Waiver Expansion Study
State of Wyoming
Department of Health

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NAVIGANT CONSULTING

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Chapter Five: Cost-Effectiveness Analysis

Introduction

The increasing lack of health care coverage continues to affect access to care and place financial stress on individuals, families and healthcare providers. Nationwide, the number of nonelderly uninsured increased from 16.1 percent to 17.7 percent between 2000 and 2003.[1] In Wyoming, the number of nonelderly uninsured has increased from 18.1 percent to 19.2 percent since 2000.[2]

The increase in the uninsured has been driven by the decline in employer-sponsored insurance and the increase in the number of individuals below the poverty level.[3] While children's coverage has not declined nationwide over the same time period due to increases in public healthcare coverage programs such as Medicaid and the State Children's Health Insurance Program (SCHIP), this has not been the case for adult populations.[4] The working poor between the ages of 19 and 64 have the least number of options to obtain coverage as they may earn too much to qualify for public health insurance programs and may not have access to (or be able to afford) employer-based coverage.

Being uninsured results in poor health outcomes and increased financial stress on individuals, families and health care providers, specifically:

- The uninsured, when compared to persons with health insurance receive less preventive care, are diagnosed at more advanced disease states, and tend to receive less therapeutic care and have higher mortality rates once diagnosed.[5]

- Over one-third of the uninsured have a serious problem paying medical bills.[6]

- In 2004, the majority of the estimated $40.7 billion in costs of uncompensated care[7] for the uninsured was incurred by hospitals, followed by office-based physicians and direct care programs or clients.[8] While historically approximately 85 percent of the costs of this care is covered by government funding (i.e., additional payments made by Medicare and Medicaid to hospitals that serve a disproportionate number of Medicaid or low-income patients), the remaining costs of providing care to the uninsured are not paid by any entitlement or insurance programs. In Wyoming, hospitals provided $66.3 million in bad debt and charity care charges in State Fiscal Year 2003.[9]

In response to Wyoming-specific concerns regarding the personal and financial cost of being uninsured, the Department of Health engaged Navigant Consulting, Inc. in July 2004 to conduct a study of Wyoming's ability to expand health insurance coverage using Medicaid or State Children's Health Insurance Program waivers.

Purpose and Scope of the Study

This study has its origins in Wyoming's State Planning Grant, which was funded in 2002 by the federal Department of Health and Human Services. Using this Grant, the State conducted a comprehensive research study on health insurance coverage in Wyoming, and developed recommendations for improving health insurance. This Grant was lead by a 17-member State Planning Grant Task Force, which ultimately merged into the Wyoming Healthcare Commission, a statewide legislatively-mandated body that has been tasked with studying issues related to access, cost and quality of health care for Wyoming citizens.

For this study, Navigant Consulting, Inc. has:

- Provided an overview of public health care coverage programs funded by the federal and state governments, and how Wyoming has implemented those programs
- Described different strategies states use to expand coverage under Medicaid and SCHIP, as well as selected state-only funded initiatives
- Summarized different premium assistance strategies Wyoming could use as part of different expansion strategies
- Described an expansion approach that Wyoming may want to consider given state-specific goals and characteristics, and provided related budget impact analyses. This expansion approach includes three different coverage models for Wyoming's consideration.

Our study focuses on expanding coverage to parents of children in the State's Children's Health Insurance Program ("Kid Care CHIP") and to low-income adults; the State Planning Grant identified both of these populations for coverage expansions in its final recommendations.

Wyoming's Public Health Care System

Currently, Wyoming uses three main public programs to provide comprehensive coverage to the uninsured:

- *Medicaid* is a federal and state-funded program which covers the elderly and disabled, low-income parents and children, pregnant women and individuals receiving federally-assisted income maintenance payments. While states must cover specific mandatory populations and benefits to receive federal Medicaid

funding, states may receive federal matching funds for specific optional Medicaid benefits and populations

- *Medicaid optional populations* include children in foster care without special needs, women with breast or cervical cancer under the Prevention and Treatment Act, and pregnant women, newborns and children up to age six with incomes up to 185 percent of the federal poverty level that are not already covered under one of the mandatory populations groups.

- *Medicaid optional benefits* include prescribed drugs, nursing facilities for children under 21, organ and tissue transplants for adults and comprehensive dental services for adults.

- *State Children's Health Insurance Program*, created in 1997 by the Balanced Budget Act, is a federal and state-funded program which covers low-income children in families whose incomes exceed Medicaid eligibility limits.

- *State High-Risk Pool*, a state-only funded program that provides coverage to individuals with pre-existing conditions that preclude them from obtaining comprehensive insurance coverage at an affordable market price.

Wyoming also offers a state-only funded prescription drug assistance program for low-income non-Medicaid eligible individuals.

While Wyoming's Medicaid ("EqualityCare") and SCHIP ("Kid Care CHIP") programs cover more than 63,000 children and adults,[10] the state's eligibility levels are generally lower than that of other states and Wyoming does not offer as many Medicaid optional benefits. For example:

- Wyoming Medicaid covers pregnant women up to 133 percent of the federal poverty level under Medicaid while the majority of states provide coverage at 185 percent or higher.[11]

- Wyoming Medicaid does not provide Medicaid adult recipients with the following optional Medicaid benefits: extended inpatient psychiatric services, podiatrist services and non-waiver personal care services. The majority of states provide adults with these services under their Medicaid programs.[12]

While 20 percent of Wyoming Medicaid's 2002 expenditures are for optional services, the majority of these expenditures can be attributed to prescription drug services.[13] Many policymakers considered these services critical to preventing the use of other health care services, and no state has eliminated this coverage.

Wyoming was one of the last two states in the country to obtain state legislative authority to implement SCHIP and its program upon implementation covered only children in families up to 133 percent of the federal poverty level while the original federal SCHIP allotment was intended to cover children up to 200 percent of the federal poverty level. As a result, $14 million of Wyoming's 10-year block grant was redistributed to other states and Wyoming will not be eligible for additional funds from other states until all retained and current allotments are spent.

Coverage Expansion Options

States generally expand coverage through their Medicaid and SCHIP programs as participation in these programs allow states to access federal matching funds. There is no one standard expansion approach that states follow. While state Medicaid and SCHIP programs must all comply with certain federal and state regulations, implementation of these programs varies widely across states based on state-specific characteristics and goals. When considering an expansion initiative, states must carefully analyze their existing Medicaid and SCHIP programs and determine the best way to expand coverage to meet their policy goals.

States can choose to simply expand Medicaid eligibility through a State Plan Amendment; however, this option requires an indefinite additional state commitment of funds and does not allow states to cap enrollment if the costs of the expansion population exceed available state resources. Many states obtain flexibility to develop expansion programs by asked the federal government to waive Medicaid or SCHIP requirements in Section 1115(a) of the Social Security Act. These "1115(a) waivers" allow states flexibility to redesign their Medicaid programs within the limits of their current expenditures (and federal requirements). Under these 1115 waivers, many states expand coverage within their current Medicaid and SCHIP budgets by reducing costs in certain areas – i.e., reducing benefits for an existing population or adjusting the financial structure of Medicaid (i.e., implementing managed care). Some states use special Medicaid payments to hospitals serving a disproportionate number of Medicaid and low-income patients ("DSH" payments) to fund expansions.

In 2001, the federal government implemented a new waiver initiative designed to encourage states to increase the number of individuals with health insurance coverage by integrating SCHIP and Medicaid funding and maximizing the use of private insurance coverage. These 1115(a) waivers, known as Health Insurance Flexibility and Accountability (HIFA) waivers, have a special streamlined waiver application and an expedited review process.

Although 1115(a) waivers provide states with substantial flexibility, states must still comply with federal regulations regarding mandatory Medicaid benefits and other coverage policies such as exempting pregnant women from paying part of their health care costs out-of-

pocket ("cost-sharing"). To obtain waiver approval, states must maintain access to and quality of care, and achieve federal budget or SCHIP allotment neutrality. These waivers typically combine a variety of state and federal funding sources and states must construct their waiver programs carefully to comply with existing federal regulations. Even with the expedited HIFA waiver process, waiver programs generally entail a lengthy development and application period and require annual progress reports and periodic independent assessments after implementation.

Some states use premium assistance as their sole means to expand coverage, or in conjunction with the expansion of their direct Medicaid or SCHIP coverage. Expanding health care coverage by funding all or part of an employer-sponsored premium is considered advantageous because it provides a strong link to the workforce and encourages existing health care coverage. While states are able to implement premium assistance options as part of their Medicaid programs and SCHIP programs, state participation in these options has been relatively low because they consider the related federal regulations administratively burdensome. The HIFA waiver initiative, however, has encouraged state premium assistance programs by relaxing federal cost-sharing and benefit requirements.

Potential Wyoming Coverage Expansion Approach

The coverage expansion approach described in this study is structured to address Wyoming-specific characteristics and goals, which we summarize in Table A.

Table A: Wyoming Coverage Goals and State-Specific Characteristics

Coverage Goals	Wyoming Characteristics
• Promoting employer-based insurance • Maintaining expansion costs within budget constraints • Obtaining federal matching funds • Providing health care coverage to the working poor • Reducing the fiscal burden on health care providers of providing health care services to the uninsured • Taking advantage of current Medicaid and SCHIP administrative structure and efficiencies	• Has little or no managed care due to the state's rural and frontier nature • Uses 100 percent of federal funding for disproportionate share hospital payments • Estimates that it will have little or no federal SCHIP funding allotment available • Covers fewer Medicaid optional populations and benefits than other states • Has only one small state-only funded program that it may be able to wrap into a waiver program to achieve federal budget neutrality • Has a relatively limited Medicaid and SCHIP administrative burden due to its small program size

Given the goals and state-specific characteristics identified in Table A, Wyoming may want to consider the following policies as part of its coverage expansion:

- Provide coverage to parents of Medicaid and SCHIP children and childless poor adults
- Incorporate the coverage expansion into the current Medicaid and SCHIP program administration
- Use a premium assistance program as a component of the expansion project
- Limit program enrollment to a specific number of participants
- Expand coverage using a HIFA waiver that allows significant flexibility in the design of the benefit packages and premium assistance programs

Many states fund their coverage expansion using savings from sources that are not readily available to Wyoming, i.e., implementation of managed care, use of Medicaid disproportionate share hospital and SCHIP funding and the reduction of optional Medicaid benefits. As such, while Wyoming may be able to meet federal budget neutrality and SCHIP allotment neutrality requirements, it is limited in its ability to create an expansion program that is budget neutral for the State and may need to identify additional state funds to implement the expansion.

We present in this study a potential expansion that provides Wyoming with three different benefit package models and a premium assistance component. This potential expansion approach is based on the assumption that Wyoming will be able to use SCHIP allotment for its coverage expansion, or use additional Medicaid funding if the SCHIP allotment is not sufficient for the coverage expansion. We summarize this approach in Exhibit A on the following page.

The cost to the state and federal government of implementing this approach varies according to the coverage package and the use of a premium assistance program, ranging from $4.9 to $12.8 million state and federal funds (premium assistance only coverage as compared to basic general coverage without a premium assistance component).[14] The overall estimated program costs for State Fiscal Year (SFY) 2007 are summarized in Table B; administration and outreach may increase these cost by an additional three to five percent.

Exhibit A: Summary of Wyoming Expansion Approach

Summary of Potential Coverage Approach	
Overall Expansion Approach	Use a HIFA waiver to access both SCHIP and Medicaid funding and to allow the state flexibility in implementing a premium assistance option.
Populations Covered	• Parents of Medicaid and SCHIP children • Childless adults up to 150 percent of the federal poverty level
Employer-Sponsored Insurance	State could select between: • Premium assistance-only expansion • State insurance program expansion only (no premium assistance) • Combination of state insurance program expansion and premium assistance expansion
Benefit Package	For the non-premium assistance expansion, the State could select between: • Basic general coverage • Primary care • Catastrophic care (inpatient-only) The premium assistance expansion benefit package would vary depending on the benefits offered by the employer. The catastrophic care benefit package has not been used by a state as part of a Medicaid and SCHIP waiver expansion. While CMS has not indicated that it would reject such an approach, we recommend an exploratory discussion with the federal government regarding the likelihood of approving such a benefit package under a waiver approach if Wyoming would like to proceed with this option.
Cost-sharing	State can vary cost-sharing policies by benefit package and population.
Federal Funding	The State would need to meet federal budget neutrality requirements to obtain waiver approval. Funding for the parents of SCHIP children and childless adults would come from Wyoming's SCHIP allotment, and funding for the parents of Medicaid children would be considered a hypothetical program expansion, which is considered budget neutral by the federal government.
State Funding	Additional Medicaid state funding would be needed to cover the parents of Medicaid children; Wyoming could consider reducing existing benefits or increasing prescription drug controls to obtain additional funding.

Table B: Summary of Estimated Program Costs[15]

Program	Estimated Program Costs		
	Coverage Type	**Total**	**State Share***
Waiver Expansion Program Without Premium Assistance Component Eligibles: 27,000 Enrolled: 4,000	Basic general coverage	$12,813,000	$4,382,000
	Primary care coverage	7,376,000	2,534,000
	Catastrophic coverage	4,942,000	1,677,000
Waiver Expansion Program With Premium Assistance Component Eligibles: 38,000 Enrolled: 6,800	Basic general coverage	14,484,000	4,897,000
	Primary care coverage	10,150,000	3,430,000
	Catastrophic coverage	8,197,000	2,746,000
Waiver Expansion Program – Premium Assistance Only Eligibles: 22,000 Enrolled: 4,400	Benefit package determined by employer	5,251,000	1,757,000

** For purposes of this estimate, we have applied Wyoming's Federal Fiscal Year 2005 Medicaid federal matching assistance percentage to estimate expenditures for parents of Medicaid children, and the State Children's Health Insurance Program federal matching assistance percentage to the remaining expansion populations.*

If Wyoming decides to proceed with a coverage expansion, it would need to make decisions regarding:

- Covered populations
- Benefit package content
- Use of premium assistance component
- Beneficiary cost-sharing amounts
- State and federal funding availability

Next steps would include:

- Working with stakeholders to reach consensus on key policy decisions regarding benefit package content, covered populations, use of cost-sharing, involvement of employer-based insurance and outreach initiatives

- Developing a waiver application, which would involve preparing preliminary conversations with CMS staff and conducting a more detailed cost estimate

- Submitting a waiver application and obtaining approval

Contents of Study

We have divided our study into five main chapters. The first three chapters provide extensive background reference materials regarding state expansions and Wyoming's current public health care programs and how they compare to other states. Specifically:

- **Chapter One: Publicly-Funded Programs –** Summarizes public heath care coverage programs funded by the federal and state governments, and details how Wyoming has implemented those programs as compared to other states

- **Chapter Two: State Expansion Approaches –** Provides a detailed description of the different strategies states use to expand coverage under Medicaid and SCHIP, as well as selected state-only funded initiatives

- **Chapter Three: Premium Assistance Options –** Describes different premium assistance options available to states under Medicaid and SCHIP

The final two chapters describe Wyoming-specific expansion models and the related budget impact. Specifically:

- **Chapter Four: Potential Wyoming-Specific Coverage Options –** Discusses Wyoming-specific characteristics and goals and how they may affect policy decisions and describes potential Wyoming-specific coverage options involving three different benefit package types and a premium assistance option

- **Chapter Five: Cost-Effectiveness Analysis –** Describes the estimated costs to the state and federal government of implementing the Wyoming-specific coverage options described in Chapter Four

[1] John Holahan and Arunabh Ghosh, "The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003." The Urban Institute (September 2004). Available online: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46827, 1/12/05.

[2] "Health Insurance Coverage in America, 2001 Data Update." The Kaiser Commission on Medicaid and the Uninsured (January 2003).
"Health Insurance Coverage in America, 2003 Data Update." The Kaiser Commission on Medicaid and the Uninsured (November 2004).

[3] John Holahan and Arunabh Ghosh, "The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003." The Urban Institute (September 2004). Available online: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46827, 1/12/05.

[4] John Holahan and Arunabh Ghosh, "The Economic Downturn and Changes in Health Insurance Coverage, 2000-2003." The Urban Institute (September 2004). Available online: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46827, 1/12/05.

[5] Jack Hadley, Ph.D. and John Holahan, Ph.D, "The Cost of Care for the Uninsured: What Do we Spend, Who Pay and What Would Full Coverage Add to Medical Spending." The Kaiser Commission on Medicaid and the Uninsured, page 4 (May 10, 2004). Available online: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=35965, 1/13/05.

[6] *The Uninsured and Their Access to Health Care*. Kaiser Commission on Medicaid and the Uninsured. November 2004.

[7] Uncompensated care is medical care received, but not fully paid for, either out-of-pocket by individuals or by a private or public insurance payer. Jack Hadley, Ph.D. and John Holahan, Ph.D., who prepared this estimate of uncompensated care for the Kaiser Commission on Medicaid and the Uninsured, indicated that they estimated the cost of unpaid care by using a benchmark of what would have been paid for the services by private insurance. The footnote below provides the reference document for this estimate.

[8] Jack Hadley, Ph.D. and John Holahan, Ph.D, "The Cost of Care for the Uninsured: What Do we Spend, Who Pay and What Would Full Coverage Add to Medical Spending." The Kaiser Commission on Medicaid and the Uninsured, page 2 (May 10, 2004). Available online: http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=35965, 1/13/05.

[9] Bad debt and charity care data provided by the Wyoming Hospital Association from the American Hospital Association (AHA) 2003 Annual Survey. According to the AHA 2003 Annual Survey instructions, bad debt expense is the provision for actual or expected uncollectibles resulting from the extension of credit. Charity care are health services that were never expected to result in cash inflows, and result from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria. For purposes of the AHA survey, charity care is measured on the basis of revenue forgone, at full established rates.

[10] Number of Medicaid individuals covered: Jana Gizinksi, Eligibility Coordinator, State of Wyoming Department of Health, Telephone Interview (November 15, 2004).
Number of SCHIP individuals covered: Jeanne Scheneman, Kid Care CHIP Insurance Unit Manager, State of Wyoming Department of Health, Electronic mail correspondence. (September 8, 2004).

[11] *Income Eligibility Levels for Other Medicaid Enrollment Groups as a Percent of Federal Poverty Level, 2000, 2001 and 2003.* Kaiser Family Foundation Health Factors Online (2003). http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Wyoming&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=Levels+for+Other+Enrollment+Groups, 11/12/04.

[12] *The Medicaid Resource Book*, The Kaiser Commission on Medicaid and the Uninsured, pg. 82, (July 2002). Available online: http://www.kff.org/medicaid/2236-index.cfm, 11/15/04.

[13] *Medicaid 101: Innovation and Flexibility in Public Programs*. Wyoming Department of Health. April 2, 2003.

[14] Based on State Fiscal Year 2004 expenditure data brought forward to State Fiscal Year 2007, and projections of future Medicaid and SCHIP enrollment. Chapter Five contains a description of the datasources and assumptions used to prepare these estimates.

[15] For purposes of this estimate, we have applied Wyoming's Federal Fiscal Year 2005 Medicaid federal matching assistance percentage rate to estimate expenditures for parents of Medicaid children, and the State Children's Health Insurance Program federal matching assistance percentage rate to the remaining expansion populations.

Chapter One Introduction

Chapter One describes national Medicaid and SCHIP program requirements and how other states have chosen to implement these programs and state-only funded programs. For Wyoming, these programs are:

Medicaid	marketed in Wyoming as:	equalitycare
State Children's Health Insurance Program	marketed in Wyoming as:	KidCare CHIP – Wyoming's Choice for Healthy Kids
State High-Risk Pool	marketed in Wyoming as:	**Wyoming Health Insurance Pool, or WHIP**

This chapter also provides background information on Wyoming's uninsured population.

Publicly-Funded Health Insurance Program Overview

States provide health care coverage to low-income, uninsured populations using federal, state and local funds.

Federal/State Funded

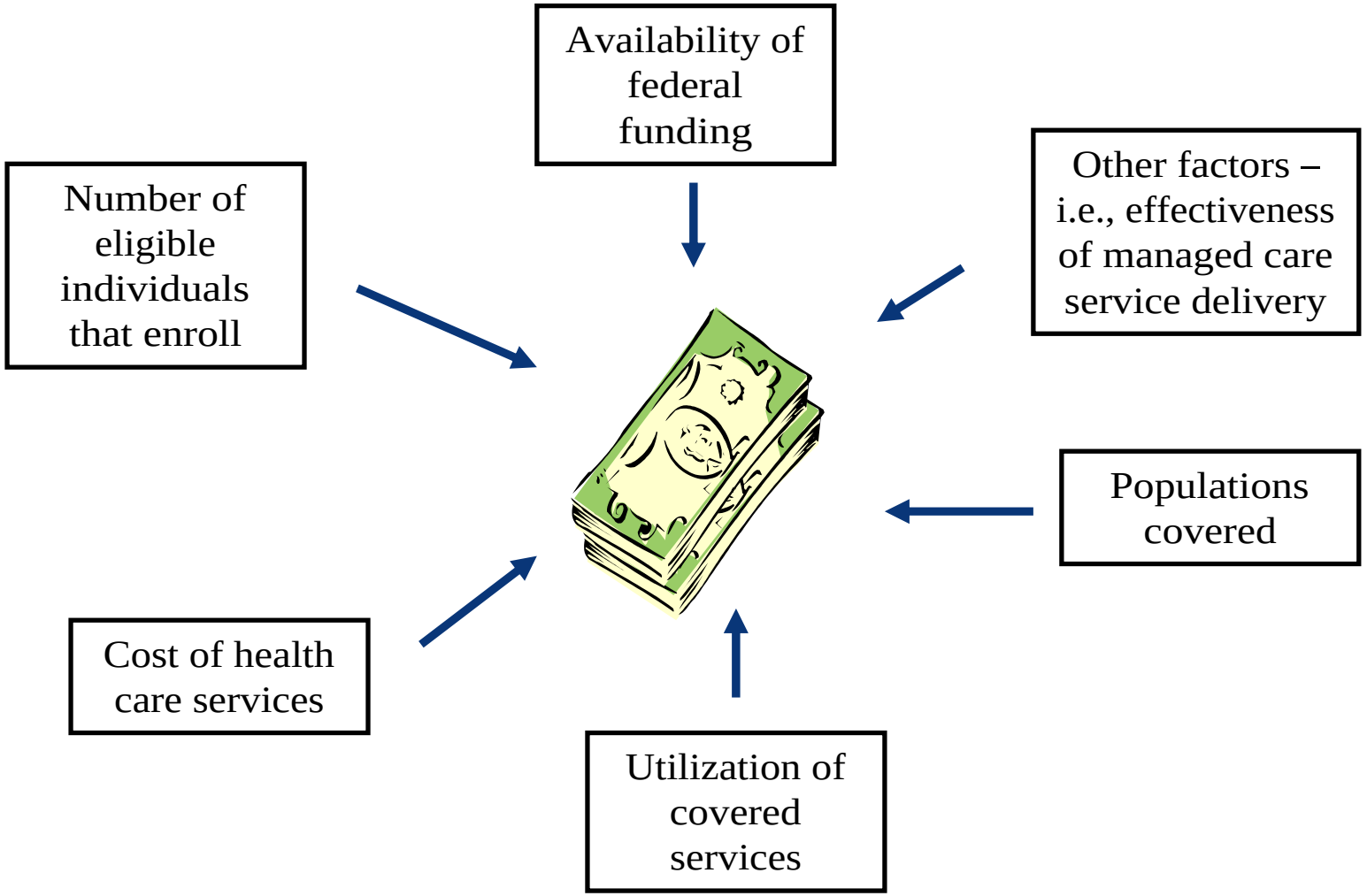
- **Medicaid –** Covers low-income parents, children, elderly and disabled. Medicaid is an entitlement program; the federal government matches states' Medicaid spending on an open-ended basis, i.e., the federal government does not cap its annual Medicaid funding to states.
- **SCHIP –** Covers low-income children that are not eligible for Medicaid; some states also use SCHIP funding to cover parents of SCHIP children and childless adults. SCHIP is a capped program, i.e., each state has an annual SCHIP allotment that may not be exceeded.

State or Locally Funded

- **Major medical insurance coverage –** direct coverage or premium assistance for selected portions of the uninsured population such as the disabled or individuals with a life-threatening illness
- **High-risk pool programs –** coverage for individuals with pre-existing conditions that preclude them from obtaining comprehensive insurance coverage at an affordable rate
- **Tax incentive programs –** tax deductions or credits to employers or individuals. Some states are advocating for federal tax credits.

Publicly-Funded Health Insurance Program Overview

Publicly-funded health care programs and related state expenditures are influenced by the state-specific factors below:

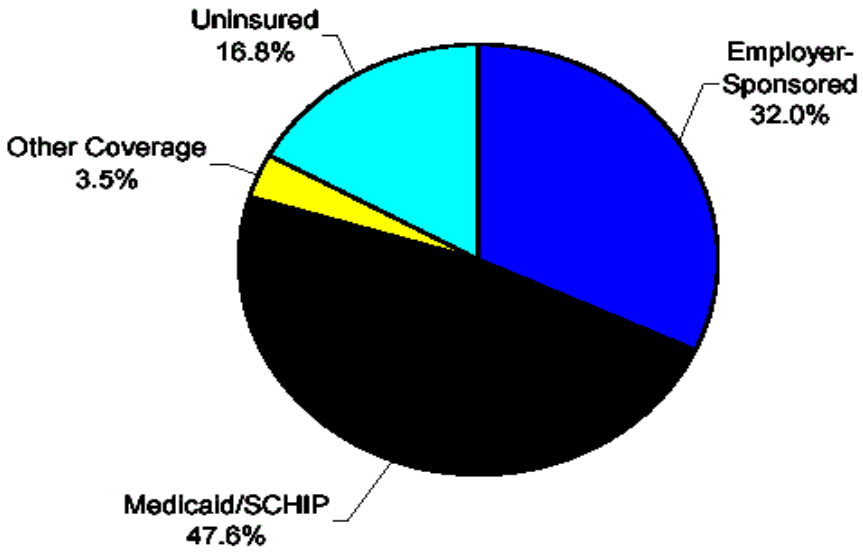


Publicly-Funded Health Insurance Program Overview

States have been able to use publicly-funded programs to provide coverage to approximately 50 percent of low-income children nationally. While approximately 32 percent of low-income children are covered by employer-sponsored health care insurance, 17 percent remain uninsured nationwide.

Source: Genevieve Kenney, Jennifer Haley, and Alexandra Tebay, *Children's Insurance Coverage and Service Use Improve.* Snapshots III, No. 1: Assessing The New Federalism (2002). Available online: http://www.urban.org/UploadedPDF/900655.pdf, 11/12/04.

Insurance Coverage of Low-Income Children*, 2002



*Low-Income is defined as below 200 percent of the federal poverty level.

Although Medicaid and the State Children's Health Insurance Program cover approximately 50 million low-income children and adults, more than one in seven Americans go without health insurance (43 million adults and children). These Americans are too poor to afford health insurance but do not meet federal poverty level requirements to be eligible for Medicaid.

Publicly-Funded Health Insurance Program Overview

In Wyoming, over 50,000 children and adults are covered through Medicaid, SCHIP, the Wyoming Health Insurance Pool (WHIP) program and the Prescription Drug Assistance Program (PDAP).

Program	Number Of Individuals Covered
Medicaid	59,050
SCHIP	4,000 in SFY 2004, and an estimated 7,500 for SFY 2005 due to an eligibility expansion
WHIP	666
PDAP	2,256

Sources: Jeanne Scheneman, Kid Care CHIP Insurance Unit Manager, State of Wyoming Department of Health, Electronic mail correspondence (September 8, 2004).
Mark Pring, Insurance Standards Consultant, Wyoming Department of Insurance, Telephone interview (November 16, 2004).
Aimee Lewis, Pharmacist Consultant, Wyoming Department of Health, Electronic mail correspondence (November 16, 2004).

Although enrollment in Wyoming Medicaid increased 55 percent from 1997 – 2002, there were still approximately 70,000 uninsured Wyoming residents as of October 1, 2003.

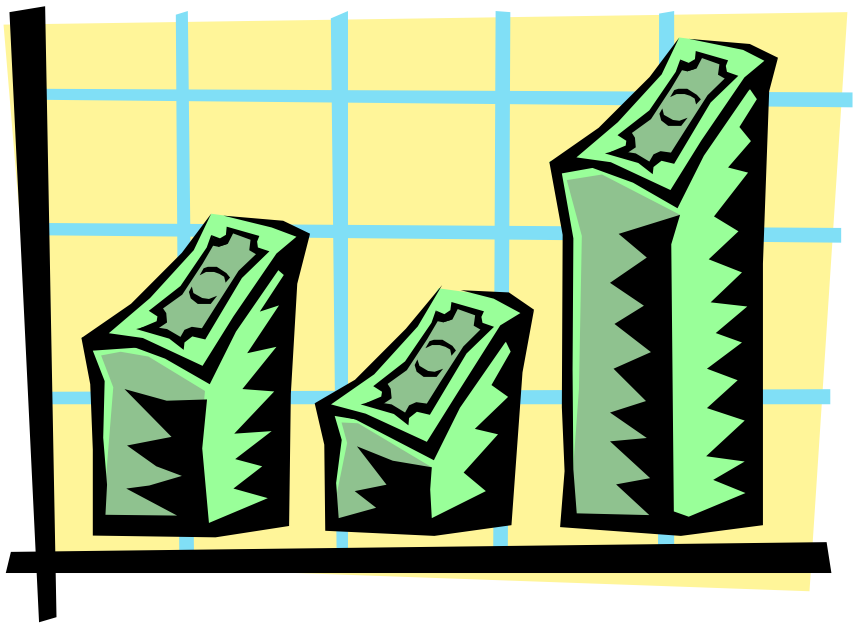
Publicly-Funded Health Insurance Program Overview

The federal poverty level (FPL) threshold is used in conjunction with other factors to determine eligibility for Medicaid and other health care and social service programs.

The 2004 federal poverty level threshold is referred to as "100 percent of the FPL" and equals $18,850 for a family of four.

Wyoming's Medicaid program, for example, covers:

- Children below age six, up to 133 percent of the FPL ($25,071 for a family of four in 2004)
- Children from age six to age eighteen up to 100 percent of the FPL ($18,850 for a family of four in 2004)



Source: *2004 Federal Poverty Level Guidelines.* Federal Register, Vol. 69, No. 30, pgs. 7336-7338 (February 13, 2004). Available online: http://www.cms.hhs.gov/medicaid/eligibility/pov0104.pdf, 11/12/04.

Publicly-Funded Health Insurance Program Overview

The 2004 Federal Poverty Level Guidelines including the District of Columbia (except Alaska and Hawaii) are:

Annual Guidelines:

Family Size	100%	133%	150%	185%	200%	250%
1	$ 9,310	$12,382	$13,965	$17,224	$18,620	$23,275
2	12,490	16,612	18,735	23,107	24,980	31,225
3	15,670	20,841	23,505	28,990	31,340	39,175
4	18,850	25,071	28,275	34,873	37,700	47,125

Monthly Guidelines:

Family Size	100%	133%	150%	185%	200%	250%
1	$ 776	$1,032	$1,164	$1,435	$1,552	$1,940
2	1,041	1,384	1,561	1,926	2,082	2,602
3	1,306	1,737	1,959	2,416	2,612	3,265
4	1,571	2,089	2,356	2,906	3,142	3,927

Source: *2004 Federal Poverty Level Guidelines.* Federal Register, Vol. 69, No. 30, pgs. 7336-7338 (February 13, 2004). Available online: http://www.cms.hhs.gov/medicaid/eligibility/pov0104.pdf, 11/12/04.

Publicly-Funded Health Insurance Program Overview– Medicaid vs. SCHIP

Medicaid and SCHIP are the two major public insurance programs states use to cover the uninsured. Medicaid spending represents about 16 percent of the average state budget and 43 percent of all federal grants to states. SCHIP is a smaller program with Federal Fiscal Year 2002 expenditures equaling about $5 billion nationwide, while Medicaid expenditures equaled approximately $250 billion. The table below summarizes the major differences between these two programs.

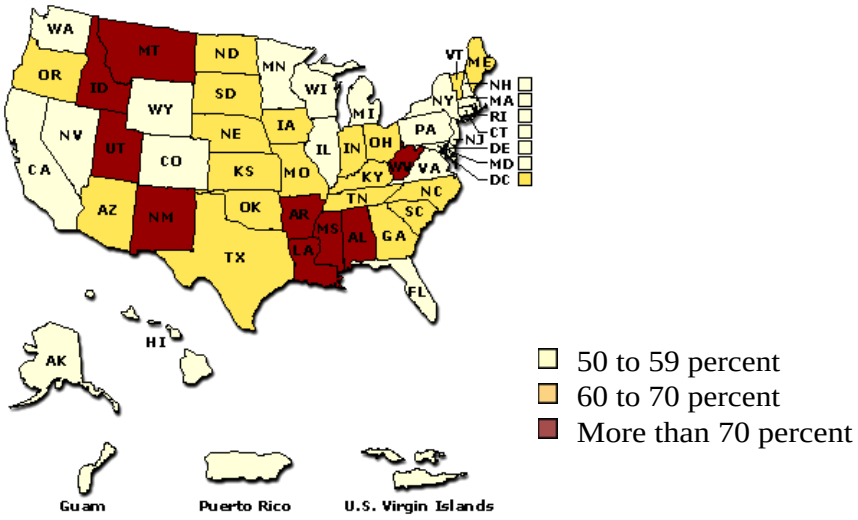
Program	Medicaid	SCHIP
Funding	Open-ended entitlement program using both federal and state funds	Capped annual funding allotment consisting of federal and state funds, with federal funds provided at a slightly higher rate than in the Medicaid program
Eligible population	Low-income parents, children, elderly and disabled, pregnant women, and individuals receiving federally-assisted income maintenance payments	Low-income children that are not covered by Medicaid; states may choose to cover the parents of these children using a federal waiver
Benefits	Federally mandated services, but states may choose to provide additional services	

Sources: *State Fiscal Conditions and Medicaid.* Kaiser Commission and the Uninsured. April 2004.
Embry M. Howell, Ian Hill, and Heidi Kapustka, *SCHIP Dodges the First Budget Ax*. Urban Institute (December 2002).
Total Medicaid Spending and SCHIP Expenditures. State Health Facts Online. Kaiser Family Foundation (2002). Available online: http://statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Total+Spending%2c+2002, 11/12/04.44

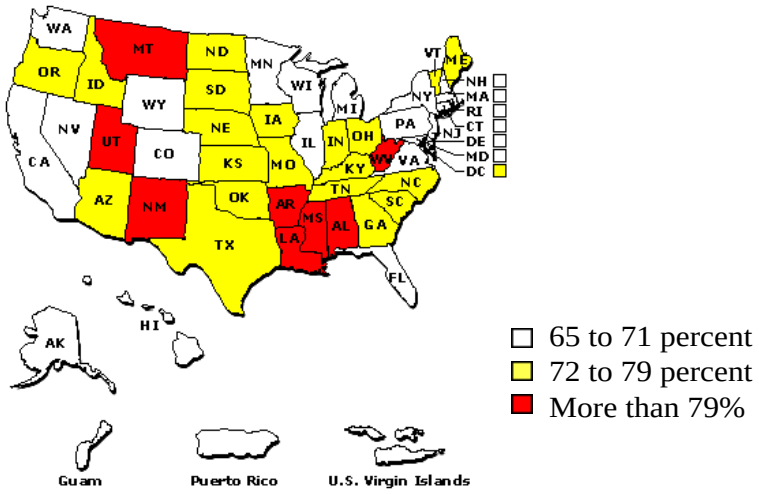
Publicly-Funded Health Insurance Program Overview– Medicaid vs. SCHIP

The federal government shares the financial burden of Medicaid and SCHIP with states by matching state expenditures with federal monies using a state-specific matching rate (the Federal Medical Assistance Percentage, or FMAP rate). The FMAP is highest for states with the lowest per capita income. Medicaid FMAP rates range from 50 to 70 percent or higher. States receive an enhanced FMAP rate for SCHIP, ranging from 65 to 79 percent or higher.

