

NATIONAL ACADEMY

for STATE HEALTH POLICY

**Using Medicaid to
Cover the Uninsured:
*Medicaid Participant Buy-in
Programs***

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USING MEDICAID TO COVER THE UNINSURED: MEDICAID PARTICIPANT BUY-IN PROGRAMS

The National Academy for State Health Policy (NASHP) carried out a project during the end of 2002 and the beginning of 2003 to study the potential of using Medicaid as a vehicle to cover the uninsured through participant buy-in programs. A Medicaid participant buy-in program is defined to include any program in which participants pay a prospective fixed premium or other kind of fee, such as an enrollment fee, to participate in Medicaid.

To carry out the study, NASHP conducted a literature review, a survey of the 50 states, and an expert meeting to examine various issues related to Medicaid participant buy-in programs. The literature review and survey served as background material for the invitational meeting of state representatives experienced in designing and implementing Medicaid buy-in programs in January 2003. The invitees discussed the potential of allowing participants to buy in to Medicaid as a way to expand coverage to the uninsured. The findings from these three activities are the basis for this report on the issues related to allowing people to pay a premium to obtain Medicaid health coverage.

Medicaid programs in many states have experience charging and collecting premiums from participants, who typically have slightly higher incomes than Medicaid participants who are not charged premiums. Most of the participants who pay premiums are in states with section 1115 research and demonstration waivers. The waivers permit states to waive the typical Medicaid prohibition on charging premiums. Some premium paying participants are working disabled people who ordinarily earn too much to qualify for Medicaid.

Many of the central issues related to Medicaid buy-in programs do not have to do with specific issues tied to charging and collecting premiums, but rather to other aspects of the Medicaid program rules that create barriers to the success of buy-in programs. This report identifies several possible modifications to current Medicaid rules that could promote greater enrollment in participant buy-in programs.

Several state officials attending the January 2003 meeting asserted that simply adding a premium sharing component to existing Medicaid programs would not reduce in a meaningful way the number of uninsured. They felt that fundamental changes in benefits and eligibility rules for Medicaid were needed to effectively offer a commercial insurance-like benefits package to those of the uninsured who can afford to share in some portion of the costs of coverage. Some state meeting participants urged that states be permitted to replace categorical eligibility groups with single income levels and that they be allowed to offer different benefits and cost sharing levels to enrollees at different income levels. In addition, state participants drew attention to several other federal obstacles that impede the coordination of Medicaid with the private insurance offered by the employers of Medicaid participants.

This report briefly reviews findings from the health services research literature on issues related to charging premiums for public health coverage programs. Findings from an October 2002 survey of the 41 current Medicaid buy-in programs operated by 29 states also are presented. Finally, a discussion of the implications of the research findings from the perspectives of the state officials attending the expert meeting is presented. The group addressed practical and policy issues related to charging premiums for Medicaid and, more broadly, some topics pertinent to redesigning Medicaid.

Full detail from the literature review can be found in Appendix A and complete results from the NASHP survey are contained in Appendix B. A copy of the NASHP survey instrument can be found in Appendix C.

Findings from the Literature

In brief, the health services research literature provides evidence that:

As premiums increase, enrollment falls predictably

- The greatest enrollment seems to occur when premiums are set at one or two percent of the income of the target population.
- As premiums increase above four or five percent of people's incomes, enrollment falls off drastically.
- When premiums represent more than ten percent of income, only a small proportion (20 percent or less) of the population is still willing to purchase coverage.
- A \$10 increase in monthly premium appears to lower the likelihood of enrolling by 13 percent.

The research suggests that the demand curve for health insurance changes as the price of health insurance rises. For most of the population (70 to 80 percent) price elasticity¹ appears fairly high. When the price of health insurance is one or two percent of income, 50 to 60 percent of families will purchase health insurance. As price increases to five percent of income, many families will drop their coverage and participation in one study fell to around 20 percent. See page Appendix A-4 for sources.

However, the purchase of health insurance becomes almost inelastic to price for the remaining 20 to 30 percent of the population who appear willing to spend more than six or seven percent of their income on health insurance. This group tends to hold on to their health insurance, even as the price increases to ten percent or more of their income.

¹ "Price elasticity" of demand refers to changes in demand in response to changes in price. A very elastic product has big changes in demand when price goes up or down, and a product whose demand is inelastic to price has similar demand regardless of price.

This pattern of health insurance purchase is consistent with the notion that adverse selection will occur if health insurance is priced too high. The presumably healthier portions of the population will drop their coverage as the cost increases because they are sensitive to price changes, while the smaller sicker portion of the population will retain their coverage even when charged increasingly high premiums. See Appendix A for more detail and diagrams.

Those who enroll are different from those who do not

Given that substantial portions of the target population do not enroll when premiums exceed five percent of income, it becomes important to look at those who do not purchase coverage. Research suggests that those who do not enroll are:

- Lower income,
- Less well educated, and
- More likely to be members of minority groups.

Research findings comparing the health status of those who enroll and those who do not are conflicting. One study found those who do not enroll have worse health; another study found similar health profiles for those who do and do not enroll. Again, see Appendix A for more information from the literature.

NASHP 50-State Survey of Medicaid Buy-in Programs

NASHP sent out a survey in October 2002 on Medicaid buy-in programs to all 50 states and the District of Columbia. By December 2002, all the states had responded. The survey obtained information about the extent to which states collect premiums to participate in Medicaid. Detailed findings by state are in Appendix B and the full text of the survey can be found in Appendix D.

Authority to charge premiums for Medicaid

Under federal law, Medicaid agencies may charge premiums or enrollment fees using one of the following five authorities. The survey findings are reported using these categories of programs.

