STATE HEALTH POLICY MONITOR

In this Monitor: Childless Adults, Uninsured Adults

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State Efforts to Cover Low-Income Adults Without Children

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Most Americans assume that our health insurance safety net covers the poor, regardless of family status.[1] In reality, a majority of uninsured Americans are low-income, childless adults who are not eligible for public programs. While nearly half of states have programs in place to serve at least some of this population, many of these programs limit enrollment and provide limited benefits.

In the United States today, 80 percent of the approximately 47 million people without health insurance are adults ages 19 to 64.[2] Within this population, adults without dependent children, or "childless adults," are the group most likely to be uninsured (See Figure 1).[3] Low-income, childless adults make up more than one-third – 34 percent or approximately 16 million people – of the total uninsured population.[4]

There are several reasons why so many low-income, childless adults are uninsured. First, while most low-income children are eligible for Medicaid or the State Childrens Health Insurance Program (SCHIP), adults are generally only eligible for Medicaid if they are disabled, pregnant, or a parent, *and* they meet Medicaid's income, asset, and other requirements. Second, low-income adults are more likely to be in lower-paying jobs that do not offer employer-sponsored insurance (ESI). Finally, even if their employer does offer health insurance, low-wage employees may be ineligible for the employer plan, or may forego coverage due to premiums and cost sharing.[5]

Being uninsured is a significant risk factor that contributes to poorer health outcomes. Because uninsured adults are less likely than their insured counterparts to have regular outpatient or preventive care, they are more likely to be hospitalized for avoidable health problems and diagnosed in later stages of disease. And since they are often unable to pay, the uninsured are more likely to forgo needed medical treatments and prescription drugs, leading to poorer health.[6]

To overcome these barriers, many states have tried to create affordable coverage options for this uninsured group. Currently, 23 states and the District of Columbia[7] operate a variety of programs specifically focused on low-income, childless adults (See Figure 2). Some of these programs are financed through Medicaid §1115 waivers and others are financed solely through state dollars. This *State Health Policy Monitor* examines states' initiatives that provide subsidized or free health coverage to low-income, childless adults,[8] including options for financing coverage, as well as key features of

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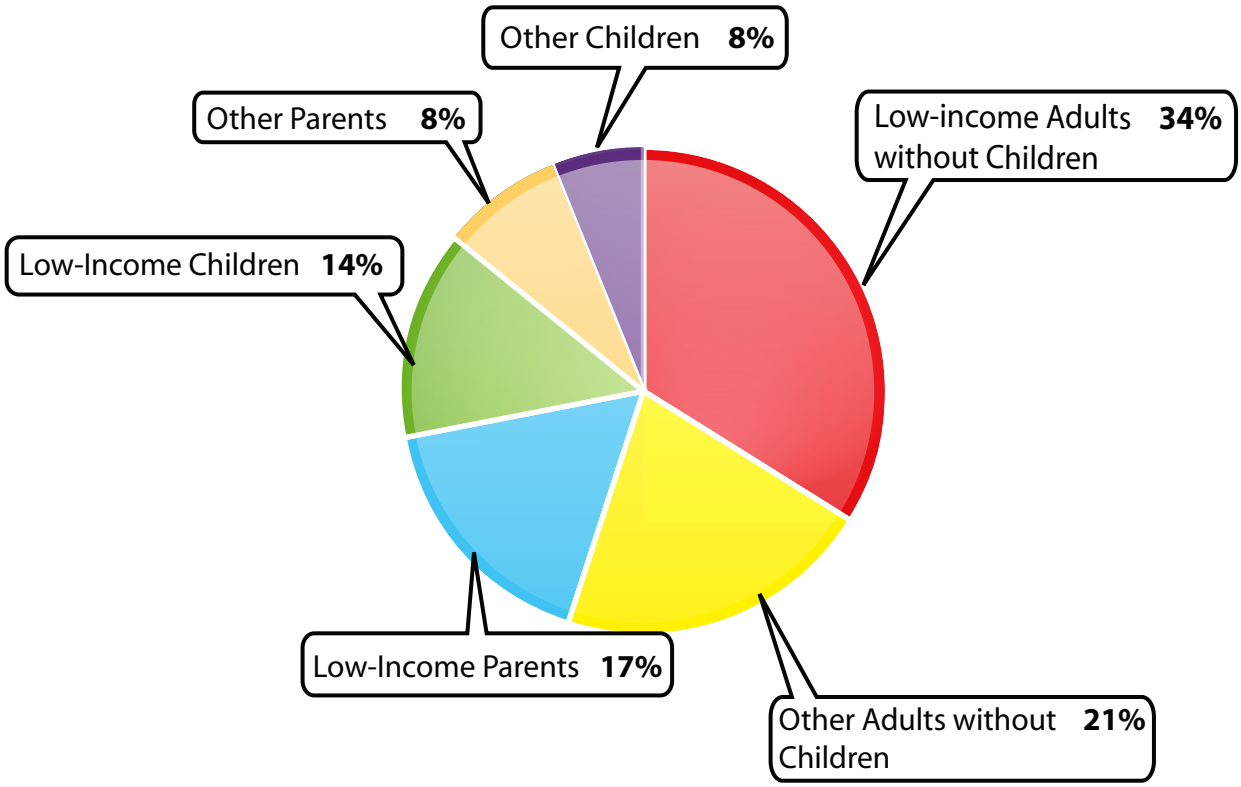
FIGURE 1: THE NONELDERLY UNINSURED, BY AGE AND INCOME GROUPS, 2006



Note: Low-income includes those family incomes less than 200% of the federal poverty level.