Medicaid FMAP rates:



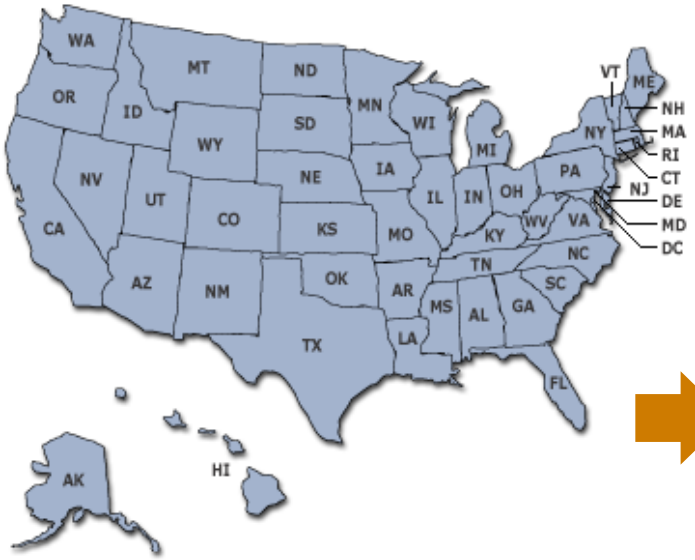
SCHIP FMAP rates:



Sources: *Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the State Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2004 Through September 30, 2005.* Federal Register, Volume 68, Number 232, 67676-67678 (December 3, 2003). Available online: http://aspe.hhs.gov/health/FMAP05.htm, 11/12/04.
Federal Matching Rate for Medicaid and SCHIP, FY2005. Kaiser Family Foundation State Health Facts Online (September 9, 2004). Available online: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&welcome=1&category=Medicaid+%26+SCHIP, 11/12/04.

Wyoming's 2005 FMAP rates: Medicaid = 57.90; SCHIP = 70.53

Medicaid Overview – Introduction

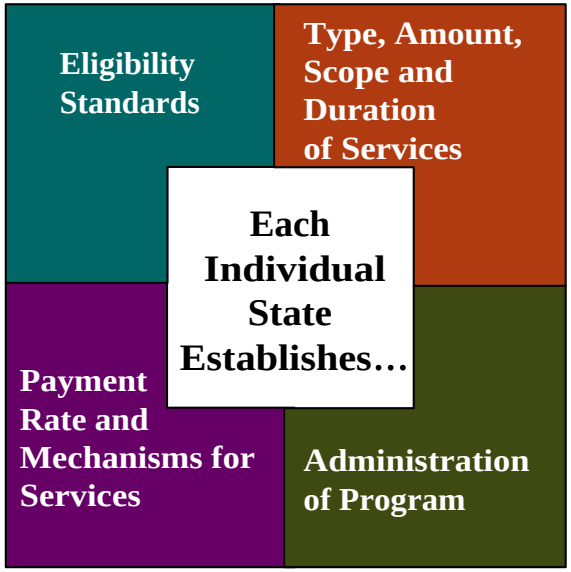


Medicaid is a federal and state-funded health insurance program that provides coverage to qualified low-income people. In 2002, 47 million people were covered under Medicaid.

"If you've seen one Medicaid program, you've seen one Medicaid program."

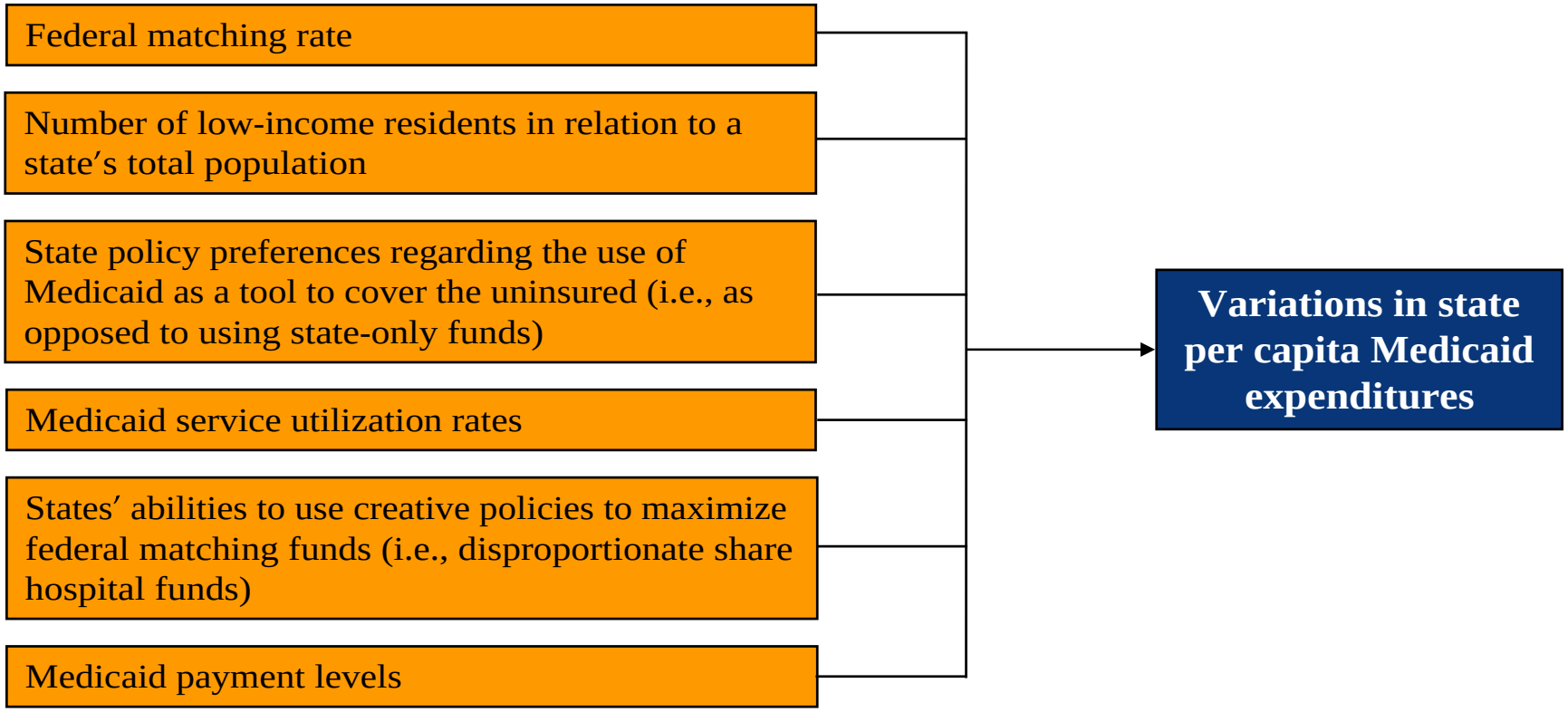
- Unknown Medicaid official

While Medicaid programs are subject to general federal regulations regarding eligibility, benefits, payments and program administration, states are granted substantial flexibility within these constraints.



Medicaid Overview – Funding

Medicaid spending varies widely by state; in 2000, Medicaid spending averaged $3,762 per capita nationwide, but varied from $2,068 per capita in California to $7,609 per capita in New York. Wyoming's per capita spending for Federal Fiscal Year 2000 equaled approximately $4,070. These variations in Medicaid spending are due to a wide variety of factors:



Source: *Total (Federal and State) Medicaid Spending per Enrollee.* Kaiser Family Foundation State Health Facts Online, (FFY2000). Available online: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Spending&topic=Medicaid+Spending+per+Enrollee, 11/12/04.

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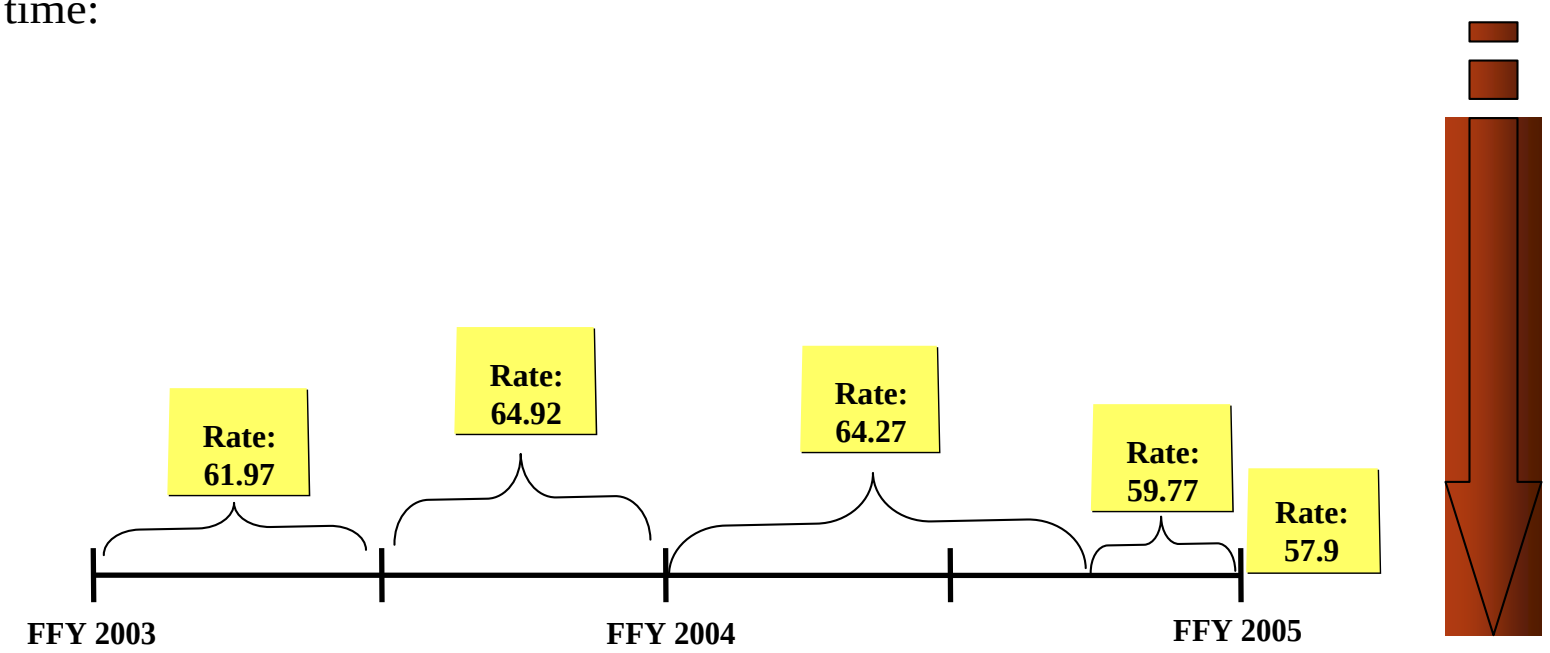
Medicaid Overview – Wyoming's Funding

In the last two quarters of Federal Fiscal Year (FFY) 2003 and the first three quarters of FFY 2004, states were eligible for a 2.95 percent temporary increase in their Medicaid FMAP under the Jobs and Growth Tax Relief Reconciliation Act of 2003. Since this temporary increase expired, however, FMAPs have returned to standard levels. Wyoming's FMAP is decreasing over time:



Wyoming's FMAP ranks 22nd in the country.

Medicaid Overview – Funding

Over time, and in large part in response to fiscal stress and the competing demands for state funds, states have developed creative policy solutions to increase the amount of federal Medicaid revenues (sometimes referred to as "Medicaid maximization" or "Medicaid revenue enhancement"). Some of these approaches, described below, have recently come under intensive federal scrutiny.

Examples	Increased Federal Scrutiny
Using non-state local funding (i.e., county taxes or provider taxes) as the non-federal share of Medicaid payments	✓
Covering services under Medicaid that have traditionally been solely state or locally funded (i.e., public health services such as immunizations for children)	
Increasing special payments to hospitals serving a disproportionate number of uninsured and Medicaid patients ("disproportionate share hospitals") using non-state local funding to increase payment up to the maximum Medicaid payments that can be made to specific types of hospitals ("upper payment limit")	✓
Using tobacco settlement funding for health care programs	

Some federal officials argue that these policies distort the mutual federal/state partnership and inappropriately increase federal Medicaid expenditures.

Medicaid Overview – Eligibility for Mandatory Populations

To receive Federal Medicaid funding, states must cover specific mandatory populations.

Mandatory Populations

- Individuals receiving federally assisted income-maintenance payments
- Children under 6 with family income below 133 percent of the FPL
- Children ages 6 to 19 with family income up to 100 percent of the FPL
- Pregnant women with family income below 133 percent of the FPL (services limited to pregnancy-related care)
- Supplemental Security Income (SSI) recipients
- Special protected groups (usually those who lose cash assistance due to income earnings, but who may stay enrolled in Medicaid temporarily)
- Low-income Medicare beneficiaries, also known as "dual-eligibles"
- Persons with a specific disease or condition (i.e., tuberculosis or breast cancer)

Mandatory Medicaid populations must meet certain income requirements and be either a child, elderly, disabled or a non-disabled parent receiving cash assistance.

Medicaid Overview – Eligibility for Optional Populations

States choose to cover additional optional populations such as those listed below.

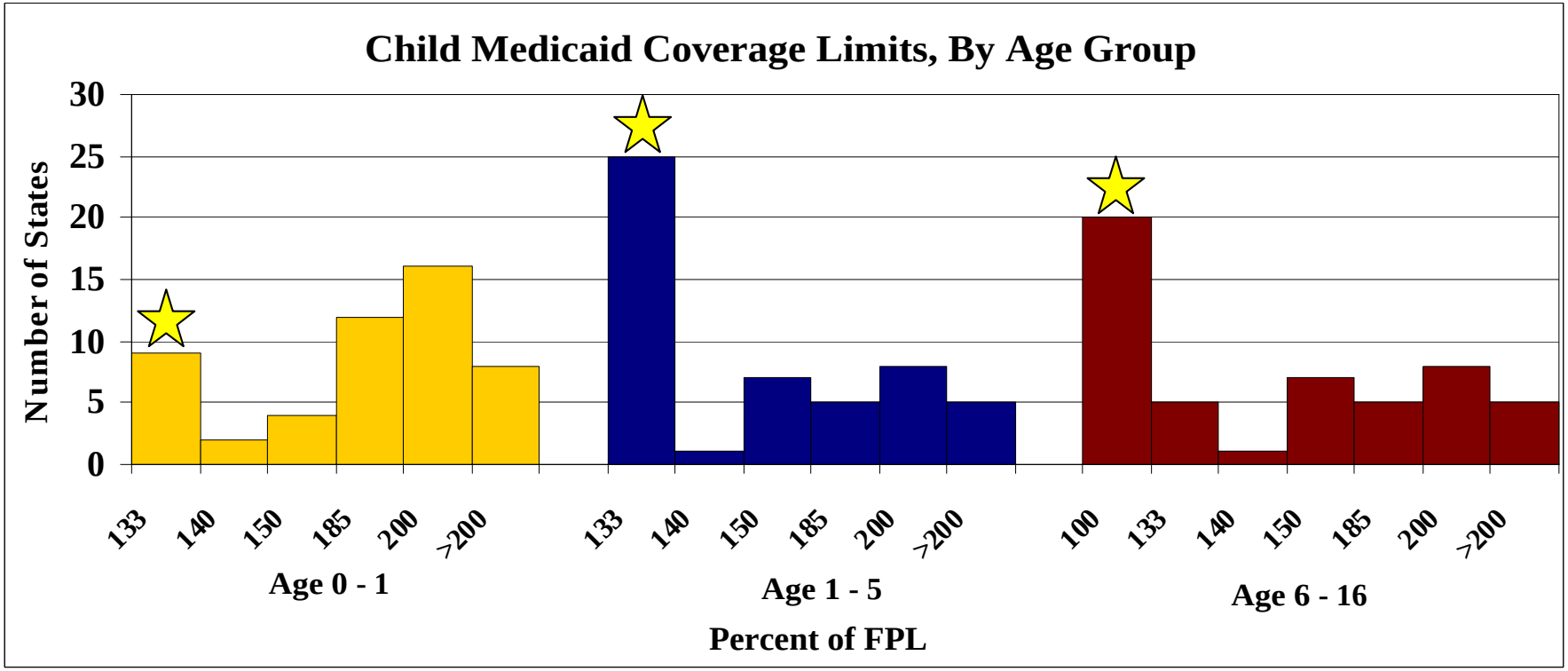
Selected Optional Populations

- ☑ **Children in foster care without special needs**
- ☑ **Women with breast or cervical cancer under the Prevention and Treatment Act**
- ☑ **Institutionalized individuals or individuals receiving home and community–based services under a waiver (up to 300 percent of SSI income, or $1,656/month)**
- ☑ **Working individuals with disabilities (up to 100 percent of the FPL), under Ticket to Work and Work Incentives Improvement Act**
- ☐ Pregnant women, newborns and children up to age six with incomes up to 185 percent of the FPL that are not covered under one of the mandatory population groups
- ☐ "Medically needy" adults and children
- ☐ Disabled adults up to 100 percent of the FPL (many receive SSI and Medicare)
- ☐ Working disabled individuals up to 250 percent of the FPL
- ☐ Disabled children who are neither institutionalized nor covered through a home-and community-based services (HCBS) Medicaid waiver

☑ = **Wyoming optional populations**

Medicaid Overview – Other States' Eligibility Standards

We summarize state Medicaid income eligibility standards for low-income children below. Compared to other states, Wyoming's Medicaid program uses a relatively low percentage of the FPL to determine eligibility, i.e., 133 percent of the FPL for children aged 1 to 5 as compared to other states that cover children up to 200 percent of FPL.



★ Wyoming's coverage policy

Source: *Income Eligibility Levels for Children Under Medicaid as a Percent of Federal Poverty Level.* Kaiser Family Foundation State Health Facts Online (April 2003). Available online: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Wyoming&category=Medicaid+%26+SCHIP&subcategory=Medicaid+and+SCHIP+Eligibility&topic=Eligibility+Levels+%2d%2d+Medicaid+for+Children, 11/12/04.

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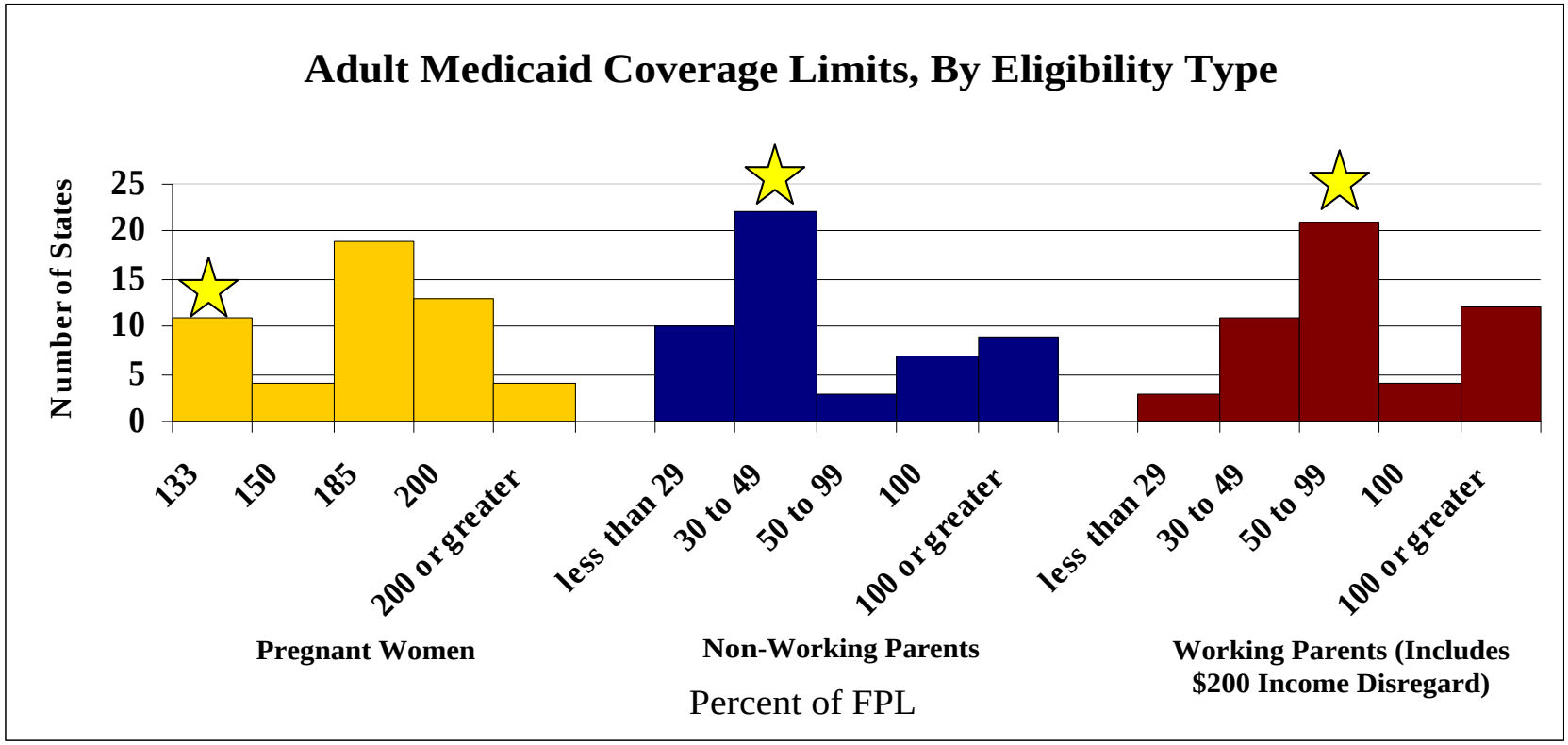
Medicaid Overview – Other States' Eligibility Standards

State Medicaid income eligibility standards for low-income adults vary by type of adult, as indicated below. Wyoming Medicaid does not cover medically needy individuals and uses a relatively low percentage of the FPL to determine eligibility for pregnant women.



★ Wyoming's coverage policy

Source: *Income Eligibility Levels for Other Medicaid Enrollment Groups as a Percent of Federal Poverty Level, 2000, 2001, and 2003*. Kaiser Family Foundation State Health Facts Online (2003). http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Wyoming&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=Levels+for+Other+Enrollment+Groups, 11/12/04.

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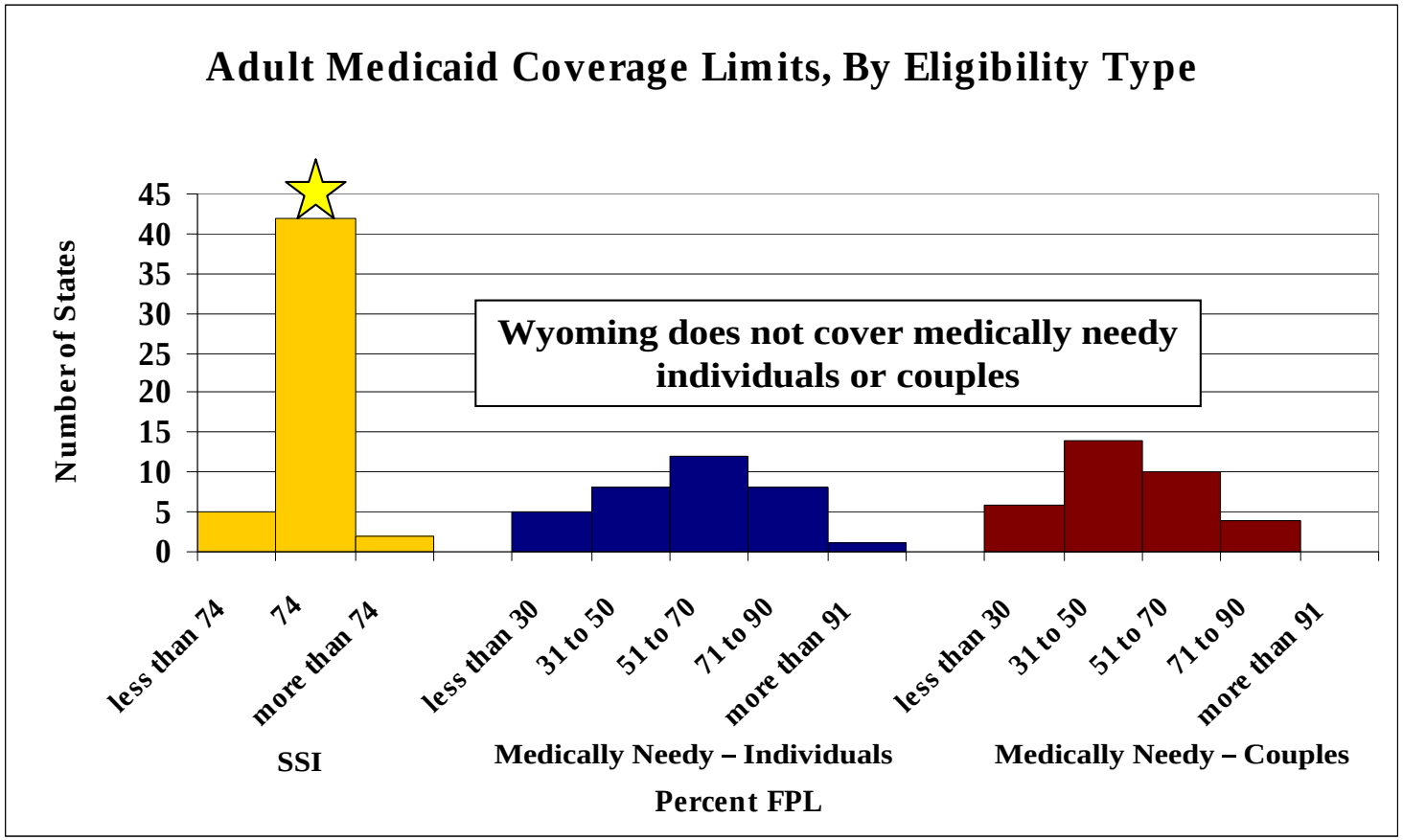
Medicaid Overview – Other States' Eligibility Standards



Wyoming's coverage policy

Notes: SSI data not included for Hawaii or Mississippi. Massachusetts and Texas have specific eligibility standards not covered or included in this chart.

Sources: *Income Eligibility Levels for Other Medicaid Enrollment Groups as a Percent of Federal Poverty Level, 2000, 2001, and 2003* and *Medically Needy Eligibility as a Percent of Federal Poverty Level, 2001.* Kaiser Family Foundation State Health Facts Online, (2000-2001). Available online: http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Wyoming&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Eligibility&topic=Levels+for+Other+Enrollment+Groups and http://www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=profile&area=Wyoming&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Medically+Needy&topic=Medically+Needy+Eligibility, 11/12/04.

Wyoming, along with 15 other states, does not offer coverage for the Medically Needy.

Medicaid Overview – Mandatory Benefits

While each state is given the flexibility to design a unique Medicaid benefits package, federal law requires states to provide certain mandatory services to their Medicaid populations, as listed below.

Medicaid Mandatory Benefits	
Inpatient and outpatient hospital services	Home health care for those eligible for care in a skilled nursing facility
Prenatal care	Laboratory and x-ray services
Vaccines for children	Pediatric and family nurse practitioner services
Physician services	Nurse midwife services
Nursing facility services for individuals 21 and older	Federally Qualified Health Care Center (FQHC) and FQHC-like services
Family planning services and supplies	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21 (e.g., organ transplants, eyeglasses and speech therapy)
Rural health clinics	
Medical/surgical dentist services	

Federal law also requires that states cover certain mandatory benefits, but allows them the flexibility to provide additional services as well.

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Medicaid Overview – Optional Benefits

States may elect to cover additional optional benefits.

Selected Optional Medicaid Benefits (Non-EPSDT)	
☑	**Clinic services (ambulatory surgical center, end stage renal disease)**
☑	**Intermediate care facilities for the mentally retarded (Wyoming State Training School)**
☑	**Prescribed drugs**
☑	**Nursing facilities for children under 21**
☑	**Transportation Services**
☑	**Rehabilitation (e.g., outpatient rehabilitation, community mental health)**
☐	Organ and tissue transplants for adults
☐	Comprehensive dental services for adults
☐	Dentures
☐	Institutions for mental diseases (IMD) for 65 and older
☐	Diagnostic, screening and preventive services for adults (with some exceptions)

☑ **= Wyoming Medicaid Benefit**

Medicaid Overview – Optional Benefits

The following benefits are mandatory for children under EPSDT, but optional for adults:

Selected Optional Adult Medicaid Benefits (Non-EPSDT)

- ☐ Hearing aids
- ☑ **Hospice**
- ☑ **Targeted case management (developmentally disabled & mental health)**
- ☑ **Prosthetics**
- ☑ **Optometrist services (Wyoming Medicaid limits to the diagnosis and treatment of medical eye problems)**
- ☑ **Physical therapy**
- ☐ Podiatrist Services

☑ = **Wyoming Medicaid Benefit**

Source: *The Medicaid Resource Book*, The Kaiser Commission on Medicaid and the Uninsured, pg. 82, (July 2002). Available online: http://www.kff.org/medicaid/2236-index.cfm, 11/15/04.

Approximately 65 percent of Medicaid spending nationwide is for optional services and over half of this spending is for prescription drugs.

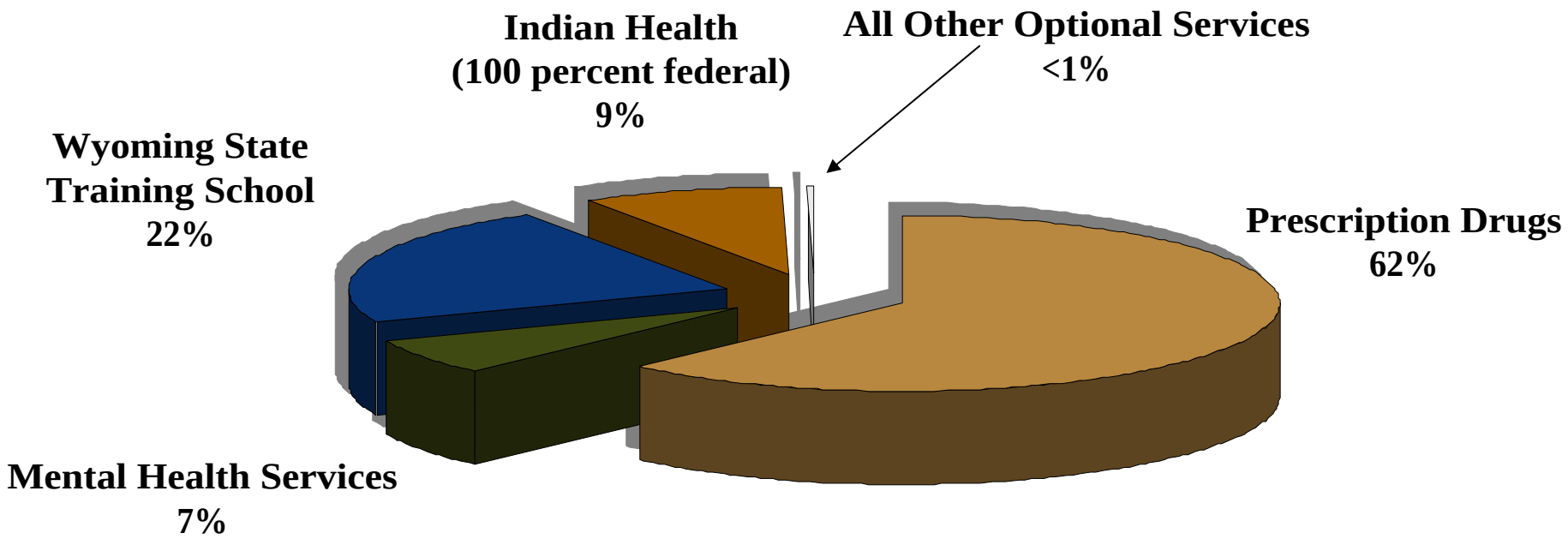
Medicaid Overview – Other States' Benefits

Since all states are required to provide the same set of federally-mandated Medicaid benefits, states differ only in the amount, scope and duration of optional benefits that they provide.