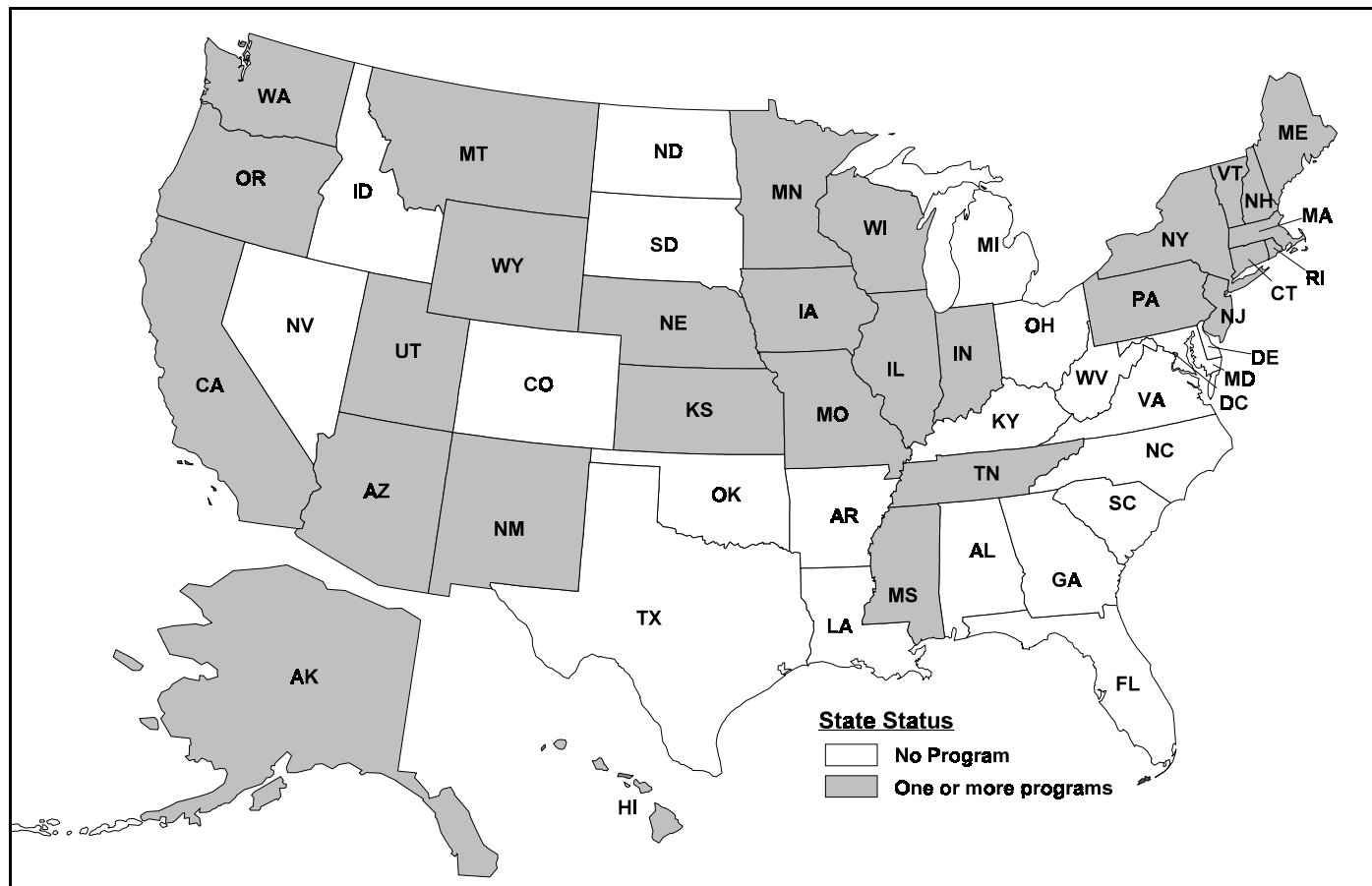
1. Under an approved *1115 waiver* states may charge premiums or enrollment fees to individuals who wish to participate in the Medicaid program.
2. ***Work Incentives***: Both the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) allow states to charge some working people with disabilities who would not otherwise qualify for Medicaid a premium for participating in Medicaid.

3. **Transitional Medical Assistance (TMA):** Section 1925(b)(5)(A) of the Social Security Act (SSA) permits states to charge families a premium for their second six-month period of TMA.
4. **Certain Pregnant Women and Infants:** Section 1916(c)(1) of the SSA allows states to charge certain pregnant women and infants whose family income equals or exceeds 150 percent of poverty a nominal premium.
5. **Medically Needy *Pay-In Spenddown* Option:** Section 1903(f)(2) of the SSA permits Medicaid agencies, at their option, to allow individuals, at their option, to spend down to the medically needy eligibility level through a lump sum payment or installment payments to the state.

No state reported charging certain pregnant women and infants premiums under Section 1916 (c)(1) of the SSA. This group does not appear again in the analysis.

As shown in Figure 1, 29 states offer some type of a Medicaid participant buy-in program.

Figure 1 Most States Charge Some Participants for Medicaid: 2002



Extent of state use of Medicaid participant buy-in programs

The survey found that most states charge some groups to participate in Medicaid.

- 29 states reported 41 programs in which some or all participants must pay a premium or enrollment fee in order to participate in Medicaid. Program names and implementation dates can be found at Appendix B-1. Some states operate more than one buy-in program.
 - Maine, Minnesota, and Utah each have three programs.
 - Nebraska, New Jersey, Oregon, Vermont, Washington, and Wisconsin each have two programs.
 - Two buy-in programs were excluded from the analysis: Arizona's Health Insurance Flexibility and Accountability (HIFA) waiver and California's parent coverage program. Arizona's HIFA waiver is excluded because the waiver is for their separate SCHIP program and follows all the standard SCHIP rules, including those for premium collection. California's 1115 parent coverage waiver is

excluded because the state has not established an implementation date. (Both states operate another program that is included in the analysis.)

- The majority of programs (54 percent) that charge premiums are Work Incentives programs established under the BBA or TWWIIA.
- The majority of people (97 percent) who pay premiums or enrollment fees to participate in Medicaid do so under Section 1115 waiver programs. See Table 1, and Appendix B-4 for a breakdown of enrollment by state.
- A total of 471,856 Medicaid beneficiaries were in buy-in programs in May 2002. In most states with programs, buy-in participants represented only a small percentage of all Medicaid participants. In 32 of the 41 surveyed programs, buy-in participants represent less than one percent of total Medicaid enrollment in that state. The remaining nine programs have enrollment representing more than one percent of total Medicaid enrollment, and two buy-in programs (MinnesotaCare and TennCare) account for 70 percent of total buy-in participants nationwide. These two state programs account for 330,440 out of the total national 471,856 enrollment.
- Most programs that require participants to pay for participation in Medicaid are relatively new. More than half (54 percent) of these programs were implemented within the last two years, and two (Arizona and New Mexico) were scheduled to begin in early 2003.

