

kaiser
commission onTHE HENRY J.
KAISER
FAMILY
FOUNDATION

medicaid and the uninsured

July 2010

Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences

Executive Summary

The Medicaid expansion to cover nearly all low-income individuals up to 133% of the poverty level (\$14,404 for an individual in 2009) is the foundation for coverage in the new health reform law. Prior to reform, states could only cover non-disabled adults without dependent children through a Medicaid waiver or fully state-funded program. Expanding Medicaid to newly eligible childless adults will be among the key issues in implementing health reform. Based on interviews with officials in seven states and the District of Columbia and national experts, this report provides lessons learned to help inform reform expansion efforts as well as profiles of programs included in the study. Key findings include:

Historic lack of eligibility for Medicaid, limited connection to public programs, fluctuating incomes, and language and cultural barriers all serve as challenges to reaching and enrolling childless adults. Many low-income childless adults may not be aware of their eligibility for Medicaid or understand the value of coverage. Further, certain subgroups may face particular enrollment challenges such as those with limited English proficiency or literacy issues, young adults aging out of children's coverage, and individuals with chronic physical and/or mental conditions who have complex health needs.

Many best practices for enrolling parents and children in Medicaid and CHIP will apply to childless adults, but reaching these adults will also require new outreach strategies and messages. As true for parents and children, simplified enrollment procedures that minimize paperwork and utilize technology as well as clear outreach messages will be important for facilitating enrollment among childless adults. However, given childless adults' historic exclusion from the program, it will be particularly important to communicate their new eligibility for coverage, that the "rules have changed," and that they are "wanted" in the program. Further, messages that highlight the services coverage will provide access to and that focus on the health and financial risks of being uninsured are likely to be more compelling than preventive messages for this population. Partnering with community-based organizations and providers will be key for reaching and enrolling childless adults, and facilitated enrollment processes could be effective for enrolling adults with complex health needs or language or literacy issues. Additionally, outreach may need to be conducted through new avenues, such as unemployment offices, job training programs, shelters, community colleges, and employee organizations.

More needs to be learned about the health needs of low-income childless adults and how to best deliver and manage their care. Some of the states in this study found that childless adult enrollees had greater health needs than expected. This may, in part, reflect pent-up demand for services among childless adults who have been uninsured for a long period of time and some adverse selection. Most states in this study used a managed care arrangement to serve childless adults and some used assessment tools to identify the needs of new enrollees and connect them with disease or case management services. However, more work is needed to understand the health needs of these adults and how to best manage their care.

Health reform will expand Medicaid to millions of low-income adults, including childless adults who have historically been ineligible for the program, necessitating one of the largest enrollment efforts in the program's history. Many best practices for enrolling parents and children will apply to childless adults, but successful efforts will also require new strategies and messages. Given the significance and size of the expansion, it will be key for states to be ready and prepared with the necessary systems, technology, and administrative capacity in place to process enrollments and to coordinate coverage and care with the new Health Insurance Exchanges.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: 202-347-5270, FAX: 202-347-5274
WEBSITE: WWW.KFF.ORG

Introduction

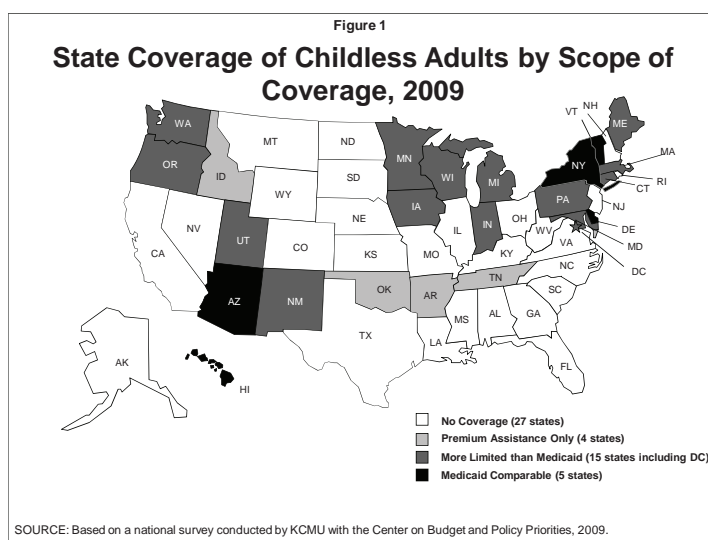
An expansion of the Medicaid program to cover nearly all low-income individuals up to 133% of the poverty level (\$14,404 for an individual or \$29,327 for a family of four in 2009) is the foundation for coverage in the newly passed health reform law. Prior to health reform, non-disabled adults without dependent children (childless adults) were not included in the categories of people states could cover through Medicaid and receive federal matching funds, so states could only cover this population through a Medicaid waiver or fully state-funded program. Reaching, enrolling and delivering care to childless adults will be among the key issues in implementing health reform. Based on interviews with officials in seven states and the District of Columbia and national experts, this report provides lessons learned and best practices to help inform reform expansion efforts as well as profiles of the waiver and state-funded programs included in the study (see Appendix A: State Profiles). The findings in this report focus on three key questions:

- What are the challenges in reaching and enrolling childless adults?
- What works best in efforts to reach and enroll childless adults?
- What are some lessons learned in how to best deliver care for this population?

Background

Prior to health reform, Medicaid coverage for adults was limited. Before reform, states were required to cover certain groups through Medicaid, including children, pregnant women, elderly and disabled individuals, and parents, to federal minimum levels and had the option to expand eligibility to higher incomes. Some states used their optional authority to expand eligibility to parents above minimum levels (called Section 1931 expansions) and other states expanded parent eligibility through waivers or state-funded programs. However, as of 2009, Medicaid coverage for parents remained limited, with 34 states restricting Medicaid eligibility to less than 100% of poverty and 17 of these states limiting eligibility to less than 50% of poverty.