Selected Adult Optional Benefits (Non-EPSDT)	Number of States Providing the Benefit	Wyoming Provides Benefit?
Prosthetics and Orthotics	43	✓
Diagnostic, Screening and Preventive Services	23	No
Extended Inpatient Psychiatric Services	45	No
Podiatrist Services	44	No
Physical Therapy Services	31	✓
Chiropractor Services	28	No
Non-Emergency Transportation Services	44	✓
Hospice	44	✓
Hearing Aids/Dentures	33	No
Personal Care Services (non-waiver)	30	No

Medicaid Overview – Mandatory vs. Optional Services

While approximately $50 million, or about 20 percent of Wyoming's 2002 Medicaid expenditures, represent optional services, the majority of these expenditures can be attributed to prescription drug services which are considered critical to preventing the use of other health care services.



Source: *Medicaid 101: Innovation and Flexibility in Public Programs*. Wyoming Department of Health. April 2, 2003.

Medicaid Overview – Cost-Sharing

Cost-sharing refers to the practice of requiring beneficiaries to pay part of their health care costs out-of-pocket. States may impose nominal deductibles, coinsurance or co-payments on some Medicaid beneficiaries for certain services. States may use waivers to implement cost-sharing beyond the federal limits.

Coinsurance
Beneficiary pays a fixed percentage of the cost of health care service(s)
Deductible
Beneficiary pays a fixed amount of health care charges before the insurance company begins to pay the rest of the claim
Co-payment
Beneficiary pays a fixed amount for each service, paid at the time of service, i.e., the beneficiary pays $5.00 for each physician visit

Populations Exempt From Cost-Sharing
Pregnant women
Children under 21
Hospital or nursing home patients who contribute most of their income to institutional care
ALL Medicaid beneficiaries are exempt from cost-sharing for emergency and family planning services

Some providers view Medicaid cost-sharing as a hidden tax because it is the health care provider's responsibility to collect cost-sharing amounts and to provide services even if they cannot collect these amounts.

Medicaid Overview – Wyoming Cost-Sharing

Wyoming uses co-payments, the most common method of cost-sharing for Medicaid programs. Wyoming Medicaid does not apply coinsurance or deductibles, or charge premiums.

Wyoming's Medicaid Co-Payments

$2 – Physician or Outpatient Visit

$2 – Prescription

$6 – Non-emergency visit to emergency room

Cost-sharing policies have the potential to decrease program participation if cost-sharing levels are set too high for the targeted population.

Medicaid Overview – Other States' Cost-Sharing

States determine the amount of cost-sharing based on family income, or use a fixed rate for a particular service. Co-payments are the most frequently used cost-sharing policy and are generally applied to prescriptions and physician visits. Co-payments vary by service and state, ranging from $0.50 to $25 for prescription drugs and physician services. Over 40 states use cost-sharing for most if not all categories of adults, and almost half of all states use premiums for some adult populations. States may impose premiums or enrollment fees on Medicaid beneficiaries only through federal waivers.

Number of States Using Medicaid Co-Payments, by Eligibility and Service

	Inpatient Hospital	Physician Services	Prescription Drugs
Children	4	5	4
Pregnant Women	2	2	2
Non-institutionalized Elderly	18	25	35
Adults with Disabilities	19	26	36
Parents	16	22	31

Source: *States' Premium and Cost-sharing Requirements for Beneficiaries in Medicaid and SCHIP*. General Accounting Office, GAO-04-491, March 2004.

Due to increasing fiscal constraints, thirty states increased Medicaid beneficiary contributions for adults from 2001 to 2003 and six states have received SCHIP 1115 waivers to require beneficiary contributions for children in their SCHIP Medicaid expansion programs.

Medicaid Overview – Health Insurance Premium Payment Program

The Health Insurance Premium Payment Program (HIPP), enacted in 1990 as part of the Social Security Act – Section 1906, authorizes the use of Medicaid funds to purchase employer-sponsored insurance for eligible individuals and families if this insurance is more cost-effective than Medicaid coverage. This program covers health insurance premiums, coinsurance and deductibles and provides enrollees with the full range of Medicaid benefits through wrap-around coverage (i.e., the provision of Medicaid benefits not provided under the private health insurance plan). The Health Insurance Premium Payment Program is optional and enrollment is low.

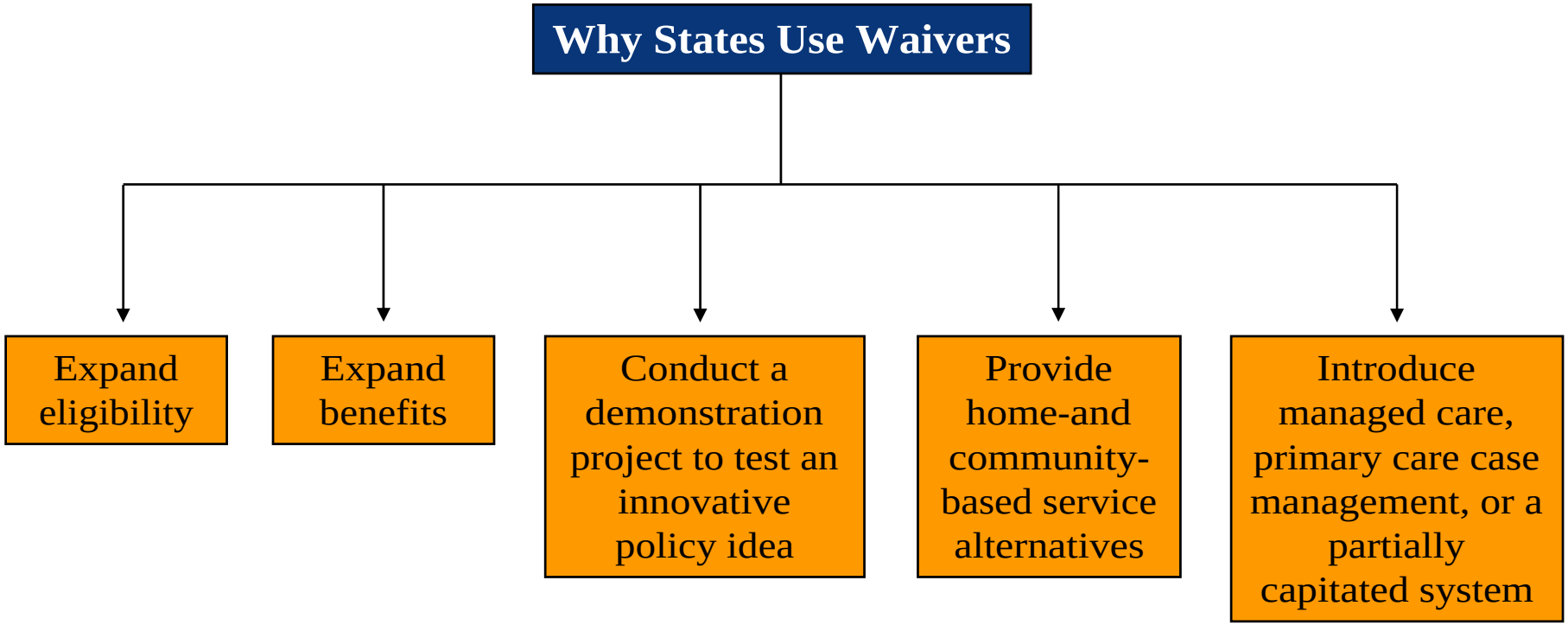
Examples of State HIPP Programs

- *Missouri* reimburses employers directly for Medicaid-eligible employees′ portions of their premium, coinsurance and deductible costs.
- *Iowa* directly reimburses Medicaid-eligible employees for their portions of premium, deductibles and coinsurance, but employers may be directly reimbursed if they make the necessary changes to the payroll system.

Major obstacles to implementation include limited access to employer- sponsored insurance for low wage-workers, identification of beneficiaries′ employers and difficulty of cost-effectiveness evaluation.

Medicaid Overview – Waivers

States request waivers for certain portions of federal regulations to customize their Medicaid programs to fit the needs of their constituents.



Waiver programs must be cost neutral and may not adversely impact access to care or quality of care.

Medicaid Overview – Waivers

Waivers allow states to receive federal matching funds even if the state is no longer in compliance with requirements or limitations of the federal Medicaid statute.

Type of Waiver	Function	Wyoming Uses?
1115	Gives states flexibility to create new research and demonstration health care programs	No
1915(b)	Allows the restriction of choice of providers for beneficiaries (i.e., managed care); may be used in conjunction with an 1115 waiver to expand coverage to new populations	No – Wyoming previously used a 1915(b) waiver to implement a selective contracting program for specialty inpatient hospital services.
1915(c)	Allows home-and-community based services to be covered for beneficiaries as an alternative to institutional care	Yes – Wyoming uses the following waivers: • Long-term care waiver for elderly and physically disabled age 19 and over • Assisted living facility waiver • Developmentally disabled child waiver • Developmentally disabled adult waiver • Acquired brain injury waiver

This report will focus on 1115 coverage expansion waivers.

SCHIP Overview

The State Children's Health Insurance Program provides capped federal funding to states to increase coverage to over five million low-income children.

SCHIP Basic Facts	
When?	SCHIP was created in 1997 as part of the Balanced Budget Act, under Title XXI of the Social Security Act.
Who Does it Cover?	SCHIP covers low-income and uninsured children whose families are at or below 200 percent of the federal poverty level. SCHIP funds may not be used to cover children who already have coverage under private health insurance or Medicaid. Some states use funding to cover parents of SCHIP children by using a federal waiver.
Relationship To Medicaid?	SCHIP covers children whose family incomes are too high to qualify for Medicaid.
Funding?	SCHIP is state- and federally-funded with an enhanced federal match rate. SCHIP is not an open-ended entitlement program; Congress capped the federal contribution as a block grant at $40 billion over 10 years.

SCHIP Overview – Options for Implementation

States can choose from three options to structure their SCHIP program:

1	2	3
Medicaid Program Expansion	**Stand-Alone Program Separate From Medicaid**	**Combination of 1 and 2**
Uses SCHIP funds to expand coverage to children under Medicaid; subject to federal Medicaid regulations	A completely separate program from Medicaid; subject to federal SCHIP regulations	Combines options of both programs

Wyoming Chose This Option

SCHIP Overview – Wyoming History

The history of Wyoming's SCHIP allotment shows how its SCHIP funds were redistributed to other states.

Original Wyoming SCHIP Allotment

- Wyoming was one of the last two states in the country to obtain state legislative authority to implement SCHIP.
- Upon implementation, Wyoming's SCHIP program covered children only up to 133 percent of the FPL, although the original allotment intended to cover children up to 150 percent of the FPL.
- Therefore, the State did not exhaust its first year allotment of federal funding.

Redistribution of SCHIP Funds

- As a result, $14 million of Wyoming's 10-year block grant was redistributed to other states.
- Wyoming is not eligible for additional funds from other states until all retained and current allotments are spent.

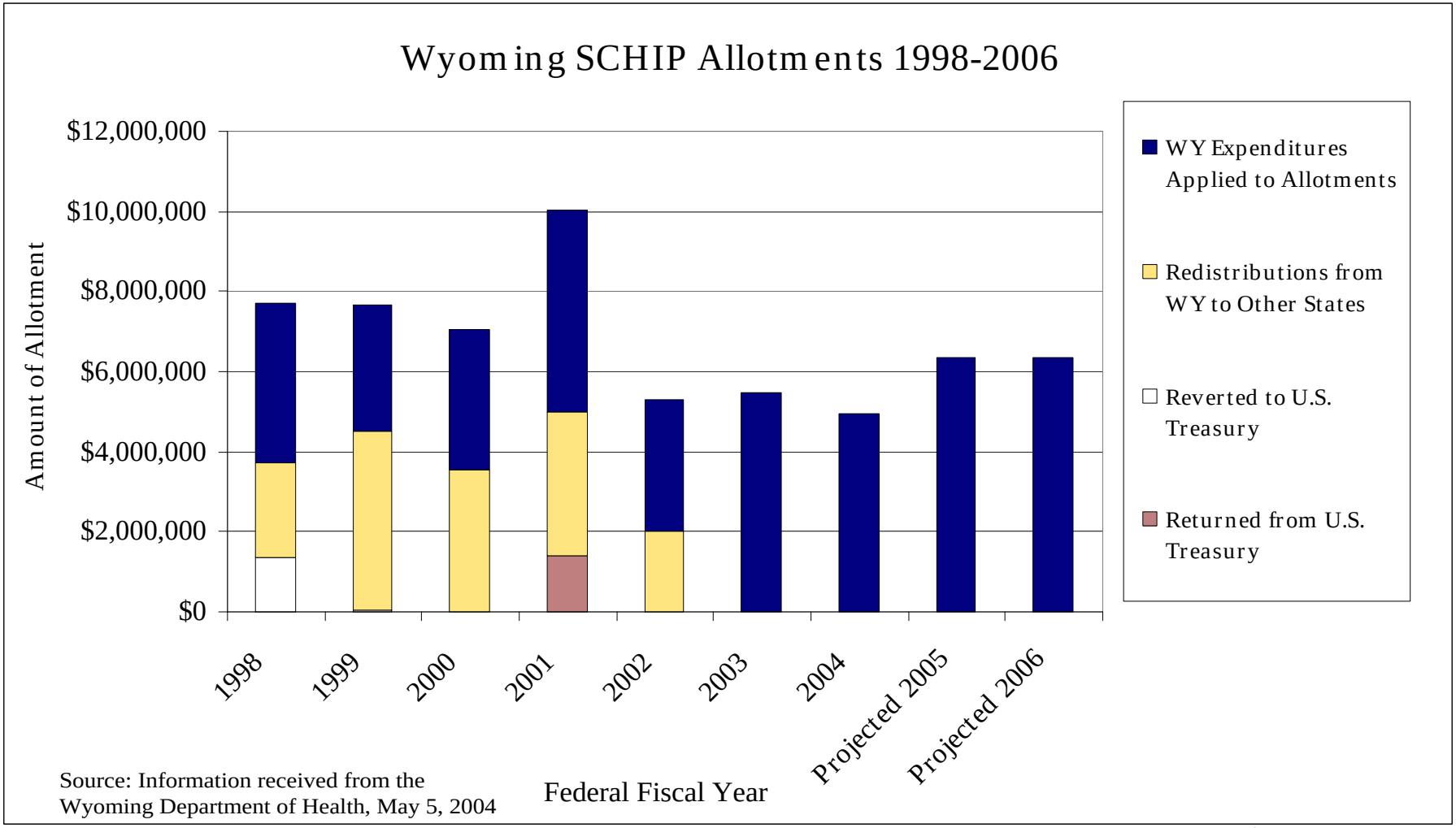
SCHIP Reauthorization

- The Bush administration plans to distribute $660 million to states expecting shortfalls in their SCHIP programs, and has also proposed reauthorizing SCHIP in 2005, instead of 2007.
- As of October 2004, the administration has not released the specifics of how they are going to distribute the funds; however, they anticipate that for fiscal year 2005, six states (Arizona, Minnesota, Mississippi, Nebraska, New Jersey, and Rhode Island) will receive most of the SCHIP redistribution, leaving little for the other 24 states eligible for SCHIP redistributions. Wyoming is not one of these 24 states.

Sources: *Administration to Release $660 Million; Early Program Reauthorization Recommended.* Health Care Policy Report, Vol. 12, No. 39 (October 4, 2004). Available online: http://healthcenter.bna.com/pic2/hc.nsf/id/BNAP-65FL67?OpenDocument, 11/12/04.
Matt Broaddus, Health Division Research Associate, Center on Budget and Policy Priorities, Telephone interview, (November 15, 2004).

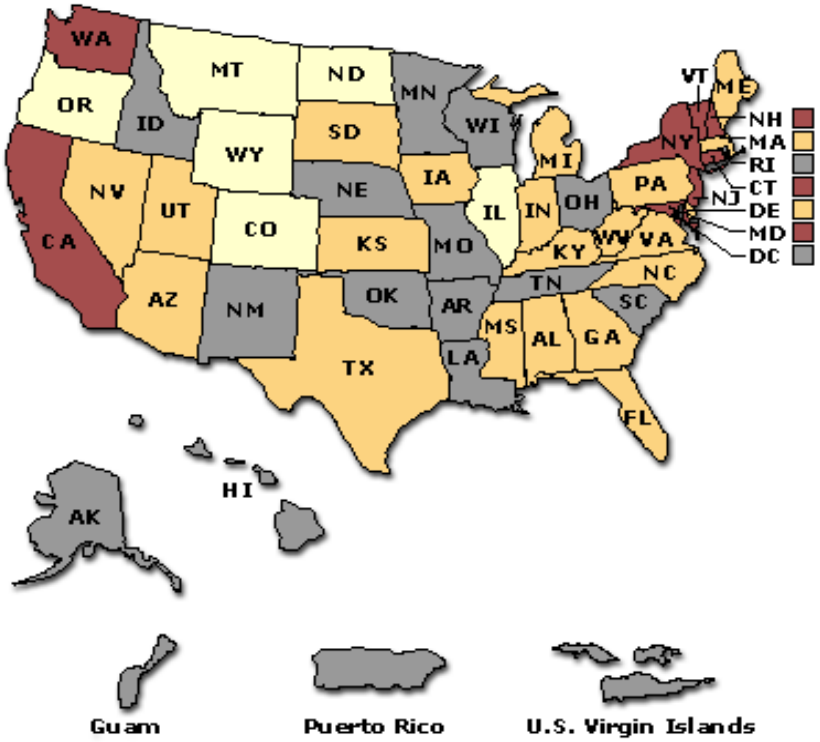
SCHIP Overview – Wyoming History

The following figure describes how Wyoming's SCHIP allotment has been used over time, and anticipated expenditures through 2006.



SCHIP Overview – Federal Eligibility

Each state determines its eligibility, which is based on a percentage of the FPL up to 200 percent. States may seek federal approval through a waiver to increase eligibility beyond 200 percent of the FPL. States may not cover children already covered under a group health plan or under health insurance coverage (including Medicaid or state employee health insurance), or children residing in institutions for mental disease.



Income Eligibility Levels for Children Under SCHIP, as a Percent of Federal Poverty Level, April 2003

- Less than 200 percent
- 200 percent to 235 percent
- More than 235 percent
- No data available/NSD

Source: *Preserving Recent Progress on Health Coverage for Children and Families: New Tensions Emerge. A Fifty-State Update on Eligibility, Enrollment, Renewal, & Cost-Sharing Practices in Medicaid & SCHIP. Table 1: State Income Eligibility Guidelines for Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions & Separate SCHIP Programs.* Center on Budget and Policy Priorities for Kaiser Commission on Medicaid & the Uninsured, (July 2003). Available online: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14355, 11/12/04.

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SCHIP Overview – Wyoming Eligibility

Since 1999, Wyoming has been incrementally increasing its SCHIP eligibility to ultimately reach 200 percent of the FPL in SFY 2006.

Wyoming SCHIP Eligibility			
	100 to 133 Percent FPL	**133 to 185 Percent FPL**	**Up to 200 Percent FPL**
Birth to 5 Years	**Not applicable: covered under Medicaid**	✓	**SFY 2006**
6 – 18 Years	✓	✓	**SFY 2006**

SCHIP Overview – Wyoming Eligibility

Wyoming implemented SCHIP in three stages.

Stage 1

- Covered children up to 133 percent of the FPL and was implemented in December 1999
- Known as Kid Care Plan B
- Created as a "Medicaid Look-Alike" plan with all the same benefits of Medicaid

Stage 2

- Attempted to increase eligibility from 134 percent to 150 percent of the FPL
- Not implemented due to a lack of bids from private insurance companies

Stage 3

- Covered children up to 185 percent of the FPL
- Known as Kid Care CHIP
- Replaced the Kid Care Plan B Program
- Administered through Blue Cross Blue Shield of Wyoming

SCHIP Overview – Federal Benefits Standards

States choose between four main benefit package options when determining SCHIP benefits.

Benchmark Coverage	Coverage must be similar to Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option Service Benefit Plan; a state employees′ benefits plan; or the largest commercial, non-Medicaid enrollment HMO plan in the state.
Benchmark Equivalent Coverage	Coverage must equal at least an aggregate actuarial value of one of the benchmark plans, and must include: inpatient and outpatient hospital services, physicians′ surgical and medical services, laboratory and X-ray services, and well-baby and well-child care, including age-appropriate immunizations.
Existing State-Based Comprehensive Coverage	Coverage equals the benefits in a pre-existing state-based comprehensive coverage program.
Secretary-Approved Coverage	These programs have included state Medicaid coverage; a Medicaid demonstration project for children that was previously approved by the Secretary and benchmark coverage plus any additional coverage.

Source: *Welcome to the State Children's Health Insurance Program.* Centers for Medicare and Medicaid Services. Available online: http://www.cms.hhs.gov/schip/about-SCHIP.asp, 11/12/04.

When states first implemented SCHIP in 1998, the majority chose to use either a Medicaid benefit plan, a modified Medicaid waiver benefit plan or benefits consistent with the State employee coverage plan.

SCHIP Overview – Federally Required Benefits

Regardless of the type of SCHIP coverage program a state chooses, the federal government requires that states cover four major categories of services in addition to other general coverage regulations.

Mandatory Categories of Services	General Coverage Regulations
• Inpatient and outpatient hospital services • Physicians' surgical and medical services • Laboratory and X-ray services • Well-baby and well-child care, including appropriate immunizations	• Abortion services can be provided only in life-threatening situations for the mother and in cases of incest or rape. • Pre-existing condition exclusions are not permitted. • If SCHIP plans provide coverage through group health plans, preexisting conditions can exist only as far as HIPAA rules allow.

SCHIP Overview – Wyoming Benefits

The Wyoming SCHIP program uses a "Secretary-Approved Plan," effective October 2003.

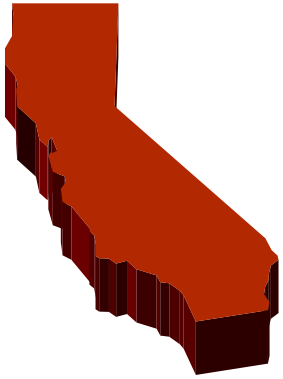
Wyoming's SCHIP Benefits

- Inpatient and outpatient hospital services
- Doctor visits
- Laboratory and X-ray services
- Well-baby, well-child and well-adolescent care, including immunizations
- Prescriptions
- Mental health services
- Dental services – no braces, only preventive and some basic services are covered
- Vision services – contacts not included
- Physical therapy

Blue Cross/Blue Shield administers Wyoming's SCHIP health benefits and Delta Dental administers Wyoming's SCHIP dental benefits.

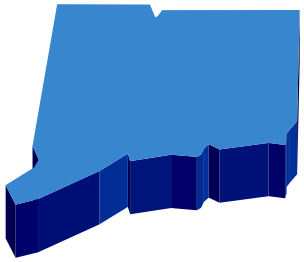
SCHIP Program – Other States' Benefits

In general, most states offer coverage for basic services benefits with cost-sharing and caps on expenditures for certain services. Some states have extended covered services.



California

- Specialized pediatric services
- County mental health services

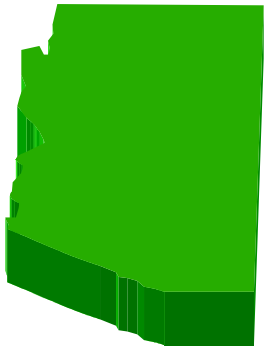


Connecticut

- Nurse midwives and naturopath services
- Preventive dental services
- Inpatient mental health and substance abuse detoxification programs

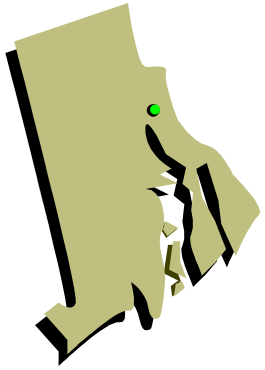
SCHIP Program – Other States' Benefits

Additional examples of states that have expanded benefits are:



Arizona

- Non-emergency transportation
- Unlimited behavioral health
- Dental and vision services



Rhode Island

- Transportation, through the Rhode Island Public Transportation Authority
- Translation services
- Unlimited mental health and substance abuse services
- School-based clinic services

SCHIP Program – Federal Cost-Sharing Standards

States may use cost-sharing for SCHIP enrollees except for American Indian or Alaska Native children, or members of a federally-recognized tribe. States with Medicaid expansion SCHIP programs are subject to the same cost-sharing regulations as under Medicaid. States with separate SCHIP programs may not impose cost-sharing totaling more than five percent of family income. Additional regulations apply.

For All Families

States must inform beneficiaries of:

- The yearly SCHIP cost-sharing maximum
- The cost-sharing methodologies
- The consequences due to unpaid beneficiary contributions
- The disenrollment protections available for those beneficiaries who are unable to meet cost-sharing obligations

For Families Below 150 Percent of the FPL

- More than one type of cost-sharing may not be imposed.
- Only one type of cost-sharing may be charged during a single office visit.
- Cost-sharing is limited to nominal amounts as set forth in the SCHIP regulation.

A state may disenroll beneficiaries from SCHIP if they do not make cost-sharing payments. Before the disenrollment process may begin, however, a state must first allow families to pay any past-due cost-sharing charges and/or show a decrease in income.

SCHIP Program – Wyoming's Cost-Sharing

Wyoming limits SCHIP benefits to a lifetime amount of $1 million. Wyoming does not use premiums or deductibles and limits co-payments to $200 per family per benefit year.

Type of Service	Co-pay Amount
Physician visits and outpatient hospital care	$5 co-pay (excludes laboratory and x-ray)
Prescription drugs	$3 co-pay for generics $5 co-pay for brand name drugs
Emergency room visits	$5 co-pay

Wyoming SCHIP does not use co-payments for inpatient services, dental or vision services, lab work or x-rays, well child/well baby services, or immunizations and preventive care.

SCHIP Program – Other States' Cost-sharing

Approximately half of all states use some kind of cost-sharing mechanisms for their SCHIP programs. For example:

Premiums

- Flat rate per child or per family – Washington
- Rate varies by FPL level – Arizona, Colorado, Delaware, Kansas, New Mexico, North Carolina, Pennsylvania and Vermont
- Annual enrollment fee – Montana
- Rate varies by family size – Nevada
- Rate varies by age of child – Georgia

Co-payments

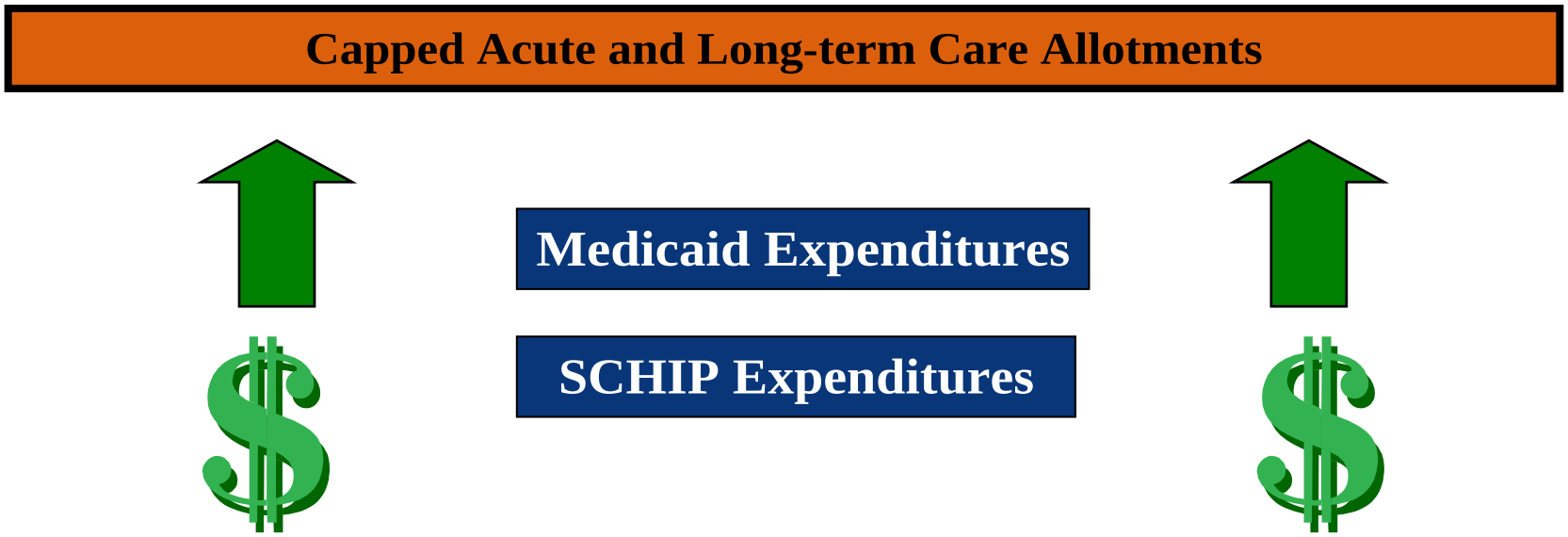
- Non-emergency room visits – Delaware, Iowa
- Emergency room visits – Arizona, Connecticut, Mississippi
- Dental Services – California
- Prescription drugs – Arkansas, Illinois, Indiana, Missouri

Maximum payments

Some states also use maximum per month or per year out-of-pocket expense cost-sharing policies. These maximums may, for example, vary by poverty level or equal a percentage of total family income per year.

Medicaid and SCHIP Program – Future Funding Issues

President Bush, in his FY 2005 budget, proposed the consolidation of Medicaid and SCHIP funding into acute and long-term care "block grants." This state-specific voluntary initiative would set payment based on 2002 spending, with annual inflation adjustments specific to each state. This initiative is similar to the block grant system implemented for cash assistance in 1996.



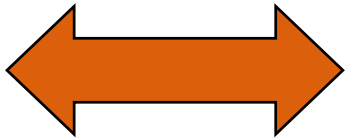
The primary goal of a Medicaid/SCHIP block grant is to cap the federal funding for these programs as opposed to expanding coverage to uninsured populations.

Medicaid and SCHIP Program – Future Funding Issues

The block grant concept has important implications for state flexibility and budget control:

Advantages

- Increases federal budget predictability
- Promotes cost containment efforts as states must avoid exceeding caps
- Increases state program design flexibility
- Decreases focus on special state funding mechanisms such as intergovernmental transfer programs



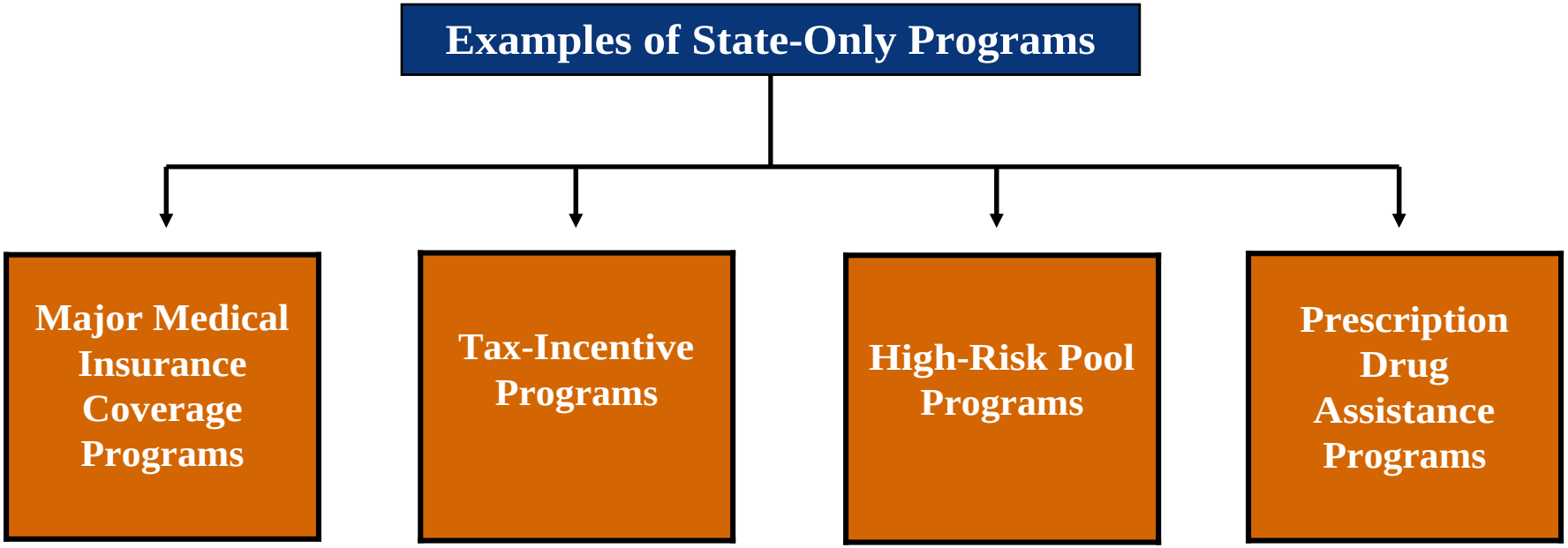
Disadvantages

- Does not guarantee coverage for eligible beneficiaries if a state exceeds its cap
- Increases states' susceptibility to budget shortfalls if federal cap is exceeded
- Reduces state incentives to expand coverage
- Locks in current differences in federal funding between states

Governor Rowland in Connecticut was supportive of a Medicaid/SCHIP block grant initiative, but his state legislature was not. Florida, however, appears to be supportive. Governor Jeb Bush, for example, had anticipated submitting a Medicaid/SCHIP block grant plan for approval to the federal government in the fall of 2004 and then to the Florida Legislature in the spring of 2005.