Table 1 State Use of Medicaid Participant Buy-in Options: 2002

	# States w/Programs		# Program		# Participants who pay to participate in Medicaid (May 2002)	
	#	%	#	%	#	%
Work Incentives	22	76%	22	54%	8,010	2%
1115 Waiver	12	41%	12	29%	457,849	97%
Pay-in Spenddown	4	14%	4	10%	3,177	1%
TMA ²	3	10%	3	7%	2,820	1%
Certain pregnant women or infants	0	0%	0	0%	0	0%
Any Program	29	100%	41	100%	471,856	100%

² Nebraska has a program that combines a TMA program and an 1115 waiver. It is reported as a TMA program.

Who pays to participate in Medicaid?

- The majority of programs that charge premiums or enrollment fees charge them to working people with disabilities.
- When the analysis is narrowed to 1115 waivers (which serve 97 percent of those who must pay to participate), adults are the most likely group to be required to pay for participation. Five of the twelve 1115 programs that charge premiums do so for adults (three programs), childless adults (one program), or parents (one program). More detail about who is eligible for Medicaid buy-in programs by state can be found in Appendix B-7.

Table 2 Number and Type of Medicaid Programs Requiring Premium Contributions, by Targeted Group of Enrollees: 2002³

	Any Program	Work Incentives	1115 Waiver	Pay-in Spenddown	TMA
People with disabilities	24	22	2		
Families	5		2		3
Medically Needy	4			4	
Adults	3		3		
All low-income	2		2		
All insurable/ uninsured	1		1		
Parents	1		1		
Childless adults	1		1		
Any Group	41	22	12	4	3

³ In this table each program is assigned to one category that represents the most inclusive definition of a coverage group. For example a state that covered both parents and childless adults would be shown as covering adults.

At what income level do participants start paying premiums?

- Among all 41 programs, Medicaid agencies reported being most likely to begin charging premiums at 150 percent of the Federal Poverty Level (FPL); 12 of the 41 programs do so. See Table 3. More detail by state can be found in Appendix B-10.
- Among work incentive programs, the most frequently reported income threshold for premium payment is also 150 percent FPL (eight programs). The second most frequently chosen threshold level was “any who would not otherwise qualify for Medicaid” (six programs).
- Among the 1115 waiver programs, the most frequently selected income threshold for premium payment was “anyone who would not otherwise qualify for Medicaid” (four of twelve 1115 waiver programs). Three 1115 waivers begin charging premiums for enrollees over 150 percent FPL and two more do so for those over 100 percent FPL. Oregon’s 1115 program charges premiums to all enrollees at any income (childless adults from 0 to 100 percent FPL are eligible for that program).
- Two of the 41 programs begin charging premiums at different levels of income for different groups of program participants. (Only the lowest threshold was used to create Table 3.) Both programs operate under an 1115 waiver.
 - Rhode Island begins charging families premiums at 150 percent FPL, while it does not begin charging pregnant women, women and infants premiums for participation until their family’s income reaches 185 percent FPL.
 - Hawaii charges premiums to (1) employed adults when their incomes reach 100% FPL, (2) all self-employed adults who would not otherwise qualify for Medicaid, and (3) children from families with incomes over 200 percent of FPL.

Table 3 Who Pays to Participate in Medicaid? Minimum Income as a Percentage of FPL for Requiring Premium Payment⁴: 2002

	Any Program	Work Incentives	1115 Waiver	Pay-in Spenddown	TMA
Any one who would not otherwise qualify for Medicaid	14	6	4	4	
Enrollees at any income level	1		1		
>50% FPL	1		1		
>100% FPL	8	4	2		2
>150% FPL	12	8	3		1
>200% FPL	2	2			
Other ⁵	3	2	1		
Any Authority (N=41)	41	22	12	4	3

How do states determine premium levels?

- Programs most frequently used a sliding scale based on income to determine an individual payment level. Sixteen of the 41 total programs use this method. Indiana’s work incentive program, for example, uses six income bands. As income increases, so does the premium amount. Participants with incomes of 150 to 175 percent FPL pay \$48/individual and \$65/married couple per month to participate in Medicaid; those with incomes of more than 175 percent up to 200 percent FPL pay \$69/individual and \$93/couple per month; and so on. More detail on premiums by state can be found in Appendix B-10.
- Massachusetts, Minnesota, Oregon, and Wisconsin each reported using more than one method of determining individual premium amounts. Under Massachusetts’ 1115 waiver, for example, participants at lower income levels pay a percentage of their income that increases as their income increases, while higher income participants pay a

⁴ Some states may assign different income eligibility levels for different eligible groups, this table shows only the lowest threshold used for any group of participants.

⁵ “Other” income thresholds for premium payments are: Arizona expects all participants in their work incentives program who earn more than \$500.01/month to pay a premium, Massachusetts expects all people with disabilities who participate in their 1115 waiver and earn more than \$16,361/year to pay a premium, and Wyoming expects all people with disabilities participating in their work incentives program who earn more than \$600/year to pay a premium. These programs do not make adjustments for family size.

percentage of income that varies based on whether the member has other health insurance, but does not vary according to an individual's income.

- Other factors that are considered in setting individual premium amounts include: whether the participant has other insurance (Massachusetts' 1115 waiver), child care costs (Washington's TMA program), and the number of adults and children in the family (New Jersey's 1115 waiver).

Table 4 Methods Used to Determine Individual Premium Amounts: 2002

	Any Program	Work Incentives	1115 Waiver	Pay-in Spenddown	TMA
Actuarially based	0				
Sliding Scale: % of income	12	9	2		1
Sliding Scale: income bands	16	9	7		
All participants over a threshold, e.g. 150% FPL	5	1		4	
Fixed regardless of income	4	1	3		
Other	8	4	2		2
Any Method	41	22	12	4	3

How much do states charge for participation?

