAMC program has the lowest. Both programs are funded with state-only dollars.

New York's Health Care Reform Act of 2000 authorized a health care coverage expansion for several populations, including low-income adults. The state submitted an amendment to its existing 1115 waiver for these and other expansions.¹ Family Health Plus covers both parents and childless adults under 100 percent of the FPL.

Oregon's efforts to cover uninsured residents have gone through several iterations since the original expansion in 1994. The Oregon Health Plan—Standard program for adults up to 185 percent of the FPL offers basic health services and recently re-opened to new enrollees, drawing people from a large waiting list by lottery each month until the program reaches the current enrollment ceiling.

Pennsylvania used a significant portion of its share of tobacco settlement money to fund the first year of its program to cover uninsured adults up to 200 percent of FPL called adultBasic. Participants pay a monthly premium and co-payments and coinsurance for a set of comprehensive services. The program is

¹ New York State Department of Health. "Executive Summary – New York State's Request for an Amendment to its Current Section 1115 Waiver." May 2001. Accessed July 7, 2010 at: <http://www.health.state.ny.us/nysdoh/fhplus/summary.htm> and Centers for Medicare and Medicaid Services. "Expenditure Authority – Partnership Plan Medicaid Section 1115 Demonstration, New York State Department of Health." Accessed July 7, 2010 at: http://www.health.state.ny.us/health_care/managed_care/appextension/partnership_plan/docs/expenditure_authorities.pdf

now also funded through an assessment on non-profit health plans and employs a full buy-in program for adults on the program's waitlist.

Through the **Vermont** Health Access Plan, adults up to 150 percent of the FPL meeting certain other conditions have been eligible receive a Medicaid package of benefits since 1994. This program is one of several Vermont has implemented to realize the goal of universal coverage for all of its residents.

Washington rolled out its Basic Health Plan in 1987 — the first among the 10 states we reviewed — offering comprehensive coverage to adults under 200 percent of the FPL through pre-paid, capitated health plans. Basic Health, as it is known, requires cost sharing for all participants through monthly premium payments, deductibles, and co-insurance for certain services. Solely state-funded and subject to budget constraints, the program has maintained a waitlist through much of its history, opening slots on a first-come, first-served basis. Washington also provides medical benefits for very low-income individuals who are not eligible for any other government benefits through its General Assistance program. The program was renamed Disability Lifeline in 2010 and all beneficiaries must now enroll in the Community Health Plan of Washington, a managed care organization.^{2,3}

Wisconsin's BadgerCare Plus Core Plan is the newest of the programs we researched, beginning coverage of childless adults up to 200 percent of the FPL in July 2009. Although in existence less than one year, the state instituted an enrollment cap in October 2009 and a waitlist. The program is part of a larger 1115 waiver CMS has granted the state.

² Washington State Department of Social and Health Services. "Disability Lifeline Managed Care Benefits." Website Accessed July 9, 2010 at: <http://hrsa.dshs.wa.gov/gaumc/GAU%20MC%20Benefits.htm>

³ Washington State Institute for Public Policy. "General Assistance Programs for Unemployable Adults." December 2009. Accessed July 9, 2010 at: <http://www.wsipp.wa.gov/rptfiles/09-12-4101.pdf>

Appendix B: Sources Consulted

Following is a list of sources consulted in the development of *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States*, a policy brief coauthored by the Center for Health Care Strategies and Mathematica Policy Research in August 2010. To download the policy brief, visit www.chcs.org.

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