State-Funded Program Overview

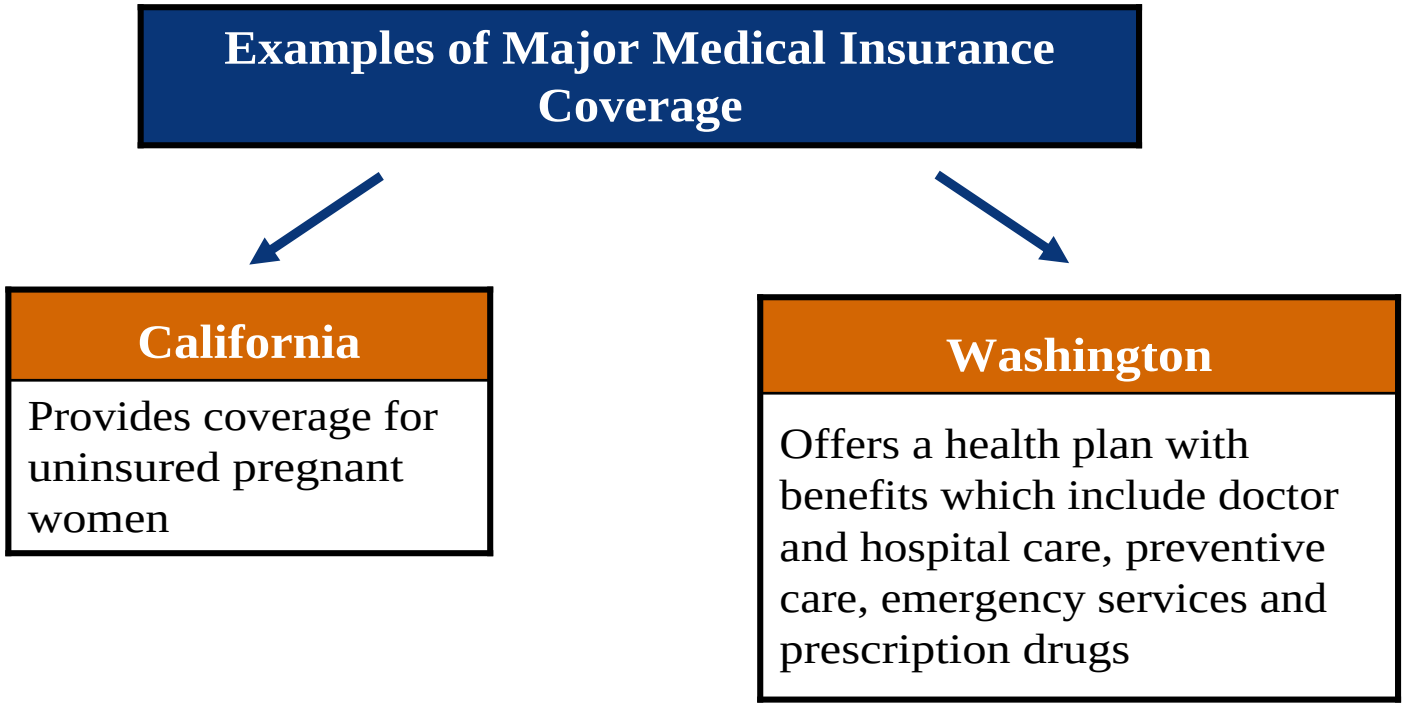
State-only funded programs may be used to expand coverage for the uninsured, increasing coverage according to the particular needs of the state. These programs allow states to use innovative approaches to expanding access while maintaining expenditures within state budgets. We describe these programs on the following pages.



The State of Wyoming has implemented two state-only programs: a State high-risk pool and a prescription drug program.

State-Funded Program Overview – Major Medical Insurance Coverage

Major medical insurance coverage programs provide major medical health coverage or premium assistance for specific populations. Covered populations include the disabled and individuals with a life-threatening illness. Examples of these programs are described below.



Thirteen states have implemented major medical insurance coverage programs.

State-Funded Programs – Tax Incentive Programs

Tax-incentive programs provide state income tax deductions or credits to employers or individuals who purchase health insurance. These programs also reduce tax liability (not deductions) that would reduce adjusted gross income or taxable income. Non-refundable tax programs do not refund any excess payments to employers or individuals. Selected examples of these programs are listed below.

Examples of Tax-Incentive Programs

States allowing tax breaks in the amount of a percentage deduction of premium expenditures:

- *Wisconsin* uses a 100 percent deduction for self-employed workers, spouses and dependents, and a 50 percent deduction for those who do not have employer-based coverage, as well as their spouses and dependents.
- *New Mexico* uses a percentage of premium that is determined on a sliding scale based on income.

States using tax credits:

- *Kansas* uses a flat $35 credit per eligible employee per month.
- *Maine* uses $125 per employee with dependents or 20 percent of dependent coverage.
- *North Carolina* uses a fixed credit amount, varying if an individual is above or below 225 percent of the FPL.

Fifteen states have implemented tax-incentive programs; as Wyoming has no state income tax, these approaches are not feasible.

State-Funded Programs – High-Risk Pool Programs

High-risk pool programs provide coverage to individuals with pre-existing conditions that preclude them from obtaining comprehensive insurance coverage at an affordable market price. These programs are generally subsidized by assessments on insurers, premium taxes, tobacco settlement funds or by state revenue. The creation of a separate pool for high-risk individuals encourages already healthy, eligible individuals to maintain coverage by keeping the cost of private insurance down.

Examples of High-Risk Pool Programs

- *California* provides a comprehensive benefit package for 36 months to qualifying citizens who cannot obtain private insurance. Participants pay a premium with assistance from the State.
- *Wyoming's* WHIP program has a premium cap of 200 percent of the standard market rate for health insurance. Members can choose from two different plans (Brown or Gold Plan); coverage under both plans includes Type A, Type B and Type C benefits and differs by the specific benefits and how those benefits are paid. The Brown Plan generally has higher deductibles, out-of-pocket maximums and lifetime maximums as compared to the Gold Plan.

Thirty-two states have implemented state high-risk pools, including Wyoming.

State-Funded Programs – Prescription Drug Assistance Programs

State prescription drug assistance programs provide prescription drug funding through subsidies or discounts. Senior citizens and disabled individuals make up a large majority of the beneficiaries of these programs. Some states have chosen to seek federal funding for these programs using 1115 waivers, as described in more detail in the Chapter Two. The new Medicare drug benefit for seniors will change these programs substantially.

Examples of State Pharmacy Assistance Programs

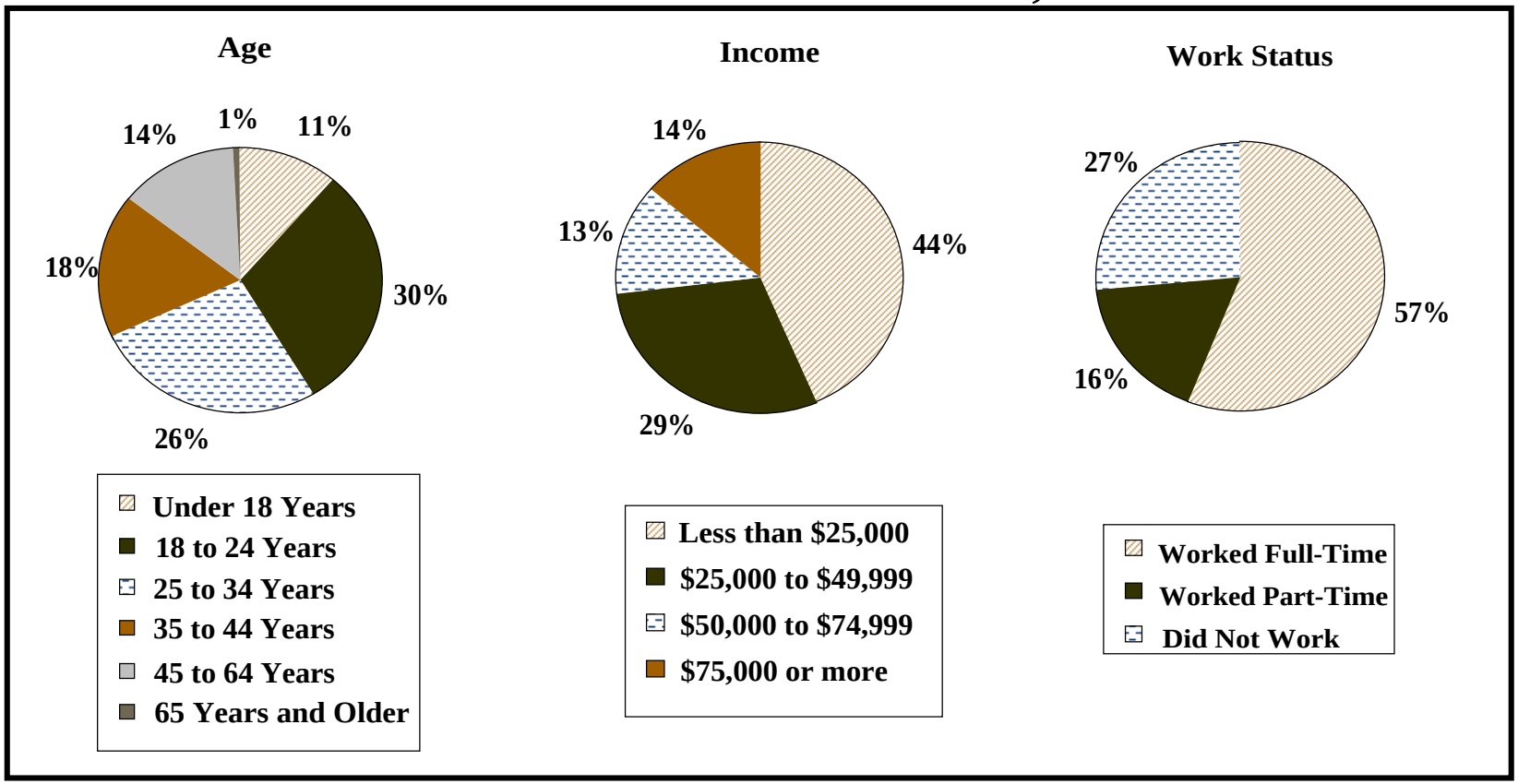
- *Minnesota* provides direct assistance to seniors with annual incomes below 120 percent of the FPL, and expanded the program in July 2002 to help disabled individuals. The plan requires a $35 monthly deductible. Costs for prescription drugs over the $35 are covered by the state.
- *Wyoming* offers a state-only funded prescription drug assistance program for low-income non-Medicaid eligible individuals. Participants pay either $10 or $25 per prescription (generic and brand prescriptions, comparatively), and are limited to three prescriptions per month.

Twenty-four states have implemented state pharmacy assistance programs and only four states have been approved for federal funding for these programs under an 1115 waiver.

The United States' Remaining Uninsured Population

Approximately 43 million people in the United States, or one in seven people, do not have health insurance even with the efforts of existing public health care programs. The majority of the uninsured are the working poor between the ages of 18 and 65, as illustrated below:

Characteristics of the Uninsured, 2003



Source: *Current Population Survey*. Annual Social and Economic Supplements, 2003 and 2004. U.S. Census Bureau. Available online: http://www.census.gov/hhes/hlthins/hlthin03/hi03t5.pdf, 11/12/04.

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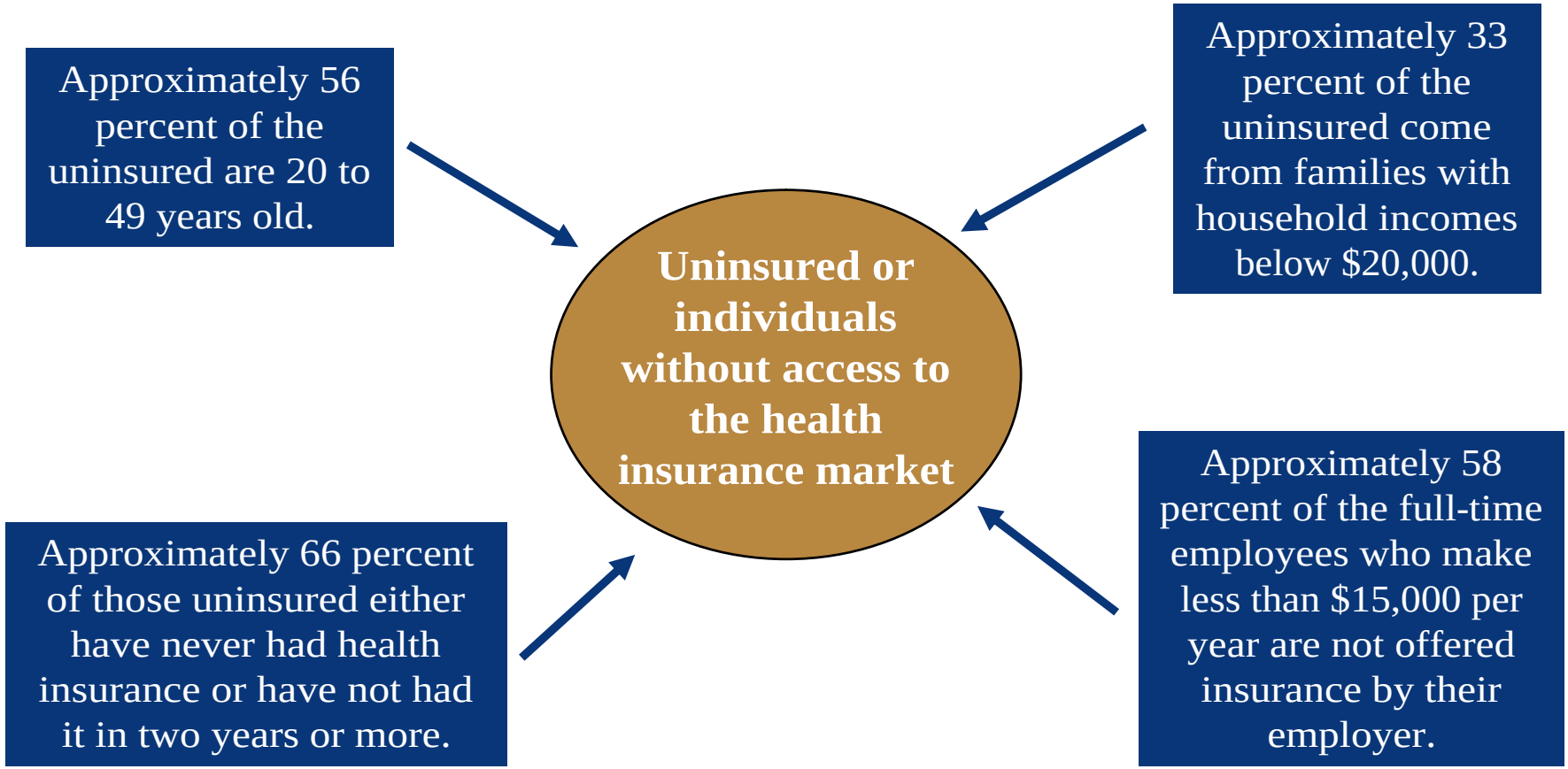
Wyoming's Remaining Uninsured Program

Approximately 19.2 percent of Wyoming's nonelderly population is uninsured according to the Census Bureau's March 2004 Supplement (based on calendar year 2003). According to a household survey conducted as part of Wyoming's State Planning Grant:



Sources: Health Insurance Coverage in America, 2003 Data Update." The Kaiser Commission on Medicaid and the Uninsured (November 2004). *State Planning Grant Task Force Strategic Research and Committee Activities Report*. Center for Rural Health Research and Education, University of Wyoming, October 1, 2003.

Conclusion

While public health care programs have gone a long way to cover the nation's vulnerable populations, a large portion of people remain uninsured. The following chapter will detail coverage options available to states.

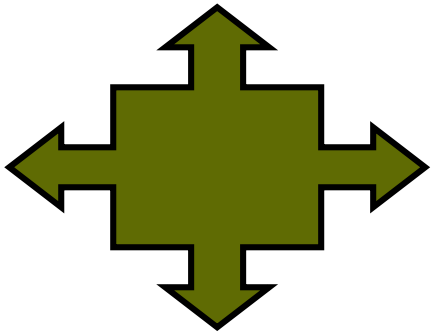
Chapter Two Introduction

Chapter Two provides an overview of waiver and non-waiver Medicaid and State Children's Health Insurance Program strategies that states have used to expand health care coverage to the uninsured. It describes how different states have used these initiatives to expand coverage to the uninsured, and provides specific detail on premium assistance programs. This Chapter, along with the Wyoming-specific information provided in Chapter 1, provides the framework for the Wyoming-specific coverage approach presented in Chapter Four.

Overview of Expansion Types

With 44 million uninsured people nationwide, many states have taken steps to expand health insurance coverage to their populations using SCHIP, Medicaid and state-only funds.

As of 2004, 40 states offer coverage to pregnant women that exceeds the federal minimum of 133 percent of the FPL.



As of 2004, 27 states have increased income eligibility above the federal standard for children ages 6 to 19.

Between June 1997 and June 2000, states increased, on average, SCHIP eligibility from 121 percent to 206 percent of the FPL.

Sources: John Holahan, Joshua H. Wiener and Amy Westpfahl Lutzky, *Health Policy for Low-Income People; States' Responses to New Challenges.* p. W198. Health Affairs: May 22, 2002.
Barbara Yandorf, Laura Tobler and Leah Oliver, *State Options for Expanding Health Care Access*. Balancing Health Needs with Resources, National Conference of State Legislatures: March 2004.

As a result of expansion efforts, hundreds of thousands of uninsured people gained access to health care. In 2002 alone, Medicaid enrollment grew by 3.2 million.

Overview of Expansion Types

Expansion programs vary by state according to state-specific characteristics such as population size, state income levels and the size of state budgets. The chart below describes the three main expansion types.

Expansion Type	Program
Medicaid Expansion	Extends coverage to populations that are traditionally ineligible for Medicaid and/or allows for the modification of covered services
Medicaid and SCHIP Waivers	Expands coverage by obtaining cost savings (i.e., reducing benefits for existing population) or adjusting the financial structure of Medicaid (i.e., implementing managed care). These waivers may also expand the use of employer-sponsored health insurance.
State-Specific Expansion Initiatives	Vary by state and include: • Subsidizing major medical insurance through state funds for low-income individuals who do not qualify for Medicaid or other federal programs, or those who cannot afford employer sponsored insurance • Offering high-risk pool programs for individuals with pre-existing conditions who are unable to obtain private health insurance • Allowing deductibles to be tax-free through tax incentive programs that make coverage more affordable

Overview of Expansion Types

The overall advantages and disadvantages to these three approaches are described below:

	Advantages	Disadvantages
Medicaid Expansions	• Does not entail the administrative burden of applying for and maintaining a federal waiver • Takes advantage of the pre-existing Medicaid structure • Uses federal matching funds to supplement state funding	• Requires funding of all eligibles; capped enrollment is not allowed • Creates political challenges if a coverage reduction is later needed due to budgetary stress • Requires compliance with all federal Medicaid regulations
Medicaid and SCHIP Waivers	• Allows for increased flexibility in program design as standard Medicaid or SCHIP regulations are waived • Allows states to cap program enrollment, limiting state expenditures	• Entails an administratively burdensome waiver application, implementation and maintenance process
State-Specific Expansion Initiatives	• Allows states additional flexibility as these programs are not tied to federal Medicaid or SCHIP requirements	• Does not use federal funds to match state funds

Overview of Expansion Types

Public healthcare expansion initiatives can be generally divided into two main categories: entitlement and capped. In an entitlement program, states must cover all individuals that meet eligibility requirements. Capped expansion programs limit the number of people allowed to participate, regardless of the number of eligible individuals.

Entitlement Expansions	Capped Expansions
• Medicaid non-waiver expansions • State-only funded programs, for example: high-risk pool programs that are open to all eligible individuals	• State Children's Health Insurance Program • Medicaid waiver programs • State-only funded programs, for example: high-risk pool programs with capped enrollment and expenditure limits

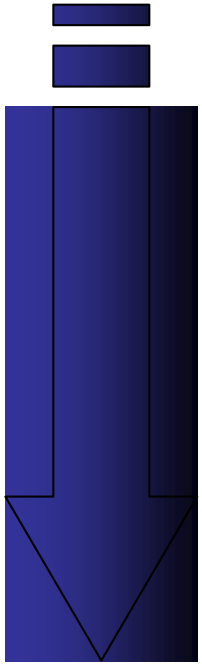
Overview of Expansion Types

The decision to use an entitlement versus a capped expansion approach has a significant impact on a state's expenditures and its ability to expand coverage. There are both advantages and disadvantages of entitlement and capped expansions.

	Entitlement Expansions	Capped Expansions
Advantages	• Approach is considered a highly effective method of increasing health care coverage because program enrollment is unlimited. • Federal matching dollars, if used, continue with increased enrollment.	• Federal and state government have limited exposure to federal and state expenditure increases. • States may still obtain matched federal funding up to a cap (if federal funding is used for initiative).
Disadvantages	• Some states may not have funds to cover all eligibles. • Approach does not limit federal and state government exposure to expenditure increases.	• The program may not have sufficient capacity to serve its entire target population. • States will not receive federal funding, if used, for eligibles after enrollment reaches the cap.

Overview of Expansion Types

Although states have made great progress in expanding health care coverage, budget shortfalls continue to present challenges to maintaining and expanding this coverage. In 2004, states confronted a total budget deficit of $78.4 billion, and an increasing number of states have had to make program cuts to address budget shortfalls. While most states have been able to maintain the eligibility levels previously established in their SCHIP programs, Medicaid programs have not fared as well, specifically:



25 states reduced eligibility levels for Medicaid programs.

35 states reduced Medicaid benefits between FY 2002 and 2004.

43 states implemented Medicaid pharmacy cost controls.

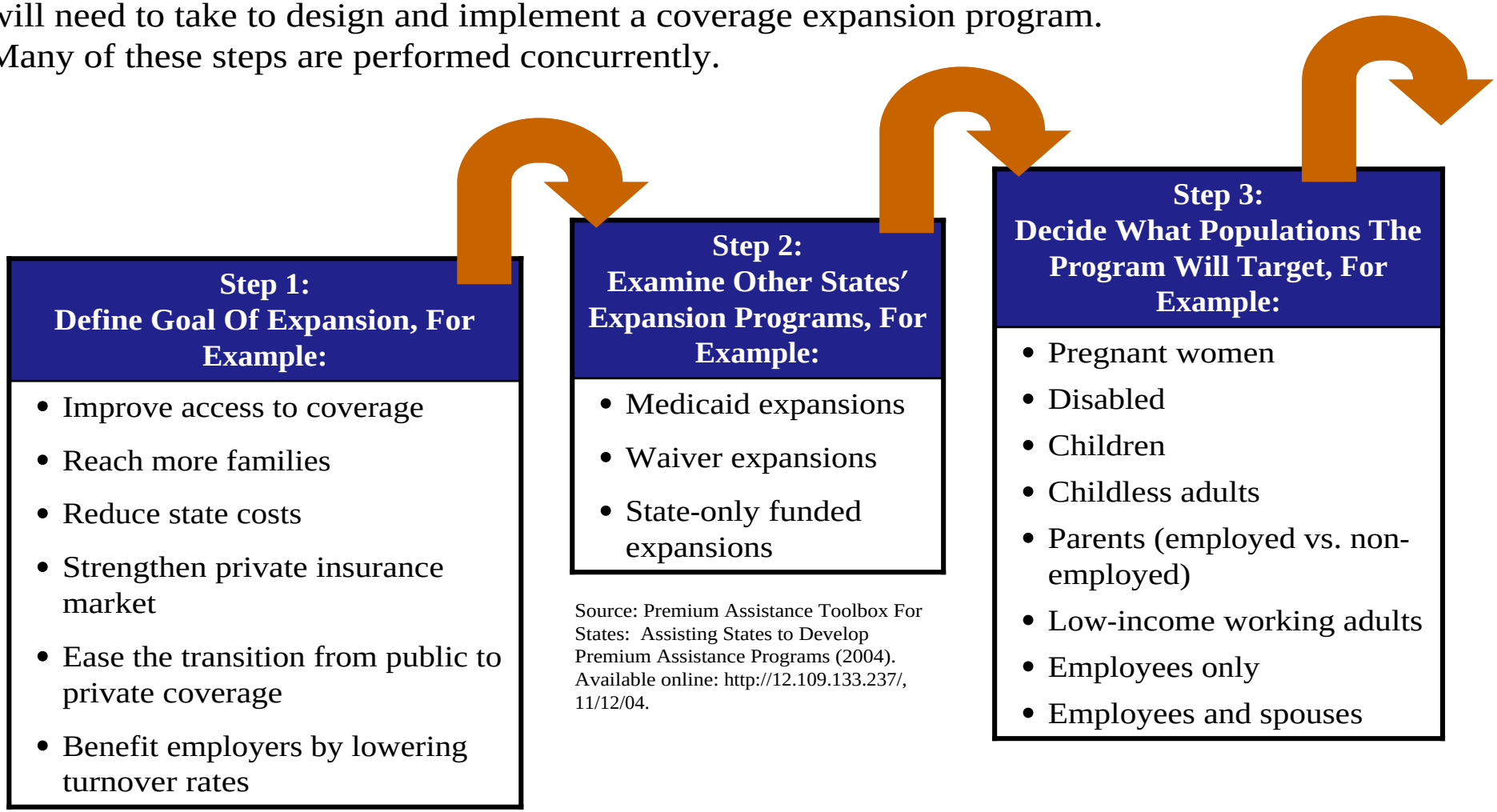
39 states froze Medicaid provider rates.

21 states implemented new or increased Medicaid co-payments.

Sources: Isabel Friedenzohn, et al., *State of the States: Cultivating Hope in Rough Terrain.* State Coverage Initiatives, p. 9, January 2004.
Medicaid Program at a Glance. Kaiser Commission on Medicaid and the Uninsured (January 2004). Available online: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30463, 11/12/04.
State Fiscal Conditions and Medicaid. Kaiser Commission on Medicaid and the Uninsured, April 2004.
Ian Hill, Holly Stockdale, and Brigette Courtot, *Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis.* New Federalism: Issues and options for States, The Urban Institute. Available online: http://www.urban.org/uploadedPDF/311015_A-65.pdf, 11/12/04.

Steps For Developing And Implementing A Coverage Expansion Program

Although every state program is unique, the following are major steps a state will need to take to design and implement a coverage expansion program. Many of these steps are performed concurrently.



Source: Premium Assistance Toolbox For States: Assisting States to Develop Premium Assistance Programs (2004). Available online: http://12.109.133.237/, 11/12/04.

Steps For Developing And Implementing A Coverage Expansion Program

Step 5: Determine Who Should Be Involved in Planning, For Example:

- State insurance department
- Insurance brokers and carriers
- Health plans and providers
- Advocates and consumers
- Employers
- State legislators
- Governor's office
- Centers for Medicare and Medicaid Services
- State Medicaid and SCHIP staff
- Business groups
- State labor department

Step 6: Identify Funding Options Available, For Example:

- Medicaid funds
- SCHIP funds
- Disproportionate share hospital funds
- Tobacco taxes and/or fees

Step 7: Identify Challenges, For Example:

- Ability to obtain accurate data to determine program feasibility
- Identification and funding of administrative functions
- Identification of funding sources
- Addressing political concerns regarding issues such as private insurance sector participation and obtaining funds to support expansion

Source: Premium Assistance Toolbox For States: Assisting States to Develop Premium Assistance Programs (2004). Available online: http://12.109.133.237/, 11/12/04.

Steps For Developing And Implementing A Coverage Expansion Program

Step 8: Investigate How Expansion Will Interact With The Private Market, For Example:

- Research available products in local insurance market
- Investigate the possibility of "crowd-out" and adverse selection

Consider the following if implementing a premium assistance-specific program:

- Number of potential enrollees based on availability of employer-based insurance
- Benefit packages provided under private insurance plans
- Amount of public subsidy
- Administrative organization

Step 9: Design Benefit Package and Cost-Sharing

Benefit Packages may include:

- Primary care
- Specialty care
- Mental health
- Qualified employer health plans

Cost-sharing policies may involve:

- Monthly premium
- Enrollment fees
- Co-payments

Source: Premium Assistance Toolbox For States: Assisting States to Develop Premium Assistance Programs (2004). Available online: http://12.109.133.237/, 11/12/04.

Steps For Developing And Implementing A Coverage Expansion Program

Step 10: Conduct Feasibility Study, Which Would Include:

- Examine pros and cons of expansion approach
- Analyze population data
- Analyze employment data
- Estimate expected costs
- Demonstrate administrative feasibility
- Assess how program would fit into administrative existing structure

Source: Premium Assistance Toolbox For States: Assisting States to Develop Premium Assistance Programs (2004). Available online: http://12.109.133.237/, 11/12/04.

Step 11: Determine Program's Overall Cost-Effectiveness

- Start-up costs
  - Surveys of the target population, employers, brokers and insurers
  - Stakeholder meetings
  - Consultant services
  - Systems development
- Administrative costs
- Estimated savings
- Systems development and maintenance
- Employer contributions
- Premiums

Steps For Developing And Implementing A Coverage Expansion Program

Step 12

Redesign and Advertise New Eligibility Rules

- Find methods to identify and contact newly eligibles
- Provide information to applicants

Final Step

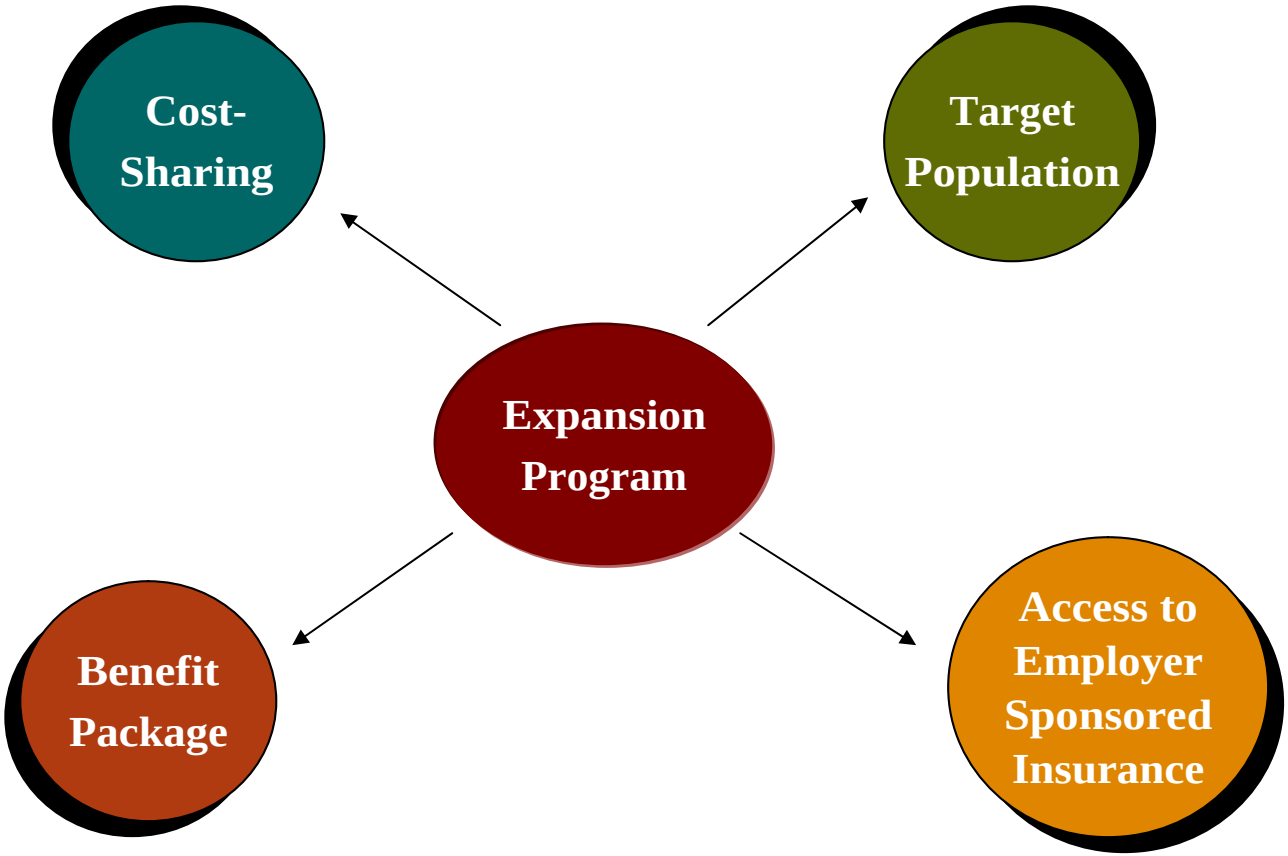
Develop Implementation Plan

- Develop timeline for expansion
- Obtain state funding and approval
- Obtain federal approval for federally funded programs

Source: Premium Assistance Toolbox For States: Assisting States to Develop Premium Assistance Programs (2004). Available online: http://12.109.133.237/, 11/12/04.

Key Policy Issues

When implementing an expansion program, states must make important policy decisions regarding cost-sharing, employer participation, benefit package content and target populations. These policy decisions will have a significant impact on a state's budget, access to care, the uninsured population and the private health insurance market.



Key Policy Issues – Cost-Sharing

Cost-sharing, as described in Chapter 1, involves requiring beneficiaries to pay part of their health care costs out-of-pocket and may include deductibles, coinsurance or co-payments. States must carefully consider the benefits and challenges of cost-sharing policies, described below, as these policies impact both beneficiary and provider participation levels.

Benefits	Challenges
• Cost-sharing policies are consistent with private insurance market beneficiary contributions. • Beneficiaries may be deterred from using unnecessary services, possibly reducing overall expenditures. • Medicaid beneficiaries generally may still receive services even if they are unable to meet cost-sharing obligations.	• Some providers view cost-sharing as a hidden tax or a reduction in provider reimbursement rates since the burden of collection lies with the provider. As providers must generally serve Medicaid recipients regardless of a recipient's ability to make cost-sharing payments, providers may be discouraged from participating in Medicaid. • Beneficiaries may be deterred from using necessary services. • The elderly and disabled may incur a disproportionate amount of cost-sharing due to their greater use of health services.

Establishing effective cost-sharing policies entails promoting efficient management of health care utilization without discouraging beneficiaries from using necessary services.

Key Policy Issues – Benefit Package

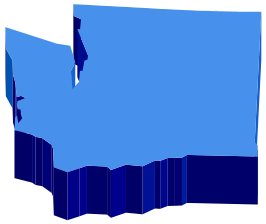
As benefit changes impact health care expenditures, states must determine which services best meet the health care needs of the target population. Benefit categories may be population-specific or consistent across various populations.