Source: The Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer*. (Washington, DC: The Kaiser Family Foundation, October, 2007). Data based on the Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of the March 2007 Current Population Survey.

programs such as eligibility rules, benefit design, and cost sharing.

States' Options for Financing Coverage to Childless Adults

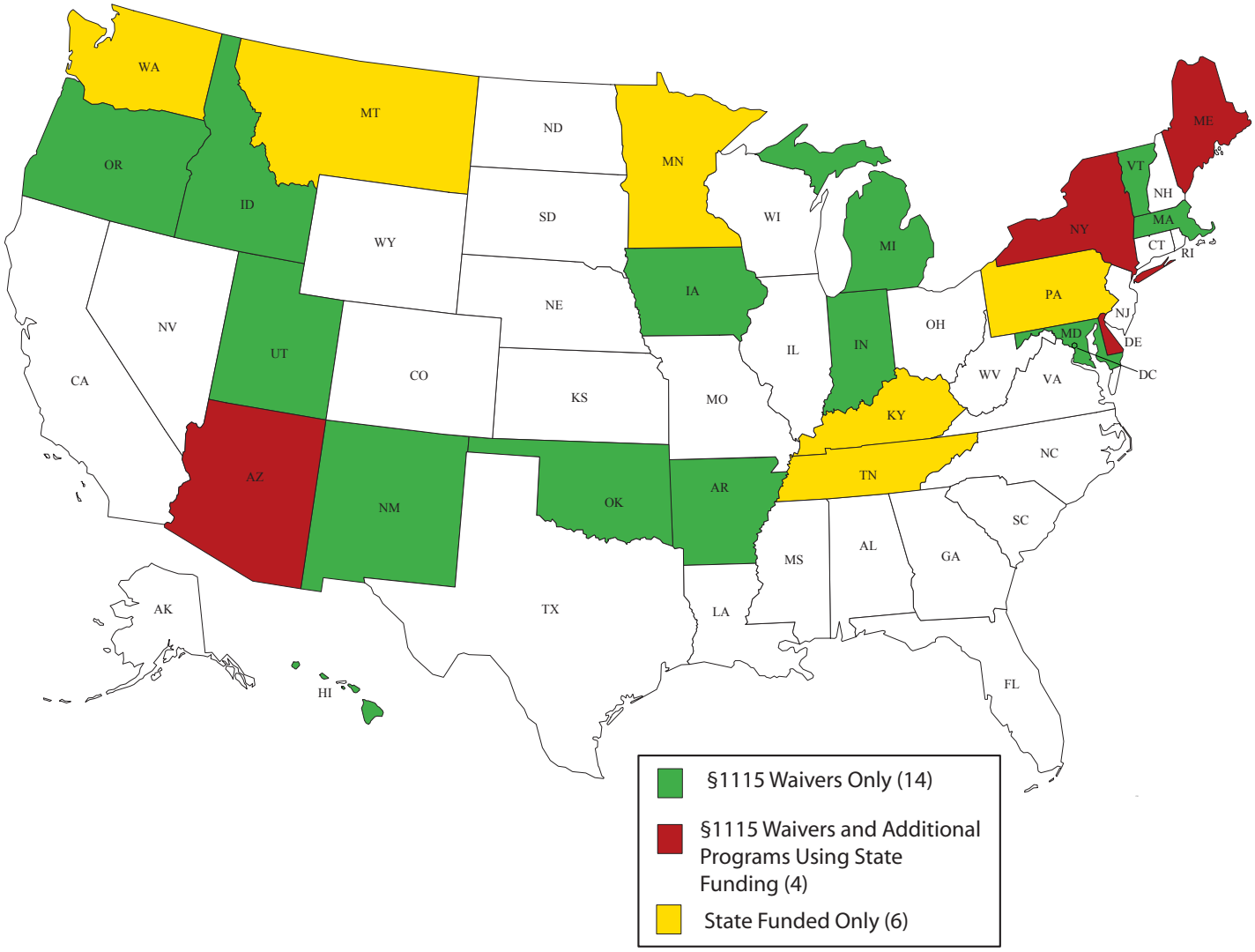
States have approached coverage of low-income, childless adults in a number of ways, with varying benefit design and cost sharing, eligibility rules, levels and types of employer involvement, and sources of funding (see Table 1). Of the 24 states that have programs that provide free or subsidized coverage to low-income, childless adults, 18 accomplish this in whole or in part through a §1115 waiver.[9] Four of these waiver states also have created additional programs using state funding in an attempt to reach a larger population. The remaining six states use only state funding in order to provide coverage to their low-income adult populations.