Adults without dependent children were not included in the categories of people states could cover through Medicaid and receive federal matching funds before reform, regardless of their income. States could only cover these adults through a waiver or fully state-funded program. Reflecting these limitations, more than half of states did not provide coverage to childless adults as of 2009 (Figure 1). Five states provided coverage comparable to Medicaid, fifteen states only provided coverage more limited than Medicaid, and four states solely covered childless adults through a premium assistance program limited to adults who meet certain employment-related eligibility requirements.¹

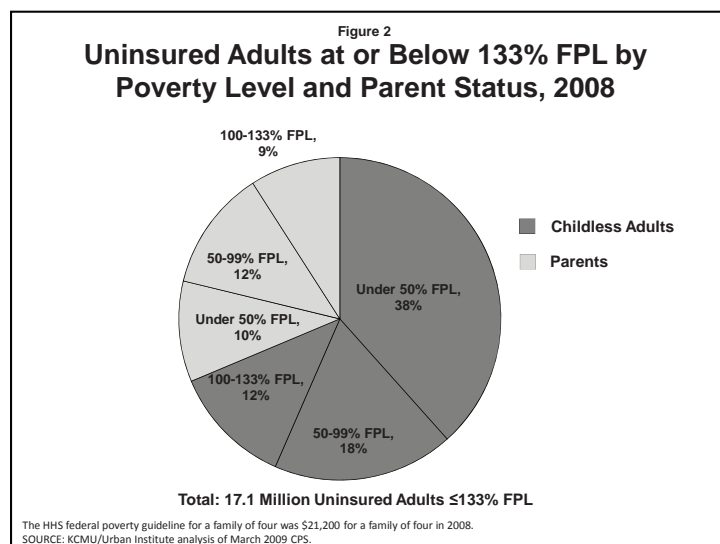


¹ Kaiser Commission on Medicaid and the Uninsured. "Where are States Today? Medicaid and State-Funded Coverage Eligibility Levels for Low-Income Adults." December 2009.

Effective in 2014, the new health reform law expands Medicaid to a national floor of 133% of the federal poverty level (FPL), which is \$14,404 for an individual or about \$29,326 for a family of four in 2009. This expansion will effectively eliminate categorical eligibility requirements for Medicaid, making childless adults newly eligible for the program and reducing state-by-state variation in eligibility for Medicaid. These changes help to provide a base of seamless and affordable coverage nationwide through Medicaid for individuals with incomes up to 133% FPL. Subsidies for coverage will be available for individuals with incomes between 133% and 400% of poverty through state-based Health Insurance Exchanges. Individuals eligible for Medicaid would not be eligible for subsidies in the state exchanges. For most Medicaid enrollees, income would be based on modified adjusted gross income without an assets test or resource test.²

An estimated 17.1 million uninsured adults are at or below 133% FPL, the new Medicaid coverage floor.

These adults comprise 37% of all the uninsured in the United States. The majority of these uninsured adults do not have dependent children and about half have family incomes below 50% FPL (Figure 2). Very low-income adults have limited access to affordable private coverage. Uninsured childless adults have historically been and continue to be significantly more likely to be below 50% FPL than uninsured parents, which is due to higher rates of Medicaid coverage among the lowest income parents. Further, uninsured childless adults at or below 133% FPL are more likely to be either on the younger end of the age spectrum (34% are age 19-25) or to be older adults (13% are age 55-64), while uninsured parents at or below 133% FPL are predominantly in the 26-54 age range (81%).³ Uninsured adults aged 55-64 are particularly vulnerable when uninsured, since they are at an increased risk of serious health problems.



One in six uninsured childless adults at or below 133% FPL are in fair or poor health and many have problems with access to care.⁴ About one-third of uninsured childless adults with family incomes at or below 133% FPL have been diagnosed with a chronic condition.⁵ However, over 60% of uninsured childless adults in this income group have no usual source of care, which can make it more difficult for them to access needed care and may make it less likely that they will receive preventive care.⁶ For example, about one-third of these adults have not had their blood pressure checked in the past two years, even though this low-cost screening can detect hypertension before it leads to disability or death, and, among those with a chronic condition, more than four in ten did not have a doctor's office visit in the past year.⁷

² There is a special deduction to income equal to five percentage points of the poverty level raising the effective eligibility level to 138% of poverty. The legislation maintains existing income counting rules for the elderly and groups eligible through another program like foster care, low-income Medicare beneficiaries and Supplemental Security Income (SSI).

³ Kaiser Commission on Medicaid and the Uninsured. "Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty." April 2010.

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

Study Approach

Prior to the broad Medicaid expansion under reform, a number of states were leaders in expanding coverage for childless adults to help provide affordable coverage options for this population and reduce the number of uninsured. This study examined the experiences in a selected number of these states and also drew on the perspectives of a number of national experts in eligibility and enrollment to help inform expansion efforts under reform. More details on each state program included in this study are available in the “State Profiles” section at Appendix A.

Reflecting the fact that federal law did not provide states the option to cover childless adults through Medicaid before reform, existing programs for childless adults vary significantly based on longevity, structure, financing, enrollment, benefits and cost sharing. This report focused on programs in seven states and the District of Columbia that vary across these factors as well as geographically (Table 1). Five programs operate under Section 1115 Waiver authority (Arizona, Indiana, New York, Wisconsin and Vermont) and three are fully state-funded programs (District of Columbia, Pennsylvania and Washington). Upper income eligibility for childless adults in these programs ranged from 100% FPL to 300% FPL, with most limiting eligibility to 200% FPL. Programs vary in how income is verified, application of income disregards or assets tests and limits for individuals with access to employer sponsored coverage.

Several of the studied programs for childless adults have slimmer benefit packages compared to Medicaid. Further, some charge premiums or enrollment fees and above-nominal cost sharing amounts. For example, Wisconsin imposes a one-time \$60 enrollment fee and Pennsylvania, Vermont (Catamount Health) and Washington charge monthly premiums.

Table 1:
Key Characteristics of Selected Programs Covering Childless Adults, 2010

State	Program Name	Income Eligibility Limit	Premiums	Cost Sharing	Benefits (Relative to Medicaid)
1115 Waiver Programs					
Arizona	Health Care Cost Containment System	100% FPL	No	Nominal	Medicaid
Indiana	Healthy Indiana Plan	200% FPL	Yes	Above Nominal	More limited
New York	Medicaid (Home Relief)	78% FPL	No	Nominal	Medicaid
	Family Health Plus	100% FPL	No	Nominal	Medicaid-like
Vermont	VHAP	150% FPL	>50% FPL	Nominal	Medicaid-like
	Catamount Health	150-300% FPL	Yes	Nominal	More limited
Wisconsin	BadgerCare Plus Core Plan	200% FPL	\$60 enrollment fee	Nominal	More limited
	BadgerCare Plus Basic Plan	200% FPL	Yes	Above Nominal	More limited
State-Funded Programs					
DC	Healthcare Alliance	200% FPL	No	No	More limited
Pennsylvania	adultBasic	200% FPL	Yes	Above Nominal	More limited
Washington	Basic Health	200% FPL	Yes	Above Nominal	More limited*

* According to actuarial analysis Basic Health benefits are equal to about 90% of Medicaid benefits.