Type of Benefit Package	Goal	Example
Population-specific	Targets certain populations and services related to those populations	• Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under 21 • Family planning services for low-income women and teenagers • Services for tuberculosis-infected individuals not eligible for Medicaid
Service-specific	Guarantees beneficiaries will receive a certain group of services	• Medicaid and SCHIP benefit packages which include a group of federally mandated benefits • Commercial comprehensive health insurance benefit packages

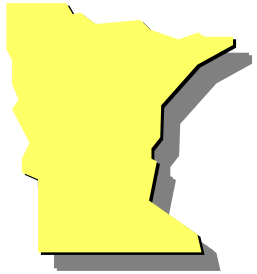
Key Policy Issues – Benefit Package

While Medicaid and SCHIP generally require comprehensive benefit packages, states sometimes use reduced benefit packages to implement coverage expansions.

Basic General Coverage, or "Bare Bones" Packages	These benefit packages are less comprehensive than standard or comprehensive health insurance coverage and may include doctor and hospital care, preventive care, emergency services and prescription drugs. These packages will often exclude mental health, dental, substance abuse and vision services.



Washington offers a basic plan for low-income adults which is limited to physician and hospital care, preventive care, emergency services and prescription drugs.

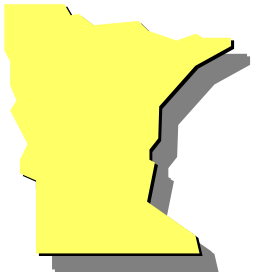


Minnesota offers basic coverage for childless adults which is limited to inpatient hospital services up to $10,000 and physician care, drugs and laboratory and diagnostic services up to $5,000 per year.

Key Policy Issues – Benefit Package

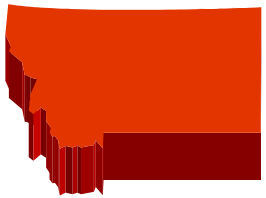
Additional examples of reduced benefit packages are:

"Catastrophic" Coverage Packages	These benefit packages cover large medical expenses or expensive episodes of care, but cover limited or no preventive care services.



Minnesota offers a catastrophic hospitalization-only coverage option for childless adults. Coverage begins on the day of admission and ceases the day of discharge with a $1,000 deductible per admission.

"Front-End" Coverage Packages	These benefit packages cover preventive and primary services, and may or may not include prescription drugs, limited laboratory services and specialty services.



Montana offers a plan that includes coverage of outpatient and preventive care services but excludes inpatient hospital care.

Key Policy Issues – Benefit Packages

The type of benefit package a state uses has implications for the services a population receives, and therefore, their health care status. The table below outlines the benefits and challenges of each approach.

Type of Benefit Package	Benefits	Challenges
Basic General Coverage Packages	• Provide a wide range of health care services • Are less costly than a comprehensive health care plan	• May result in reduced access to key services (i.e., exclusion of dental and mental health services from the benefit package) • May be more costly than catastrophic or primary care packages
Front End Coverage Packages	• Provide preventive care services that can help reduce future health care expenditures • Are less costly than comprehensive or basic general coverage	• Do not cover the high-cost inpatient services that result in the provision of charity care and bad debt by hospitals

Key Policy Issues – Benefit Packages

The benefits and challenges of each benefit package approach, continued:

Type of Benefit Package	Benefits	Challenges
Catastrophic Health Care Packages	• Provide payment for crucial inpatient hospital services, encouraging access • Reduce charity care and bad debt for hospitals that would have to provide inpatient services regardless of a patient's ability to pay	• Do not address the lack of access to primary care and other services that could prevent future inpatient hospitalizations

Key Policy Issues – Access to Employer-Sponsored Insurance

One strategy states use to expand coverage is to subsidize the purchase of private health insurance via premium assistance.

Benefits of Employer-Sponsored Insurance Approaches

- Provides support for low-income people who have access to employer-sponsored insurance but who cannot afford it
- Promotes reduced insurance "churning" as families enrolled in public coverage may unexpectedly become ineligible due to income fluctuations
- Subsidizes the employer-based system, which may strengthen low-income workers' attachment to the workforce
- Captures employers' premium contributions, which has the potential to reduce public costs and to expand access to health insurance
- May reduce "crowd-out," the substitution of public coverage for private coverage
- May enable all members of a family to be covered in the same health care plan
- Potentially provides better access to providers for recipients as private insurance plans may reimburse providers at higher rates than Medicaid

Sources: Barbara Yondorf, Laura Tobler, and Leah Oliver, *State Options for Expanding Health Care Access*. National Conference of State Legislatures, March 2004.
Serving Low-Income Families Through Premium Assistance: A Look At Recent State Activity. Kaiser Commission on Medicaid and the Uninsured, October 2003.

Key Policy Issues – Access to Employer-Sponsored Insurance

Employer-sponsored insurance initiatives face specific challenges, as described below. Rural states face additional implementation obstacles due to lack of access to a large private insurance market and the generally large proportion of beneficiaries working for small employers that may be less likely to offer employer-based insurance.

Administrative Burden

It may be administratively burdensome for states to:

- Identify and evaluate eligible applicants' and beneficiaries' employers
- Determine if coverage under a particular employer plan is cost-effective
- Pay and collect premiums from individual enrollees
- Determine if employer coverage has the same benefits and cost-sharing as Medicaid, assuming this is a program requirement

Source: Barbara Yondorf, Laura Tobler, and Leah Oliver, *State Options for Expanding Health Care Access*. National Conference of State Legislatures, March 2004.

Key Policy Issues – Access to Employer-Sponsored Insurance

Employer participation and enrollment barriers also present challenges:

Employer Participation

- Small employers may lack interest or the ability to participate, given their limited administrative resources.
- Instability in the private insurance market may lead to employers dropping coverage or increasing the amount of employee contributions, effectively disenrolling participants in an employer-sponsored insurance approach.
- Employers may be reluctant to participate in a government-run program.

Enrollment Barriers

- Low-wage workers may have a high level of job mobility and limited access to employer-sponsored insurance.
- Reduced benefit packages (as compared to existing Medicaid and SCHIP benefit packages), increased cost-sharing, waiting periods and confidentiality concerns may reduce employee participation.

Key Policy Issue – Target Populations

When creating expansion programs, states must decide which populations to target beyond federal requirements.

Children Under 19 Over Federally-Mandated Coverage Levels
In 2002, 9.3 million children were uninsured in the United States.

Disabled Working Individuals
There are approximately 6.7 million disabled working individuals nationwide.

Pregnant Women Over Federally-Mandated Coverage Levels
As of 2002, there were approximately 100,000 uninsured women nationwide.

Parents of SCHIP Children
In 19 states, a parent working full-time at minimum wage ($9,300 per year), earns too much to qualify for Medicaid.

Sources: Amy Davidoff, et. al., *Medicaid and State-Funded Coverage for Adults: Estimates of Eligibility and Enrollment*. Kaiser Commission on Medicaid and the Uninsured, p. 5. April 2004.
Health Insurance Coverage in America: 2002 Data Update. Kaiser Commission on Medicaid and the Uninsured, December 2003.
Medicaid and Ticket to Work – States' Early Efforts to Cover Working Individuals with Disabilities. General Accounting Office – Report to Congressional Committees: GAO-03-587, June 2003.

Some states have targeted uninsured working childless adults. Typically ineligible for public health care coverage, this group made up approximately half of the uninsured population in 2002 in the United States.

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Key Policy Issues – Target Populations

The selection of the target population presents specific benefits and challenges that Wyoming should consider as it explores a potential expansion program:

Benefits of Covering Different Target Populations	Challenges In Identifying Target Populations
• Covering pregnant women and children over federally-mandated coverage levels increases access to care during critical time periods in an individual's life. • Covering disabled individuals supports the successful integration of individuals with disabilities into the workforce. • Covering parents of SCHIP children promotes the inclusion of the same family under one insurance plan, as opposed to having different health care coverage levels within the same family. • Covering childless working adults allows for these individuals to access critical health care services, and encourages their continued participation in the workforce.	• Determining the most cost-effective use of available funding, given different populations' health care needs and expected present and future expenditures. • Focusing efforts on one population does not address the unmet health care needs in the remaining uninsured populations.

Non-Waiver Medicaid Expansions

If a state is not seeking to change federally-mandated Medicaid requirements (i.e., by using managed care or a reduced benefits package), it may expand Medicaid coverage by submitting an amendment to its state plan (the federally-mandated document that governs state programs). This approach allows states to benefit from the existing Medicaid infrastructure, does not require a waiver and does not have to be budget neutral. One of the main challenges of this approach is that states may not cap enrollment, resulting in unlimited exposure to increased expenditures. States may choose to expand coverage by:

Of the 50 million people covered under Medicaid, non-waiver Medicaid expansions cover 12 million people.

Non-Waiver Medicaid Expansions

Examples of non-waiver Medicaid expansions are:

Low-income Adults

Arizona, Hawaii and Maine, among several other states, offer Medicaid coverage to low-income adults who otherwise do not qualify for Medicaid.

Low-income Women with Breast Cancer

49 states have adopted legislation authorizing their Medicaid programs to include low-income women with breast or cervical cancer as of 2003.

Disabled Individuals

23 states extend Medicaid coverage to independent individuals with disabilities that receive state supplementary payments beyond the state's income eligibility level.

Medically Needy

34 states have implemented medically needy programs.

Children

27 states have increased Medicaid income standards for children ages six to 19.

Source: Barbara Yondorf, Laura Tobler, and Leah Oliver, *State Options for Expanding Health Care Access*. National Conference of State Legislatures, March 2004.

In the following pages, we describe the three non-waiver Medicaid expansion approaches that states can use: Transitional Medical Assistance, Section 1931 and programs to support the disabled through the Balanced Budget Act (BBA) of 1997 and the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999.

Medicaid Expansions – Section 1931

According to Section 1931 of the Social Security Act, states must provide Medicaid coverage to parents in families that met the cash assistance eligibility requirements as they existed on July 16, 1996. States may, however, choose to identify more eligible individuals by using less restrictive income and resource methodologies to establish Medicaid eligibility. As of March 2004, 27 states had expanded Medicaid eligibility under Section 1931.

North Dakota disregards $90 or 27 percent of monthly earnings (whichever is more advantageous to the family), plus an additional $30 and 33 percent of the remaining earnings.

Washington, D.C. disregards all income that falls between its old cash assistance income standard and 200 percent of the FPL for families with children up to 200 percent of the FPL; the state does not use a specific earnings disregard (i.e., a flat $100).

Wyoming disregards $200 in monthly earnings for employed single individuals, and $400 for married couples even if only one person in the couple is working. If a parent is working, Wyoming disregards an additional $50 if the parent receives child support.

Wyoming could choose to expand Medicaid eligibility by increasing its income disregards. For example, Ohio disregards $250 and 50 percent of remaining earnings for twelve months.

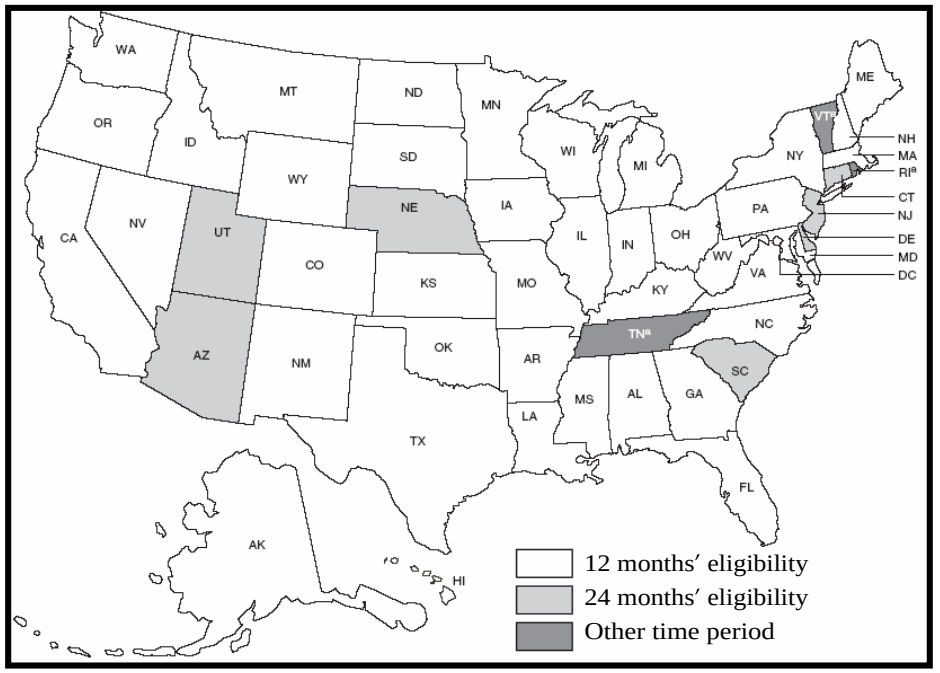
Source: *State Coverage Matrix – Strategies Used to Expand Health Insurance Coverage Across the US.* State Coverage Initiatives (March 2004). Available online: http://www.statecoverage.net/matrix.htm, 11/12/04.

Non-Waiver Medicaid Expansions – Transitional Medicaid Assistance

Transitional Medicaid Assistance (TMA) extends Medicaid coverage temporarily to families that would lose Medicaid coverage due to increased earnings in excess of the 1996 welfare cash assistance limit ("TANF"). While all states must offer TMA for 12 months, some states have extended this time frame, for example:

- Arizona, Delaware, Nebraska, Utah, Rhode Island and South Carolina offer 24 months of coverage.
- Tennessee and Vermont offer an 18-month eligibility period.

Source: William J. Scanlon, *Medicaid: Transitional Coverage Can Help Families Move from Welfare to Work.* General Accounting Office: GAO-06-677T (April 23, 2002). Available online: http://www.gao.gov/new.items/d02679t.pdf, 11/12/04.



While TMA encourages welfare recipients to leave welfare and enter the workforce, this approach has not been used extensively. Obstacles for implementation of this type of expansion include identifying eligible individuals and administrative burdens for the state. Wyoming could choose to expand coverage beyond 12 months.

Medicaid Expansions – Coverage for Disabled Individuals

Many disabled individuals forgo employment to maintain their health care benefits under Medicaid. Through the BBA of 1997 and the TWWIIA of 1999, states have the option of expanding eligibility for disabled individuals who would otherwise not qualify for Medicaid coverage.

	Balanced Budget Act (BBA) of 1997
Eligibility Group	• States have the option of implementing a coverage category for disabled working individuals who cannot qualify for Medicaid because of their earnings. • Medicaid coverage is extended for individuals who meet the SSI definition of disability, have incomes greater than the SSI eligibility limit, but whose income remains below 250 percent of the FPL.
Options Available to States	• States may require premium payments and other cost-sharing charges on a sliding scale based on income. • Earned income may be completely disregarded and unearned income may not exceed SSI income standard ($512/month for individuals and $769 for couple).
Response	• As of December 2002, 12 states had implemented a BBA option for working individuals with disabilities: Alaska, California, Iowa, Maine, Mississippi, Nebraska, New Mexico, Oregon, South Carolina, Utah, Vermont, and Wisconsin.

Source: *Medicaid and Ticket to Work: States' Early Efforts to Cover Working Individuals with Disabilities.* General Accounting Office: GAO-03-587, June 2003. *BBA and TWWIIA Comparison Chart.* Centers for Medicare and Medicaid Services (September 16, 2004). Available online: http://www.cms.hhs.gov/twwiia/comchart.asp, 11/12/04.

Medicaid Expansions – Supporting Disabled Individuals

The TWWIIA builds upon the BBA of 1997 by creating two new optional categorically needy Medicaid eligibility groups:

	Ticket to Work and Work Incentives Program Improvement Act of 1999 (TWWIIA)
Eligibility Groups	• *Basic Coverage Group*: Working individuals aged 16-64 who, except for their income and resource levels, are eligible to receive SSI. • *Medical Improvement Group*: Employed individuals who lose Medicaid Coverage because they no longer meet the SSI definition of disability at the time of continuing disability review.
Options Available to States	• States may establish their own income and resource standards. States may also opt to have no income or resource standards. • Earned income is not automatically disregarded for either group. • States may require premium payments and other cost-sharing charges on a sliding scale based on income. For annual incomes less than 450 percent of the FPL, states may require premiums and other cost-sharing charges up to 7.5 percent of income.
Response	• As of December 2002, 12 states have adopted the option under the Basic Coverage Group, and five states have used the option under the Medical Improvement Group.

Source: *Medicaid and Ticket to Work: States' Early Efforts to Cover Working Individuals with Disabilities*. General Accounting Office: GAO-03-587, June 2003. *BBA and TWWIIA Comparison Chart.* Centers for Medicare and Medicaid Services. http://www.cms.hhs.gov/twwiia/comchart.asp, September 16, 2004.

Medicaid Expansions – Ticket to Work

Enrollment by State for Ticket to Work Medicaid Buy-In Programs, 2002	
Missouri	8,461
Minnesota	6,178
Indiana	3,318
Connecticut	2,433
Pennsylvania	1,325
New Hampshire	968
New Jersey	551
Kansas	489
Illinois	323
Washington	144
Arkansas	65
Wyoming	3

Examples of states' eligibility policies under the TWWIIA program are:

Wyoming has expanded eligibility to those individuals with an income of up to 100 percent of the FPL. The premium varies depending on income.

New Mexico has expanded eligibility to those with an income of up to 250 percent of FPL and requires co-payments for doctor, dental, emergency visits, inpatient hospital admissions and prescriptions. The State does not consider retirement accounts when determining eligibility.

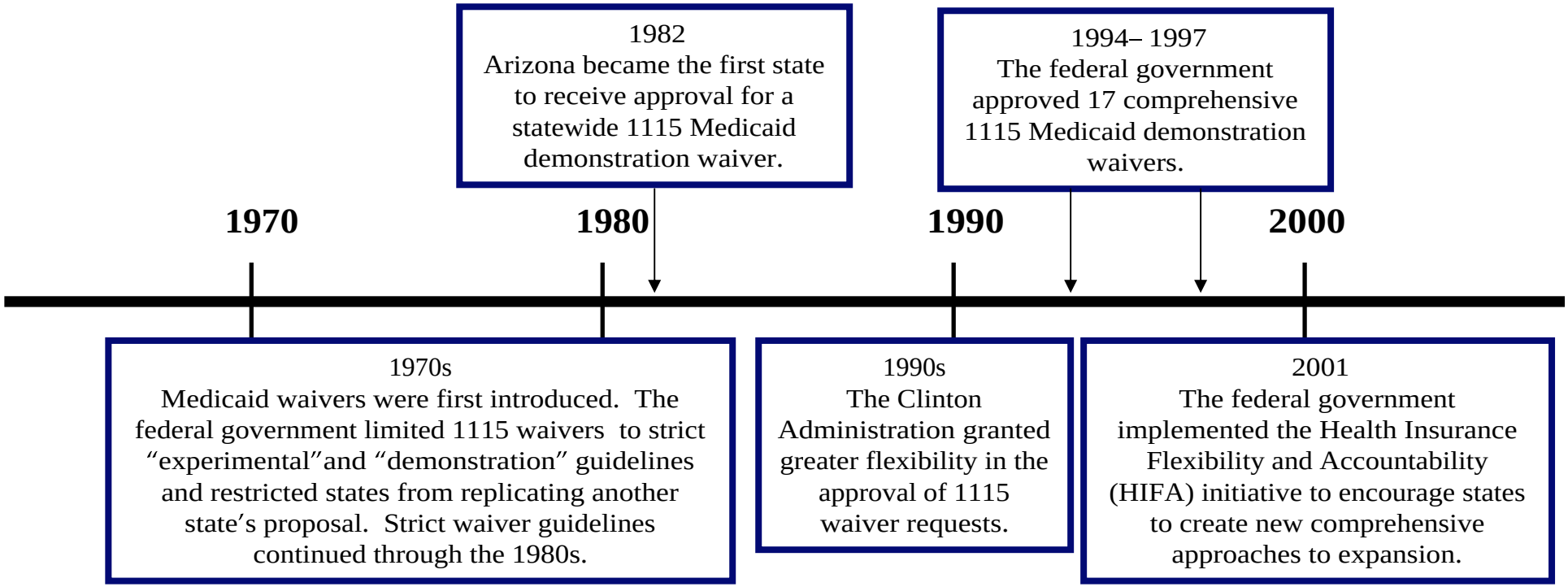
Connecticut has expanded eligibility to those with a yearly income of less than $75,000. Premiums are ten percent of income for those with incomes above 250 percent of the FPL. The State does not consider retirement accounts or medical savings accounts when determining eligibility.

Source: *Medicaid and Ticket to Work: States' Early Efforts to Cover Working Individuals with Disabilities*. General Accounting Office: GAO-03-587, June 2003. *Work Incentives Eligibility Groups.* Centers for Medicare and Medicaid Services (September 13, 2004). Available online: http://www.cms.hhs.gov/twwiia/statemap.asp, 11/12/04

At the end of 2002, enrollment ranged from three individuals in Wyoming to 8,461 individuals in Missouri.

Waiver Expansions – 1115(a) Overview

Some states use Section 1115(a) waivers to expand coverage. Under Section 1115(a) of the Social Security Act, the federal government may waive compliance with specific federal Medicaid requirements so that a state may implement an experimental, pilot or demonstration project. Over time, this expansion approach has been widely used:



In the absence of nationwide health care reform, Section 1115(a) waivers have become a critical vehicle for state health care expansions.

Waiver Expansions – Steps in the 1115(a) Application Process

While there is no general or standardized format for application because each state's 1115 proposal is a unique research and demonstration project, there are five general phases.

Step One: Concept Phase

- State submits a general outline of its proposal, also known as a "concept paper" to CMS to obtain feedback.
- State and CMS resolve initial concerns before the state formally submits its 1115 waiver application.

Step Two: Proposal Review Phase

- State submits a formal proposal to CMS, which must include compelling policy reasons for proposing the coverage expansion and detailed information on the program's:
  - Benefit package, eligibility and cost sharing
  - Delivery system
  - Project administration and management
  - Evaluation plan
  - Supporting budget and cost information
- The CMS and several other federal agencies review the proposal.
- The State and the federal government negotiate the terms and conditions of the waiver program.

Source: Charles Milligan. *Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage*. State Coverage Initiatives, May 2001.

Waiver Expansions – Steps in the 1115(a) Application Process

Step Three: Pre-Implementation Phase

- The State prepares for implementation and makes any changes required by the federal government.
- The CMS generally performs a site visit to evaluate the State's readiness for implementation. If approved, the waiver is effective for a five-year period.

Step Four: Operational Phase

- The State implements the program.

Step Five: Assessment Phase

- States conducts annual progress reports for submission to the federal government.
- States must conduct an independent assessment of their program upon waiver renewal. The independent assessment must document the cost-effectiveness of the project, and the impact on access to care and the quality of services, among other issues.

Preparing for and obtaining a federal waiver can take a significant amount of time; obtaining approval for a 1115 waiver can take as long as 25 months, although six months between federal approval and state implementation is more common. Maintaining an 1115 waiver requires an on-going state commitment of funding and resources. As the federal government adjusts its waiver requirements over time, states must follow these developments closely and make the appropriate policy adjustments.

Waiver Expansions – Denied Waivers

There is no guarantee that CMS will approve an 1115 waiver. Provided below are examples of denied or withdrawn 1115 waivers.

State	Waiver Description	Reason for Denial or Withdrawal
Delaware	Designed to cover childless adults and pregnant women and uninsured parents of Medicaid or SCHIP children	Denied – Delaware did not plan to expand coverage or coordinate with the private health insurance market.
Hawaii	Designed to lower the maximum eligibility limit for the State pharmacy discount plan to 200 percent of the FPL	Denied – Hawaii did not demonstrate budget neutrality.
Michigan	Designed to extend coverage to parents of Medicaid children and childless adults below 100 percent of the FPL	Withdrawn – Michigan did not have enough revenue to fund the expansion.
Florida	Designed to integrate Medicaid and Medicare services for dual eligibles	Withdrawn – Florida wanted to avoid time associated with waiver process and narrowed its focus to two counties.

Sources: *SCHIP: HHS Continues to Approve Waivers that Are Not Consistent with Program Goals.* General Accounting Office: GAO-14-166R, January 5, 2004.
States and "Pharmacy Plus" Medicaid Waiver Options. National Conference of State Legislatures, December 2, 2003.
State Responses to Budget Crisis in 2004: An Overview of 10 States. Kaiser Family Foundation, January 2004.
Implementing State Demonstrations for Dual Eligibles Has Proven Challenging. General Accounting Office: GAO/HEHS-00-94, August 2000.

Waiver Expansions – 1115(a) Requirements

1115(a) waiver programs must maintain access to and quality of care, and achieve budget or SCHIP allotment neutrality.

States generally achieve budget or SCHIP allotment neutrality using the following approaches:

- Savings generated by managed care implementation
- Redirection of Medicaid disproportionate share hospital payments
- Use of unspent SCHIP allotments, also known as "allotment neutrality"
- Reduction of benefits and imposition of higher cost-sharing for some beneficiaries beyond federal limits
- Inclusion of hypothetical expansion expenditures for the targeted group in the budget neutrality calculation
- Inclusion of state-only funded programs in the waiver program

Regardless of the approach states use, 1115 waivers must continue to promote the goals and objectives of Medicaid and SCHIP. Generally speaking, these waivers are administratively burdensome to implement and administer.

Waiver Expansions – 1115 HIFA Overview

The Health Insurance Flexibility and Accountability Act (HIFA) introduced a streamlined 1115 waiver approach to encourage states to increase coverage within current Medicaid and SCHIP resources.

The federal government provides flexibility by:

- Expediting the review for proposals
- Allowing program design flexibility through the 1115 waiver

The federal government's goals are to:

- Expand coverage of the uninsured
- Promote employer-sponsored insurance

Waiver Expansions – 1115 HIFA Overview

States benefit from using their unspent SCHIP allotment because:

Allotment neutrality is required, instead of budget neutrality. This means that states may use unspent portions of their SCHIP allotments up to the annual allotment cap. Additionally:

- States receive a higher matching rate under SCHIP than Medicaid.
- States may potentially use any additional redistributed funds from other states that were unable to spend their full allotments.

Source: Cynthia Shirk, *Shaping Public Programs through Medicare, Medicaid, and SCHIP Waivers: The Fundamentals*. National Health Policy Forum, September 15, 2003.

Since the introduction of HIFA, the federal government has approved eight HIFA demonstration waivers, and two more are under review.

Waiver Expansions – 1115 HIFA Requirements

Under HIFA regulations, states must:

- Continue to cover mandatory SCHIP populations
- Offer Medicaid benefits to mandatory Medicaid populations
- Integrate Medicaid/SCHIP funding with private health insurance options (i.e., use a premium assistance policy)
- Meet 1115 waiver budget neutrality regulations, but not necessarily be cost-effective

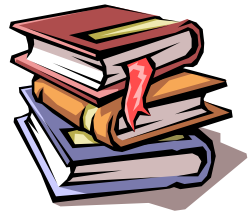
Once states meet federal requirements they may opt to use the following policies:

- Use SCHIP funding to cover additional populations, such as childless adults
- Modify current Medicaid benefits for optional populations and use basic primary care packages for expansion populations
- Increase cost-sharing for optional and expansion populations, limited to five percent of family income
- Use federal funding for previously state-only funded programs
- Implement enrollment caps
- Use DSH funding to finance expansion

Waiver Expansions – 1115 HIFA Waiver Application Process

States must include the following information as part of their HIFA waiver proposal:

- **Assessment of current uninsured rates for all groups under 200 percent of the FPL, groups being considered for expansion and projections of future uninsured rates**
- **Assessment of state coverage sources and levels, including public and private insurance**
- **Goal of state's coverage and comprehensive strategy to reduce the number of uninsured**
- **Report changes and trends in coverage types by monitoring employer contribution levels and private insurance coverage throughout entirety of HIFA demonstration**
- **List of performance measures that address issues such as access to care, quality of care and outcomes**



State proposals that meet all HIFA application requirements receive an expedited approval process. The HIFA waiver application includes a Medicaid budget-neutrality and/or SCHIP allotment neutrality template.

Waiver Expansions – 1115 HIFA Waiver Application Process

States must submit progress reports within six months of each HIFA waiver demonstration year. These reports must include:

- Uninsured rates
- Effectiveness of HIFA approach
- Impact of HIFA wavier program on employer coverage
- Other factors effecting change in uninsured rates
- Progress on achieving performance measures goals

Upon renewal, states must hire an external contractor to conduct an independent evaluation, which must include the following:

- Comparison of state's progress as compared to its original goals
- Evaluation of differences in outcomes according to various approaches used by states
- Evaluation of the general effectiveness of the HIFA waiver program in reducing overall uninsured rates

Source: *Guidelines for States Interested in Applying for a HIFA Demonstration.* Centers for Medicare and Medicaid Services (September 16, 2004). Available online: http://www.cms.hhs.gov/hifa/hifagde.asp, 11/12/04.

HIFA waivers are approved for a five-year period after which a state must apply for a renewal.

Waiver Expansions – 1115(a) Budget Neutrality

States must estimate costs before and after waiver implementation to determine compliance with 1115(a) budget neutrality provisions. For example:

Calculating Budget Neutrality

Demonstration Year Enrollment (actual or projected)	x	Cost per Eligible Individual	≤	Medicaid Base Year Costs	x	Growth Rate

≤

"With Waiver" Costs

"Without Waiver" Costs, also known as the budget-neutrality cap

Note: States are allowed to include hypothetical expenditures for a state expansion group that could have been added under current Medicaid law without a waiver (i.e., low-income parents eligible under Section 1931 expansions)

Source: Cynthia Shirk, *Shaping Public Programs through Medicare, Medicaid, and SCHIP Waivers: The Fundamentals*. National Health Policy Forum, September 15, 2003.

Waiver Expansions – Comparison of Cost-Effectiveness Calculations

While all 1115 waivers must be budget neutral with respect to the federal funds that would be spent under the state's program without the waiver, the cost-effectiveness test is somewhat different for 1115 HIFA waivers, as detailed below.

1115(a) HIFA Waiver Cost-Effectiveness Calculations

- Unlike non-HIFA waivers, HIFA waiver cost-effectiveness calculations are subject to the SCHIP allotment limit.
- HIFA waiver federal financial payments are capped on a per person basis over the waiver time period.
- States calculate HIFA waiver federal financial payments by multiplying the number of individuals enrolled in the waiver (split into mandatory and optional groups) by the product of:
  - A base year per capita spending estimate for each mandatory and optional group included in the waiver; and
  - A growth rate
- States may not adjust the federal per person payment amount over the course of the waiver if costs rise above the projections.

Source: *Side-by-Side Comparison of HIFA Guidance and Medicaid and CHIP Statutory Provisions Appendix*. The Kaiser Family Foundation (August 2001). Available online: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14109, 11/12/04.

Waiver Expansions – 1115 Family Planning Waivers

States are increasingly using 1115 Family Planning Waivers to expand eligibility for Medicaid family planning services by expanding coverage for these services:

- Beyond the previous 60-day postpartum period during which states may provide Medicaid-funded family planning services and supplies as part of postpartum care
- To individuals leaving Medicaid for any reason
- To individuals that have incomes beyond Medicaid's income eligibility standards

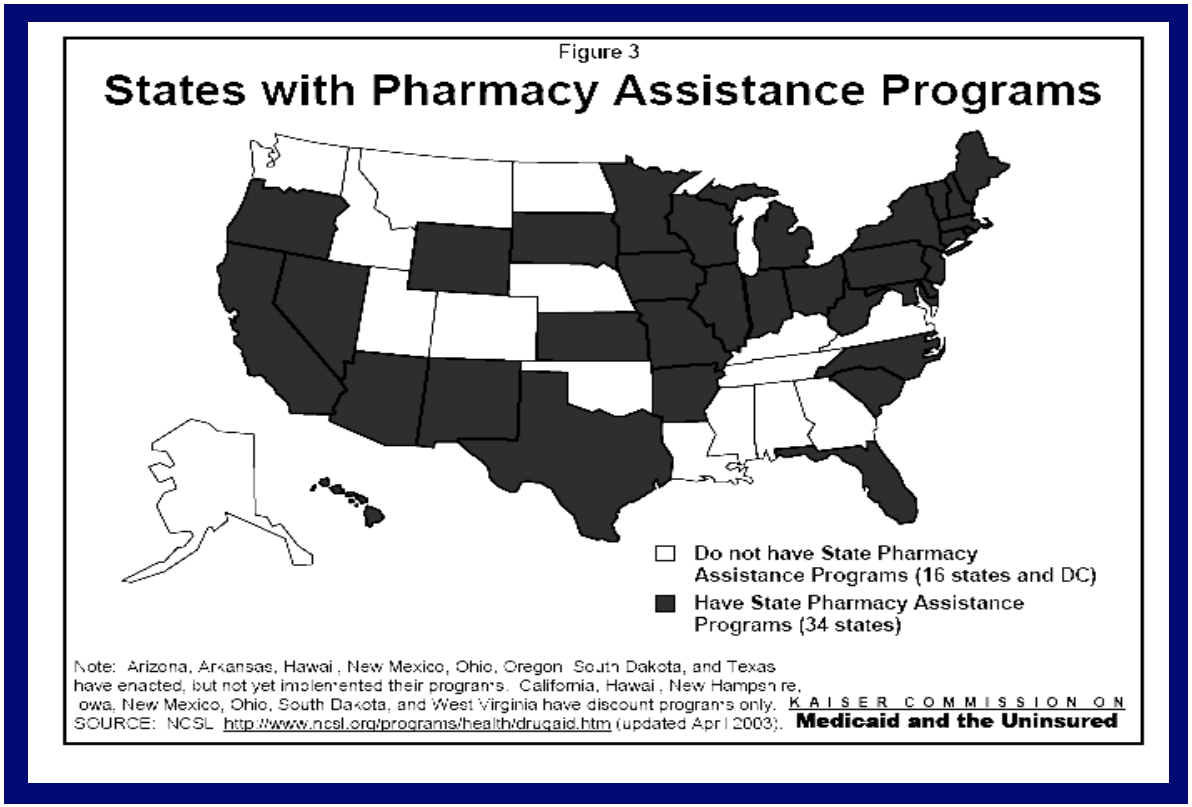
Examples of 1115 Family Planning Waivers

- *Florida* extends eligibility for family planning services for two years to childbearing-age women with incomes at or below 185 percent of FPL who have received Medicaid pregnancy-related services in the two years prior to losing Medicaid.
- *Illinois* extends family planning eligibility to Medicaid-participating, childbearing-age women who would otherwise lose Medicaid eligibility.
- *Arkansas* extends family planning eligibility to women ages 14-44 between 133 percent and 200 percent of FPL.
- *California*, *New York*, *Oregon* and *Washington* have expanded coverage to men, which includes contraceptive supplies and sexually transmitted disease screenings.