Medicaid §1115 Demonstration Waivers

Many might assume that Medicaid automatically covers low-income, childless adults, because it is the key federal health program that provides health coverage to low-income populations. However, Medicaid's mandatory and optional eligibility categories do not include childless adults, regardless of their poverty level.[10]

States wishing to use federal Medicaid funds to finance coverage for childless adults may do so only through a §1115 waiver. Under §1115 of the Social Security Act, the Centers for Medicare and Medicaid Services (CMS) may waive many of Medicaid's requirements to allow states to demonstrate alternative approaches that "promot[e] the objectives" of the Medicaid program. In 2001, the U.S. Department of Health and Human Services launched the Health Insurance Flexibility and Accountability (HIFA)

FIGURE 2: STATE COVERAGE OF LOW-INCOME ADULTS WITHOUT CHILDREN



initiative with a goal of expanding health coverage to the uninsured while using only current levels of federal Medicaid and SCHIP spending. With an emphasis on encouraging employer-sponsored insurance (such as through premium assistance programs), the HIFA initiative provided states with unprecedented flexibility in crafting their §1115 demonstration programs (such as through reducing benefits, increasing cost sharing, or imposing enrollment caps).[11]

100 Percent State-Funded Programs

Ten states have financed one or more free or subsidized coverage programs using 100 percent state dollars. These programs are financed using combinations of tobacco tax increases, tobacco settlement dollars, taxes on health care providers, enrollee premiums and cost sharing, employer contributions, and state general fund appropriations. By using state-only funds instead of accepting federal matching funds, states have even more flexibility to structure their programs.

Public-Private Partnerships

A growing number of states have implemented programs that are funded jointly by government and private contributions. This joint financing structure reduces the amount the enrollee must pay and enables this population to afford the premiums in their employer's plan or other private health insurance. These initiatives include premium assistance programs, small employer programs, or reinsurance programs.

§1115 Waivers and Budget Neutrality

Using §1115 waivers, states have been able to use federal Medicaid matching funds to cover childless adults. Under a waiver, a state must meet budget neutrality requirements. Budget neutrality requires that a waiver program cannot result in a higher level of federal spending than would result from the state's traditional Medicaid program, as demonstrated through a comparison of the projected "with waiver" and "without waiver" expenditures over the five-year waiver period.[1] These budget neutrality requirements often limit spending, which often leads to a more-restricted benefits package than otherwise provided through Medicaid.

Many states have met these budget neutrality requirements by reallocating other federal Medicaid funds – uncompensated care cost payments, disproportionate share hospital payments, and unspent SCHIP funds[2] – or using savings from enrolling existing beneficiaries into managed care programs in an effort to stretch the state's Medicaid dollars further.

Premium assistance programs use Medicaid and/or SCHIP funds to help pay for employer-based or other private health insurance coverage, and they often also use employer or enrollee fees to help pay premium costs. States can operate premium assistance programs through §1115 waivers.[12] Enrollment rates vary significantly from state to state and depend on a number of factors, including program design, eligible populations, and whether enrollment is mandatory or voluntary for those who meet eligibility criteria.[13]

For example, Insure Oklahoma's premium assistance program offers both a premium assistance option for small employers as well as an individual plan for employees without access to an employer program, the self-employed, or temporarily unemployed individuals seeking employment. Employees and their spouses who are eligible for Insure Oklahoma must be between the ages of 19 and 64 and have an income at or below 200 percent of the federal poverty level (FPL). In order for employers to be eligible for the Insure Oklahoma Employer Sponsored Insurance program, they must have 50 or fewer full-time employees, contribute at least 25 percent of premiums for qualified employees, and offer a qualified health plan; the employee must contribute up to 15 percent of premium costs. The Insure Oklahoma program contributes at least 60 percent of the employee's premium costs and 85 percent for the employee's spouse, but the employer is not required to contribute to the premium for eligible spouses. The premium in the Individual Plan is based on a sliding scale of income. As of August 2008, the Insure Oklahoma Employer Sponsored Insurance Program had almost 10,000 enrollees, with approximately 3,100 firms participating, and the Insure Oklahoma Individual Plan had more than 3,500 enrollees.[14]

A few programs have unique public-private financing structures that focus on small employers with low- to moderate-wage employees. This focus is important, since small employers have much higher rates of uninsured employees compared to larger firms. In 2007, more than 35 percent of workers in firms with fewer than 10 employees were uninsured compared to 13 percent of employees in firms with 1,000 or more employees reporting as uninsured.[15]

For example, the Insure Montana program allows small employers with up to nine employees to participate in a purchasing pool. Employees must earn less than $75,000 (excluding the employer) in gross wages per year. Employers must contribute at least 50 percent of the employee's premium, while the employee pays the rest. The state reimburses the employer half of what it pays, and reimburses between 20 to 90 percent of the employee's share, depending on the employee's household income.[16] The average employer payment is $198, while employees receive an average of $156 from the state.[17] In addition, employers who already pay for group health insurance may receive a refundable tax credit for each enrollee covered by the employer's plan. As of August 2008, 747 businesses were participating in the Insure Montana purchasing pool with almost 4,000 individuals receiving coverage. In addition, more than 700 businesses received a tax credit through the program.[18]