Key Lessons Learned from State Experiences

While current state programs for childless adults vary based on structure, financing, benefits and cost sharing, childless adult coverage will become more standardized across the country with national standards for determining eligibility and benefits as mandated in health reform. However, a great deal about the challenges and best practices of reaching, enrolling and delivering care to childless adults can be learned from states that have been leaders in providing coverage to this population.

1. What are the challenges in reaching, enrolling and delivering care to childless adults?

While past efforts to enroll childless adults were severely limited by state fiscal capacity, broad enrollment efforts under reform will be supported with additional federal financing and a new entitlement to coverage. Since, prior to reform, childless adults were not included in the categories of people states could cover through Medicaid, states could not receive additional federal financing to support coverage of these adults. As such, historically, financing for these programs has been limited. However, states implementing these programs experienced high demand for coverage given the lack of affordable coverage options available to this population. Further, similar to Medicaid and other public assistance programs, the need and demand for coverage has been growing as a result of the recession at the same time states are looking to reduce program spending to meet balanced budget requirements. Reflecting these factors, a number of states have had to limit enrollment in their programs due to funding constraints, and several have significant waiting lists for coverage (Table 2). For example, in Pennsylvania, demand has always exceeded the available funding for its adultBasic program, and, as of June 2010, it had some 397,000 adults on its waitlist compared to the 46,000 adults enrolled. Similarly, recent budget constraints required Washington to dramatically reduce enrollment in its Basic Health program and, as of June 2010, there were over 110,000 adults on the waitlist for Basic Health coverage. Indiana also has a cap on its childless adult enrollment and a growing waitlist for coverage.

Table 2:
Childless Adult Enrollment, Enrollment Caps, and Waitlists in Study Programs

State	Program Name	Enrollment	Enrollment Cap?	Waitlist
1115 Waiver Programs				
Arizona	Health Care Cost Containment System	212,941	No	-
Indiana	Healthy Indiana Plan	18,694	Yes	49,995
New York	Medicaid (Home Relief)	683,918	No	-
	Family Health Plus	98,720	No	-
Vermont	VHAP	35,700*	No	-
	Catamount Health	10,700*	No	-
Wisconsin	BadgerCare Plus Core Plan	56,300	Yes	30,000
	Badge Care Plus Basic Plan	2,500	No	-
State-Funded Programs				
DC	Healthcare Alliance	57,000**	No	-
Pennsylvania	adultBasic	46,000	Yes	397,000
Washington	Basic Health	65,000	Yes	110,000

Source: KCMU interviews with state officials and analysis of state materials, 2010.

Notes: Enrollment data is as of June 2010, except for Arizona, which is as of July 2010; New York, which is as of December 2009; and Wisconsin's Badger Care Plus Basic Plan, which is as of July 2010.

*Enrollment includes parents and childless adults and some adults who receive premium assistance for employer-sponsored insurance.

**As of July 1, 2010, approximately 32,000 of these childless adults had been moved to Medicaid coverage under the new PPACA adult coverage option implemented by the District.

Under reform, coverage up to the new minimum threshold of 133% FPL will be an entitlement and states will receive significant new federal financing to support the expansion. For individuals made newly eligible for Medicaid coverage under health reform states will receive full federal financing from 2014 through 2016, and then federal support phases down to 90 percent by 2020.⁸ Childless adults currently covered by state-funded programs as well as those covered by Medicaid in a plan with benefits that do not meet a benchmark, will be eligible for the higher “newly eligible” match rate. States that have already expanded coverage to childless adults through a Medicaid 1115 Waiver will be eligible for an enhanced match rate that will be phased in to be equal to the “newly eligible” match rate of 93% by 2019 and 90% in 2020. Analysis of the financing shows that the federal government will finance about 95 percent of the costs of the Medicaid expansion.⁹ This additional financing will give states greater fiscal capacity to enroll more individuals and the new entitlement will prohibit states from imposing enrollment caps on coverage for childless adults up to the new coverage floor.

Lack of awareness and historic lack of eligibility for coverage may contribute to challenges enrolling low-income childless adults. Many participants noted that a key barrier to coverage for childless adults will likely be awareness. Low-income childless adults may not be aware that benefits exist and/or assume they are not eligible, particularly since they have not previously been eligible for the program. Similarly, if they are working and associate Medicaid coverage with welfare, they may not think the program is available to them or may be reluctant to go through the enrollment process, particularly if they think they must sign up through a welfare office.¹⁰

It was further noted that the problem of lack of awareness is compounded by the fact that it is difficult to reach childless adults since they have limited connections with public programs in general. For example, while uninsured parents and children who may be eligible for Medicaid may be participating in Temporary Assistance for Needy Families, assistance programs for low-income childless adults are significantly more limited. Thus, they are less likely to be in other program enrollment files or state databases. Additionally, unless they have a chronic condition, adults may have very limited interaction with the health system and may not fully understand the value of coverage.¹¹ While children must get vaccines to be able to attend school, which often facilitates interaction with the health care system, this built-in interaction does not exist for adults. They often may not connect with the health care system until they become sick and need care.

Low-income individuals often have fluctuating incomes that can make enrollment more complex. Participants described two key enrollment challenges that can arise due to fluctuating incomes. First, individuals may move in and out of eligibility for Medicaid as their incomes fluctuate. Second, the fluctuations can make both income documentation and administrative verification difficult since these individuals may not be receiving a regular paycheck.¹² Many of the study states verify income by requiring applicants to submit copies of tax returns or statements of not filed tax returns. Some of the states also perform data matches with other administrative systems to verify income. For example, Washington does data matches with the Employment Security Department to verify income for its Basic Health enrollees. Indiana also performs automatic cross checks with state databases to verify income

⁸ Kaiser Commission on Medicaid and the Uninsured, “Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and the States.” May 2010

⁹ Holahan, J and Headen, I. “Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL.” Kaiser Commission on Medicaid and the Uninsured, May 2010.

¹⁰ Goldstein A, “Childless Adults: Barriers to Enrollment in Public Health Programs,” Supported by a grant from the United Hospital Fund. April 2010

¹¹ Ibid.