The range in premiums charged in Medicaid participant buy-in programs was wide, from a low of \$4 per child per month to a high of \$1,375 per family per month. However the range in incomes of the eligible populations was diverse, as well. Income eligibility levels extended from 0 percent FPL (in Oregon's 1115 waiver to cover childless adults everyone pays regardless of income) to no upper income limit (uninsured/uninsurable participating in Tennessee's 1115 waiver could have incomes over 600 percent FPL). See Appendix B-10 for a state-by-state breakdown of premium amounts.

- Twenty-two of the 41 programs reported the minimum premium amount charged to any participant as a dollar amount.
 - The lowest minimum premiums charged to any program participant in these 22 programs was \$4 per child per month (Minnesota and Vermont's 1115 programs⁶).
 - Six programs reported that the minimum premium was \$20 per month.

⁶ Utah's 1115 waiver actually charges \$50/year, which is the equivalent of about \$4/month.

- The average minimum premium reported by all 22 programs was about \$22 per month.
- Fifteen programs reported the highest amount charged to any participant as a dollar amount.
 - The highest maximum premium charged to any program participant in these 15 programs was \$1,375 per month per family at 600 percent FPL. (Tennessee's 1115 waiver program which, at that time, covered all uninsured/uninsurable with essentially no upper income limit.)
 - Two programs reported charging maximum premium amounts of \$35 per month.
 - The average maximum premium amount reported was \$216 per month.
- Ten programs reported minimum premium amounts as a percentage of income.
 - The lowest minimum premium amount reported was 1 percent of adjusted income (Washington's TMA program).
 - Two programs reported charging maximum premiums of 3 percent of income and two reported maximum premiums of 7.5 percent of income.
 - The average minimum premium was 7.3 percent of income.
- Thirteen programs reported maximum payment amounts as a percentage of income.
 - The highest maximum premium charged was 55 percent of adjusted income (Utah's work incentive program).
 - Two programs reported charging maximum premiums of 5 percent of adjusted income (Mississippi's and Pennsylvania's work incentives programs), two reported maximums of 7.5 percent of income (Connecticut's and Minnesota's work incentives programs), and two reported maximums of 10 percent of income (Alaska's work incentive and Massachusetts's 1115 programs). The average maximum premium was about 10 percent of adjusted income.
- States' individual premium calculations were often complicated. Wisconsin's work incentives program, for example, reported that each participant's total monthly premium is the sum of premiums for earned and unearned income. The premium for earned income, 3 to 3.5 percent of earned income, is added to the premium for unearned income, 100 percent of total unearned income remaining after deductions, including a living allowance, medical expenses, and work-related expenses.

Total collected revenue from premiums

The NASHP survey found a range of less than \$100 per month to \$4.9 million per month collected from Medicaid participant premiums. 29 of the 41 programs reported the total amount of participation fees collected in a typical month, May 2002. Most of the 12 programs that did not report total collected premiums for that month had just begun their program or had not yet implemented the program at that time. See Appendix B-30 for monthly collection totals by state.

As shown in Table 5, 15 programs reported that they collected less than \$50,000 in May 2002. Most of these programs were fairly new. Three programs collected between \$50,000 and \$100,000 per month and seven collected between \$100,000 and \$500,000. Two programs collected over \$500,000 but less than \$1 million per month, and Minnesota's and Tennessee's 1115 waiver programs collected over \$1 million per month (\$3.3 million in Minnesota and \$4.9 million in Tennessee).

Table 5 Total Collected Revenue from Premiums per Month: May 2002

	Not reported	\$0 to \$50,000	\$50,000 to \$100,000	\$100,000 to \$500,000	\$500,000 to \$1,000,000	Over \$1,000,000
Work Incentives (N=22)	6	14	1	1		
1115 Waiver (N=12)	3		1	4	2	2
Pay-in Spenddown (N=4)	1		1	2		
TMA (N=3)	2	1				
Any Program (N=41)	12	15	3	7	2	2

Logistics of collecting premiums

Most states use a state agency to collect premiums (36 states), seven states use an external contractor, and two states use local eligibility offices. See Appendix B-37 for more detail by state. Additional information about various methods the seven states use to oversee their external contractors' performance also can be found at Appendix B-45.

States typically mail their bills two to four weeks before payment is due; payment is due either a couple weeks before or after coverage starts; late notices are sent typically two weeks later; some states follow-up with phone calls; and termination for non-payment can occur anywhere from one week to four months later. Information on the timing and sequence of activities states use in their billing process can be found in Appendix B-47 and B-56.

Why states charge for participation

- Programs most frequently reported that they charged premiums in order to “offset the cost of the expansion” (90 percent of the 41 programs) and to “promote personal responsibility” (83 percent of the 41 programs). See Table 6 and Appendix B-20.
- Among the four types of participant buy-in programs only TMA programs did not follow this pattern. Among the four TMA programs charging premiums for participation, the most frequently reported reasons for collecting premiums was to “offset the cost of the expansion” and “equity.”

Table 6 Why States Charge for Participation: 2002

	Equity	Make program more like commercial insurance	Offset the cost of expansion	Prevent crowd-out of private insurance	Promote personal responsibility	Other
Work Incentives (N=22)	16	17	21	13	19	5
1115 Waiver (N=12)	8	11	12	10	11	2
Pay-in Spenddown (N=4)	2	1	2	1	1	2
TMA (N=3)		1	2	1	3	1
Any Program (N=41)	26	30	37	25	34	10

Has premium collection been considered successful?

- The majority of programs (32 programs) reported that they considered their premium collection program had been successful. Five additional programs reported they could not label their program successful or unsuccessful; four of these said they felt their programs were too new to assess success.
- Among the 32 programs that considered premium collection to be successful, when asked to elaborate, the majority (18 programs) said they were successful because participants were paying their premiums. Some added that the premiums were paid on a “timely” basis. More detail from individual states can be found in Appendix B-22.
- When asked to name the top two barriers to success, states reported the following:
 - “Technical/billing systems/operations” were reported as barriers by 23 programs;

- “Client Understanding” was reported by 11 programs;
- “Failure to pay” was reported by five programs; and
- “Insufficient staff” was reported by three programs.

More specifics on barriers identified by states and on the activities they have undertaken to address these barriers are available in Appendix B-24.

