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State Approaches to Expanding Family Coverage

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The states and the federal government continue to make strides in expanding health care coverage incrementally. All 50 states have implemented programs to expand health insurance to low-income children through the State Children's Health Insurance Program (CHIP), and more than 2 million children have been enrolled. Now, many states are examining proposals to expand coverage to the parents of children eligible for CHIP and for Medicaid.

The three major vehicles states have used — and are considering using — to expand coverage to families are:

- State Children's Health Insurance Program (Title XXI of the Social Security Act);
- Medicaid (through Section 1115 Research and Demonstration Waivers and Section 1931 income disregards); and
- State-only programs (funded without federal dollars).

To date, most state coverage expansions to parents have been achieved through Medicaid — either through Section 1115 waiver programs or, more recently, through Section 1931 income disregards. A few states have received federal approval to expand coverage to families through CHIP and several others are now moving in that direction. Some states have also established their own coverage programs directed to working families.

Parental Coverage through CHIP

The CHIP program was explicitly designed to provide coverage to low-income children. However, through negotiations with the Health Care Financing Administration (HCFA), some states have been able to direct enhanced federal matching funds under CHIP to cover the parents of eligible children as well.

Restrictions on family coverage. To obtain federal approval for CHIP family coverage, states must meet a number of requirements, including:

- ***Cost-effectiveness.*** States must demonstrate that the cost of covering the entire family will be less than or equal to the cost of covering only the children under the state program. Typically, the only way to achieve this is by capturing private funds by establishing an employer buy-in program.
- ***Minimum employer contribution.*** HCFA requires that employers pay at least 60 percent of the insurance premium for family coverage in order for the employer plan to qualify for Title XXI funding. Because employer premium contributions for family coverage are often lower than 60 percent, many states have sought to lower this requirement (though with limited success).
- ***Minimum benefit standards.*** The family coverage provided through the employer plan must meet the minimum benefit standards required in Title XXI. States must provide wrap-around coverage in cases where the benefits offered do not meet the standard. In addition, cost-sharing under the private plan must not exceed the caps set out in Title XXI (5 percent of annual income for families with incomes above 150 percent of the federal poverty level [FPL]).
- ***Crowd-out provisions.*** States must also show that family coverage expansions will not cause substitution, or crowd-out, of private coverage. To ensure that public funds are not simply replacing existing private funds, HCFA requires states to verify that applicants for CHIP premium subsidies have not been covered under an employer-based plan for the previous six months.

Continued on page 2

CHIP waivers/variances. States continue to seek greater flexibility to expand coverage to parents under CHIP and have requested increased waiver authority to circumvent some of these program requirements. However, HCFA has sought to gain more experience with the program before granting waivers to the law's original provisions.

Denied state applications. Some states, such as Vermont and Wisconsin, originally sought to provide direct public coverage — rather than subsidized private coverage — to parents through CHIP, but they were not able to secure HCFA approval. These states instead expanded coverage to parents through 1115 programs at regular Medicaid matching rates, and, in Wisconsin's case, through a CHIP employer buy-in program.

State programs. To date, three states have received approval from HCFA to provide family coverage through CHIP using an employer buy-in mechanism: Massachusetts, Wisconsin, and Mississippi (see Box 1). Massachusetts' program is the most sizable, with approximately 1,000 parents covered through CHIP at the end of 1999. Wisconsin has been successful in enrolling adults and children through its 1115 program (BadgerCare), but participation in its employer buy-in program funded through CHIP is currently very low. Mississippi received HCFA approval but has not implemented its program. In addition to these three states, many other states, including Connecticut, California, Iowa, Maryland, and New Jersey, are also examining options to provide family coverage under CHIP.

Medicaid Family Coverage: Basic Provisions

Medicaid eligibles. The Medicaid program provides coverage to categorically eligible individuals, including low-income pregnant women and children, impoverished seniors, and the disabled. Prior to welfare reform in 1996, families receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program were automatically eligible to receive Medicaid benefits. This provided coverage to a fairly limited number of parents because welfare programs targeted single-parent families in very low-income households. According to the Urban Institute, in 1995 the median income threshold for families under AFDC was less than two-thirds of FPL.

Delinking Medicaid and welfare. With the passage of welfare reform, eligibility for Medicaid and welfare were delinked. The law required states to establish a new eligibility category, now referred to as the "family coverage category" or the "Section 1931 eligibility group." This group includes the people who were eligible to receive Medicaid under the AFDC eligibility standards in effect on July 16, 1996. Under the welfare reform law, these people continue to be eligible for Medicaid regardless of their enrollment status in the new welfare program Temporary Assistance for Needy Families (TANF).

Coverage for two-parent families. HCFA released regulations in August 1998 which loosened the Medicaid eligibility requirement for two-parent families. The regulations allow states to eliminate the 100-hour rule, which had precluded parents from Medicaid eligibility if the primary wage earner in the family worked more than 100 hours per month.

Section 1931 Medicaid Expansion Options

Coverage expansion options under 1931. In addition to locking in place each state's AFDC Medicaid eligibility criteria from July 1996, the welfare reform law allows states to expand Medicaid coverage to families through several means: income disregards, asset disregards, and increases in income and resource standards based on inflation.