Source: *Medicaid: A Critical Source of Support for Family Planning in the United States.* Kaiser Family Foundation Commission on Medicaid and the Uninsured, April 2004.

Waiver Expansions – 1115 Pharmacy Plus Demonstration Initiative

Pharmacy assistance programs may either be funded entirely with state funds, or with both federal and state funds using an 1115 waiver. Wyoming offers a state-only funded prescription drug assistance program for low-income Medicaid ineligible individuals, as described in Chapter 1. Although 30 states offer pharmacy assistance programs, as of September 2003 only four states had approved 1115 Pharmacy Plus demonstration initiatives.



Source: *Pharmacy Plus Demonstrations Program Status.* Centers for Medicare & Medicaid Services, September 24, 2003.

Waiver Expansions – 1115 Pharmacy Plus Demonstration Initiative

The 1115 Pharmacy Plus Demonstration Initiatives allow states to provide prescription and over-the-counter drug coverage to Medicare beneficiaries and/or people with disabilities who are not eligible for full Medicaid up to 200 percent FPL. This initiative encourages the adoption of competitive private sector approaches to provide more cost-effective, modern prescription drug benefits. These 1115 programs assist beneficiaries by providing pharmaceutical products, aiding those who have private insurance coverage with high premiums and cost-sharing, and providing wrap-around pharmaceutical coverage.

	General Description	Cost Sharing
Florida	• Converted its state-only funded program into a demonstration program • Expanded eligibility to seniors with incomes below 120 percent of FPL	All enrollees have a benefit limit of: • $160 per month • $2 co-pay for generic drugs • $10 co-pay for drugs on the Medicaid Preferred Drug List, $30 for non-Preferred Drug List drugs
Illinois	• Moved enrollees from the state-only funded pharmacy benefit program into a demonstration that extended coverage to seniors at or below 200 percent of the FPL	• Enrollment fee of $25 and a $3 co-pay • Eligible individuals with private insurance coverage may choose a monthly rebate check of $25

Source: *Pharmacy Plus Demonstration Initiative.* Centers For Medicare And Medicaid Services *(*September 16, 2004). Available online: www.cms.hhs.gov/medicaid/1115/pharmacyplus.asp, 11/12/04.

Waiver Expansions – Case Studies

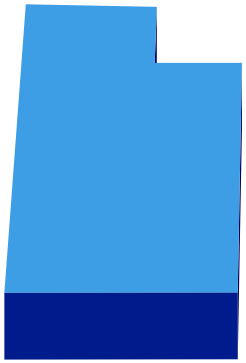
As states seek new and creative ways to expand coverage to their uninsured populations, innovative strategies emerge and the challenges in different approaches become more apparent. We describe three states' approaches in more detail on the following pages.

Expansion Case Studies
1. *Utah* reduced Medicaid benefits to expand primary care coverage to additional populations.
2. The *Oregon* Health Plan (OHP) aimed to expand Medicaid eligibility for children, pregnant women, and other adults by reducing benefits, increasing cost sharing and capping enrollment for previously eligible parents and other adults.
3. *Maine's* Dirigo Health Plan intends to expand coverage to every citizen in Maine within five years using a combination of state, federal and local funds.

Chapter Three provides a detailed discussion of premium assistance programs, and we present New Mexico and Idaho's premium assistance programs in that Chapter.

Waiver Expansion Case Studies – Utah's 1115 Medicaid Waiver

Utah was the first state to receive an 1115 federal waiver that allowed the reduction of the current Medicaid benefit package for certain beneficiaries to expand limited coverage to uninsured low-income populations. Utah's waiver encompasses the following two programs:



- The Primary Care Network (PCN) provides coverage to low-income parents and other adults using a limited benefit package. Utah financed this expansion by increasing cost sharing and reducing benefits to current "non-traditional" Medicaid beneficiaries.
- The Covered At Work Program uses Medicaid funds to provide premium assistance to those that would be eligible for the Primary Care Network, but have access to employer-sponsored health insurance.

These two programs are capped at 25,000 participants, which includes a cap of 6,000 participants for the Covered at Work Program. As of September 2004, PCN was at capacity.

While Utah's waiver is a part of a national initiative to give states more flexibility in approaches to increase coverage, a number of patient and advocacy groups are wary of such expansions because of their belief that it sets a precedent of cutting Medicaid benefits.

Source: Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, *Assessing State Strategies for Health Coverage Expansion: Profiles of Coverage: Arkansas, Michigan, New Mexico, New York, Utah, and Vermont.* Economic and Social Research Institute / Commonwealth Fund, State of Utah, Primary Care Network (September 13, 2004). Available online: http://www.cmwf.org/usr_doc/silow-carroll_sixstate_597.pdf, 11/12/04.

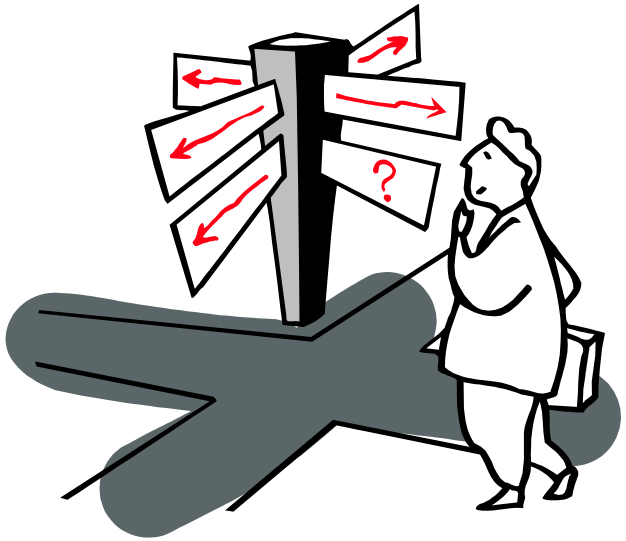
Waiver Expansion Case Studies – Challenges to Utah's Primary Care Network

Major obstacles to implementation have included barriers to enrollment, access to specialty services and beneficiaries' limited access to employer-sponsored insurance.

Barriers to Enrollment

The enrollment fee for the PCN was initially set at $50 (excluding children). This fee became a barrier to enrollment for very low-income individuals, and two solutions emerged to encourage eligible families to enroll:

- Not-for-profit organizations provided some financial support to cover the enrollment fee.
- The legislature agreed to reduce the fee to $15 for very low-income individuals (i.e., those who make less than $300) and to use state funds to cover the remaining $35. The Department of Health also provided a subsidy so that those enrolled in the PCN program through their involvement with the Department of Workforce Services paid only a $15 enrollment fee.



Source: *Profiles in Coverage: Utah's Primary Care Network,* State Coverage Initiatives (November 2003). Available online: http://www.statecoverage.net/pdf/utahprofile.pdf (11/15/04).

Waiver Expansion Case Studies – Challenges to Utah's Primary Care Network

Access to Specialty Services

- Previously, Utah funded the Medical Assistance Program (UMAP), which provided low-income individuals with serious medical conditions specialty and emergency coverage.
- The PCN program replaced UMAP and shifted the state's focus to providing primary care anticipating that the private insurance market would somewhat replace UMAP and supplement PCN by providing coverage for specialty and catastrophic care. Unfortunately, this has not occurred and as a result, PCN beneficiaries have reported difficulty accessing specialty care.
- While several community and physician groups have come together to create a referral charity system to provide needed specialty physician services, it remains to be seen if this system will be adequate long-term.

Access to Employer-Sponsored Insurance

- In February 2002, House Bill 122 was passed, allowing private insurers to offer employers the same limited benefit package as the PCN to similar populations in hopes of expanding private health insurance coverage without expanding public programs.
- No private insurance company has yet to offer a product similar to PCN.

Sources: *Profiles in Coverage: Utah's Primary Care Network,* State Coverage Initiatives (November 2003). Available online: http://www.statecoverage.net/pdf/utahprofile.pdf (11/15/04).
Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, *Assessing State Strategies for Health Coverage Expansion: Profiles of Coverage: Arkansas, Michigan, New Mexico, New York, Utah, and Vermont.* Economic and Social Research Institute / Commonwealth Fund, State of Utah, Primary Care Network (September 13, 2004). Available online: http://www.cmwf.org/usr_doc/silow-carroll_sixstate_597.pdf, 11/12/04.
Wu Xu, Norman Thurston, Mike Martin, and Keely Cofrin, *Outcome Evaluations of Utah's Primary Care Network (PCN)*. Utah Department of Health's Office of Health Care Statistics, June 2004.

Waiver Expansion Case Studies – Challenges to Utah's Primary Care Network

Tracking Charity Care Expenditures

- The dissolution of UMAP has been of concern to Utah's hospitals. Without public coverage, previous UMAP beneficiaries are reliant on the charity care provided by hospitals.
- To gain buy-in from hospitals, the State promised the Utah Hospital Association that their members would have to provide only $10 million in charity care annually. Going forward, the State will need to track and control this expense by:
  - Certifying uninsured Utah citizens who were least able to pay by qualifying them for PCN, thus allowing hospitals to focus their collection efforts.
  - Triaging patients and directing referrals as evenly as possible.

Source: *Profiles in Coverage: Utah's Primary Care Network,* State Coverage Initiatives (November 2003). Available online: http://www.statecoverage.net/pdf/utahprofile.pdf (11/15/04).

Waiver Expansion Case Studies- Oregon's 1115 Medicaid Waiver Program

Oregon used an 1115 waiver to expand Medicaid eligibility for children, pregnant women and other adults, making the following adjustments to coverage for previously eligible parents and adults:

- Reducing benefits
- Increasing cost sharing
- Capping enrollment

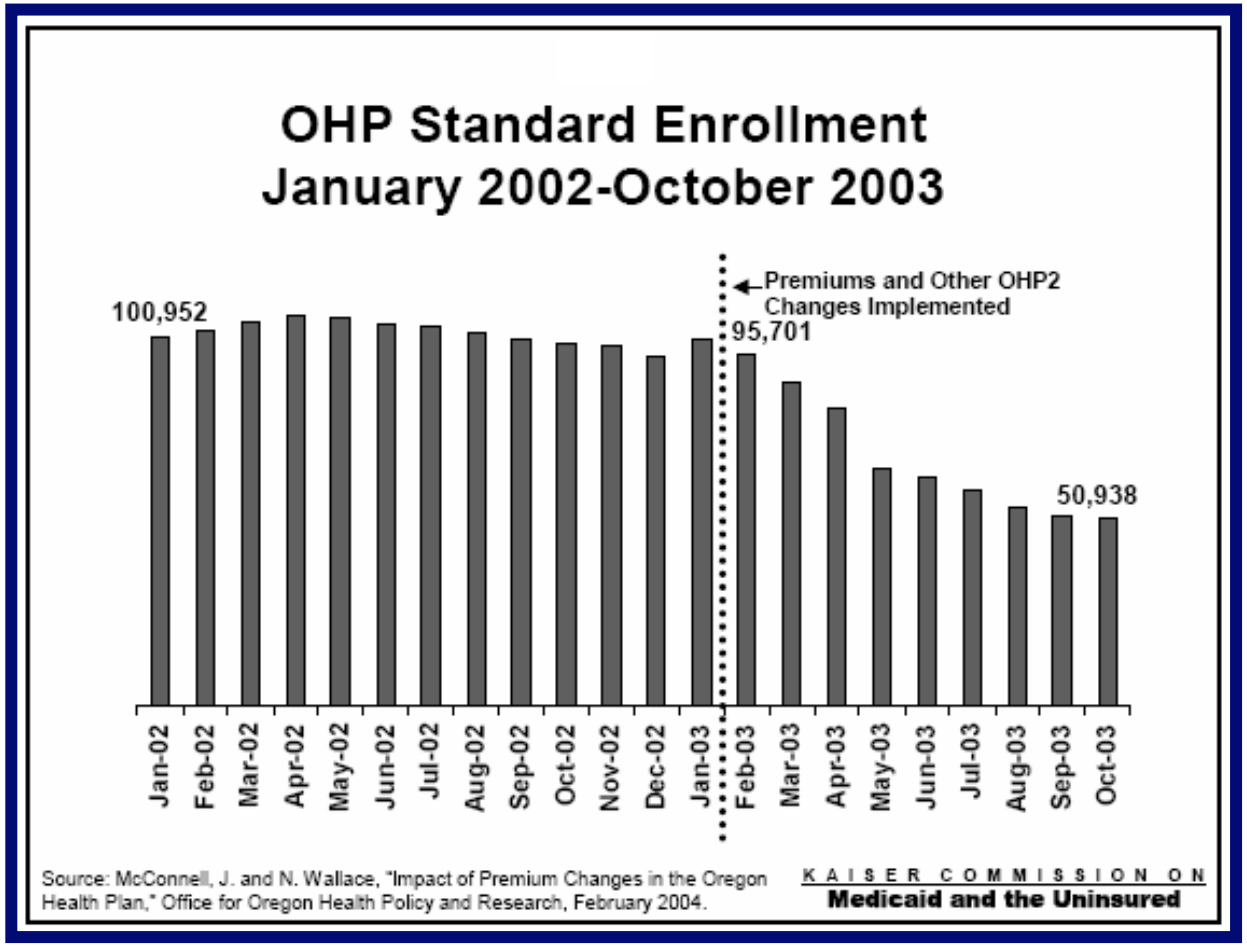
The State also expanded a pre-existing state-funded premium assistance program by using SCHIP funds.

The Oregon waiver allowed the state to implement the reduction part of the waiver without simultaneously implementing the expansion. As a result, Medicaid coverage losses were greater than coverage gains, leading to reduced enrollment.

Source: *Oregon Section 1115 Waiver Fact Sheet.* Kaiser Family Foundation (April 2, 2003). Available online: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14330, 11/12/04.

Waiver Expansion Case Studies – Challenges to Oregon's 1115 Medicaid Waiver Program

Reductions in enrollment in OHP Standard Enrollment over time:



The waiver application estimated that 60,000 people would gain coverage; however, only 2,000 people had gained coverage as of late 2003 while 50,000 had lost coverage by this date.

Source: Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program.* Kaiser Commission on Medicaid and the Uninsured, June 2004..

Waiver Expansion Case Studies – Challenges to Oregon's 1115 Medicaid Waiver Program

Oregon's 1115 waiver allowed the state to drop coverage after one missed premium payment. All individuals subject to the new Medicaid premiums had significant coverage losses and individuals with the lowest incomes experienced the greatest coverage losses.

Proportional Change in Enrollment by FPL and Family type

Percentage drop in enrollment, from average enrollment in 2002 to enrollment in October, 2003

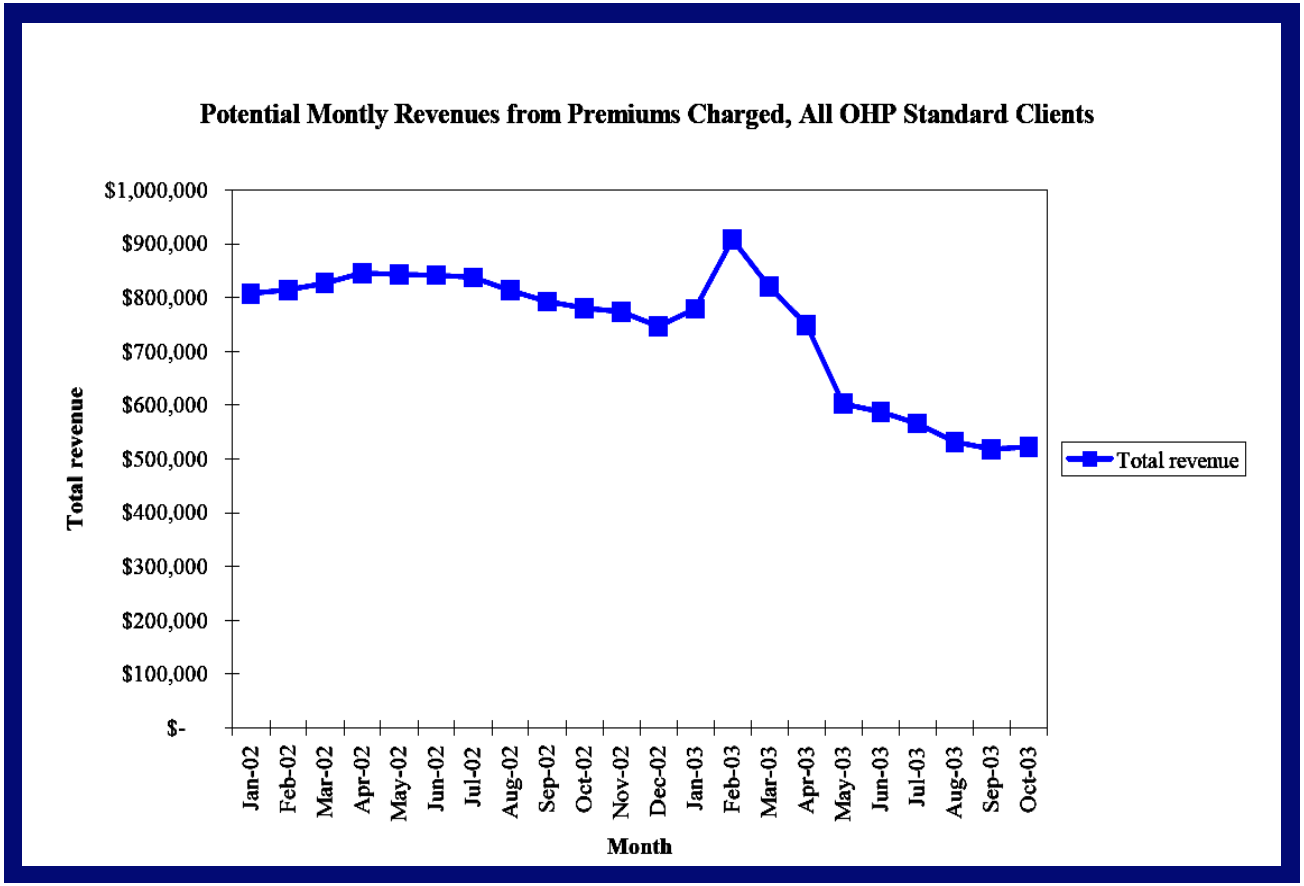
	1-Person cases with no children	1-Person cases with children	2-Person cases with no children	2-Person cases with children
Zero Income	55.3%	79.0%	55.2%	74.7%
0-10% FPL	41.9%	64.6%	35.9%	54.9%
10-50% FPL	41.0%	53.5%	37.8%	54.4%
50-65% FPL	36.1%	44.2%	35.8%	44.7%
65-85% FPL	39.3%	41.6%	39.9%	50.0%
85-100% FPL	36.8%	44.2%	38.9%	50.7%

Sources: Cindy Mann and Samantha Artiga, *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program.* Kaiser Commission on Medicaid and the Uninsured, June 2004.
John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan.* The Office for Oregon Health Policy and Research, February 2004.

Waiver Expansion Case Studies – Challenges to Oregon's 1115 Medicaid Waiver Program

Reductions in Medicaid also appeared to increase pressures on other segments of Oregon's health care system. The number of emergency room visits by uninsured patients increased by 17 percent in the three months after the changes had been implemented, compared to the previous year.

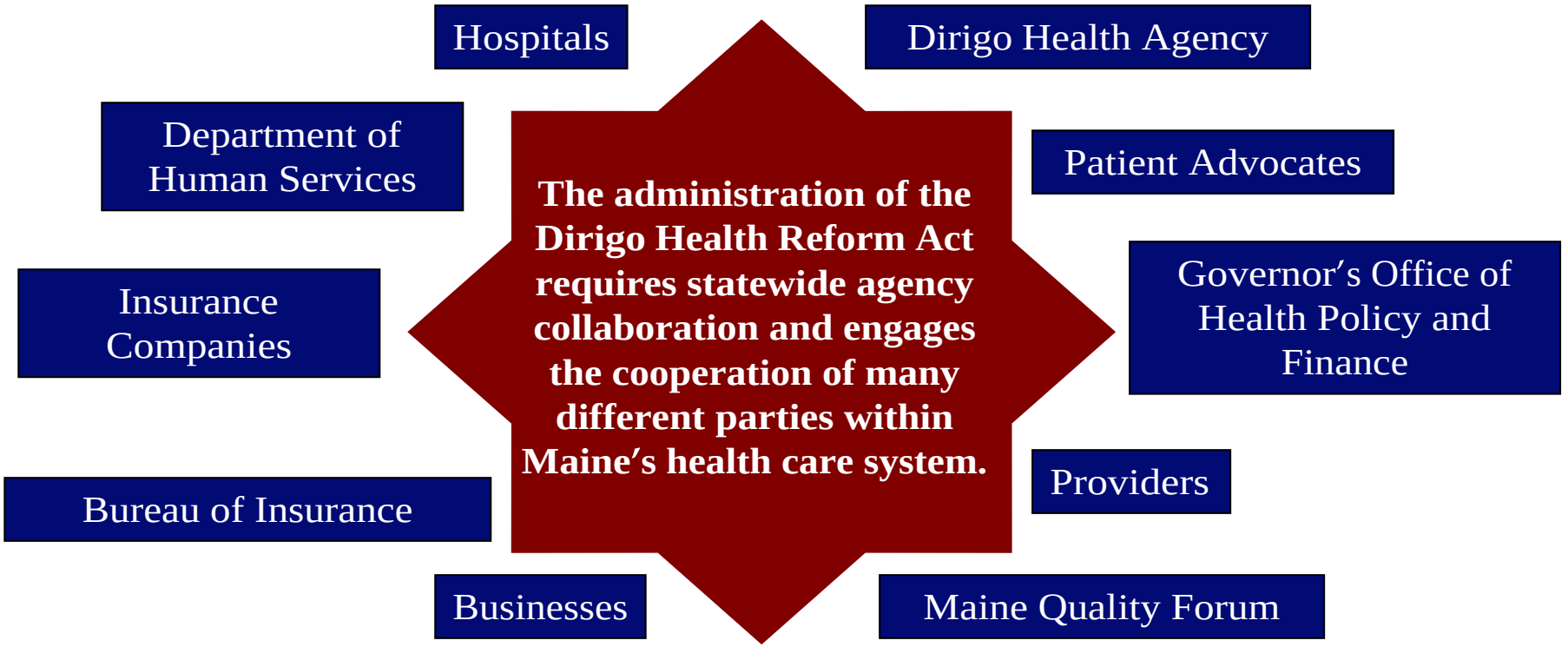
Due to enrollment declines, Medicaid savings were achieved; however, these declines led to decreases in Oregon's premium collections and federal matching funds.



Sources: *Individual Characteristics of Patients in the OHSU Emergency Room.* Oregon Health Research and Evaluation Collaborative, February 2004.
John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan.* The Office for Oregon Health Policy and Research, February 2004.

Waiver Expansion Case Studies – Maine's Dirigo Health Reform Act

The purpose of this Act is to assure every citizen of Maine access to quality, affordable healthcare within five years. Signed into law on June 18, 2003, this Act attempts to address cost, quality and access simultaneously under the assumption that addressing each component of healthcare delivery individually will not lead to long-term reform.



Waiver Expansion Case Studies – Maine's Dirigo Health Reform Act

The creation of Dirigo Health Plan will expand eligibility to provide access to health care for all Maine citizens and to offer a full range of necessary benefits while maintaining cost-effectiveness and quality.

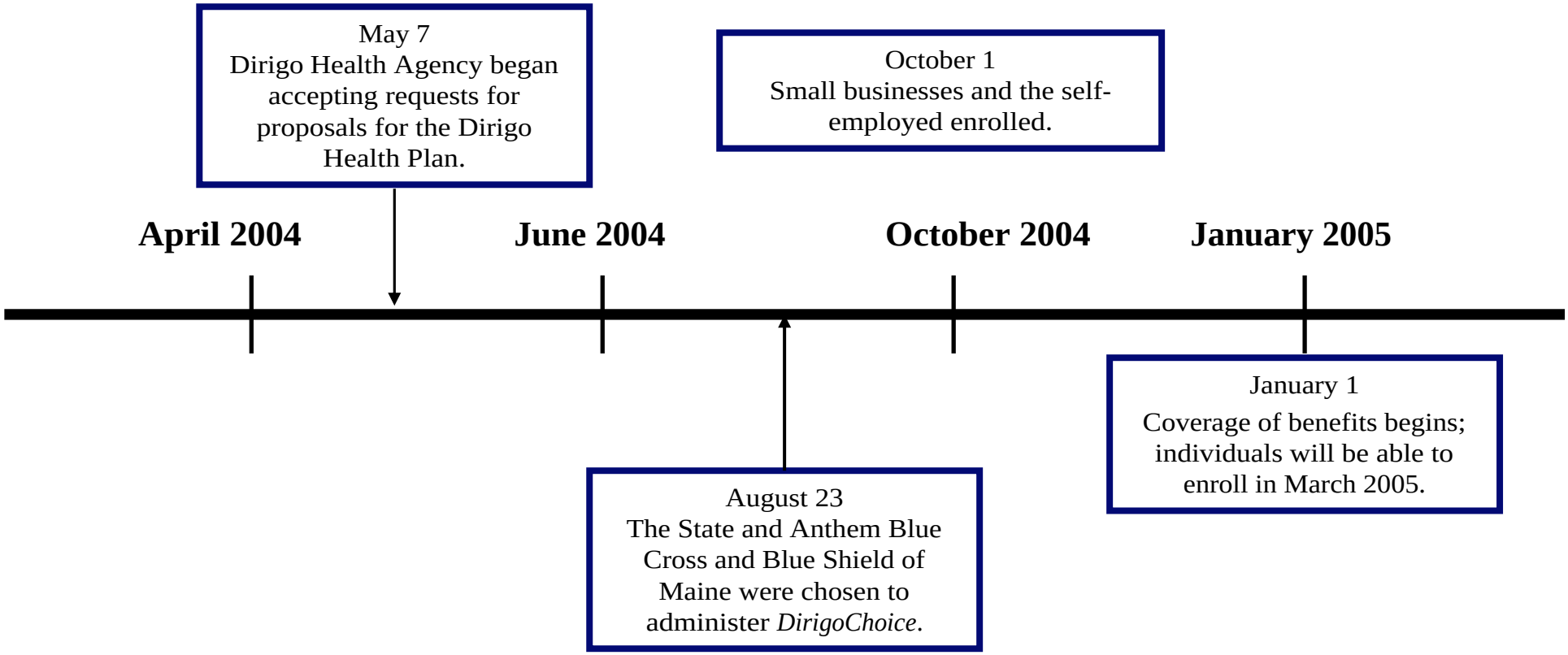
Cost Containment	Quality Assurance	Healthcare Access
• Biennial state health planning • Hospital planning • Public price disclosure • Simplification of administrative functions and reduction of paperwork • Enhanced public purchasing • Oversight of insurance costs • Reduction in cost shifting • Voluntary limits on growth of insurance premiums and healthcare costs	• Involvement of a Quality Watchdog Group (Maine Quality Forum) • Effective use of data	• Expand eligibility for individuals and small and medium sized businesses • Provide comprehensive benefits • Use large group bargaining to lower costs of participation

Source: Jill Rosenthal and Cynthia Pernice, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality and Access in Maine*. June 2004.

The Dirigo Health Plan anticipates providing universal access to health care by helping Maine's small businesses offer coverage to employees through discounts and expanding eligibility under Maine Care to cover the uninsured up to 300 percent of the FPL.

Waiver Expansion Case Studies – Maine's Dirigo Health Reform Act

The Dirigo Health Agency expects to enroll 31,000 people in the first year and the State's plan to expand coverage has proceeded as follows:



Source: *Maine's Dirigo Health Reform Act, A First-Year Progress Report*, Governor's Office of Health Policy and Finance (September 13, 2004). Available online: http://www.dirigohealth.maine.gov/09-13-04%20Annual%20Report.pdf, 11/15/04.

Waiver Expansion Case Studies – Maine's Dirigo Health Reform Act

The components of the *DirigoChoice* plan are*:*

- 100 percent coverage of preventive care
- Mental health parity
- Comprehensive benefits package
- Incentives to participate for small businesses, the self-employed and individuals
- Payment to providers at negotiated, commercial rates

The Dirigo Health Program is projected to cost approximately $90 million in its first year and then become self-funded. In 2004 only, the State will contribute $53 million from State general revenue funds.

***DirigoChoice* Proposed Rates**
• $310 per month for individuals
• Financial discount program based on income allows affordable health insurance
• Community rating based on Preferred Provider Organization (PPO) block of business

Waiver Expansion Case Studies – Maine's Dirigo Health Reform Act

Future funding for Maine's Dirigo Health Program is expected to come from five sources:

1. $50 million in federal subsidies
2. Four percent fee that will be assessed on gross revenue of insurers and administrators; the assessment will be eliminated once the state can document cost savings.
3. Premiums paid by employers and the insured
4. Cost savings resulting from less charity care and bad debt
5. Federal Medicaid fund

Selected Challenges To Date

1. Employer participation may be challenging due to concerns about the costs of the Dirigo Health Plan and increased administrative burden.
2. Extensive stakeholder involvement is critical due to the broad reach of this program.
3. Tracking the cost savings resulting from increased coverage may be administratively burdensome.

Source: *Employers are Key to Success of DirigoChoice Health Plan.* Times Record, September 1, 2004.

The Dirigo Health Agency plans to extend health insurance to all of Maine's citizens by 2009.

Overall Expansion Challenges

Regardless of the expansion type chosen, there are specific benefits and challenges inherent in the policies that these expansions may use:

Capping enrollment for existing beneficiaries →

Benefits:

Provides greater budget predictability

Challenges:

May not allow for coverage of all uninsured individuals in the target population, and may result in potential delays and/or denials for eligible individuals

Narrowing benefit packages and implementing premiums and/or cost sharing for new beneficiaries →

Benefits:

Focuses the impact of limited state expenditures and mimics the private insurance market

Challenges:

Creates potential new barriers to access to care for new beneficiaries, especially for those with significant medical needs

Overall Expansion Challenges

Using Medicaid and SCHIP funds for premium assistance by subsidizing coverage that does not meet Medicaid or SCHIP benefit package standards

→

Benefits:

Supports the private market and reduces crowd-out; potentially increases access to providers who might not otherwise take Medicaid or SCHIP payment

Challenges:

Potentially increases access barriers due to limited benefits, cost sharing and other coverage restrictions

Using SCHIP funds for adults without dependent children

→

Benefits:

Expands coverage to a previously uninsured population; uses federal funding

Challenges:

Potentially reduces funding for children in future years

Overall Expansion Challenges

Implementing different benefits and cost sharing obligations for different groups of beneficiaries

Benefits:

Provides states with the ability to target expenditures and adjust policies to the specific characteristics of different target populations

Challenges:

Increases administrative complexity; confusion among beneficiaries and providers could possibly lead to decreased participation

Conclusion

While states have many policy options available to them, the success of expansions programs is largely dependent on state-specific factors such as available funding and employer participation. Many of these expansions combine funding sources and their corresponding regulations, resulting in highly complex programs that states must implement and maintain. The following Chapter will provide expansion options through premium assistance.

Chapter Three Introduction

Chapter Three provides an overview of premium assistance strategies under Medicaid and SCHIP funding. The Chapter contains detailed descriptions of what premium assistance approaches states may use under waiver and non-waiver programs, and provides two state case studies.

Medicaid Premium Assistance

States may use the following two premium assistance options under their Medicaid programs.

Medicaid Programs	Description and Requirements of Medicaid Premium Assistance Program Strategies
Health Insurance Premium Payment (HIPP) (See Chapter 1 page I-27)	• States can use Medicaid funds to pay premiums and deductibles of Medicaid beneficiaries and their family members who choose to enroll in group health plans. • States must provide beneficiaries access to all the benefits covered under the state's regular Medicaid program through the provision of "wrap-around" coverage.
Ticket to Work (See Chapter 2, page II-31)	• States can use Medicaid funds to buy employer-sponsored insurance in order to supplement Medicaid coverage for working people with disabilities. • States are free to establish their own income and resource standards.

Source: Barbara Yondorf, Laura Tobler, and Leah Oliver, *State Options for Expanding Health Care Access*. National Conference of State Legislatures, March 2004.

SCHIP Premium Assistance

States may also use premium assistance programs as part of their SCHIP programs.

SCHIP Premium Payment Description and Requirements

- States may pay:
  - Part of the premiums for employer-sponsored insurance for eligible children
  - Employer-sponsored insurance premiums for parents of eligible children when the state subsidizes a family premium for eligible children
- States must comply with federal regulations to avoid replacing private insurance in the marketplace with public insurance ("crowd-out"). These regulations include:
  - Making premium assistance available only to SCHIP eligible individuals who have been uninsured for six months and have completed a "reasonable" waiting period
  - Identifying reasonable minimum employer contribution levels that are representative of the state's employer-sponsored market
  - Extending the minimum benefits and cost-sharing protections established under the SCHIP statute by providing wrap-around coverage
- States must determine whether it is cost-effective to cover an uninsured child under employer-sponsored insurance rather than enrolling the child in SCHIP.

Medicaid and SCHIP Premium Assistance

Medicaid and SCHIP premium assistance programs are limited by federal regulations. State and beneficiary participation in Medicaid and SCHIP premium assistance programs has been low, in part due to the restrictive regulations and the administrative burden of these programs.

Enrollment of Medicaid/SCHIP Eligibles in Section 1115 Premium Assistance Programs

State	Date Enrollment Began	Number of Medicaid/ SCHIP Eligibles Receiving Premium Assistance	Percent Participating in Premium Assistance
MA	August 1998	6,800	.76%
MD (SCHIP)	July 2001	*101	< .5%
NJ (SCHIP)	July 2001	721	< .5%
OR	July 1998	1,080	< .5%
RI	February 2001	3,500	2.99%
VA (SCHIP)	September 2001	*26	< .5%
WI	July 1999	*98	< .5%

**Refers to the number of families, not individuals. For these states, a family of four was assumed to estimate the percentage of individuals receiving premium assistance.*

Source: *Serving Low-Income Families Through Premium Assistance: A Look At Recent State Activity*. Kaiser Commission on Medicaid and the Uninsured, October 2003.