¹² Ibid.

reporting. However, state data suggest that income verification remains a challenge to enrollment and renewal for some childless adults. For example, Pennsylvania reported that problems documenting income were a key reason people failed to renew coverage in the adultBasic program. Additionally, data from the Healthy Indiana Plan reveal that enrollment denials and failed renewals are primarily due to documentation problems.¹³

Language and cultural barriers can be significant barriers to enrollment. Low-income childless adults may have limited English proficiency, lower education levels, and literacy issues that can make completing the enrollment process challenging. Participants commented that program applications and resource materials that are written at or above a 9th grade level and use legalese often create enrollment difficulties for populations with limited English proficiency or lower education. In particular, Latinos may face language and cultural issues that can serve as enrollment barriers and one expert noted that Latino males can have a difficult time understanding the value of coverage given cultural biases. Further, past studies of the low-income Hispanic population have shown that not having program materials printed in Spanish and not having access to Spanish-speaking providers are commonly-perceived barriers to obtaining health insurance.¹⁴ Families that have mixed immigration status where some may be eligible for coverage while others are not also may be harder to reach.

There are vulnerable sub-groups of childless adults with complex needs that may be hard to reach and enroll. Several participants highlighted specific groups of childless adults who may benefit from targeted outreach under the expansion due to their complex needs and enrollment challenges, including young adults aging out of coverage and individuals with chronic conditions (including mental health conditions). As children transition between late adolescence and young adulthood, they have historically aged out of the Medicaid program (which has higher income eligibility limits for children compared to adults). It was noted that foster care children often lose Medicaid coverage when they turn 19 (although some states provide coverage to this population up to age 21). This problem may be mitigated under reform as the law establishes Medicaid coverage (with Early Periodic Screening, Diagnosis and Treatment Services) for children under age 26 who were in foster care when they turn 18. However, it still will be key to track what happens to children’s Medicaid coverage as they become young adults to assure they do not experience any gaps in coverage. Children also face challenges to maintaining private coverage as they become young adults and lose eligibility as a dependent under a parent’s private health insurance plan. Younger adults often move in and out of jobs, work part-time, move around, or are employed in lower wage positions, making it difficult to obtain private coverage on their own. Further, some may feel they do not need health insurance coverage. This group is often referred to as the “young invincible” population and may require specific, targeted outreach messages.

Another segment of the uninsured low-income childless adult population who may face significant enrollment challenges is those with physical and/or mental health conditions, including homeless individuals and those with substance abuse problems. These individuals often have complex health needs and may be unable to complete the enrollment process without assistance. For example, the District of Columbia noted that one group that remains challenging to reach and enroll in its HealthCare Alliance program is people with disabilities who do not have a caretaker that can act on their behalf.

¹³ Healthy Indiana Plan, “HIP Monthly Dashboard,” As of December 31, 2009.

¹⁴ Perry M, S Kannel, E Castillo. “Barriers to Health Coverage for Hispanic Workers: Focus Group Findings,” The Commonwealth Fund. December 2000.

2. What works best in efforts to reach and enroll childless adults?

Many best practices for enrolling parents and children in Medicaid and CHIP will apply to childless adults. For example, research has clearly demonstrated that simplifying the enrollment process, reducing necessary paperwork, providing multiple options to enroll, and using technology, data matching and agency coordination to facilitate enrollment are all key ingredients to a successful enrollment effort.¹⁵ Further, research and past experience show that it is important to promote a culture of coverage with simple outreach messages and to engage community-based organizations, providers and other stakeholders in enrollment efforts.¹⁶ Many of the same strategies will also apply to low-income childless adults. For example, for both its Medicaid and Family Health Plus programs, New York has eliminated use of asset tests and face-to-face interview requirements.¹⁷

Clear messaging about coverage opportunities and the value of coverage is imperative. Participants agreed that one of the biggest messaging challenges to overcome for childless adults is the historic lack of eligibility for this population. It was noted that adults may have applied for coverage in the past and been denied. As such, it will be vital for messaging to this population to focus not only on the fact that they are newly eligible, but also newly “wanted” to enroll in coverage. In addition, providing a clear message that the “rules have changed” will be key to overcoming this challenge. For example, communicating that this is a “new Medicaid program” and that eligibility has no ties to welfare or other public assistance programs.

Beyond these issues, it also will be important to use terminology that will help adults understand they are eligible for coverage. For example, the term “childless adults” is a bit of a misnomer and may contribute to some confusion among eligible adults, since many newly eligible adults are, in fact, not childless. Non-custodial parents and parents with adult children who are no longer dependents in the household all fall into the category of newly eligible adults. Some of the study states pointed to the importance of using a program name that clearly communicates that adults are eligible for coverage. For example, Pennsylvania’s adultBasic program makes clear that the program is intended to serve adults. In contrast, when New York began marketing its Family Health Plus program, which serves both parents and childless adults, it found there was some confusion among adults as to whether the program was intended solely for families and parents or whether “childless adults” were eligible. One report suggests changing the name to ensure that it is clear that the program covers all adults, regardless of their parental status.¹⁸

A handful of the states included in this study did some marketing to reach out to adults; however, as noted earlier, existing programs generally experienced greater demand for coverage than their funding could support, so outreach and marketing activities were largely limited among the study states. Those that did conduct marketing had campaigns that were part of broad coverage expansions to both parents

¹⁵ Kaiser Commission on Medicaid and the Uninsured, “Enrolling Uninsured Low-Income Children in Medicaid and SCHIP,” January 2009; Morrow, B., and D. Horner, “Harnessing Technology to Improve Medicaid and SCHIP Enrollment and Retention Practices,” Kaiser Commission on Medicaid and the Uninsured and The Children’s Partnership, May 2007; Morrow, B., “Emerging Health Information Technology for Children in Medicaid and SCHIP Programs,” Kaiser Commission on Medicaid and the Uninsured and The Children’s Partnership,” November 2008; and Morrow B. and S. Artiga, “Express Lane Eligibility Efforts: Lessons Learned from Early State Cross-Program Enrollment Initiatives,” Kaiser Commission on Medicaid and the Uninsured and The Children’s Partnership, August 2009.

¹⁶ Outreach Strategies for Medicaid and SCHIP: An Overview of Effective Strategies and Activities,” Children’s Defense Fund for the Kaiser Family Foundation, April 2006; and Perry, Michael J. “Promoting Public Health Insurance for Children.” *The Future of Children*, Vol. 13, No.1 (Spring 2003).

¹⁷ Medicaid Institute at United Hospital Fund, “Improving Enrollment and Retention in Medicaid and CHIP: Federal Options for a Changing Landscape.” August 2009.