Continued on page 3

Box 1: States Covering Parents through CHIP

State	*Program*	*Maximum Income (% FPL)*	*Notes*
Massachusetts	MassHealth Family Assistance	200%	Parents above 133% FPL covered through employer buy-in only (no direct coverage under MassHealth). Parents under 133% FPL covered through Medicaid waiver.
Mississippi	MS CHIP	200%	Family coverage through employer buy-in approved by HCFA (12/99) but not yet implemented.
Wisconsin	BadgerCare	185%	Families with employer plans that do not meet the CHIP cost-effectiveness test may be covered under the 1115 program at a regular matching rate.

Box 2: Medicaid Income Disregards in Selected States

State	*Earnings Disregard for Medicaid Applicants (based on monthly income)*
Arizona	$90 + 30% of remainder or $30 + 33% of remainder (whichever is greater)
California	All income between old AFDC standard and 100% FPL
D.C.	All income between old AFDC standard and 200% FPL
Maine	All income between old AFDC standard and 100% FPL
Minnesota	$120 + 33% of remainder
Montana	$200 + 25% of remainder
New Mexico	$120 + 33% of remainder
New York	42% for families whose gross income does not exceed 100% FPL
Ohio	$250 + 50% of remainder
Oklahoma	$120
Oregon	50% or $120 + 33% of remainder (whichever is greater)
Pennsylvania	50%
Rhode Island	All income between old AFDC standard and 185% FPL
Vermont	$150 + 25% of remainder
Washington	50%
Wisconsin	$120 + 33% of remainder
Wyoming	$200

Source: *State Policy Documentation Project, "States' Implementation of Selected Medicaid Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996," January 2000; Alpha Center analysis.*

Note: *Figures included are for Medicaid applicants. Some states have more generous income disregards in place for Medicaid recipients.*

Because most states have already expanded coverage to low-income children, this option primarily provides states an opportunity to cover additional parents. Under Section 1931, states can expand coverage to the parents of children already eligible for a state Medicaid program (whether that coverage is financed through Title XIX Medicaid or CHIP's enhanced match); however, states cannot use this option to extend coverage to parents of children eligible for a non-Medicaid CHIP program.

Income disregards. In making eligibility determinations for Medicaid, the federal government requires states to disregard $90 in monthly income for applicants' work-related expenses. Under Section 1931, states have the option to expand income disregards, effectively increasing Medicaid eligibility by not counting portions of family income. The federal government applies no upper limit to these disregards, so states can extend Medicaid coverage as high as they choose under the family coverage category. For example, Rhode Island has used income disregards under Section 1931 to extend Medicaid coverage for adults up to 185 percent of FPL (see Box 2).

Asset disregards. Section 1931 also allows states to have more flexibility in measuring personal assets. Using 1931, states may disregard portions of an applicant's automobile value or bank savings, for example. Several states, such as Florida, Georgia, and Ohio, have used this approach to increase eligibility for Medicaid and extend coverage to families.

Increasing the income and resource standard. Under Section 1931, states have the option to increase income and resource standards as high as the percentage increase in the Consumer Price Index subsequent to July 16, 1996. This provision of 1931 provides a fairly limited coverage expansion opportunity given the low rates of inflation in recent years.

No requirement for waiver. An advantage of expanding coverage through Section 1931 is that states are not required to submit a waiver to HCFA. States can submit a state plan amendment and the eligibility change can be placed into effect very quickly.

Limiting enrollment. Some states have been reticent to expand coverage through Section 1931 because Medicaid is an entitlement program. However, Section 1931 does provide states with the flexibility to scale back the expansion at any time. Under the 1931 option, states can establish different income disregard standards for recipients and applicants. A state facing budgetary pressures can reduce income disregards for new applicants in order to control enrollment levels.

Continued on page 4

Box 3: States Covering Parents through Medicaid 1115 Waivers

State	*Program*	*Maximum Income (% FPL)*	*Notes*
Delaware	Diamond State Health Plan	100%	All adults eligible to 100% FPL.
Hawaii	QUEST	100%	Full cost Medicaid buy-in available to parents between 100-300% FPL.
Minnesota	MinnesotaCare	275%	Adults with no children covered to 175% FPL with state-only funds.
Missouri	Missouri Managed Care Plus (MC+)	300%	Parents transitioning from TANF to work that have incomes <300% FPL are eligible for Medicaid coverage for two years. Certain other parents covered to 100% FPL.
Oregon	Oregon Health Plan	100%	All adults <age 65 are eligible.
Tennessee	TennCare	No maximum income	Tennessee initially expanded eligibility to uninsured and uninsurable persons regardless of income, with sliding scale premium subsidies for those between 100% and 400% FPL. However, financial pressures have caused the state to cap enrollment (except for select groups).
Vermont	Vermont Health Access Plan	150%	Eliminated categorical eligibility and expanded coverage to 150% FPL to uninsured residents.
Wisconsin	BadgerCare	185%	Coverage available through an employer buy-in mechanism (where cost-effective), or directly through the 1115 program. Once enrolled, families are eligible until income exceeds 200% FPL.