Reinsurance programs are a third type of financial assistance program that are funded jointly by public and private contributions. Reinsurance programs work under the principle that if the state or federal governments create a program that assumes responsibility for the majority of extreme health insurance expenses, insurers will have

less reason to fear adverse selection and can therefore significantly lower overall premiums. Currently, Healthy New York uses a state-funded reinsurance mechanism that provides benefits to nearly 150,000 New York residents. The program offers lower premiums than individual or small group policies because the state reimburses health plans for 90 percent of claims paid between $5,000 and $75,000 per enrollee.[19]

Qualifying small employers, sole proprietors, and individuals are eligible for Healthy New York provided they have not been insured in the past 12 months or have lost their insurance due to a qualifying event. In 2007, income eligibility was capped at $25,284 per year for single adults and $51,384 for a family of four. Eligibility for the program is also conditioned on employment history, requiring an individual and his or her spouse to have worked sometime in the past 12 months. Small employers may buy into the program if they have fewer than 50 employees and 30 percent of their employees earn less than $36,500 annually (adjusted annually for inflation). Employers must contribute at least 50 percent of the premium, and at least 50 percent of employees must participate in the program or have coverage through another source.

Key Features of Programs for Childless Adults[20]

Eligibility Rules

Most states' programs (see Table 1) have eligibility rules based on both age and income level. Some programs also have residency requirements, minimum periods of uninsurance, or may require enrollees to have a particular employment status. In addition, under new rules set forth under the Deficit Reduction Act, Medicaid-funded programs require applicants to meet citizenship and identity documentation requirements.

Age-based eligibility varies only slightly between programs. Nineteen programs require enrollees to be between the ages of 19 and 64, whereas four programs' eligibility begins at 18, and programs in Maine and Minnesota start at age 21. Eight programs serve childless adults of all ages so long as they fall within the other eligibility specifications.

All state programs specify income limits for individual enrollees and/or the employees of participating employers. Seven programs limit eligibility to individuals with incomes at or below 100 percent of FPL, 18 programs provide coverage to individuals with incomes at or below 200 percent of FPL, and five programs extend coverage to individuals with incomes at or below 300 percent of FPL.

Many programs, particularly small employer and premium assistance programs, also condition eligibility on individuals' employment status, requiring that they be employed, seeking employment, or be the spouse of an employee. The Healthy New York program specifies that an individual or spouse must have worked, full-time or part-time, at some point in the last 12 months.

Enrollment and Funding Caps

Due to state budget constraints, and the nature of Medicaid §1115 waivers, most childless adult programs have either capped enrollment or capped funding. Several programs, including Pennsylvania's adultBasic, maintain long waiting lists. Insure Montana currently has a waiting list of 437 businesses for its purchasing pool and 47 businesses for its tax credit.[21] A few programs are capped at very low numbers, such as Idaho's Access to Health Insurance program, which is limited to 1,000 adults working for a small business.

Benefit Design

Eight programs listed in Table 2 provide limited benefits, and 22 programs provide comprehensive benefits.[22] "Limited" benefits denote that the program includes a limited number of provided services or allowable visits, or that covered benefits do not include inpatient hospital care and/or specialty physician care. Otherwise, programs are listed as "comprehensive." While for the purposes of this paper many programs are called "comprehensive," fewer than half of all programs for childless adults cover dental care and/or mental health services. The state programs that operate under a §1115 waiver generally offer a stripped-down version of the state's Medicaid benefits and may be limited or comprehensive.

Some programs, such as Arkansas' ARHealthNet, Utah's Primary Care Network (PCN), and Tennessee's CoverTN offer limited benefits. ARHealthNet provides enrollees with coverage for a limited number of services: six outpatient clinician visits, seven inpatient hospital days, two outpatient procedures or emergency room visits per year, and up

to two prescriptions per month. Through Utah's PCN, enrollees receive limited preventive care, but no specialty care or hospital coverage (except in emergencies).[23] The CoverTN program covers one adult physical and/or one well woman visit per year without a co-pay as well as up to six doctor visits, two emergency visits, one outpatient surgical visit and two outpatient diagnostic visits per year, all requiring co-pays.[24] These limited programs are not meant to ensure that all enrollees' health needs are met, but rather to cover specific health services that the state believes are the most needed and/or cost effective.

A few programs provide more comprehensive benefits. For example, Minnesota's General Assistance Medical Care program and MinnesotaCare both cover preventive and non-preventive clinic and physician care, emergency care, hospitalization, outpatient surgery, vision, dental, mental health, and prescriptions. Washington's Basic Health, another comprehensive program, covers physician care; inpatient, outpatient, and emergency care; organ transplants; mental health; chiropractic; and prescription drugs; all with no or nominal co-pays. Like many other comprehensive programs, it does not cover vision or dental care.