¹⁸ Goldstein A, “Childless Adults: Barriers to Enrollment in Public Health Programs,” Supported by a grant from the United Hospital Fund. April 2010.

and childless adults. Indiana, New York and Vermont all did some marketing that included ads on radio, television and billboards. Vermont contracted with a marketing group to do their media campaign, which included a catchy TV commercial that the state felt resonated well with the public. Indiana's statewide media campaign included the slogan, "We've got you covered" with an image of an umbrella to promote the idea that broad coverage was available to uninsured adults in the state.

Beyond communicating the availability of coverage, it also will be important for outreach messages to communicate the value of coverage in a way that resonates with low-income childless adults. It was noted that low-income childless adults may not find messaging around prevention to be effective, particularly since many have been uninsured for a long-time. It was suggested that messaging that highlights the specific services and benefits that coverage will provide access to, such as free or low-cost doctor visits, prescription drugs, or dental care may be more effective. Further, messages that highlight the risks of being uninsured, such as potential injury and its impact on the ability to work, and the financial protections of having coverage may be particularly compelling for this population.

Enlisting community-based organizations and providers as partners to help with outreach and enrollment of childless adults is key for success. Participants noted that marketing and outreach is generally most effective if coming from people with whom uninsured adults can identify and/or organizations they trust. The more that messaging comes through community-based organizations and non-government agencies, the more it may resonate with the target population and help overcome linguistic and cultural barriers. For example, it was suggested that enlisting new enrollees who have benefited from coverage as outreach workers can be particularly effective in providing culturally appropriate outreach. In addition to community based organizations, participants stressed the importance of engaging providers in outreach and enrollment. Adults without coverage will seek care at community health clinics, behavioral health clinics, hospital emergency rooms, drug treatment programs, pharmacists/state pharmacy assistance programs, health fairs, and dental fairs. As such, these are all potentially effective places at which to conduct outreach and enrollment by providing outreach materials, having outstationed enrollment workers available, or allowing the providers to conduct the enrollment themselves. It was noted that providers often support such efforts since they will gain additional revenue from enrolling uninsured individuals in coverage.

States in this study effectively used community-based organizations (CBOs) and providers to promote enrollment. For example, in Washington, about 175 community-based organizations can assist individuals in filling out the applications and sending them to the Basic Health Program, but the CBOs cannot actually enroll individuals. Vermont made small grants to community organizations to help with outreach and also engaged colleges and other private sector organizations. Prior to the launch of their programs, Wisconsin and Indiana engaged community-based organizations and providers in workshops and training to aid those on the front lines to help with enrollment.

In Wisconsin, there were roughly 200 CBOs across the state that were actively working to enroll individuals at the start of the program by promoting awareness of the program and providing computers to complete applications. Wisconsin also set up community access points throughout the state to assist in filling out applications, including many community health clinics that have served this population for years. Wisconsin had provided many clinics with "mini-grants" of around \$20,000 to help in outreach and marketing for the launch of BadgerCare Plus in 2007 and 2008, so they applied the same techniques used for outreach to children to the adult populations. The state also hired outstationed workers to help enroll eligible individuals at the clinics. The health systems in the state, including Ministry Hospital, trained

workers to help the uninsured sign up for the program. These providers also had financial incentives for enrolling adults and making sure as many individuals were insured as possible. Community-based groups and providers also pooled funds to help individuals pay the \$60 enrollment fee.

Facilitated enrollment has proven to be effective in helping individuals to enroll in coverage.

Participants noted that using facilitated enrollment could be very important for helping adults successfully enroll, particularly if they have a mental health condition, limited literacy, or limited English skills that may make the process particularly challenging. Through the facilitated enrollment process, organizations and trained staff can help applicants complete an application, gather necessary materials, and then advocate and act as a liaison for the applicant if coverage is denied.¹⁹ Since Family Health Plus was implemented in 2001 in New York, it has used a facilitated enrollment process in which the state works with about 40 lead agencies across the state that subcontract with other community-based organizations and health plans to process applications. Overall, about half of Family Health Plus program applications come in through these agencies. This process utilizes best practices the state learned from a facilitated enrollment process that has been in use since 2000 to reach children. Facilitated enrollment was also used as part of Disaster Relief Medicaid (DRM) in New York City. DRM was a temporary coverage program implemented in New York City after the September 11th attacks to quickly expand coverage to individuals utilizing a simplified enrollment process.²⁰ When DRM was implemented, enrollment facilitators were placed throughout the city, for example in mobile vans, CBOs, supermarkets, and neighborhoods, and these facilitators assertively worked to enroll people, which created a large culture shift that made people feel “wanted” in the program.

New outreach avenues may need to be explored to reach low-income childless adults. As previously noted, childless adults may be more difficult to reach than parents and children since they have limited connections with public programs in general. Thus, they are less likely to be in other program enrollment files or state databases. It was suggested that new avenues may need to be explored for reaching these adults, such as unemployment offices, assisted housing programs, job training programs, homeless and domestic violence shelters, food stamp offices and food banks, programs serving migrants or seasonal hires, child support enforcement agencies, one-stop career centers, community colleges, literacy/GED programs, and employer/employee organizations.²¹ Further, it was suggested that partnering with SSI offices may be particularly useful for reaching some adults. For example, an individual may apply for SSI and be denied if they do not qualify as disabled, but still be income-eligible for Medicaid under the new broad expansion. State experience also points to the potential benefits of exploring new avenues to connect with adults. For example, when Vermont found that one of the most difficult groups to reach was the young and healthy adult population, it began focusing some of its outreach at the state colleges and experienced some success by reaching out to parents and graduating students about health care coverage for young adults.

Coordinated enrollment efforts and technology help advance enrollment efforts. Electronic applications can help promote enrollment, save staff time and reduce errors. Most states in the study had applications that were available on-line and several states, including Arizona, Pennsylvania and Wisconsin, have sophisticated on-line applications that can be electronically submitted. Arizona has encouraged on-line applications for new enrollees to help deal with cuts in administrative staff.

¹⁹ Goldstein A, “Childless Adults: Barriers to Enrollment in Public Health Programs,” Supported by a grant from the United Hospital Fund. April 2010.

²⁰ Perry M, “New York’s Disaster Relief Medicaid: Insights and Implications for Covering Low-Income People,” Kaiser Commission on Medicaid and the Uninsured in collaboration with the United Hospital Fund, August 2002.

²¹ Kaiser Commission on Medicaid and the Uninsured. “Optimizing Medicaid Enrollment: Perspectives on Strengthening Medicaid’s Reach under Health Reform.” April 2010.

Approximately 25% to 30% of new enrollees use the on-line application to obtain coverage. The state has a help desk phone number for people who need assistance in applying online. The survey section at the end of the online application indicates that the online process is extremely well-received by users. Similarly, in Pennsylvania, about 10-15% of applications are completed electronically independently by the applicant and about 40% are completed electronically in an eligibility office.