The introduction of HIFA in August 2001 encouraged state premium assistance program enrollment by relaxing federal cost-sharing and benefit barriers, as described on the following pages.

HIFA Premium Assistance

Under HIFA, states may give beneficiaries two coverage options: a direct state coverage plan and/or employer-sponsored insurance coverage. States are allowed additional flexibility in regards to premium assistance program design under a HIFA waiver, specifically:

Flexibility Under HIFA Premium Assistance

- For optional Medicaid and SCHIP eligibles, states are no longer required to offer wrap-around benefits and cost-sharing protections
- States may waive the federal requirement regarding the minimum employer contribution.

Sources: *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity*. The Kaiser Family Foundation, October 2003.
Claudia Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs.* The National Academy for State Health Policy, April 2003.

States still need to monitor the costs of HIFA premium assistance programs to make sure costs are not significantly higher than costs from direct coverage.

Comparison of Premium Assistance Programs

The following is a comparison of Medicaid HIPP, SCHIP and HIFA premium assistance options.

	Medicaid HIPP	SCHIP	HIFA
Cost-Effectiveness	• Cost of employer-sponsored insurance may not be greater than the cost of direct coverage • Cost-effectiveness may be measured on individual or aggregate basis		No specific cost-effectiveness test, although aggregate costs must not be "significantly higher" than costs in public program
Covering Non-Eligibles	Non-eligible family members enroll if: • Enrollment is required to obtain coverage for the Medicaid eligible • Enrollment is cost-effective	• States can purchase family employer-sponsored insurance coverage through SCHIP premium assistance by obtaining a family coverage waiver. • Coverage for non-eligibles must be cost-effective and cannot substitute for private insurance.	• States may cover optional and expansion populations, including childless adults. • Generally CMS has not permitted coverage above 200 percent FPL unless the state has already reached significant coverage below that level.

Sources: Claudia Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs.* The National Academy for State Health Policy, April 2003.
Richard E. Curtis and Edward Neuschler, *Premium Assistance*. Creative Solutions: Vol. 13, No. 1. Available online: http://www.futureofchildren.org /usr_doc/tfoc13-1p.pdf, 11/12/04.

Comparison of Premium Assistance Programs

	Medicaid HIPP	SCHIP	HIFA
Benefits	Beneficiaries must have access to full Medicaid benefits either through employer-sponsored insurance or wrap-around coverage.	Covered children must receive benefits meeting one of the SCHIP benchmarks packages.	Primary care is the only required benefit, including immunization for SCHIP eligible children.
Cost-Sharing	Cost-sharing must be "nominal" and children are excluded.	• For all children enrolled in SCHIP, cost-sharing cannot exceed five percent of family income. • Only cost-sharing for the children in the family must be counted toward the cumulative cost-sharing maximum. • Cost-sharing is not permitted for preventive care.	There is no specific standard for cost-sharing.

Sources: Claudia Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs.* The National Academy for State Health Policy, April 2003.
Richard E. Curtis and Edward Neuschler, *Premium Assistance.* Creative Solutions: Vol. 13, No. 1. Available online: http://www.futureofchildren.org /usr_doc/tfoc13-1p.pdf, 11/12/04.

Comparison of Premium Assistance Programs

	Medicaid HIPP	SCHIP	HIFA
Insurance Status	Beneficiaries are eligible regardless of current coverage status.	Beneficiaries are ineligible if they already have group health coverage.	States may request to use federal matching funds to subsidize some applicants who are already insured.
Employer Contribution	No minimum employer contribution	• State must establish a minimum employer contribution. • There is no minimum percentage specified by federal regulations; however, the general employer contribution is around 30 to 40 percent.	States can request a waiver of the federal requirement to specify a minimum employer contribution.
Substitution of Private Coverage Politicies	Applicants are eligible for premium assistance if they already have employer coverage.	Eligible children must not have been covered by group health insurance coverage for six months before enrollment, but reasonable exceptions are permitted.	None specified
Mandatory Enrollment	Enrollment can be mandatory.	If enrollment is mandatory, employer plans must meet SCHIP standards for review of health services decisions.	None specified

Sources: Claudia Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs.* The National Academy for State Health Policy, April 2003.

Premium Assistance Case Studies – New Mexico's 1115 Medicaid Waiver

New Mexico received approval for an 1115 HIFA waiver in April 2002 to use SCHIP funds to provide premium assistance for a state-established reduced commercial benefit package administered by managed care companies under contract with the state. Premiums and other cost-sharing are dependent on both income level and participation of a contributing employer.

Eligible Under Waiver	• Parents 37 to 200 percent of the FPL • Blind and disabled adults up to 200 percent whose incomes exceed SSI levels (74 percent FPL) All eligibiles must be between the ages of 19-64 and not have not voluntarily dropped commercial coverage in the last six months.		
Premiums	*Premiums for Individuals*	*With Contributing Employer*	*Without Contributing Employer*
	0-100 percent FPL	$0 per month	$75 per month
	101-150 percent FPL	$20 per month	$95 per month
	151-200 percent FPL	$35 per month	$110 per month
Other Cost-Sharing (no groups are exempt)	*0-100 percent FPL*	*101-150 percent FPL*	*151-200 percent FPL*
	Co-payments range from $5-$100 depending on services rendered.	Co-payments range from $10-$100 depending on services rendered.	Co-payments range from $10-$150 depending on services rendered.

Source: *State Children Health Insurance Program (SCHIP) Approved Section 1115 Demonstration Projects.* The Centers for Medicaid & Medicare Services (July 12, 2004). Available online: http://www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14328, 11/12/04.

Premium Assistance Case Studies – New Mexico's 1115 Medicaid Waiver

The benefit package is similar to that of a basic commercial plan and includes the following services:

Benefit Package	
• Inpatient and outpatient hospital services • Emergency care and transportation • Primary and specialty care • Preventive health services • Physical therapy, occupational therapy and speech therapy • Skilled nursing and inpatient physical rehabilitation	• Home health services • Durable medical equipment • Pharmaceuticals • Lab/diagnostics/x-rays • Behavioral health and substance abuse • Reconstructive surgery • Diabetes treatment

Source: *New Mexico State Coverage Initiative.* New Mexico Human Services Department, August 2004.

While New Mexico has not yet implemented this program due to a change in administration in January 2003, the new governor plans to fully implement the program.

Premium Assistance Case Studies – New Mexico's 1115 Medicaid Waiver

The State's goal is to reduce the number of uninsured adults by 10 percent, and New Mexico projects that coverage will reach a total of 40,000 adults.

Funding	• New Mexico will use its unspent SCHIP allotment to cover uninsured childless adults, and use regular Medicaid matching funds to cover parents. • If SCHIP funds are insufficient, the State may limit enrollment for single childless adults and fund the parents of Medicaid and SCHIP children through regular Medicaid matching funds.
Enrollment	• In the first year of the program, New Mexico plans to fund 7,500 uninsured childless adults and 7,500 parents from SCHIP funds. • New Mexico plans to cover 11,000 uninsured childless adults and 29,000 parents by the conclusion of the demonstration period through unused SCHIP funds and federal matching.

Source: *New Mexico Application Template for Health Insurance Flexibility and Accountability (HIFA) Section 1115 Demonstration Proposal* (November 10, 2004). Available online: http://www.state.nm.us/hsd/mad/pdf_files/GeneralInfo/HIFAWaiver9302.pdf, 11/12/04.

New Mexico's waiver proposal is both allotment and budget neutral.

Premium Assistance Case Studies – Idaho Access Card 1115 Medicaid Waiver

Idaho has two premium assistance initiatives in various stages of development, as follows.

Program	Status	Description
Children's Access Card – premium assistance program administered in partnership with private insurance companies	Approved on November 4, 2004	• *Eligibility:* Targets children eligible for Idaho's CHIP-A and CHIP-B programs, which provide coverage to children up to 185 percent of the FPL • *Benefits:* Determined by the recipient's choice of private coverage, with the exception of the required inpatient/outpatient hospital and physician clinic/surgical services • *Premium assistance:* Idaho makes premium assistance payment directly to insurance companies in the amount of $100 per eligible up to $300 per month for families with three or more children. • *Enrollment:* Legislation effective July 1, 2004 authorized up to 5,600 children.

Source: *CHIP-B/Access Card Programs*. Idaho Department of Health and Welfare (September 10, 2004). Available online: http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3351/DesktopDefault.aspx, 11/12/04.
Patti Campbell, Program Manager, Idaho Access Card, Telephone interview (November 2, 2004).

Premium Assistance Case Studies – Idaho Access Card 1115 Medicaid Waiver

Program	Status	Description
Adult Access Card, or the Small Business Health Insurance Premium Program	Submitted waiver in November 2004	• *Eligibility:* Parents of Medicaid or SCHIP children up to 185 percent of the FPL, pregnant women 133 to 185 percent of the FPL and childless adults through 185 percent of the FPL. Individuals must be either employed by a small business (2 to 50 employees) or be spouses of an employee in a small business. • *Benefits:* Determined by the employer's coverage • *Employer contribution:* Employers pay at least 50 percent of the cost of an eligible adult's premium • *Premium assistance:* Idaho makes premium assistance payment directly to insurance companies in the amount of $100 per eligible up to $300 per month for families with three or more children. • *Enrollment:* Limited to 1,000 adults

Source: *CHIP-B/Access Card Programs*. Idaho Department of Health and Welfare (September 10, 2004). Available online: http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3351/DesktopDefault.aspx, 11/12/04. Patti Campbell, Program Manager, Idaho Access Card, Telephone interview (November 2, 2004).

Premium Assistance Case Studies – Idaho Access Card 1115 Medicaid Waiver

Funding

- State match for CHIP-B and the Access Card programs comes from a premium tax imposed on all entities that sell insurance (not just health insurance) in Idaho.
- Administrative costs are paid for by the State's General Fund.
- Additional start-up funds were received through the Coalition for Covering Kids and Families.
- The children's portion of the waiver has limited funding from the SCHIP allotment.

Cost-sharing

- Premium assistance cost sharing requirements are set by private or employer-based insurance for children whose parents enroll them in the Access Card program. This will also apply to the Adult Access Card program.
- Adults who choose premium assistance will have cost-sharing requirements as set by their private or employer-based insurance coverage.

Source: *CHIP-B/Access Card Programs*. Idaho Department of Health and Welfare (September 10, 2004). Available online: http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3351/DesktopDefault.aspx, 11/12/04.
Patti Campbell, Program Manager, Idaho Access Card, Telephone interview (November 2, 2004).

Premium Assistance Case Studies – Idaho Access Card 1115 Medicaid Waiver

Administration

- One administrative unit processes all premium payments from parents and also pays the insurers.
- Idaho has eight staff members to handle all administrative roles, including eligibility determination, clerical and supervisory tasks.
- Staffing numbers are sufficient to manage the administrative tasks for the enrollment numbers they received.

Monitoring

- The State will capture billing information from private insurance companies when Access Card participants submit an invoice for reimbursement of a premium assistance subsidy. The State will use this information to determine the per member per month costs.
- Through monitoring, Idaho will demonstrate cost-effectiveness, such that the costs under the waiver are not significantly higher than the cost of direct coverage.

Source: *CHIP-B/Access Card Programs*. Idaho Department of Health and Welfare (September 10, 2004). Available online: http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3351/DesktopDefault.aspx, 11/12/04.
Patti Campbell, Program Manager, Idaho Access Card, Telephone interview (November 2, 2004).

Idaho's expansion program required over a year of planning and approval for the children's Access Card waiver was delayed from February to November of 2004.

Challenges to Premium Assistance Programs

Premium assistance programs, while providing a strong link to the workforce, have several challenges that states need to address during planning, implementation and administration of these programs.

Challenges to Medicaid Premium Assistance Programs

- Low-income families may face higher out-of-pocket costs in a premium assistance program as compared to under Medicaid.
- Even low levels of cost-sharing may negatively impact health care utilization and health outcomes.
- Private benefit packages are generally less comprehensive than that of Medicaid.
- Administrative services are costly and lack of staffing may limit enrollment.
- Low-wage employees generally work in industries that have limited access to employer-based coverage.
- Beneficiaries are subject to instability in the private market, such as increased cost-sharing policies.
- Beneficiaries may have concerns regarding increased cost-sharing, possible longer waiting periods for enrollment and concerns about confidentiality and job mobility.

Source: *Serving Low-Income Families Through Premium Assistance: A Look At Recent State Activity*. Kaiser Commission on Medicaid and the Uninsured, October 2003.

Issues Related to Successful Implementation of a Premium Assistance Program

The report "Evaluating Strategies for the Effective Development of the WYO-Care Health Plan," produced for Wyoming's Healthcare Commission, outlined several issues related to successful implementation of a premium assistance program, which are summarized on the following slides.

The State needs strong political leadership and acceptance of defined goals regarding health coverage expansion. Establishing specific goals increases the legislators' ability to enact reforms.

Promoting employer-sponsored insurance to the public is a challenge. States need to educate businesses on misconceptions of program requirements, administrative burdens, and financial burdens.

It is important to foster communication with stakeholders. Programs that require private plan participation benefit from feedback. States should promote public forums with patient advocacy groups and providers.

States have seen the greatest success when expanding coverage under one program across different eligibility groups. Under one program, for example, states may benefit from more public and legislative support, less administrative complexity and improved coverage for families.

Source: Steven J. Manley and George B. Bryce, *Evaluating Strategies for the Effective Development of the "Wyo-Care" Health Plan* (September 27, 2004). Available online: http://www.wyominghealthcarecommission.org/_docs/FINALREPORT083004.doc, 11/12/04.

Issues Related to Successful Implementation of a Premium Assistance Program

Careful determination of program features contribute largely to the success of the program. For example, states may want to consider:

- Rules to reduce adverse selection and promote higher participation rates
- Precise definitions of: full-time vs. part-time employment status
- Employer eligibility requirements for small firms vs. large firms
- Methods to determine if an employer offers insurance
- Premium contribution levels
- Benefit package design that are more affordable to small businesses: comprehensive versus basic general coverage packages
- Assessment on how program would fit into existing administrative structure to keep administrative costs low
- Adjustment of employee eligibility requirements to target beneficiaries based on length of time without insurance, length of time as a resident, job tenure and benefits under other programs
- Emphasis on wellness, prevention and care coordination
- Amount of subsidy based on income requirements

Source: Steven J. Manley and George B. Bryce, *Evaluating Strategies for the Effective Development of the "Wyo-Care" Health Plan* (September 27, 2004). Available online: http://www.wyominghealthcarecommission.org/_docs/FINALREPORT083004.doc, 11/12/04.

Conclusion

Premium assistance programs allow states a unique opportunity to achieve efficiencies through coordinating with private insurance. These programs, however, require detailed planning, implementation and monitoring efforts. The following Chapter provides Wyoming-specific models for coverage expansions.

Chapter Four Introduction

The previous three chapters provided an overview of Wyoming's public insurance programs, other states' expansion efforts and specific information on premium assistance coverage options. Chapter Four describes how Wyoming-specific policy goals and characteristics will influence its coverage expansion options, and what Wyoming-specific models the State may want to consider. Chapter Five provides the cost-effectiveness analyses that correspond to these Wyoming-specific models.

As part of this Chapter, we evaluate each model and the corresponding approaches to achieving the cost-savings necessary for implementation to the Wyoming-specific goals and characteristics described in Chapter Five.

Wyoming-Specific Goals

Wyoming's goals for creating a coverage expansion program may lead to very specific policy plans, as described below.

Goal	Rationale	Potential Recommended Policy
Promote employer-based private insurance	• Wyoming's ability to support and strengthen private employer efforts to expand health insurance will reduce the amount of publicly-funded resources needed to provide health care coverage. • In 2002, 79 percent of Wyoming resident workers and 55 percent were eligible to receive insurance benefits.	Use a premium assistance program as part of the State's expansion effort

Sources: *Private Sector Employee Access to Health Insurance and the Potential Wyo-Care Market.* Wyoming Department of Employment, Research, and Planning, September 2004.
Percent of Private Sector Establishments that Offer Health Insurance to Employees. Kaiser Family Foundation State Health Facts Online (2002). Available online: http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Wyoming&category=Health+Coverage+%26+Uninsured&subcategory=Private+Sector+Coverage&topic=Percent+of+Firms+Offering+Coverage, 11/12/04.

Wyoming-Specific Goals

Goal	Rationale	Potential Recommended Policy
Maintain expansion costs within budget constraints	• Wyoming has limited state funding available. • Wyoming Medicaid expenditures rose approximately 20 percent from SFY 2002 to 2003.	Limit program enrollment to a specific number of participants ("capping enrollment")
Obtain federal matching funds	• Using federal matching funds reduces Wyoming's state expenditures for an expansion by over half. • The federal government will pay 58 cents for every dollar spent on Wyoming's Medicaid services, and 71 cents for every dollar spent on Wyoming's SCHIP services (FFY 2005 federal matching rates).	Expand coverage through a Medicaid or SCHIP waiver

Sources: *Federal Medical Assistance Percentages and Enhanced Federal Medical Assistance Percentages,* Federal Register Vol. 68, No. 232 (December 3, 2003). *Wyoming Draft Long-Term Strategic Plan for Reimbursement, SFY 2004.* State of Wyoming Department of Medicaid.

Wyoming-Specific Goals

Goal	Rationale	Potential Recommended Policy
Provide health care coverage to the working poor	• Promotes participation in the workforce • Provides entire family units with coverage as opposed to only pregnant women and children	Provide coverage to the following populations, in order of priority: • Parents of Medicaid children • Parents of children in Wyoming's SCHIP Program ("KidCare CHIP") • Childless poor adults *Note: It is likely that more SCHIP parents are participating in the workforce than Medicaid parents due to differences in family earnings between these populations.*

Source: *Highlights – National Health Expenditures, 2002*, Centers for Medicare and Medicaid Services, (2002). Available online: www.cms.hhs.gov/statistics/nhe/historical/highlights.asp, 11/5/04.

Wyoming-Specific Goals

Goal	Rationale	Potential Recommended Policy
Reduce the fiscal burden on health care providers of providing health care services to the uninsured	The fiscal burden of providing care to the uninsured challenges the ability of health care providers to continue delivering health care services. Wyoming's rural and frontier nature means the participation of each health care provider in the state is critical to maintaining access to health care services in the state.	Provide health care coverage to previously uninsured populations. Covering inpatient services, for example, would reduce hospitals' unreimbursed inpatient hospital costs. Covering primary care services would reduce unreimbursed physician and clinic costs and potentially curtail the need for inpatient hospital services in the future.

Wyoming-Specific Goals

Goal	Rationale	Potential Recommended Policy
Take advantage of current Medicaid and SCHIP administrative structure and efficiencies	• Wyoming Medicaid and SCHIP programs' limited administrative burden reflects the rural and frontier nature of the state. Increasing this burden would require additional outlays of state funds and increased administrative resources. • Wyoming's Medicaid and SCHIP programs already provide many of the administrative functions needed by an expansion program.	• Incorporate coverage expansion into current Medicaid and SCHIP programs as opposed to creating a separate program that would require a different department for program implementation and administration. • Use a HIFA waiver to expand coverage as this waiver approach allows the state significant flexibility in developing and administering a premium assistance program.

Wyoming-Specific Characteristics

The following Wyoming-specific characteristics will influence Wyoming's expansion efforts:

Wyoming-Specific Characteristic	Potential Recommended Policy
Wyoming has little or no managed care due to the state's rural and frontier nature.	Wyoming will not be able to use Medicaid managed care as an approach to obtain cost savings for the expansion.
Wyoming uses 100 percent of its disproportionate share hospital allotment.	Wyoming will not be able to use its disproportionate share hospital funds for an expansion program.
Wyoming estimates that it will use 100 percent of its SCHIP allotment.	If Wyoming is able to use a portion of its SCHIP allotment, the State would be able to use a HIFA waiver and have additional flexibility in premium assistance program design.
Wyoming Medicaid covers fewer optional populations than other states.	Wyoming will have a limited ability to achieve cost savings for an expansion by reducing optional benefits to existing populations.

Wyoming-Specific Characteristics

Wyoming-Specific Characteristic	Potential Recommended Policy
Wyoming has only one small state-only funded program that it may be able to wrap into a waiver (PDAP).	Wrapping this program into a Medicaid waiver approach will allow the state some cost-savings, but not a substantial amount.
Wyoming Medicaid and SCHIP programs have a limited administrative burden.	Creating a program expansion that is part of Wyoming's current Medicaid or SCHIP administrative structure will control administrative burden over time.
Wyoming Medicaid's benefit package contains few optional services as compared to other states.	Wyoming will have a limited ability to reduce the current Medicaid benefit package to obtain cost savings for an expansion.

Characteristics of Potential Expansion Populations

The following is a summary of the income levels and number of uninsured by potential expansion population.

Potential Expansion Population	Key Characteristics
Parents of Medicaid Children	• Parents of children aged 0 to 5 years with family income up to 133 percent of the FPL • Parents of children aged 6 to 19 with family income up to 100 percent of the FPL • Estimated population – 12,400 individuals
Parents of SCHIP children	• Parents of children aged 0 to 5 years with family income from 134 to 200 percent of the FPL (SFY 2006) • Parents of children aged 6 to 19 with family income from 101 to 200 percent of the FPL (SFY 2006) • Estimated population – 8,000 individuals
Childless Adults	• Childless adults up to 150 percent of the FPL • Estimated population – 17,500 individuals

Source of population estimates: *Population Estimates*, Correspondence with Milliman, Inc. November 12, 2004.

Characteristics of Potential Expansion Populations

In 2002, approximately 79 percent of Wyoming resident workers and 55 percent of non-resident workers are eligible for employer-sponsored insurance. Sixty-three percent of employers offer coverage to their full-time employees. As indicated in the chart below, 84 percent of Medicaid parents work, and about 52 percent are offered employer-based insurance.

	Total	Employed	Percent of Total	Offered Insurance	Percent of Total	Covered by Private Insurance	Percent of Total
Parents <100% FPL	15,200	10,500	69	6,600	43	2,600	17
Childless Adults < 100% FPL	15,900	12,500	79	7,800	49	2,600	16
Medicaid Parents 100% – 150% FPL	3,800	3,100	84	2,000	52	1,700	45
SCHIP Parents 100% - 150% FPL	8,800	7,300	84	4,600	52	4,000	45
Childless Adults 100% - 150% FPL	8,200	7,000	85	4,300	53	3,700	45
SCHIP Parents 150% - 200% FPL	2,700	2,300	86	1,500	54	1,200	45
Total	**54,500**	**42,800**	**78**	**26,700**	**49**	**15,700**	**29**

Note: Populations rounded to nearest 100. Percentages rounded to nearest percent.
Sources: *Population Estimates*, Correspondence with Milliman, Inc. November 12, 2004.
Private Sector Employee Access to Health Insurance and the Potential Wyo-Care Market, Wyoming Department of Employment. September 2004.

NAVIGANT CONSULTING

Overview of Expansion Approach

Based on Wyoming-specific characteristics and goals, we have constructed the following expansion approach, which allows the state to choose between various coverage models as part of the approach.

Waiver Approach →

Use HIFA waiver to access both SCHIP and Medicaid funding and to allow the state flexibility in implementing a premium assistance option.

Employer-Sponsored Insurance →

State could select between:

- Premium assistance-only expansion
- Public program expansion only (no premium assistance)
- Combination of public program expansion and premium assistance expansion (i.e., beneficiaries may decide between employer-based insurance and a state insurance program)

Overview of Expansion Approach

Populations Covered

- Parents of Medicaid children
- Parents of SCHIP children
- Childless adults

Note: Cost estimates provide information on setting eligibility levels at different FPLs within these expansion groups.

Benefit Package

State could select between:

- Basic general coverage
- Primary care
- Catastrophic care

Note: The catastrophic care benefit package has not been used by a state as part of a Medicaid and SCHIP waiver expansion. While CMS has not indicated that it would reject such an approach, we recommend an exploratory discussion with the federal government regarding the likelihood of approving such a benefit package under a waiver approach if Wyoming would like to proceed with this option.

Overview of Expansion Approach

Cost-Sharing → State can vary by benefit package and population.

Meeting Federal Budget Neutrality Regulations →

Parents of Medicaid children: Covered using SCHIP allotment neutral or covered under Medicaid program using Section 1931 ("hypothetical program expansion")

Parents of SCHIP children: SCHIP allotment neutral

Childless Adults: SCHIP allotment neutral

Note: This approach assumes that Wyoming will have SCHIP allotment available.

The following describes the different benefit packages Wyoming could consider, related cost-sharing amounts, and an Idaho-based premium assistance option.

Wyoming-Specific Models for Consideration
Model 1: Basic General Coverage

To review, basic general benefit packages are less comprehensive than standard or comprehensive health insurance coverage, but still provide a wide range of health care services. The following table describes the benefits and related cost-sharing used for this benefit package model, which we based on Oregon's Health Plan program.

Covered Benefits	Cost-sharing
Inpatient Hospital	$250 co-pay per admission
Outpatient Hospital	$20 co-pay for surgery, $5 for other services
Emergency Room	$50 co-pay, waived if admitted
Physician Services	$5 co-pay, $3 to $10 co-pay for medical & surgical procedures
Laboratory and x-ray	$3 co-pay
Ambulance	$50 co-pay
Home health care	$5 per visit
Prescription drugs	$2- $3 co-pay for generic
Physical and occupational therapy, speech language pathology therapy	$5 per visit
Preventive services*	None

* Preventive services include: well-child exams, immunizations, routine physicals, pap smears, mammograms, prostate screenings, dental check-ups and maternity

Wyoming-Specific Models for Consideration
Model 2: Catastrophic Care Coverage

Catastrophic coverage packages cover large medical expenses or expensive episodes of care and limited or no preventive care services. We used one of Minnesota's state-only funded General Assistance Medical Care (GAMC) coverage options as a model for our "catastrophic" coverage option. While we have been unable to identify a waiver program that covers only catastrophic care, CMS has not specifically rejected the possibility of using this option. The following table describes the benefits and related cost-sharing used for this benefit package model.

Covered Benefits	Excluded Services
• Inpatient hospitalization costs, including physician services • $500 co-payment for hospitalization for each admission • Coverage begins the day of admittance and ends the day of discharge	• Cosmetic surgery • Autopsy • Missed appointments • Vocational/educational services • Gender-assignment surgery • Artificial or in-vitro fertilization (including fertility drugs) • Long-term care • Home care • Personal care services

Wyoming-Specific Models for Consideration
Model 3: Primary Care Coverage

Primary care benefit packages cover preventive and primary services, and may or may not include prescription drugs, limited laboratory services and specialty services. For the primary care benefit option, we used Utah's Primary Care Network (PCN) as a model. While Utah's PCN includes a yearly fee of up to $50 and a $1,000 out-of-pocket maximum per enrollee, we have not included those cost-sharing policies in our estimates.

Covered Benefits	Cost-sharing
Primary/preventive care visits	$5 co-pay per visit
Adult immunizations	Co-pay is for physician visit, that is, no co-pay for preventive services and immunizations
Emergency room visits	$30 per visit
Emergency transportation	No co-pay, limited to emergency transportation, i.e., no cabs or public transportation
Dental exams (every 6 months) X-rays, cleanings and fillings, tooth extraction and emergency exams (ex. toothaches)	Co-pay is 10 percent of allowed amount
Diabetes products (insulin: 10 cc. vials, lancets, test strips, syringes)	Over-the-counter diabetes supplies – lancets, test strips and syringes – do not count as one of four prescriptions per month
Health education, including diabetes and asthma	$5 co-pay per visit

Wyoming-Specific Models for Consideration
Model 3: Primary Care Coverage

Covered Benefits	Cost-sharing
Durable medical equipment (coverage only for equipment for recovery)	10 percent coinsurance of allowed amount
Family planning methods: Depo provera, IUD, diaphragm, birth control-generic only	$5 co-pay per visit and/or pharmacy co-pay (see prescription drugs)
Prescription drugs (4 per month)	The current estimate does not apply the following Utah cost-sharing policy, under the assumption that this may not be administratively feasible for Wyoming to implement: • $5 co-pay for generic, over-the-counter or preferred list drugs • 25 percent of cost for name brand drugs when no generic drug is Available • Full cost when generic is available
Laboratory and x-ray tests	The current estimate does not apply the following Utah cost-sharing policy, under the assumption that the impact would be minimal: • 5 percent lab co-pay of the allowed amount if greater than $50 • 5 percent x-ray co-pay of the allowed amount if greater than $100
One eye exam per year (does not include glasses or contacts)	$30 benefit limit; $5 co-pay

Wyoming-Specific Models for Consideration
Premium Assistance Option Available Under All Models

Wyoming could choose to implement a premium assistance model similar to that used by Idaho. Under this option:

- Families can elect to use their employer-sponsored health insurance for the entire family or for selected individuals, depending on the coverage offered by the employer.
- The State would provide each family $100/month towards the cost of the premium and cost-sharing, up to $300 per covered individual.
- The benefit package would be limited to those services offered by the employer; the state would not provide wrap-around coverage.
- Cost-sharing policies would be determined by the employer's benefit.

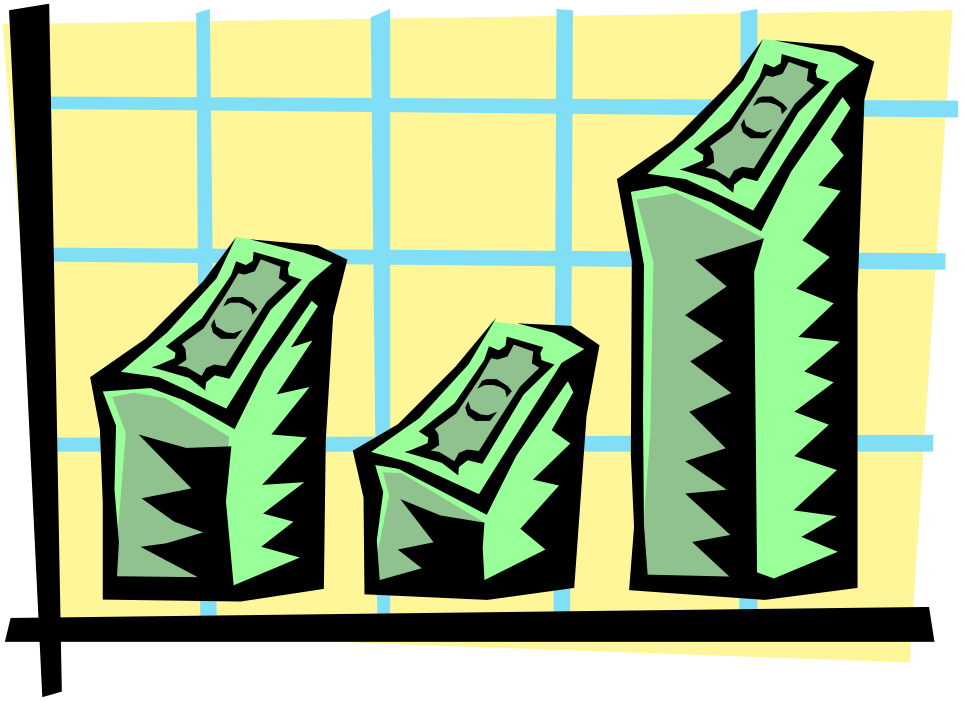
The State must use a HIFA waiver to implement this option as it does not involve using wrap-around coverage to provide the same level of benefits as the state's Medicaid coverage. To use a Medicaid waiver, the State would need to provide a premium assistance program that assesses – for each applicant – if the employer's coverage package matches the current Medicaid package and, if not, provide additional wraparound coverage for the Medicaid-covered services that the employer doesn't offer.

Summary

The following Chapter Five provides a summary of federal and state expenditures under this approach and its related models.

Chapter Five Introduction

In Chapter Four, we introduced the Wyoming-specific models that the State may want to consider. In Chapter Five, we provide an analysis of the estimated costs of these models, performed by the actuarial firm of Milliman, Inc. as part of this contract, and approaches to identifying cost savings for these models.



Estimated Program Costs – Introduction

The budget impact of this approach varies according to the coverage package and the use of a premium assistance program. The overall estimated program costs for State Fiscal Year (SFY) 2007 are summarized below; administration and outreach may increase these cost by an additional three to five percent. The following pages provide additional detail for these estimated program costs.

Program	Estimated Program Costs		
	Coverage Type	Total	State Share*
Waiver Expansion Program Without Premium Assistance Component Eligibles: 27,000 Enrolled: 4,000	Basic general coverage	$12,813,000	$4,382,000
	Primary care coverage	7,376,000	2,534,000
	Catastrophic coverage	4,942,000	1,677,000
Waiver Expansion Program With Premium Assistance Component Eligibles: 38,000 Enrolled: 6,800	Basic general coverage	14,484,000	4,897,000
	Primary care coverage	10,150,000	3,430,000
	Catastrophic coverage	8,197,000	2,746,000
Waiver Expansion Program – Premium Assistance Only Eligibles: 22,000 Enrolled: 4,400	Employer benefit package	$5,250,000	$1,757,000

*For purposes of this estimate, we have applied Wyoming's Federal Fiscal Year 2005 Medicaid federal matching assistance percentage rate to estimate expenditures for parents of Medicaid children, and the State Children's Health Insurance Program federal matching assistance percentage rate to the remaining expansion populations.

A MILLIMAN GLOBAL FIRM

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January 18, 2005

Ms. Gwyn Davidson
Navigant Consulting, Inc.
175 W. Jackson, Suite 500
Chicago, IL 60604

RE: COST ESTIMATES OF WYOMING WAIVER EXPANSION PROGRAM – V4

Dear Gwyn:

Milliman, Inc. (Milliman) has been engaged by Navigant Consulting (Navigant) to provide actuarial assistance to support its engagement with the State of Wyoming Medicaid Agency (Wyoming). Milliman was requested by Navigant to prepare cost estimates to support discussions of the possible expansion of the Medicaid program to certain low-income populations. Additionally, Milliman was requested to estimate the number of individuals who may be eligible for a Premium Assistance Program. This correspondence has been provided in response to that request.