Cost Sharing

States have taken a variety of approaches to enrollee cost sharing. Most programs require that enrollees contribute in some way to paying for their care, through co-payments and/or coinsurance, deductibles, and monthly premium payments. Some programs have shifted a large portion of the health care cost burden to individuals and/or employers while others continue to cover all costs through state or federal funds. Free (or nearly free) programs include MaineCare for Childless Adults, Maryland's Primary Adult Care program, and Washington, DC's Healthcare Alliance program. Programs with higher cost-sharing requirements include Healthy New York, Tennessee's CoverTN, and Vermont's Catamount Health.

Conclusion

Recognizing that low-income, childless adults have little-to-no access to affordable health coverage, nearly half of states have created programs that extend some coverage to this large and needy population. This examination of state programs reveals a great variety of approaches, some more limited and some more generous than others, that incrementally attempt to reduce the number of uninsured in the United States.

Table 1: Eligibility and Financing[1]

State program	Ages	Income eligibility (as a percentage of the federal poverty level)	For workers only	Source of funding		Enrollment and/or funding cap
				§1115 waiver	State funds	
Arizona HIFA	19-64	0-100 (phase 1)		✓		Phase 1 limited to 27,000; total expenditures limited to available SCHIP funds.
Arizona Primary Care Program	All	0-200			✓	Fiscal year 2007 budget of $13 million.
Arkansas ARHealthNet[2]	19-64	0-200	✓	✓		Phase 1 capped at 15,000 parents, childless adults; Phase 2 at 80,000 parents, childless adults.
Delaware Community Healthcare Access Program	All	0-200			✓	
Delaware Diamond State Health Plan	19-64	0-100		✓		
District of Columbia Healthcare Alliance Program	All	0-200		✓		
Hawaii QUEST Adult Coverage Expansion	19-64	0-200		✓		Capped at 20,000 adults who exceed the QUEST cap of 125,000.
Idaho Access to Health Insurance[3]	18-64	0-185	✓	✓		Capped at 1,000 adults.
Healthy Indiana Plan[4]	19-64	0-200		✓		Capped financing; enrollment cap may be implemented.
IowaCare	19-64	0-200		✓		Capped, non-entitlement (SCI). Uses uncompensated care funds.
Kentucky ICARE[5]	18-64	Special	✓		✓	Budget of $20 million for first two years of pilot program.
MaineCare for Childless Adults	21-64	0-100		✓		Capped at 20,000 individuals and DSH diversion of at most $90 million.
Maine Dirigo Choice	All	0-300			✓	
Maryland Primary Adult Care Program[6]	19-64	0-116		✓		
Massachusetts Commonwealth Care	19-64	0-300		✓		
Massachusetts Insurance Partnership	19-64	0-300	✓	✓		
Michigan Adult Benefits Waiver	19-64	0-35		✓		Enrollment cap may be implemented if SCHIP funds exhausted.
MinnesotaCare	19-64	0-200			✓	

Table 1: Continued

State program	Ages	Income eligibility (as a percentage of the federal poverty level)	For workers only	Source of funding		Enrollment and/or funding cap
				§1115 waiver	State funds	
Minnesota General Assistance Medical Care (comprehensive plan)	21-64	0-75			✓	
Insure Montana[7]	All	Special	✓		✓	State allocated $20 million to fund 2008 and 2009.
New Mexico State Coverage Insurance[8]	19-64	0-200	✓	✓		
Healthy New York[9]	All	0-250	✓		✓	Enrollment cap may be implemented if funds exhausted.
New York Family Health Plus	19-64	0-100		✓		
Insure Oklahoma[10]	19-64	0-200	✓	✓		Premium assistance for employer sponsored insurance and individual plan programs each capped at 25,000 adults.
Oregon Family Health Insurance Assistance Program[11]	All	0-200		✓		Currently has a waiting list. Goal to cover 25,000 individuals.
Oregon Health Plan (standard plan)	19-64	0-100		✓		Capped enrollment; currently accepting 2,000 new members per month.
Pennsylvania adultBasic[12]	19-64	0-200			✓	Waiting list of 70,000.
Tennessee CoverTN[13]	19-64	Special	✓		✓	$100 million available for three years.
Utah Premium Partnership[14]	19-64	0-150	✓	✓		
Utah Primary Care Network[15]	19-64	0-150		✓		Enrollment cap of 25,000.
Vermont Catamount Health[16]	18-64	150-300	✓	✓		
Vermont Health Access Plan[17]	18-64	0-150		✓		
Washington Basic Health	All	0-200			✓	

Table 2: Benefits Design[1]