Table 3:
Use of Online, Electronic, and Combined Applications in Study Programs, 2010

State	Program	Online Application?	Electronic Submission?	Combined With Other Programs
1115 Waiver Programs				
Arizona	Health Care Cost Containment System	Yes	Yes	KidsCare (CHIP), AHCCCS Freedom to Work, Medicare Savings Programs, Nutrition Assistance, TANF Cash Assistance
Indiana	Healthy Indiana Plan	Yes	No	No
New York	Family Health Plus	Yes	No	Medicaid, Family Health Plus, and Child Health Plus (CHIP)
	Medicaid (Home Relief)	Yes	No	
Vermont	VHAP	Yes	No	Catamount Health with premium assistance, Dr. Dynasaur (CHIP)*
	Catamount Health	Yes	No	
Wisconsin	BadgerCare Plus Core Plan	Yes	Yes	All BadgerCare Plus Medicaid waiver programs, FoodShare, Family Planning Waiver, Medicaid, Child Care
	BadgerCare Plus Basic Plan	Yes	Yes	
State-Funded Programs				
DC	Healthcare Alliance	No	No	Medicaid, Food Stamps, Interim Disability Assistance, TANF
Pennsylvania	adultBasic	Yes	Yes	Medicaid, CHIP
Washington	Basic Health	Yes	Yes	Medicaid

Source: KCMU interviews with state officials and analysis of state materials, 2010.

*Individuals who buy into Catamount Health without premium assistance must fill out a separate application

Wisconsin had an electronic application in place prior to the expansion of coverage to childless adults. When the expansion was implemented, an estimated 83 percent of applicants came through the online application and the rest were enrolled by phone; Wisconsin no longer offers a paper application. When an individual applies online, he or she creates an account with a log-in and password through the ACCESS website that works for all public programs (medical assistance, food assistance, TANF, child care assistance). There is also a call-in number for assistance. An applicant can check on the status of their application as well as any benefits. The state's goal is to have an individual applied and enrolled within 30 days, but this can take less time depending on how quickly the state can verify income. The state has gotten positive feedback about having an online or phone application – especially when tied to other public services like FoodShare or TANF. Traditionally, enrollment in public programs has been county-based, but the state decided to centralize the eligibility and enrollment process for the BadgerCare Plus Core Plan program because of concern about overburdening the counties' workload, especially with the recession. The state is currently in the process of taking over all public service cases for childless adults, not just health care coverage.

A number of states with separate programs for childless adults, including the District of Columbia, Pennsylvania, Vermont, Washington and Wisconsin coordinated applications for childless adult programs with other health programs. The District and Pennsylvania experienced significant increases in applications when they moved to a coordinated or combined application form. In Wisconsin, they have found that individuals have been primarily coming in for assistance with health care coverage but many found that they are also eligible for food benefits and, therefore, the state has seen a significant increase in its FoodShare participation.

Technology can also be used to conduct data matching across state agencies and reduce the documentation requirements for applicants. Some states in this study are using matching efforts to verify income and a few are experimenting with other advanced ways to use technology to promote enrollment and renewal of applications, such as through text-messaging or automated phone systems to process renewals.

3. What are some lessons learned in how to best deliver care for this population?

While this study primarily focused on efforts to reach and enroll childless adults in coverage programs, information on the characteristics of childless adults enrolled in the study state programs and some lessons on how to best deliver care to these low-income adults was also obtained. However, more research in this area is needed.

Most states in the study used some type of managed care arrangement to serve childless adults.

These plans may or may not be the same plans that serve the Medicaid population. The District of Columbia requires plans to bid for Medicaid and Alliance. In Washington, Basic Health is served by five plans, with the two largest plans participating in Medicaid and utilizing their Medicaid provider network to serve Basic Health enrollees. Pennsylvania and Washington pay commercial rates for their childless adults programs. In Wisconsin, there are 16 HMOs that the state contracts with and enrollees have several options from which to choose. If individuals do not choose a plan, they are auto-assigned to a plan based on an algorithm that includes a health needs assessment with an individual's health status, preferred doctors (weighted the most), and nearby hospitals and/or clinics. Payment rates for childless adults vary across states. Some state programs use commercial rates, while others use the Medicaid rate. The per person costs may be higher or lower than coverage for other adults in Medicaid based on the benefits covered, the population covered as well as the underlying payment rates.

As expansion efforts move forward, it will be important to understand the characteristics and health needs of low-income childless adults enrolling in the program. Some of the study states noted that childless adult enrollees had greater health needs than expected. For example, in Arizona, the state estimated that the newly eligible childless adult population would be similar to their parent population. However, due to higher than expected rates of chronic illnesses and co-morbidities, childless adults have been three times more expensive than their parent population and more expensive than disabled adults qualifying through SSI. Similarly, state officials in Indiana noted that childless adult enrollees have had lower incomes and greater health needs than anticipated. Further, Pennsylvania reported experiencing some adverse selection in its adultBasic program, particularly among adults paying "full premium costs" to enroll while on the waiting list for subsidized coverage. Some of this experience may reflect pent-up demand for services among childless adults who have been uninsured for long periods of time. Levels of adverse selection will likely be mitigated under reform given the broad scope of the expansion and the presence of the individual mandate (even though the Medicaid population is largely exempt from the penalties for failure to comply with the mandate).

Connecting childless adults to primary care providers and conducting care management will be important for assuring their access to care. Since many low-income childless adults may have been uninsured for long periods of time and have little experience with the health care system, it will be important to connect them with a primary care provider or medical home, particularly if they have significant health needs. Some of the study states have taken steps in their programs to connect adults to providers and identify high-need cases. For example, Indiana uses a self-assessment form to screen individuals for special needs (like cancer care or other chronic conditions), and these individuals are

enrolled in a managed care organization designed to deal with high-need cases. In Wisconsin, enrollees are required to get a physical exam within the first 12 months of enrolling or they will be disenrolled. This exam may identify untreated and unmanaged chronic conditions and establishes a medical home. Within the last year, the vast majority of enrollees have met the physical exam requirement. Further, in Arizona, there have been attempts to enroll individuals with high utilization, particularly those with chronic conditions and co-morbidities into disease or case management programs.