LIMITATIONS

The information contained in this letter has been prepared for Navigant, the State of Wyoming Medicaid Agency, and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for Wyoming by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

The claim costs presented in this correspondence were developed from historical costs associated with the non-disabled, non-aged Medicaid program. These costs were used as an estimate of the costs associated with a currently uninsured population. To the extent that the uninsured population has different morbidity characteristics than the values assumed, actual program costs will differ from the projections shown.

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EXECUTIVE SUMMARY

Wyoming is considering offering medical benefits to certain low-income populations who are not currently eligible for Medicaid. Wyoming is also considering establishing a Premium Assistance Program for low-income individuals who are offered medical insurance through their employer. Milliman has prepared per member per month (PMPM) benefit cost estimates of the medical benefits that are being considered for the direct coverage program. Additionally, Milliman has prepared estimates of the number of individuals in Wyoming who may qualify for the components of the waiver expansion program.

The total projected program costs are a function of the cost per individual enrolled and the number of individuals enrolled. Excluding administrative expenses (including outreach expenses), the cost per individual enrolled in the direct coverage program is the estimated PMPM benefit cost. The cost per individual enrolled in the Premium Assistance Program is the minimum of Wyoming's maximum contribution and the employee premium contribution. The upper limit on the number of individuals who may participate in the direct coverage program is the number of low-income uninsured individuals. The upper limit on the number of individuals who may participate in the Premium Assistance Program is the number of low-income uninsured individuals who are offered insurance through an employer, with an employee contribution requirement. Depending on the structure of the final waiver expansion program, some individuals may be eligible for both programs.

Table 1 provides the projected PMPM benefit costs for the benefit packages being considered. Table 1 also provides the PMPM contribution for the Premium Assistance Program.

Table 1

Wyoming Medicaid
FY 2007 Projected Per Member Per Month Claim Costs
for Direct Coverage Program and Premium Assistance Program

	Males	Females
Direct Coverage Benefits		
Basic General Coverage	$223.80	$298.24
Catastrophic Package	$98.93	$103.92
Primary Care Package	$119.04	$180.27
Premium Assistance Program	$100.00	$100.00

Note: The values reflect benefit costs only and do not include a provision for administrative expense. The values represent state plus federal dollars.

Table 2 provides the estimated number of individuals who are eligible for the components of the waiver expansion program. Exhibit 1 provides the detail by FPL and eligibility category.

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Table 2

Wyoming Medicaid
Estimated Number of Individuals Eligible for Expansion Waiver Program

	Males	Females	Total
Eligible for Direct Coverage Program Only	7,200	8,816	16,016
Eligible for both Direct Coverage Program and Premium Assistance Program	5,447	5,564	11,011
Eligible for Premium Assistance Program Only	4,562	6,332	10,896

Note: The values shown are based on current population estimates and have not been adjusted for future population growth.

The total number of individuals eligible for the direct coverage program is 27,027. This represents the total number of uninsured adults below 150% FPL plus the estimated number of parents of SCHIP children (who will be enrolled in FY 2007) up to 200% FPL.

The remainder of this correspondence documents the development of the values shown in Table 1 and Table 2. Additionally, some of the factors to consider when developing the total cost estimates for the programs are discussed.

PROJECTED PMPM COSTS FOR EXPANSION PROGRAM

Cost estimates have been developed for three benefit designs: (1) Basic General Coverage, (2) Catastrophic Package, and (3) Primary Care Package. A brief description of the coverage under each benefit package has been provided in Exhibit 2. Exhibit 2 was prepared by Navigant to support the October 19, 2004 conference call with Wyoming.

The projected benefit costs were developed from Fiscal Year (FY) 2004 Wyoming Medicaid experience for the non-disabled, non-aged, adult Medicaid population, excluding the Pregnant Women eligibility category experience.

Table 3 provides additional detail to support the benefit costs shown in Table 1. The values in Table 3 reflect projected FY 2007 costs. The projected cost for full Medicaid benefits has been provided for reference. The Medicaid benefits value represents the projected FY 2007 costs for benefits provided to the non-disabled, non-aged adult Medicaid population during FY 2004, excluding the Pregnant Women eligibility category. For each of the proposed benefit packages, the gross benefits cost reflects the Medicaid benefit package reduced by excluded services. The cost sharing component reflects the estimated PMPM value of the proposed copayments.

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Table 3

Wyoming Medicaid
FY 2007 Projected Per Member Per Month Claim Costs
for Alternate Benefit Packages

	Gross Benefits		Cost Sharing		Net Benefit Costs	
	Males	Females	Males	Females	Males	Females
Medicaid Benefits					$245.39	$327.77
Basic General Coverage	$232.20	$310.83	$8.40	$12.59	$223.80	$298.24
Reduction from Medicaid	5.4%	5.2%	3.4%	3.8%	8.8%	9.0%
Cost Sharing/Gross Benefits			3.6%	4.1%		
Catastrophic Package	$104.53	$110.46	$5.60	$6.54	$98.93	$103.92
Reduction from Medicaid	57.4%	66.3%	2.3%	2.0%	59.7%	68.3%
Cost Sharing/Gross Benefits			5.4%	5.9%		
Primary Care Package	$122.43	$186.21	$3.39	$5.94	$119.04	$180.27
Reduction from Medicaid	50.1%	43.2%	1.4%	1.8%	51.5%	45.0%
Cost Sharing/Gross Benefits			2.8%	3.2%		

Currently, Wyoming provides maternity benefits to pregnant women up to 133% FPL. The values shown in Table 1 and Table 3 exclude maternity coverage provided to women in the Pregnant Women eligibility category. If Wyoming extends benefits to individuals up to 200% FPL, the program costs will also include maternity services provided to individuals who cannot currently qualify for that coverage. FY 2007 maternity-related costs for individuals above 133% FPL have been estimated at $4,084.81 per delivery. The estimate was developed from the FY 2004 Medicaid experience and reflects the trend rates underlying Table 3. The additional maternity services are associated with a portion of the SCHIP parent population. The costs are not expected to exceed $250,000 in FY 2007.

PROJECTED PMPM COSTS FOR PREMIUM ASSISTANCE PROGRAM

The Premium Assistance Program costs shown in Table 1 assume that the employee contribution requirement is always greater than or equal to $100. The actual program costs will be the lesser of the employee contribution requirement and $100. We have assumed that participating employers will establish the employee contribution rate at the level of Wyoming's contribution.

INDIVIDUALS ELIGIBLE FOR THE PROGRAMS

The number of individuals eligible for the waiver expansion program was estimated from publicly available databases. The population estimates reflect 2003 values and have not been adjusted for potential demographic or economic changes in Wyoming. The key assumptions and sources are described in this section.

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The total number of uninsured adults by FPL was developed from a Kaiser Family Foundation report of Wyoming as of 2003. The results were consistent with the 2003 CPS statistics.

The percentage of low income individuals who are employed (full-time or part-time) was documented in a May 2004 report published by Covering Kids and Families.

The percentage of employed (full-time or part-time) workers offered health insurance was derived from research published by the Wyoming Department of Employment in the report "Private Sector Employee Access to Health Insurance and the Potential Wyo-Care Market".

The percentage of privately insured individuals who contribute towards the benefit costs was documented in a May 2004 report published by Covering Kids and Families.

The number of parents and childless adults enrolled in Medicaid by FPL was estimated from a report of July 2004 Medicaid enrollment included in the document "FFT Request Number 6.doc" provided by Navigant.

ESTIMATING TOTAL PROGRAM COSTS

The total program costs can be estimated from the information in Table 1 and Table 2. Several assumptions are required to produce a program cost estimate. The value of the assumptions used are dependent, in part, upon (1) the final structure of the Wyoming program, (2) the method and level of outreach, and (3) the speed at which enrollment is phased-in. Items one and two will be reflected in a "take-up rate" estimate, representing the percentage of eligible individuals who ultimately enroll in the program.

There is a subsection of the uninsured population that is offered benefits through their employer, but who do not elect coverage. At this time, Milliman has assumed these individuals will be eligible for either the direct coverage program or the Premium Assistance Program. Whether an individual elects coverage under the direct coverage program versus the Premium Assistance Program will be influenced by the perceived value of the direct coverage benefits compared to the benefits offered by their employer. Some of the considerations may include:

- Level of member cost sharing in the form of deductibles or large copayments
- Covered benefits (*e.g.*, does one plan offer more of the services important to the individual?)

There is also a portion of the privately insured population who meet the income levels under consideration and who are required to contribute towards their benefit costs. Milliman has assumed these individuals will be eligible for the Premium Assistance Program.

The population estimates reflect 2003 values and have not been adjusted for potential demographic or economic changes in Wyoming. The estimates assume that employers will not modify their current benefit arrangement in response to the programs under consideration. The withdrawal of private insurance when public coverage is available is known as "crowd out."

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Alternatively, employers could introduce employee contributions consistent with the Premium Assistance Program benefit.

Milliman has not included any additional costs to the program beyond the benefit costs for the direct coverage program and the Premium Assistance Program. Costs associated with administration and outreach have not been included. Administration and outreach may increase the program costs by an additional 3 to 5 percent. Additionally, Milliman has not considered whether the programs may increase the number of children enrolled in the Medicaid or SCHIP programs, or adults enrolled in the Medicaid program.

An example of the development of the program costs has been provided in Exhibits 3 through 5. Exhibit 3 assumes the waiver expansion program will include a Premium Assistance Component. Exhibit 4 assumes the waiver expansion program will not include a Premium Assistance Component. Exhibit 5 assumes that only the Premium Assistance Component will be implemented. Additional assumptions for each scenario are described below.

> **Exhibit 3.** Assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005. Assume that half the enrollees who are eligible for both the direct coverage program and the Premium Assistance Program elect the direct coverage program and half elect the Premium Assistance Program. Assume that 25% of the individuals eligible for only the Premium Assistance Program choose to enroll in the program. Exhibit 3 provides the calculation of the FY 2007 program costs for the benefit packages.
>
> **Exhibit 4.** Assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005. Exhibit 4 provides the calculation of the FY 2007 program costs for the benefit packages.
>
> **Exhibit 5.** Assume that 15% of the uninsured individuals eligible for the Premium Assistance Program choose to enroll in the program at July 1, 2005. Assume that 25% of the insured individuals eligible for the Premium Assistance Program choose to enroll in the program at July 1, 2005. Exhibit 5 provides the calculation of the FY 2007 program costs.

In Exhibits 3 through 5, we have illustrated a range of "take up" rates in the determination of the estimated program costs. For the Direct Coverage Expansion Program Only population and those eligible for both the Direct Coverage Expansion Program and the Premium Assistance Program, we have illustrated a "take up" rate of 15%. For the Premium Assistance Program Only population, we have illustrated a "take up" rate of 25%. These values were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org. The toolbox indicates an estimated "take up" rate ranging from 6% to 24%. For those eligible for the Direct Coverage Expansion Program, we illustrated the Program costs using the mid-point of the "take up" rate range. A higher "take up" rate was assumed for the Premium Assistance Program Only population since they currently receive coverage through an employer and make employee contributions.

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Milliman will work with Navigant and Wyoming to prepare additional illustrations consistent with the enrollment levels anticipated for the program.

Please call me at (317) 524 – 3512 with any questions or comments.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/sdm
Exhibits

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EXHIBIT 1

STATE OF WYOMING MEDICAID AGENCY
Estimated Individuals Eligible for Expansion Benefits

Eligible for Direct Coverage Expansion Benefits Only

	Males	Females	Total
Parents <100% FPL	791	3,164	3,955
Childless Adults < 100% FPL	3,505	1,168	4,673
Medicaid Parents 100% - 150% FPL	235	941	1,176
SCHIP Parents 100% - 150% FPL	549	2,196	2,745
Childless Adults 100% - 150% FPL	1,945	648	2,594
SCHIP Parents 150% - 200% FPL	175	698	873
Total	7,200	8,816	16,016

Note: Individuals who are eligible for direct coverage expansion benefits only are (1) not employed or (2) not offered insurance through their employer.

Eligible for Both Direct Coverage Expansion Benefits and Premium Assistance Program

	Males	Females	Total
Parents <100% FPL	807	3,227	4,033
Childless Adults < 100% FPL	3,923	1,308	5,231
Medicaid Parents 100% - 150% FPL	51	205	256
SCHIP Parents 100% - 150% FPL	119	478	597
Childless Adults 100% - 150% FPL	502	167	669
SCHIP Parents 150% - 200% FPL	45	180	225
Total	5,447	5,564	11,011

Note: Individuals who are eligible for either the direct coverage expansion benefits or the Premium Assistance Program are offered insurance through their employer, but do not currently accept coverage.

Eligible for Premium Assistance Program Only

	Males	Females	Total
Parents <100% FPL	355	1,418	1,773
Childless Adults < 100% FPL	1,330	443	1,773
Medicaid Parents 100% - 150% FPL	236	945	1,181
SCHIP Parents 100% - 150% FPL	551	2,205	2,756
Childless Adults 100% - 150% FPL	1,920	640	2,560
SCHIP Parents 150% - 200% FPL	170	682	852
Total	4,562	6,333	10,896

Note: Individuals who are eligible for the Premium Assistance Program Only are currently insured through their employer, but are required to make a contribution towards the cost.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 2

STATE OF WYOMING MEDICAID AGENCY
Benefit Package Preliminary Options

OPTION 1: BASIC GENERAL COVERAGE

Overview

In general, "Basic General Coverage" benefit packages are less comprehensive than standard or comprehensive health insurance coverage, but still provide a wide range of health care services. They generally include doctor and hospital care, preventive care, emergency services and prescription drugs and exclude mental health, dental, substance abuse and vision services.

Included and Excluded Services

We use the Oregon Health Plan (OHP) Standard as a model for our Basic General Coverage option. The OHP Standard is a reduced Medicaid benefit package, and requires that beneficiaries pay premiums and higher co-pays than the state's comprehensive Medicaid benefit package. The following table lists the included and excluded services and related cost-sharing.

Table 1
Basic General Coverage Included and Excluded Services

	Services	Cost-Sharing
Included	Inpatient hospital	$250 co-pay per admission
	Outpatient hospital	$20 co-pay for surgery, $5 for other services
	Emergency room	$50 co-pay, waived if admitted
	Physician services	$5 co-pay, $3 to $10 co-pay for medical & surgical procedures
	Laboratory and x-ray	$3 co-pay
	Ambulance	$50 co-pay
	Home health care	$5 per visit
	Prescription drugs	$2- $3 co-pay for generic
	Physical and occupational therapy, speech language pathology therapy	$5 per visit
	Preventive services**	
Excluded	Hearing aid and hearing aid exams	
	Non-emergency medical transportation	
	Routine vision coverage	
	Durable medical equipment	
	Dental services	
	Medical equipment, prosthetics, orthotics and supplies	
	Outpatient mental health and chemical dependency services	

** Preventive services include: well-child exams, immunizations, routine physicals, pap smears, mammograms, prostate screenings, dental check-ups and maternity

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 2 (Continued)

OPTION 2: "CATASTROPHIC" COVERAGE PACKAGES

Overview

Catastrophic Coverage packages cover large medical expenses or expensive episodes of care and limited or no preventive care services.

Included and Excluded Services

We used Minnesota's General Assistance Medical Care (GAMC) as a model for our "catastrophic" coverage option. The GAMC is a state-only funded program that offers two coverage options for the following groups: the primarily non-disabled, as well as low-income adults, ages 21-64, who have no dependent children under age 18 and do not qualify for federal health care programs. The first option is a comprehensive plan, and the second is a hospital-only option, which we used for our model.

The "catastrophic" coverage package only covers inpatient hospitalization costs, including physician services. There is a $500 co-payment for hospitalization for each admission, and coverage begins the day of admittance and ends the day of discharge.

The plan excludes the following services: cosmetic surgery, autopsy, missed appointments, vocational/educational services, gender-assignment surgery and artificial or in-vitro fertilization (including fertility drugs), long-term care, home care and personal care services.

OPTION 3: "FRONT-END" COVERAGE, OR PRIMARY CARE BENEFIT

Overview

Primary care benefit packages cover preventive and primary services, and may or may not include prescription drugs, limited laboratory services and specialty services.

Included and Excluded Services

For the primary care benefit option, we used Utah's Primary Care Network (PCN) as a model. Utah's Primary Care Network (PCN) is offered to low-income adults who do not qualify for Medicaid. While Utah's PCN includes a yearly fee of up to $50 and a $1,000 out-of-pocket maximum per enrollee, we have not included those cost sharing policies in our estimates.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 2 (Continued)

Table 2
"Front-End" Benefit Packages Services and Related Cost-Sharing

Services		Cost-Sharing
Included	Primary/preventive care visits	$5 co-pay per visit
	Adult immunizations	Co-pay is for physician visit, that is, no co-pay for preventive services and immunizations
	Emergency room visits	$30 per visit
	Emergency transportation	No co-pay, limited to emergency transportation, i.e., no cabs or public transportation
	Laboratory and x-ray tests	The current estimate does not apply the following Utah cost sharing policy, under the assumption that the impact would be minimal: • 5 percent lab co-pay of the allowed amount if greater than $50 • 5 percent x-ray co-pay of the allowed amount if greater than $100
	Dental exams (every 6 months) X-rays, cleanings and fillings, tooth extraction and emergency exams (ex. toothaches)	10 percent co-pay of allowed amount
	Prescription drugs (4 per month)	The current estimate does not apply the following Utah cost sharing policy, under the assumption that this may not be administratively feasible for Wyoming to implement: • $5 copay for generic, over-the-counter or preferred list drugs • 25 percent of cost for name brand drugs when no generic drug is available, and full cost when generic available
	Diabetes products (insulin (10 cc. vials), lancets, test strips, syringes)	Over-the-counter diabetes supplies – lancets, test strips and syringes – do not count as one of four prescriptions per month
	One eye exam per year (does not include glasses or contacts)	$30 benefit limit; $5 co-pay
	Family planning methods: Depo provera, IUD, diaphragm, birth control-generic only	$5 co-pay per visit and/or pharmacy co-pay (see prescription drugs)
	Durable Medical equipment (coverage only for equipment for recovery)	10 percent coinsurance of allowed amount
	Health Education including diabetes and asthma	$5 co-pay per visit

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 2 (Continued)

Table 2 Continued
"Front-End" Benefit Packages Services and Related Cost-Sharing

Services		Cost-Sharing
Excluded	Outpatient specialty services	
	Inpatient hospital services	
	Brand name drugs if generic is available	
	Glasses or other vision services	
	Pregnancy related services	
	Mental health services	
	Physical and occupational therapy	
	Chiropractic care	

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 3

STATE OF WYOMING MEDICAID AGENCY
Illustration of Program Costs
Waiver Expansion Program with Premium Assistance Component
Basic General Coverage

	Direct Coverage Expansion Program Only		Direct Coverage Expansion Program or Premium Assistance Program		Premium Assistance Program Only	
	Males	Females	Males	Females	Males	Females
Eligible Individuals	7,200	8,816	5,447	5,564	4,562	6,333
"Take Up Rate"	15%	15%	15%	15%	25%	25%
Enrolled Individuals	1,080	1,322	817	835	1,141	1,583
Direct Coverage Expansion Program	1,080	1,322	409	418	0	0
Premium Assistance Program	0	0	408	417	1,141	1,583
FY2007 PMPM Costs						
Direct Coverage Expansion Program	$223.80	$298.24	$223.80	$298.24	$223.80	$298.24
Premium Assistance Program	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
FY 2007 Annual Program Costs	$2,900,000	$4,731,000	$1,588,000	$1,996,000	$1,369,000	$1,900,000
Direct Coverage Expansion Program	$2,900,000	$4,731,000	$1,098,000	$1,496,000	$0	$0
Premium Assistance Program	$0	$0	$490,000	$500,000	$1,369,000	$1,900,000
Grand Total						$14,484,000
Parents < 100% FPL						$3,941,000
Childless Adults < 100% FPL						$4,183,000
Medicaid Parents 100% – 150% FPL						$1,042,000
SCHIP Parents 100% – 150% FPL						$2,433,000
Childless Adults 100% – 150% FPL						$2,106,000
SCHIP Parents 150% – 200% FPL						$778,000

Note: The values shown above have been provided for ***illustration only***. Any user of this report should establish reasonable assumptions for "take up" and program election rates and develop program cost estimates consistent with those assumptions.

The values shown above assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005. Assume that half the enrollees who are eligible for both the direct coverage program and the Premium Assistance Program elect the direct coverage program and half elect the Premium Assistance Program. Assume that 25% of the individuals eligible for the Premium Assistance Program only choose to enroll in the program.

The "take up" rates were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 3 (Continued)

STATE OF WYOMING MEDICAID AGENCY
Illustration of Program Costs
Waiver Expansion Program with Premium Assistance Component
Catastrophic Package

	Direct Coverage Expansion Program Only		Direct Coverage Expansion Program or Premium Assistance Program		Premium Assistance Program Only	
	Males	Females	Males	Females	Males	Females
Eligible Individuals	7,200	8,816	5,447	5,564	4,562	6,333
"Take Up Rate"	15%	15%	15%	15%	25%	25%
Enrolled Individuals	1,080	1,322	817	835	1,141	1,583
Direct Coverage Expansion Program	1,080	1,322	409	418	0	0
Premium Assistance Program	0	0	408	417	1,141	1,583
FY2007 PMPM Costs						
Direct Coverage Expansion Program	$98.93	$103.92	$98.93	$103.92	$98.93	$103.92
Premium Assistance Program	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
FY 2007 Annual Program Costs	$1,282,000	$1,649,000	$976,000	$1,021,000	$1,369,000	$1,900,000
Direct Coverage Expansion Program	$1,282,000	$1,649,000	$486,000	$521,000	$0	$0
Premium Assistance Program	$0	$0	$490,000	$500,000	$1,369,000	$1,900,000
Grand Total						$8,197,000
Parents < 100% FPL						$2,001,000
Childless Adults < 100% FPL						$2,318,000
Medicaid Parents 100% – 150% FPL						$619,000
SCHIP Parents 100% – 150% FPL						$1,444,000
Childless Adults 100% – 150% FPL						$1,356,000
SCHIP Parents 150% – 200% FPL						$458,000

Note: The values shown above have been provided for ***illustration only***. Any user of this report should establish reasonable assumptions for "take up" and program election rates and develop program cost estimates consistent with those assumptions.

The values shown above assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005. Assume that half the enrollees who are eligible for both the direct coverage program and the Premium Assistance Program elect the direct coverage program and half elect the Premium Assistance Program. Assume that 25% of the individuals eligible for the Premium Assistance Program only choose to enroll in the program.

The "take up" rates were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 3 (Continued)

STATE OF WYOMING MEDICAID AGENCY
Illustration of Program Costs
Waiver Expansion Program with Premium Assistance Component
Primary Care Coverage

	Direct Coverage Expansion Program Only		Direct Coverage Expansion Program or Premium Assistance Program		Premium Assistance Program Only	
	Males	Females	Males	Females	Males	Females
Eligible Individuals	7,200	8,816	5,447	5,564	4,562	6,333
"Take Up Rate"	15%	15%	15%	15%	25%	25%
Enrolled Individuals	1,080	1,322	817	835	1,141	1,583
Direct Coverage Expansion Program	1,080	1,322	409	418	0	0
Premium Assistance Program	0	0	408	417	1,141	1,583
FY2007 PMPM Costs						
Direct Coverage Expansion Program	$119.04	$180.27	$119.04	$180.27	$119.04	$180.27
Premium Assistance Program	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
FY 2007 Annual Program Costs	$1,543,000	$2,860,000	$1,074,000	$1,404,000	$1,369,000	$1,900,000
Direct Coverage Expansion Program	$1,543,000	$2,860,000	$584,000	$904,000	$0	$0
Premium Assistance Program	$0	$0	$490,000	$500,000	$1,369,000	$1,900,000
Grand Total						$10,150,000
Parents < 100% FPL						$2,701,000
Childless Adults < 100% FPL						$2,766,000
Medicaid Parents 100% – 150% FPL						$772,000
SCHIP Parents 100% – 150% FPL						$1,801,000
Childless Adults 100% – 150% FPL						$1,536,000
SCHIP Parents 150% – 200% FPL						$574,000

Note: The values shown above have been provided for ***illustration only***. Any user of this report should establish reasonable assumptions for "take up" and program election rates and develop program cost estimates consistent with those assumptions.
The values shown above assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005. Assume that half the enrollees who are eligible for both the direct coverage program and the Premium Assistance Program elect the direct coverage program and half elect the Premium Assistance Program. Assume that 25% of the individuals eligible for the Premium Assistance Program only choose to enroll in the program.
The "take up" rates were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 4

STATE OF WYOMING MEDICAID AGENCY
Illustration of Program Costs
Waiver Expansion Program with No Premium Assistance Component
Basic General Coverage

	Direct Coverage Expansion Program Only		Direct Coverage Expansion Program or Premium Assistance Program		Premium Assistance Program Only	
	Males	Females	Males	Females	Males	Females
Eligible Individuals	7,200	8,816	5,447	5,564	4,562	6,333
"Take Up Rate"	15%	15%	15%	15%	25%	25%
Enrolled Individuals	1,080	1,322	817	835	1,141	1,583
Direct Coverage Expansion Program	1,080	1,322	817	835	0	0
Premium Assistance Program	0	0	0		0	0
FY2007 PMPM Costs						
Direct Coverage Expansion Program	$223.80	$298.24	$223.80	$298.24	$223.80	$298.24
Premium Assistance Program	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
FY 2007 Annual Program Costs	$2,900,000	$4,731,000	$2,194,000	$2,988,000	$0	$0
Direct Coverage Expansion Program	$2,900,000	$4,731,000	$2,194,000	$2,988,000	$0	$0
Premium Assistance Program	$0	$0	$0	$0	$0	$0
Grand Total						$12,813,000
Parents < 100% FPL						$4,074,000
Childless Adults < 100% FPL						$4,321,000
Medicaid Parents 100% – 150% FPL						$730,000
SCHIP Parents 100% – 150% FPL						$1,704,000
Childless Adults 100% – 150% FPL						$1,423,000
SCHIP Parents 150% – 200% FPL						$560,000

Note: The values shown above have been provided for ***illustration only***. Any user of this report should establish reasonable assumptions for "take up" and program election rates and develop program cost estimates consistent with those assumptions.
The values shown above assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005.
The "take up" rates were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 4 (Continued)

STATE OF WYOMING MEDICAID AGENCY
Illustration of Program Costs
Waiver Expansion Program with No Premium Assistance Component
Catastrophic Package

	Direct Coverage Expansion Program Only		Direct Coverage Expansion Program or Premium Assistance Program		Premium Assistance Program Only	
	Males	Females	Males	Females	Males	Females
Eligible Individuals	7,200	8,816	5,447	5,564	4,562	6,333
"Take Up Rate"	15%	15%	15%	15%	25%	25%
Enrolled Individuals	1,080	1,322	817	835	1,141	1,583
Direct Coverage Expansion Program	1,080	1,322	817	835	0	0
Premium Assistance Program	0	0	0	0	0	0
FY2007 PMPM Costs						
Direct Coverage Expansion Program	$98.93	$103.92	$98.93	$103.92	$98.93	$103.92
Premium Assistance Program	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
FY 2007 Annual Program Costs	$1,282,000	$1,649,000	$970,000	$1,041,000	$0	$0
Direct Coverage Expansion Program	$1,282,000	$1,649,000	$970,000	$1,041,000	$0	$0
Premium Assistance Program	$0	$0	$0	$0	$0	$0
Grand Total						$4,942,000
Parents < 100% FPL						$1,480,000
Childless Adults < 100% FPL						$1,786,000
Medicaid Parents 100% – 150% FPL						$265,000
SCHIP Parents 100% – 150% FPL						$619,000
Childless Adults 100% – 150% FPL						$588,000
SCHIP Parents 150% – 200% FPL						$203,000

Note: The values shown above have been provided for ***illustration only***. Any user of this report should establish reasonable assumptions for "take up" and program election rates and develop program cost estimates consistent with those assumptions.
The values shown above assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005.
The "take up" rates were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 4 (Continued)

STATE OF WYOMING MEDICAID AGENCY
Illustration of Program Costs
Waiver Expansion Program with No Premium Assistance Component
Primary Care Coverage

	Direct Coverage Expansion Program Only		Direct Coverage Expansion Program or Premium Assistance Program		Premium Assistance Program Only	
	Males	Females	Males	Females	Males	Females
Eligible Individuals	7,200	8,816	5,447	5,564	4,562	6,333
"Take Up Rate"	15%	15%	15%	15%	25%	25%
Enrolled Individuals	1,080	1,322	817	835	1,141	1,583
Direct Coverage Expansion Program	1,080	1,322	817	835	0	0
Premium Assistance Program	0	0	0	0	0	0
FY2007 PMPM Costs						
Direct Coverage Expansion Program	$119.04	$180.27	$119.04	$180.27	$119.04	$180.27
Premium Assistance Program	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
FY 2007 Annual Program Costs	$1,543,000	$2,860,000	$1,167,000	$1,806,000	$0	$0
Direct Coverage Expansion Program	$1,543,000	$2,860,000	$1,167,000	$1,806,000	$0	$0
Premium Assistance Program	$0	$0	$0	$0	$0	$0
Grand Total						$7,376,000
Parents < 100% FPL						$2,416,000
Childless Adults < 100% FPL						$2,395,000
Medicaid Parents 100% – 150% FPL						$433,000
SCHIP Parents 100% – 150% FPL						$1,011,000
Childless Adults 100% – 150% FPL						$789,000
SCHIP Parents 150% – 200% FPL						$332,000

Note: The values shown above have been provided for ***illustration only***. Any user of this report should establish reasonable assumptions for "take up" and program election rates and develop program cost estimates consistent with those assumptions.
The values shown above assume that 15% of the individuals eligible for the direct coverage program choose to enroll in the program at July 1, 2005.
The "take up" rates were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

EXHIBIT 5

STATE OF WYOMING MEDICAID AGENCY
Illustration of Program Costs
Waiver Expansion Program – Premium Assistance Only

	Direct Coverage Expansion Program Only		Direct Coverage Expansion Program or Premium Assistance Program		Premium Assistance Program Only	
	Males	Females	Males	Females	Males	Females
Eligible Individuals	7,200	8,816	5,447	5,564	4,562	6,333
"Take Up Rate"	15%	15%	15%	15%	25%	25%
Enrolled Individuals	1,080	1,322	817	835	1,141	1,583
Direct Coverage Expansion Program	0	0	0	0	0	0
Premium Assistance Program	0	0	817	835	1,141	1,583
FY2007 PMPM Costs						
Direct Coverage Expansion Program	N/A	N/A	N/A	N/A	N/A	N/A
Premium Assistance Program	$100.00	$100.00	$100.00	$100.00	$100.00	$100.00
FY 2007 Annual Program Costs	$0	$0	$980,000	$1,002,000	$1,369,000	$1,900,000
Direct Coverage Expansion Program	$0	$0	$0	$0	$0	$0
Premium Assistance Program	$0	$0	$980,000	$1,002,000	$1,369,000	$1,900,000
Grand Total						$5,251,000
Parents < 100% FPL						$1,258,000
Childless Adults < 100% FPL						$1,473,000
Medicaid Parents 100% – 150% FPL						$400,000
SCHIP Parents 100% – 150% FPL						$934,000
Childless Adults 100% – 150% FPL						$889,000
SCHIP Parents 150% – 200% FPL						$296,000

Note: The values shown above have been provided for ***illustration only***. Any user of this report should establish reasonable assumptions for "take up" and program election rates and develop program cost estimates consistent with those assumptions.
The values shown above assume that 15% of the uninsured individuals eligible for the Premium Assistance Program choose to enroll in the program at July 1, 2005. Assume that 25% of the insured individuals eligible for the Premium Assistance Program choose to enroll in the program at July 1, 2005.
The "take up" rates were developed from information presented in the "Premium Assistance Toolbox for States" developed by the National Academy for State Health Policy and available at www.patoolbox.org.

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OFFICES IN PRINCIPAL CITIES WORLDWIDE

Identifying Cost Savings – Federal

As part of its process to expand Medicaid and for SCHIP, Wyoming must evaluate its ability to achieve cost savings for both the federal and state shares of the expansion program costs. For a HIFA waiver expansion to be approved, Wyoming must meet two budget tests. For any new populations covered using SCHIP funding, Wyoming must remain SCHIP allotment neutral. For any new populations covered using Medicaid funding, Wyoming must remain budget neutral. To meet these tests, Wyoming could consider the following approach:

Population	Federal Funding Source	Federal Budget Neutrality
Parents of Medicaid children	SCHIP allotment (if available) or Medicaid	• Use SCHIP funding ("allotment neutrality") if sufficient allotment is available *or* • Increase Medicaid eligibility through a Section 1931 expansion (increasing income disregards policy); this would be considered a "hypothetical program expansion" by the federal government and therefore be budget neutral
Parents of SCHIP children Childless adults	SCHIP allotment	Remain within SCHIP allotment to achieve "allotment neutrality"

Identifying Cost Savings – State

The approach outlined in this report could potentially achieve federal budget neutrality. However, it may be difficult for Wyoming to increase coverage without also increasing state funding. In addition to dedicating additional state general funds to this program expansion, Wyoming could choose to fund this expansion in the following ways:

- *Eliminate Medicaid optional services* – Total expenditures for optional Wyoming Medicaid services equals approximately $4.3 million, 92 percent of which are for prescription drugs.
- *Reduce Medicaid optional services* – Wyoming Medicaid could, for example, target prescription drug services as an area to achieve additional cost savings using policies such as mandatory generic drug use and preferred drug lists. Conversations with state Medicaid prescription drug staff, however, indicate that these policies, some of which are already in place, will be necessary to keep existing prescription drug services within budget constraints, and that these policies would not be able to yield additional savings to cover a new population.

Next Steps

If Wyoming decides to proceed with a coverage expansion, it would need to take the following steps:

- Develop a timeline for expansion
- Work with stakeholders to reach consensus on key policy decisions regarding:
  - Benefit package content
  - Covered populations
  - Use of cost-sharing
  - Involvement of employer-based insurance and outreach initiatives
- Develop a waiver application, which would involve conducting preliminary conversations with CMS staff and conducting a more detailed cost estimate
- Submit waiver application
- Obtain state and funding approval
- Obtain federal approval for federally funded programs