	Benefits[2]	Premiums[3]	Cost sharing[4]
Arizona HIFA	Comprehensive	None	Nominal
Arizona Primary Care Program	Limited	None	Sliding scale
Arkansas ARHealthNet[5]	Limited	Yes	Yes
Delaware Community Healthcare Access Program	Limited[6]	None	Sliding scale
Delaware Diamond State Health Plan	Comprehensive	None	Nominal
District of Columbia Healthcare Alliance Program	Comprehensive	None	None
Hawaii QUEST Adult Coverage Expansion	Comprehensive	None	None
Idaho Access to Health Insurance[7]	Premium assistance only	Varies by plan	Varies by plan
Healthy Indiana Plan[8]	Comprehensive	Yes	None
IowaCare	Comprehensive	Yes	Nominal
Kentucky ICARE[9]	Premium assistance only	Varies by plan	Varies by plan
MaineCare for Childless Adults	Comprehensive	None	Nominal
Maine Dirigo Choice	Comprehensive	Sliding scale	Yes
Maryland Primary Adult Care Program[10]	Limited	None	None
Massachusetts Commonwealth Care	Comprehensive	Sliding scale	Sliding scale
Massachusetts Insurance Partnership	Comprehensive	Varies by plan	Varies by plan
Michigan Adult Benefits Waiver	Limited	None	Nominal
MinnesotaCare	Comprehensive	Sliding Scale	Nominal
Minnesota General Assistance Medical Care (comprehensive plan)	Comprehensive	None	Nominal
Insure Montana[11]	Comprehensive	Sliding scale	Yes
New Mexico State Coverage Insurance[12]	Comprehensive	Sliding scale	Sliding scale
Healthy New York[13]	Comprehensive	Yes	Yes
New York Family Health Plus	Comprehensive	None	Yes
Insure Oklahoma[14]	Comprehensive	Sliding scale	Yes

Table 2: Continued

	Benefits[2]	Premiums[3]	Cost sharing[4]
Oregon Family Health Insurance Assistance Program[15]	Varies by plan	Sliding scale	Varies by plan
Oregon Health Plan (standard plan)	Limited[16]	Sliding Scale	None
Pennsylvania adultBasic[17]	Comprehensive	Yes	Yes
Tennessee CoverTN[18]	Limited	Yes	Yes
Utah Premium Partnership[19]	Comprehensive	Varies by plan	Varies by plan
Utah Primary Care Network[20]	Limited	Nominal	Yes
Vermont Catamount Health[21]	Comprehensive	Yes	Yes
Vermont Health Access Plan[22]	Comprehensive	Sliding scale	No
Washington Basic Health	Comprehensive	Sliding scale	Yes

Notes

1 A Kaiser Family Foundation survey found that 55 percent of those polled believed that low-income adults without children were eligible for Medicaid. Kaiser Family Foundation, *Public's Views About Medicaid Survey*, April 2005.

2 Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer.* (Washington, DC: The Kaiser Family Foundation, October 2007). The remaining 20 percent are children. Adults age 65 and older are not included in the programs examined in this *State Health Policy Monitor.*

3 Ibid. Forty-six percent of poor (at or below 100 percent FPL) and 39 percent of near-poor (between 100 and 200 percent FPL) childless adults are without health coverage, as compared to 44 percent and 34 percent of poor and near-poor parents, respectively, and 22 percent and 17 percent of poor and near-poor children, respectively.

4 Low income childless adults are defined in this *State Health Policy Monitor* as those with annual family income at or below 200 percent of the federal poverty level (FPL).

5 Sara Collins, et al. *On The Edge: Low-Wage Workers and Their Health Insurance Coverage* (New York: The Commonwealth Fund, April 2003). More than half of workers (a) whose employer does not offer health insurance or (b) who are not eligible for the employer plan are low-wage workers earning less than $10 an hour. Forty percent of these low-wage workers spend five percent or more of their income on health insurance premiums, as compared with 11 percent of workers who earn more than $15 an hour.

6 Institute of Medicine. *Care Without Coverage, Too Little, Too Late.* (Washington, DC: National Academy Press, 2002).

7 The following have implemented one or more programs that expand health coverage to childless adults: Arizona, Arkansas, Delaware, Hawaii, Idaho, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Tennessee, Utah, Vermont, Washington, and Washington, D.C. The 23 states and D.C. are referred to collectively in this *Monitor* as "states." Missouri is not included in this count, as its childless adult coverage will not begin until phase two of the Insure Missouri program.

8 This *State Health Policy Monitor* does not consider high risk pools for people with chronic medical conditions.

9 The following states currently have a §1115 waiver in place to extend coverage to low-income, childless adults: Arizona, Arkansas, Delaware, Washington D.C., Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, New Mexico, New York, Oklahoma, Oregon, Utah, Vermont.

10 The reasons for exclusion of childless adults from Medicaid are largely historical. Medicaid was created in 1965 as an adjunct to cash assistance programs established by the Social Security Act of 1935. These programs were focused on the elderly, the disabled, and families with children, and thus many of the same groups became eligible for Medicaid, leaving out childless adults. For a more in-depth explanation, see Stan Dorn et al, *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, August 2004).

11 "Medicaid, SCHIP, and Federal Authority." State Coverage Initiatives. Retrieved 11 May 2008. http://www.statecoverage.net/matrix/waivers.htm#hifa.

12 States can also offer premium assistance under Medicaid §1906 authority, but these programs cannot include childless adults.

13 For more information, see, Dan Belnap and Sonya Schwartz, *Premium Assistance* (Portland, ME: National Academy for State Health Policy, October 2007).