Conclusion

An estimated 17 million currently uninsured adults will fall below the new Medicaid coverage floor of 133% FPL under health reform, most of whom are adults without dependent children. For the first time, Medicaid eligibility will be based on income, without regard to categorical eligibility. While, in the past, state fiscal capacity has been a barrier to covering low-income childless adults, the overwhelming majority of new costs from the Medicaid expansion in reform will be paid for by the federal government, so states will have significantly greater capacity to extend coverage to this population.

With years of experience enrolling children in Medicaid and CHIP, there is already a great deal of information available about how to make enrollment and renewal simple and promote coverage among newly eligible adults. However, these adults may also face some specific challenges to enrolling in coverage due to their historic ineligibility for the program and language and cultural issues. Further, some sub-groups, such as young adults and those with chronic conditions, may be particularly challenging to reach and enroll. States that have already expanded to childless adults report that clear messaging, support from providers and community-based organizations and use of technology are keys to enrolling adults. States may also need to explore new outreach avenues.

Adults enrolling under the expansion will have varied demographic characteristics and health needs. Since individuals may have been uninsured for long periods of time, initial costs of expanding coverage to childless adults could be higher than expected due to pent up demand for services and untreated chronic conditions, and some states did say they experienced adverse selection in their programs. However, issues with adverse selection are likely to be mitigated under reform given the breadth of the expansion and the effect of a mandate (even though the Medicaid population is largely exempt from the penalties for failure to comply with the mandate).

The Medicaid expansion to low-income adults under reform will necessitate one of the largest enrollment efforts in the program's history. Given the significance and size of the expansion, it will be key for states to be ready and prepared with the necessary systems, technology, and administrative capacity in place to process enrollments and coordinate coverage and care with the new Health Insurance Exchanges. For some states, this may require significant investments in time and resources, so it will be important to begin thinking now about the steps that need to be taken to be prepared when the expansion goes into effect in 2014.

This issue paper was prepared by Samantha Artiga, Robin Rudowitz, and Molly McGinn-Shapiro with the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. The authors thank the state officials and other experts who so generously shared their time, extensive program knowledge, and valuable insights. This analysis would not have been possible without their expertise and assistance.

Appendix A: State Profiles

The following section provides greater detail on each of the state programs included in this study based on interviews with state officials and review of state materials. The programs profiled include:

- ARIZONA: Arizona Health Care Cost Containment System
- DISTRICT OF COLUMBIA: DC Healthcare Alliance
- INDIANA: Healthy Indiana Plan
- NEW YORK: Family Health Plus and Medicaid (Home Relief)
- PENNSYLVANIA: adultBasic
- VERMONT: Vermont Health Access Plan and Catamount Health Plan
- WASHINGTON: Basic Health
- WISCONSIN: BadgerCare Plus Core Plan and Basic Plan

Arizona: Arizona Health Care Cost Containment System

Coverage under the Arizona Health Care Cost Containment System (AHCCCS) was expanded to all qualified Arizona residents (including childless adults) up to 100% FPL under the voter initiative Proposition 204 in 2000, which allocated the money received from the Master Settlement Agreement with tobacco companies to fund this expansion in eligibility. Until 2009, parents were covered at 200% FPL under CHIP. The expansion had been discussed for a number of years prior to Proposition 204, as the state had already been providing coverage through state-only funds to about 19,000 childless adults and was looking for an opportunity to federalize the financing and coverage of this entire population.

When the Medicaid expansion took effect, the eligibility determination process for childless adults was shifted from the counties to the state under the agency that also determines eligibility for other public programs such as Medicaid, the Supplemental Nutrition Assistance Program, and TANF. Qualified adults that are at or below 100% FPL are eligible to enroll in AHCCCS. There is a \$90 a month income disregard per wage earner as well as a disregard for dependent care expenses. There is no asset test but all other Medicaid eligibility elements, including citizenship documentation are required. Applicants are enrolled in a managed care plan that provides Medicaid benefits. (Native American's may choose to enroll with the Indian Health Services and receive their services through a fee-for-service network.) There are no premiums and co-payments are very limited (physician visits and non-emergency use of the emergency room range up to \$1 per visit).

Applicants may apply online or through a paper application. There is one online application (Health-e-Arizona) for Medicaid (AHCCCS Health Insurance), CHIP (KidsCare), Medicare Savings Programs, Nutrition Assistance and Cash Assistance. With the paper application, enrollees can use one application to apply for Medicaid (AHCCCS Health Insurance), CHIP (KidsCare), and Medicare Savings Programs for everyone in the household. Online applications have continued to increase, with around 25 to 35 percent of enrollees using the online application to enroll within the last year. The survey section at the end of the online application indicates that the online process is extremely well-received by users.

As of July 1, 2010, there were 212,941 childless adults enrolled into the program. The enrollees in the program had a much higher acuity level than originally expected. The state anticipated that the newly eligible population would be similar to the previously enrolled adults (Section 1931 parents), but the enrolled childless adults have actually been three times more expensive than the parent population. The state has found that enrollees tend to be either younger adults with traumatic injuries or the pre-Medicare eligible group with more chronic illnesses or co-morbidities. The younger adults tend to have a shorter enrollment period of around 3 to 4 months while the older enrollees stay on the program much longer.

District of Columbia: DC Healthcare Alliance

In 2001, following the closure of District-run DC General Hospital, funds that had previously been used for the hospital's operations were moved to finance care through a new DC Healthcare Alliance program (Alliance). The goals of the program were to increase access to primary and outpatient care and reduce avoidable emergency room visits. At first, care was delivered through a defined network of non-profit health centers and DC area hospitals in a fee-for-service payment system.²² In 2006, the Alliance shifted to a managed care model through the Medicaid managed care plans. As of June 2010, the Alliance program provided coverage for over 57,000 residents, or approximately 10% of the DC population. In combination with the 26% of DC residents on Medicaid, residents on public health coverage account for one-third of the DC population.

The DC Healthcare Alliance is available for low-income uninsured residents with household incomes at or below 200% FPL, generally, childless adults or undocumented individuals. There are limited income disregards and applicants must have assets less than \$4,000 for an individual or \$6,000 for a couple (excluding owning a home). Every member is enrolled in a managed care plan and has a designated primary care provider. Health plans must participate in both the Medicaid and Alliance programs to receive a contract for health care services with the DC Department of Health Care Finance, the agency that manages public health insurance in DC. Enrollees have access to a Medicaid-like benefits package; however, there is no coverage for long-term care, mental health services, or non-emergency transportation, and prescription drug coverage is for a defined formulary available through a specified closed network of pharmacies.