Using Medicaid to Cover the Uninsured

With the literature and survey findings as background, a group of 28 state staff convened in Washington, DC, in January 2003, to discuss the potential of using Medicaid to collect premiums and help insure the uninsured. The following section identifies the issues raised at that meeting related to implementing buy-in programs and broader issues that could make these programs more accessible to the low-income uninsured.

The positions presented here are not intended to be representative of a broad range of perspectives on Medicaid. State participants were selected because of their technical expertise and experience in implementing buy-in programs. A diversity of opinions and expertise were not sought for the meeting, for example consumer representatives and federal program officials were not present.

The focus of the meeting was on states’ use of premiums in Medicaid programs. Early on in the conversation, it became clear that states have the experience and capability to charge and collect premiums for Medicaid. However, many state participants felt that certain changes to Medicaid rules and regulations were needed before they could design truly effective programs for their uninsured state residents who can afford to pay premiums. Rather than examining participant premium payment as an isolated program feature, many of the state participants urged that premium payment be considered in the broader context of the Medicaid program.

Consequently, the following section addresses:

- the policy and practical issues related to operating a Medicaid buy-in program today, and
- Medicaid redesign issues that states felt were important to their success in shaping Medicaid as a vehicle to make health coverage available to more of the uninsured.

Learning from experience

States have learned many lessons over the years from operating Medicaid buy in programs. Information from Oregon, Minnesota, and Rhode Island are presented below.

Oregon is redesigning some aspects of its Medicaid program.

In Oregon, a severe budget situation is making the state rethink central features of its Medicaid program. In the past, some participants paid premiums (though many groups had been exempt) for a fairly comprehensive benefits package. Oregon obtained a waiver in October 2002 to expand its coverage of adults from 100 percent FPL to 185 percent. The state can afford to do so only by offering a benefits package comparable to small employer coverage, with fewer benefits and higher cost sharing than traditional Medicaid coverage. Oregon officials are worried about both crowd out⁷ and adverse selection⁸ with this new expansion. Given the state's current budget shortfalls, state officials maintain that they will have to offer less coverage or they will be forced to drop entire categories of people from the program.

Minnesota: charging premiums has been successful, needs greater flexibility.

In Minnesota enrollees between 175 and 270 percent FPL, are charged premiums which can represent up to seven percent of income. Minnesota has found that enrollment is most attractive for older enrollees and people with health conditions. Enrollees are required to be uninsured for four months before enrolling, to prevent people from dropping private coverage. The state has a rule that if the employer pays 50 percent or more of the person's coverage they cannot join, but they are now seeing more people who cannot afford the \$200 to \$300 per month to pay their share of private coverage. In addition, state officials believe that the \$3 co-payments on prescription drugs are too low compared to private coverage standards.

Minnesota has experienced few problems in collecting premiums for its 1115 waiver and Ticket to Work programs. State officials have found that making automatic deductions from bank accounts using debit cards is the most efficient way to collect premiums. (More detail about state's use of credit cards, automatic deductions, mailed in checks, payroll deduction, and in-person payment can be found in Appendix B-28). At one point, the state offered to collect premiums from individual's state income tax returns, but very few people chose that option. In coordinating Medicaid and employer coverage, Minnesota officials have found that employers did not want to be closely involved with their employees' public coverage and did not want to know what their employees' family incomes were.

Rhode Island found that more children enroll when parents are eligible, too.

Rhode Island's experiences enrolling children with and without their parents are consistent with the Institute of Medicine's report, *Health Insurance is a Family Matter*. This report emphasizes that people tend to make health insurance decisions for their whole family, not for their children

⁷“Crowd out” is when people drop private health coverage to enroll in a public program.

⁸“Adverse selection” is when sick people are more likely to sign up for a health coverage program, rather than a group representative of the entire population.

in isolation.⁹ Rhode Island experienced greater enrollment increases when parents were able to enroll in subsidized coverage compared to earlier enrollment when only children were eligible.

Rhode Island has released a study recently of what happens to people who do not pay their premium and are disenrolled from RItE Care. After beginning to charge premiums of \$43 to \$58 per family per month in January 2002 to enrollees earning between 150 and 200 percent FPL, 82 percent were still enrolled in July 2002, and 18 percent were disenrolled because of failure to pay. Over 70 percent of those disenrolled lost their coverage in April, the first month that non-payment resulted in disenrollment. The survey showed that half (51 percent) of those who were disenrolled became uninsured. Those who did not pay and became uninsured were more likely to have a chronic condition and to use the emergency room for primary care than those who found other health coverage.¹⁰

Crowd out experience.

One concern with offering subsidized public health coverage to enrollees who can afford to pay some level of premium is that some people will drop their current private coverage to enroll. The worry is that public funds will be used to create a program that crowds out an existing private insurance market.

An article in the January/February 2002 article in *Health Affairs* offers information about when crowd out did and did not occur in four states with subsidized health insurance programs.¹¹ This study from the mid-1990s found very little evidence of crowd out among enrollees with incomes under 100 percent FPL. The researchers found some crowd out of private coverage among persons with incomes between 100 and 200 percent FPL.

To address the crowd out problem, Rhode Island requires RItE Care enrollees who have employer coverage available to them to enroll in their employer coverage. The state's RItE Share premium assistance program pays subsidies directly to the enrollee to help pay the employee share of the premium. Rhode Island does not impose a mandatory period of uninsurance because it wanted its state policies to promote health insurance coverage rather than separate people from coverage.

⁹ Institute of Medicine, Committee on the Consequences of Uninsurance, *Health Insurance is a Family Matter* (Washington, DC: National Academies Press, September 2002), available at www.nap.edu/books/0309085187/html/.

¹⁰ RI Medicaid Research and Evaluation Reports, *Results of RItE Care Premium Follow-up Survey*, Issue Brief #4, January 2003, available in Appendix D.

¹¹ Richard Kronick and Todd Gilmer, "Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?" *Health Affairs*, Volume 21/Number 1.

Requested federal law changes to promote employer-sponsored insurance

To encourage participation, Rhode Island places as little administrative burden as possible on participating employers. The state pays individuals directly, rather than coordinating payments through employers. Currently only three percent of Rhode Island Medicaid members are covered through premium assistance, but the state believes there is the potential to enroll many more Medicaid members through their employers. It is financially beneficial for the state to coordinate with private coverage, because premium assistance enrollees cost the state \$70 per month, compared to \$155 per month for regular Medicaid.