Section 1115 Medicaid Waivers

ELIGIBILITY EXPANSIONS FOR MEDICAID. Many states have used Section 1115 Research and Demonstration waivers to achieve significant expansions in coverage through their Medicaid programs. These waivers have allowed states to eliminate certain requirements of the traditional Medicaid program (e.g., freedom of choice of provider) to achieve cost savings and/or expand program eligibility. Several of these waiver programs have significantly extended coverage to both parents and children (see Box 3).

BUDGET NEUTRALITY. To receive HCFA approval on a Medicaid expansion through Section 1115, states must meet a budget neutrality test. States must show that the cost of the demonstration program (including the new eligibles) will be the same or less than the standard Medicaid program over the course of the demonstration period. Many states have achieved budget neutrality by shifting Medicaid enrollees from fee-for-service arrangements into managed care plans.

STATE PROGRAMS. Among the most prominent 1115 waiver programs are Tennessee's TennCare program and the Oregon Health Plan (OHP). By shifting all of its fee-for-service enrollees into capitated managed care plans, Tennessee gained HCFA's approval to expand coverage to uninsured and uninsurable adults and children regardless of income (although financial pressures later required the state to discontinue new enrollment for working adults). Oregon established a prioritized list of covered services which excluded many high-cost/low-benefit procedures. These savings enabled the state to finance a coverage expansion for all non-elderly residents living below the poverty line.

State-only Programs Targeting Parents

FLEXIBILITY IN PROGRAM DESIGN. Several states have designed and funded their own coverage programs directed to families and working adults (see Box 4). State-only programs allow states more flexibility than programs partially funded by the federal government because federal restrictions regarding benefit structure, eligibility standards, and other program components do not apply. This allows states to avoid the lengthy negotiations with the federal government that are often required for

Continued on page 5

a family coverage expansion through Medicaid or CHIP.

Financial commitment. The downside of this approach, of course, is that the states relinquish the financial support that is available through these federally funded programs. As a result, state-only programs are usually relatively limited in terms of benefit structure and/or enrollment. Unlike Medicaid, state-only programs are typically not entitlement programs and their enrollment caps often produce long waiting lists.

State programs. Washington's Basic Health Plan (BHP) provides subsidized coverage to families at or below 200 percent of FPL. The BHP benefit package is comparable to state employee benefits, except that BHP does not include dental or vision coverage. Both parents and children may receive coverage under the BHP program, although children are also eligible for Medicaid coverage up to 200 percent of FPL. The state has encouraged families to move BHP-enrolled children into Medicaid — in part because of Medicaid's broader benefit package, and in part because of the available federal match. Oregon's Family Health Insurance Assistance Program (FHIAP) uses state funds to subsidize individual contributions to private coverage for those with incomes at or below 170 percent of FPL. Children are eligible for Medicaid up to 170 percent of FPL but may receive subsidies through FHIAP along with their parents. The state requires children to be enrolled in some type of coverage for the parent to be eligible for the FHIAP program.

New Federal Proposals

FamilyCare proposal. In his FY 2001 budget, President Clinton proposed extending CHIP eligibility to the parents of eligible children. The budget allocates $76 billion to that effort over the next 10 years. To be eligible for family coverage, states would first need to extend coverage to all children under 200 percent of FPL (as most states have already done). The measure would also create a requirement that all states extend coverage to parents under 100 percent of FPL by 2006 if they had not already done so under the FamilyCare program. States would be eligible to receive enhanced matching funds to extend coverage to parents beyond the eligibility limits in effect on January 1, 2000. For those families with access to employer-based coverage, the measure would allow for premium subsidies for employer coverage that meets specific program standards.

Tax credit proposal. Congressional leaders have proposed legislation that would provide tax credits for the purchase of health care coverage. A bill supported by House Majority Leader Dick Armey and others would offer the uninsured a $2,000 refundable tax credit for the purchase of family coverage and a $1,000 refundable credit for the purchase of individual coverage. The measure is designed to support existing private coverage by making it more affordable, rather than establishing eligibility for a new or expanded public program. The plan is estimated to cost approximately $70 billion over 10 years and would serve both middle- and low-income workers.

Outlook. The likelihood that either of these proposals will pass is highly uncertain in this election year. However, both proposals would have a tremendous impact on state efforts to expand coverage to families. Congress will take up these measures later this year; in the meantime, states are continuing to examine their options under current law.

Box 4: States Providing Coverage to Parents through State-Only Programs

State	*Program*	*Maximum Income (% FPL)*	*Notes*
Oregon	Family Health Insurance Assistance Program (FHIAP)	170%	Enrollees can apply premium subsidies toward employer-based or individual coverage, or the state's high-risk pool.
Rhode Island	Health Care for Center-Based Child Care Providers	No limit	Center-based child care workers participating in a state-subsidized child care program are eligible for private coverage premium subsidies.
Washington	Basic Health Plan	200%	Uninsured adults and children.

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