14 Insure Oklahoma. Retrieved 17 June 2008. http://www.insureoklahoma.org/index.aspx.

15 Paul Fronstin, "Sources of health insurance and characteristics of the Uninsured: Analysis of the March 2007 Current Population Survey," *EBRI Issue Brief* No. 310 (October 2007).

16 For a single employee whose annual income is between $14,355 and $19,140 and whose total premium is $340 per month, the employer pays $170 and is reimbursed $85 and the employee pays $170 and is reimbursed 60 percent, or $102.

17 Christina Goe, Montana Insurance Department, personal email with Sonya Schwartz, September 4, 2008.

18 Ibid.

19 All the information in this paragraph can be found in: EP&P Consulting, *2007 Annual Report on Healthy NY* (New York: State of New York Insurance Department, January 2008).

20 *See* Table 1, Features of State Programs for Adults without Children.

21 Goe.

22 See footnotes for Table 1 for explanation of terms. The pure premium assistance programs are not included in these counts, as employer plans vary greatly in the benefits they cover.

23 Caitlin Oppenheimer et al, *A Case Study of the Utah Primary Care Network Waiver: Insights into Its Development, Design & Implementation* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, March 2006).

24 "CoverTN Benefits." Retrieved 12 April 2008. http://www.covertn.gov/web/covertn_benefits.html.

Notes- §1115 Waivers, p.4

1 National Academy for State Health Policy. "Financing State Coverage Expansions: Can New Medicaid Flexibility Help?" State Health Policy Briefing, Vol. 1, Issue 2. (September 2007).

2 Under the Deficit Reduction Act, CMS was barred from granting new waivers that would provide coverage to childless adults with SCHIP funds after October 1, 2005.

Notes- Table 1

1 Information for full table is based on state program websites, CMS fact sheets, State Coverage Initiatives, Families USA, National Conference of State Legislatures. Specific sources are on file with author.

2 Program enrollee must be an employee (or spouse of an employee) of a participating employer with 500 or fewer employees and must have annual household income at or below 200 percent FPL to receive subsidized premium. Enrollee pays 15 percent coinsurance with $1,000 out-of pocket annual maximum.

3 Employer must pay at least 50 percent of premium for employer-sponsored insurance. AHI program provides subsidy of $100 per person (up to $500 per family) toward premiums. Employee responsible for remaining premium and any cost sharing.

4 Enrollee premiums range from 2 percent to 5 percent of family income and are placed in a health savings account. Indiana contributes the remainder, for a total account value of $1,100 per adult from which enrollee pays health care costs. Once account is exhausted, enrollee receives a basic commercial benefits package. The first $500 in preventive benefits are at no cost to enrollee.

5 To participate, employer must have 2-25 employees, the average of whose salaries may not exceed 300 percent FPL and must pay at least 50 percent of employee's premium. Employer is reimbursed $40 or $60 per employee per month (depending on program), which decreases with each subsequent year of participation. Individual eligibility for participating in the employer's program is determined by the contract with the insurer.

6 Beginning in 2010, Primary Adult Care enrollees will be eligible for Medicaid. Program includes no cost sharing except nominal prescription co-pays.

7 Employer purchasing pool limited to employers with two to nine employees, none of whose annual income exceeds $75,000.

8 Program allows individuals who are self-employed or whose employer does not offer health insurance to participate; individuals must pay both the employee and the employer portions. Small (50 or fewer employees) employers who participate pay $75 per employee per month.

9 Program pays for the reinsurance of 90 percent of claims between $5,000 and $75,000. All HMOs in New York are required to offer the Healthy NY plan. Premiums vary by region and health plan. Cost sharing is higher than in most other programs: $500 co-pay for inpatient hospital, 20 percent coinsurance for surgical services up to a maximum of $200, $20 co-pay for physician visits, $10-$20 for prescriptions.

10 Program offers both a premium assistance option for small employers and an Individual Plan for employees without access to an employer program, the self-employed, and temporarily unemployed individuals seeking employment.

11 Premium assistance program that reimburses an employee 50 percent, 70 percent, 90 percent or 95 percent of his portion of the monthly premium, depending on income level. Program does not cover cost sharing. Individuals may participate in the FHIAP individual plan and are billed for their portion by FHIAP. Approved employer plans must meet benchmark for approval but benefits may be limited under the benchmark.

12 All subsidized enrollees pay a premium of $33.50 per month. Persons on the waiting list who wish to may enroll at the state's cost of approximately $305.00 per month.

13 Self-employed (and individuals whose employer does not offer health insurance) who earn less than $43,000 per year may participate if they pay two-thirds of the total premium. At least half of small (50 or fewer employees) employers' employees must earn $43,000 or less per year. Employer must agree to pay one-third of employee's premium, which is based on age, tobacco use, and body mass index. Employee pays remaining third of premium.

14 Covers remainder after employer pays at least half of employee's premium for employer-sponsored plan, up to $150 per adult. Program does not cover cost sharing.