Rhode Island is experienced in charging and collecting premiums, but in order for their program to be more successful in coordinating with employer coverage, state staff believe changes to two federally-imposed obstacles must be made.

1. *Give states the authority to collect health insurance information from both large and small employers.*

Rhode Island has difficulty collecting three needed pieces of information from about half of the potentially eligible employers. Due to the Employee Retirement Income Security Act of 1974 (ERISA), the state has no authority to collect the following benefits information from large self-insured employers: how much the employer pays toward coverage, whether the employee is eligible, and which health plans are offered.

Rhode Island staff recommended that a form modeled on the National Medical Support Notice¹² be developed for Medicaid premium assistance programs. For child support agencies to collect benefits information to enforce child medical support orders, an amendment to ERISA was made that requires employers to fill out the National Medical Support Notice and return them to the state agency.

2. *Simplify federal Medicaid eligibility rules*

Current Medicaid eligibility categories are very complex. Establishing one income level below which everyone qualifies for Medicaid and above which states may offer a commercial insurance-like benefits package would make the program easier to understand and administer, rather than today's multiple categories of eligibility and Medicaid-based benefits.

As an example, when a family is eligible for the RIte Share premium assistance program, eligibility workers must find out if:

- the family has an income below 150 percent FPL and there are any infants from birth to one year who qualify for no cost sharing;
- income is below 250 percent FPL and there are any pregnant women who qualify for extra services and no cost sharing;

¹²Available in the Federal Register and at <http://www.acf.hhs.gov/programs/cse/forms/OMB-0970-0222.pdf>

- income is below 150 percent and there are any children from one to five who qualify for no cost sharing and wraparound benefits for that child;
- income is below 133 percent FPL and there are children from 6 to 18 who qualify for no cost sharing and wraparound benefits for that child; and
- any family members have breast or cervical cancer who qualify for no cost sharing and added services.

Once established, the benefits and cost sharing levels can change when the children get one year older and/or if the mother becomes pregnant again. The current eligibility categories make eligibility determination overly complicated for both the eligibility workers and the families.

Maryland has the same problem as Rhode Island in collecting information from employers for its premium assistance program. The situation is sometimes even worse in Maryland because the state also must collect a detailed description of the employer's benefits package to compare it to the state's Medicaid benefits package. The detailed benefits description is usually only found in the certificate of coverage issued by the insurer, not in the benefits descriptions provided to employees. As in Rhode Island, about half of the Maryland employers do not respond to this information request. One option for collecting this information may be to have a state law mandating that the insurance companies (which are under the jurisdiction of states) provide the information, rather than obtaining the information from employers.

It was noted that Oregon requests similar information from employers, but employers typically respond to the state's requests. In Oregon, the state was allowed by CMS to offer whole families the choice of which benefits and cost sharing plan they would like as a way to avoid having to enroll different family members in different levels of benefits and cost sharing coverage.

Allow Medicaid employer-sponsored insurance to trigger an open enrollment period

Another federal obstacle to premium assistance programs was identified in Mississippi. When an individual is found eligible for Medicaid premium assistance this eligibility determination does not typically trigger an open enrollment period in the employer plan. Instead, the individual must be provided with regular Medicaid for the number of months before the employer's open enrollment period, and procedures must be put in place to switch the coverage to the employer coverage during the open enrollment period. In this case, the definition of special enrollment periods in the portability provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Part 7, Section 701(f)) could be modified to include eligibility for Medicaid or SCHIP as an event that will trigger a special enrollment period.

Maryland has run into this obstacle, as well, although their state laws allow Medicaid and SCHIP eligibility to create an open enrollment period for small businesses, but the state has no such jurisdiction over large self-insured employers, which are exempted by ERISA.

Simplify the benefits package.

Some states advised that the description of Medicaid health benefits should be simplified in order to make premium assistance programs more successful. The level of detail specified by a Medicaid benefits package is not a good fit with current employer benefits packages. The mismatch in terminology and detail makes it complicated to define and offer wraparound coverage, and it makes it difficult to explain the program to employers. Current Medicaid benefits descriptions do afford protections to enrollees, but they make it difficult to coordinate with private coverage.

States observed that all of the benefits packages offered in a state have been subjected to approval by that particular state's Insurance Commissioner's office. Rather than requiring a second round of review, some state representatives maintained that an Insurance Commissioner's approval should be enough for a Medicaid program to proceed with enrolling people through a premium assistance program.

Is it worth the effort to collect premiums?

It was noted that many states have spent considerable time and effort to collect premiums from individuals and to coordinate with employers, but that the total value of the collected premiums was, in many cases, relatively low. There was a discussion of whether collecting premiums is worth the effort and if it isn't more effective to impose a moderate size co-payment on, for example, prescription drugs than to collect premiums. Medicaid enrollees cannot be denied a prescription drug if they cannot pay, so access to services would not be significantly impeded. States have to find a balance between 1) charging Medicaid premiums that are so high that the healthy decline to enroll and 2) charging such high co-payments on services that the sick cannot afford the services they need.

In Massachusetts, the premiums collected from mothers and children in Medicaid are modest, but there are also premiums of up to \$1,000 per month collected from some people with disabilities. Collecting premiums for people with disabilities or for people in nursing homes can result in a substantial sum of money.

Washington State has experience with this trade-off. The state considered more substantial co-payments on prescription drugs for their public employees, but recognized a need to be cautious so that the co-payments did not present a financial barrier to people getting the prescription drugs they need. Also, when Washington State implemented a co-payment on drugs for Medicaid in 1993, if the member was unable to afford the co-payment, the pharmacist ended up absorbing the costs. The drug co-payment was discontinued within seven months.

Potential for covering the uninsured

Medicaid buy-in programs have a potential role in reducing the number of uninsured in the United States. Many of the issues raised on this topic were related to the flexibility permitted in Section 1115 research and demonstration waivers and in the Health Insurance Flexibility and Accountability (HIFA) initiative. These waiver mechanisms allow the Secretary of the Department of Health and Human Services to permit states to modify normal Medicaid program requirements. Oklahoma and Utah reported on their states' thinking about buy-in programs.

Oklahoma is considering a Medicaid participant buy-in program.

Oklahoma is debating whether to create a program that expands coverage by charging premiums for some in their Medicaid program. Oklahoma, like many other states, is facing a budget crisis, and is considering whether to reduce eligibility for Medicaid from 185 percent FPL down to federal minimums of 150 percent for young children and 133 percent FPL for older children. The state would like to expand coverage but cannot afford to do so with a comprehensive, traditional Medicaid benefits package. It would like to use a commercial insurance-like benefits package and a single eligibility level based on income, not on categories. The state also would like to move forward slowly and incrementally with its expansion, and expand in phases as the budget permits.

Oklahoma is interested in using increased cost sharing as a way to promote individual responsibility. It would like to have cost sharing for mandatory populations. At a minimum, it would like to trend the current co-payments forward with inflation, rather than leaving them at the \$1 and \$3 levels. Since Oklahoma has not been allowed to increase co-payments for prescription drugs, it has chosen, in order to contain costs, to limit the number of prescriptions allowed to three per month, which state officials believe does not make sense from a clinical perspective.

Utah has an 1115 waiver to expand coverage with a primary care benefits package.

Utah's decision to have new populations pay an enrollment fee conveyed an important message from the legislature in support of personal responsibility. Utah would prefer to cover new populations through their employers, but the state recognizes that while three quarters of the uninsured are working, most of their employers do not offer coverage at all or do not offer affordable coverage. So, Utah designed its new Section 1115 waiver to expand coverage with an affordable, minimal benefits package. Crowd out is not a major concern for this group of uninsured, since the target population has very little affordable private coverage in either the group or individual market available to them.

The program offers a publicly funded primary care benefit and a privately financed inpatient hospital benefit. Hospitals in Utah voluntarily pooled \$10 million to provide inpatient hospital care per year. The Utah Department of Health administers the hospital benefit, so that costs are distributed equitably and care is managed. Participants pay a \$50 enrollment fee and point of service co-payments or co-insurance. Since July 2002, 12,000 people have joined the program.

One new aspect of the Utah 1115 waiver is the greater flexibility permitted by CMS to make changes in the benefits package offered to both the mandatory and expansion populations compared to earlier 1115 waivers. More detail about the benefits packages and cost sharing offered by states under earlier Section 1115 waivers can be found in Appendices B-32 and B-34.

Private insurers in Utah believe the new benefits are sufficiently comparable to private coverage. They will give month-to-month credit for prior coverage with the new primary care benefit when calculating a waiting period for pre-existing conditions when people transition to private coverage. Utah was in a position of choosing between offering nothing to 25,000 uninsured people in their state or offering a primary care benefits package. Utah is experimenting with what Medicaid can do for people short of offering a comprehensive benefits package. With Medicaid structured as an entitlement, the state has faced 9 to 10 percent caseload increases in recent years. Without changes to the program requirements, Utah would have to cut some very sick people off the program. Utah believes that states' interest in expanding Medicaid to uninsured people is an important enough goal that it is worth looking at whether the program can be redesigned to better achieve that goal.

Some state representatives said they would like to offer a commercial insurance-like benefits package to people earning between 100 percent and 200 percent FPL and that the flexibility in the HIFA initiative does not go far enough to make that happen.

Medicaid redesign issues

The U.S. Congress is contemplating some significant changes to Medicaid. The President's budget offers states greater flexibility in Medicaid rules in return for accepting capped federal contributions to the program. Many states have indicated they need more flexibility with Medicaid rules and that they are very concerned about what changes will be needed to balance state budgets.

Sometimes standardization works well for programs, but several state representatives felt that with health care there is exceptionally large variation state to state. They asserted that increased flexibility with Medicaid may be the only way to continue coverage for people who may end up losing benefits if states must choose between trimming costs and maintaining a rigid, comprehensive benefits package.

One immediate change that would simplify Medicaid eligibility rules would be to stop locking out single adults without children who earn less than the poverty guidelines. Much of the Medicaid budget goes to cover the prescription drug costs of people with Medicare, and some states said that the federal government could help state budgets considerably by paying for more drug coverage for Medicare beneficiaries.

One state participant noted that the SCHIP model of offering flexibility in program design within federally-designed parameters to states worked well in her state, Mississippi. The state had to

figure out what it wanted to do with its SCHIP funding which created an important debate on the topic among Mississippi policymakers.

Ticket to Work experience

Representatives at the meeting were asked to report on their experiences with the Ticket to Work program specifically and, more broadly, on offering health insurance to disabled people.

The Ticket to Work program in New Jersey has attracted a different population than was originally expected. It was intended to provide affordable health insurance for physically disabled people who were working but who had no health insurance. It has turned out to serve many mentally ill participants in low-paying jobs. In New Jersey, unearned income is not counted, so people receiving Social Security and disability payments can qualify for the subsidized Ticket to Work health coverage. However, many people are afraid to give up their current benefits and will not take jobs that pay them more. New Jersey has struggled to emphasize that the new programs will not be going away and that participants' savings will not disqualify them from benefits in the future.

In Minnesota, 6,000 people have enrolled in the Ticket to Work program. For about half of them, it was simply a less expensive option than other Medicaid participation would have been. The state has been frustrated occasionally with its inability to define "work" and has had to qualify some people who do relatively little, often sporadic, work in their homes for their friends and neighbors. The Minnesota Ticket to Work program has to balance how much it helps higher income people with high health needs versus lower income people with less intense chronic health problems. The Ticket to Work program has turned out to be a good match with Minnesota values, such as "You'll get help when you need it, but you're supposed to help yourself when you can."

Minnesota's experiences contrast with the situation in Washington State, where the Ticket to Work program was not included in the Governor's budget this year and will likely be cut.

One state participant said it is too early to draw conclusions about the Ticket to Work program. The program is trying to make changes to a disability support system that took 40 years to create. Ticket to Work has reduced the effect of some eligibility cliffs, but the limit on Substantial Gainful Activity of \$740 per month for Social Security Disability (SSDI) benefits still discourages many people with disabilities from seeking full-time employment.

Does Medicaid pay adequately?