15 Premiums are means-tested: $15 per year for individuals receiving General Assistance, $25 per year for individuals with incomes below 50 percent of FPL, and $50 per year for all other individuals.

16 Premiums start at $60 per month for individuals at or below 200 percent FPL and scale upwards with income to $393 per month (full cost of insurance) for individuals at or above 300 percent FPL.

17 Co-payment only for emergency room use ($25). Premium ranges from $7 to $33 per month.

Notes- Table 2

1 Information for full table is based on state program websites, CMS fact sheets, State Coverage Initiatives, National Conference of State Legislatures. Specific sources are on file with the author.

2 "Limited" benefits indicates that the program includes a limited quantity of services provided or visits allowed, or that covered benefits do not include one or both of the following: inpatient hospital care or specialty physician care. Otherwise, programs are indicated as "Comprehensive" or "Premium assistance only." Comprehensive programs may or may not include oral health and/or mental health benefits.

3 Premiums are listed as none, nominal, sliding scale (ranging from zero to some non-zero amount, based on income), yes (meaning all enrollees pay a premium), or varies by plan.

4 Cost sharing includes co-payments, coinsurance, and deductibles and are listed as none, nominal, sliding scale (ranging from zero to some non-zero amount, based on income), yes (meaning all enrollees share costs), or varies by plan.

5 Program enrollees must be an employee (or spouse of an employee) of a participating employer with 500 or fewer employees and must have annual household income at or below 200 percent FPL to receive subsidized premium. Enrollees pay 15 percent coinsurance with $1,000 out-of pocket annual maximum.

6 Program is focused on providing the uninsured with a medical home for

primary care.

7 Employer must pay at least 50 percent of premium for employer-sponsored insurance. AHI program provides subsidy of $100 per person (up to $500 per family) toward premiums. Employee responsible for remaining premium and any cost-sharing.

8 Enrollee premiums range from 2 percent to 5 percent of family income and are placed in a health savings account. Indiana contributes the remainder, for a total account value of $1,100 per adult from which enrollees pays health care costs. Once account is exhausted, enrollees receive a basic commercial benefits package. The first $500 in preventive benefits are at no cost to enrollees.

9 To participate, employer must have 2-25 employees the average of whose salaries may not exceed 300 percent FPL and must pay at least 50 percent of employee's premium. Employer is reimbursed $40 or $60 per employee per month (depending on program), which decreases with each subsequent year of participation. Individual eligibility for participating in the employer's program is determined by the contract with the insurer.

10 Beginning in 2010, Primary Adult Care enrollees will be eligible for Medicaid. Program includes no cost sharing except nominal prescription co-pays.

11 Employer purchasing pool limited to employers with two to nine employees, none of whose annual income exceeds $75,000.

12 Program allows individuals who are self-employed or whose employer does not offer health insurance to participate; individuals must pay both the employee and the employer portions. Small (50 or fewer employees) employers who participate pay $75 per employee per month.

13 Program pays for the reinsurance of 90 percent of claims between $5,000 and $75,000. All HMOs in New York are required to offer the Healthy NY plan. Premiums vary by region and health plan. Cost sharing is higher than in most other programs: $500 co-pay for inpatient hospital, 20 percent coinsurance for surgical services, $20 co-pay for physician visits, $10-$20 for prescriptions.

14 Program offers both a premium assistance option for small employers and an Individual Plan for employees without access to an employer program, the self-employed, and individuals seeking employment.

15 Premium assistance program that reimburses an employee 50 percent, 70 percent, 90 percent, or 95 percent of his portion of the monthly premium, depending on income level. Program does not cover cost sharing. Individuals may participate in the FHIAP individual plan and are billed for their portion by FHIAP. Approved employer plans must meet benchmark for approval but benefits may be limited under the benchmark.

16 Covers hospital care and dental care only in emergencies.

17 All subsidized enrollees pay a premium of $33.50 per month. Persons on the waiting list who wish to may enroll at the state's cost of approximately $305.00 per month.

18 Self-employed (and individuals whose employer does not offer health insurance) who earn less than $43,000 per year may participate if they pay two-thirds of the total premium. At least half of small (50 or fewer employees) employers' employees must earn $43,000 or less per year. Employer must agree to pay one-third of employee's premium, which is based on age, tobacco use, and body mass index. Employee pays remaining third of premium.

19 Covers remainder after employer pays at least half of employee's premium for employer-sponsored plan, up to $150 per adult. Program does not cover cost sharing.

20 Premiums are means-tested: $15 per year for individuals receiving General Assistance, $25 per year for individuals with incomes below 50 percent of FPL, and $50 per year for all other individuals.

21 Premiums start at $60 per month for individuals at or below 200 percent FPL and scale upwards with income to $393 per month (full cost of insurance) for individuals at or above 300 percent FPL.

22 Co-payment only for emergency room use ($25). Premium ranges from $7 to $33 per month.

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Keavney Klein and Sonya Schwartz, "State Efforts to Cover Low-Income Adults without Children," State Health Policy Monitor, Vol. 2, Issue 3. (Portland, ME: National Academy for State Health Policy, September 2008).

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