Another state official posited that if Medicaid and Medicare paid the full costs of the care provided to their participants that private health insurance would be more affordable, because there would be less cost shifting,¹³ and there would be fewer uninsured. Many of Medicaid's complexities stem from the concept of trying to separate the deserving poor from the

¹³When Medicaid and Medicare pay less than the costs of providing services to these beneficiaries, some providers may charge more to private insurers to make up the difference.

undeserving poor, and it would be simpler to have a national health care program for anyone under, for example, 150 percent FPL.

Whether Medicaid pays its full costs or not varies by state. In Utah, for example, the Medicaid program pays 75 percent of average rates in urban areas and 93 percent in rural areas. Some private health insurers that pay less for hospital care than Medicaid does. In addition, the differing amounts that hospitals receive in “disproportionate share” adjustments adds to the complexity in many states.

What happens if Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is not covered?

In pursuing whether there should be more flexibility for states to design their Medicaid benefits package, one participant wondered what the consequences would be if EPSDT were no longer mandatory for children in Medicaid. EPSDT provides comprehensive screening (e.g., vision, dental and hearing screening) and diagnosis services, and it covers treatment services for the conditions identified by the screening or diagnosis, even if that state’s Medicaid program does not ordinarily cover that benefit. In particular, there was a concern about how important the treatment component of that program is for low-income children.

In Mississippi much of what is covered under EPSDT and what is not covered under commercial insurance packages are services related to educational developmental (such as speech therapy and occupational therapy) services.

Another state participant said it makes more sense for special education services in schools to be adequately funded than to have schools bill Medicaid for these education-related services. This can set up inequities among schools where the more advantaged schools are capable of billing Medicaid and many of the under-resourced schools do not have the administrative infrastructure to bill for Medicaid services.

What are the consequences of Medicaid’s current “all or nothing” approach?

One participant asked the group to elaborate on the choices created for states by the current “all or nothing” structure of Medicaid benefits and eligibility rules.

As an example, Oregon reported state officials were frustrated that they were allowed to eliminate their Medicaid prescription drug benefit but could not modify its hospital inpatient benefit. He said states would like to have the flexibility to make more detailed changes than are currently permitted.

Right now if a state wants to offer or take away a benefit under Medicaid they have to offer it or take it away from the entire Medicaid population. States normally do not have the option to reduce or eliminate a benefit for higher income beneficiaries who could afford to pay for the services on their own, if need be.

As another example, Minnesota put a \$25 co-payment on eyeglasses in 1995. This state would like to increase the co-payment in 2003, but they have been told by CMS they cannot.

Minnesota's only remaining option is to cut the vision benefit for the whole Medicaid program. Similarly, they would like to modify their dental benefit, but without the flexibility to do so they may need to cut dental services entirely.

Flexibility is a critical issue for states right now. New Jersey has a \$5 billion deficit and anticipates significant cuts in the state's Medicaid program.

Oregon would like to consider cutting some inpatient benefits and offer some mental health and chemical dependency services instead to adults. The current construct of defining large benefits blocks for large population groups does not permit states to do the hard work necessary to design a rational benefits package for specific populations.

The current all-or-nothing structure led Massachusetts to cut optional physical therapy, speech therapy, and occupational therapy services when they are delivered in an office setting. However, because the state cannot modify its outpatient hospital benefit, it still has to cover these services when they are delivered in an outpatient hospital setting, which is a much more expensive setting. As another example, even though Massachusetts cut dental, vision, and hearing services, it still has to pay for hearing services if they are provided by a physician but not if they are provided by an audiologist.

The fastest growing components of Medicaid budgets

A meeting participant asked which health care cost components are growing fastest for states?

Most state representatives answered that hospital and pharmaceuticals were growing the fastest, along with nursing home costs.

The Medicaid beneficiaries in Massachusetts age 65 and over cost an average of \$17,000 per year and those in nursing homes cost \$40,000 per year. It is frustrating for the state, because Medicaid first learns of many of these participants when they are admitted to a nursing home, and it would be helpful to know of them before nursing home care is needed so alternatives could be explored. Most costs are for mandatory services for mandatory populations, which cannot be modified under HIFA.

A useful federal law change would allow states to have a longer look back at long-term care recipients' assets, because many people transfer wealth to their heirs and then qualify for Medicaid nursing home coverage. In Minnesota there is a campaign entitled "2030" to encourage people to plan ahead for their long-term care needs and buy long-term care insurance now. Giving Medicaid programs more latitude to provide home- and community-based care makes more sense than just providing nursing home care.

Approximately 60 percent of the nursing home care in Washington is paid for by Medicaid. Some people transfer their assets to family members in order to qualify for Medicaid rather than purchasing insurance or using personal savings. As a way to encourage the purchase of long-term care insurance, Washington State started offering group long-term care insurance to state employees (fully paid for by the employee) for the past four years with the goal of encouraging

people in their 40s to start planning for long-term care costs. Only 1,200 people purchased the coverage with the initial offering. She said a change has to be made in the social construct of how long-term care services are financed, or a deliberate decision needs to be made to fund it publicly for everyone.

Operational issues related to collecting premiums

Participants were asked to discuss other topics related to the operational issues of collecting premiums.

New Jersey reported they found the thought of collecting premiums more daunting than actually doing it. The state decided to out-source this activity and as a result it has been expensive to administer.

Whether to out-source premium collections or develop the capability in-house has created an internal debate for Maryland. The state agency is actively questioning whether they are an administrative services organization or whether they serve more as a health insurance company for their participants. Maryland officials also noted that SCHIP received a full and thoughtful debate on what kind of program it was and what its purpose was when it was created in 1997, but that the same debate has not happened for Medicaid in recent years. She suggested that Medicaid is intended to assure a complete benefits package to a core group of low-income beneficiaries and that it makes sense to offer different benefits and different cost sharing levels to higher income participants.

Conclusion

Medicaid participant buy-in programs have increased in both number and enrollment in recent years, and states have demonstrated that they can design and implement participant buy-in programs using existing waiver mechanisms. A debate about the role and purpose of Medicaid could help clarify what changes to the program would be beneficial for the future. Several participants at the January 2003 meeting said they believe that continuing an active dialogue between state and federal officials will be particularly important as Medicaid changes are debated by Congress and the administration.