Enrollment into the Alliance is accomplished through a combined application that also includes Medicaid and other public assistance programs including Food Stamps, TANF, and LIHEAP. The District is considering establishing an on-line application as well. In DC, managed care plans can do outreach and marketing. DC has not experienced any significant challenges to enrolling eligible adults into the program, and enrollment has always exceeded expectations and projections.

DC is among the first states to pursue the new option under the Patient Protection Affordable Care Act to expand coverage to adults with incomes up to 133% FPL through Medicaid without regard to parental status or disability. Under this option, DC has transitioned approximately 32,000 childless adults from the Alliance to Medicaid as of July 1, 2010, with additional individuals scheduled to move over once citizenship and other eligibility criteria are verified. Subsequently, the District will seek an 1115 waiver to use Disproportionate Share Hospital (DSH) funds to expand Medicaid coverage to remaining individuals in the Alliance between 134% and 200% FPL. DC will receive federal Medicaid matching funds for individuals transferred from the Alliance at a 70 percent federal match rate until a higher match rate goes into place in 2014 under health reform.

²² Sacks, H. and J. Meyer. "Childless Adult Coverage in the District of Columbia." Economic and Social Research Institute for the Kaiser Commission on Medicaid and the Uninsured. August 2004.

Indiana: Healthy Indiana Plan

On January 1, 2008, Indiana began enrolling adults (parents and childless adults) in its new Healthy Indiana Plan. The plan is the first that allows a state to provide a benefit package modeled after a high-deductible plan and health savings account to a low-income population using Medicaid funds. The program is funded through a Medicaid waiver that diverts some DSH funds. The program is also funded through a dedicated cigarette tax. Enrollment in the program is limited based on available funding.²³

To be eligible, individuals must not have private coverage options, must be uninsured for at least 6 months, and have an income less than 200% FPL (no asset test). The benefit package is modeled after a high-deductible plan and health savings account. It consists of three components provided through managed care plans. After meeting a \$1,100 deductible, individuals are covered for state-specified benefits up to a \$300,000 annual cap and a \$1 million lifetime cap. A POWER Account is used to cover the \$1,100 deductible. It is funded by the enrollee (and sometimes an employer), state, and the federal government and administered by the enrollee's managed care plan. Individuals are covered for preventive care that is not subject to the deductible and does not draw down from the POWER Account.

To obtain and maintain coverage, enrollees must make monthly POWER Account payments, which are scaled by family income and range from 2%-5% of income. The state (along with federal match funds) pays for the gap between enrollees' payments and the \$1,100 deductible for the POWER Account. If an enrollee misses a monthly payment, the individual loses coverage, forfeits 25% of his or her POWER Account contributions, and is barred from re-enrolling for 12 months. By obtaining state-specified preventive care, enrollees can carry over state POWER Account contributions to the next year, which helps offset required enrollee payments.

As of June 2010, 46,160 adults were enrolled in the program, including 18,694 childless adults. Childless adult enrollment is capped at 36,500 (up from 34,000 originally). Enrollment for childless adults was first closed in March 2009; it was temporarily opened for 5,000 individuals to move off the waitlist in November 2009, but has since remained closed. Enrollees tend to be poor (69%), women (66%), and age 40 or older (55%). About 20% of enrollees fall into the lowest income groups and are not required to make contributions to their POWER Accounts. At first there were more childless adults than parents enrolling in the program, although that balance has now shifted due to the cap on childless adult enrollment.

²³ Kaiser Commission on Medicaid and the Uninsured. "Summary of Healthy Indiana Plan: Key Facts and Issues." June 2008.

New York: Family Health Plus and Medicaid (Home Relief)

New York has covered very low-income childless adults in its Medicaid program through an 1115 Waiver since 1966. Childless adults with income up to 78% FPL are eligible for the Medicaid (Home Relief) program. In 2001, responding to an increasing uninsured population and a strong coalition of stakeholders including SEIU and the Greater NY Hospital Association, the state expanded coverage to childless adults up to 100% FPL (and parents up to 150% FPL) through the Family Health Plus program (FHP). FHP was federally authorized through an amendment to the state's existing 1115 waiver, legislated in-state by New York's Health Care Reform Act (HCRA) of 2000. The FHP expansion was implemented in October 2001, while at the same time expanded eligibility occurred in New York City through Disaster Relief Medicaid (DRM), which was temporarily implemented in response to the 9/11 attacks.²⁴

FHP is a fully subsidized health insurance program targeted to the adult population that is not currently eligible for Medicaid. Enrollees choose among participating managed care plans to receive services. FHP enrollees receive comprehensive benefits with no premiums or enrollment fees and pay modest co-pays (\$6 for brand name prescriptions, \$3 for generic prescriptions, \$5 for clinic visits, \$5 for physician or dental visits, 50 cents for labs, \$1 for radiology, \$25 for an inpatient hospital stay, \$3 for non-urgent ER visits, and 50 cents for smoking cessation supplies and certain over-the-counter supplies).

As of December 2009, 683,918 childless adults were enrolled in the Medicaid (Home Relief) program and 98,720 were covered through FHP. Between 2001 and 2003, New York experienced a significant increase in enrollment of childless adults due to DRM in New York City following September 11th. DRM quickly expanded coverage, vastly simplified enrollment and renewal procedures, and utilized facilitated enrollment processes for adults.²⁵ Outside of DRM, adult enrollment has also been impacted by changing policies and processes. For example, since FHP was first implemented, there has been a lot of shifting between Medicaid and FHP due to changes to align rules across the programs and standardize Medicaid coverage levels for childless adults across counties. Further, over the years, the state has worked to streamline enrollment and renewal processes in both programs, for example by eliminating asset test and interview requirements.

²⁴ Silow-Carroll S, "New York: A Case Study in Childless Adult Coverage" Economic and Social Research Institute for the Kaiser Commission on Medicaid and the Uninsured. August 2004.

²⁵ Birnbaum, M. "Medicaid Coverage for Adults in New York, 2001-2003: Trends and Policy Implications." *Medicaid Institute at United Hospital Fund*. June 2006.

Pennsylvania: adultBasic

In 2002, the state built upon the concept of providing affordable health coverage to children through CHIP to create the fully state-funded adultBasic program for adults. The overall intention was to do the “best that could be done” in terms of purchasing affordable coverage for adults who were ineligible for Medicaid using whatever state resources could be pulled together.

Almost as soon as the program began it had a waitlist, and demand for the program has always exceeded funding availability. Financing has been able to support enrollment of about 50,000 adults although funding for the program is diminishing. Tobacco Settlement funds, which originally was the major source of the program’s funding, have been decreasing. This is the result of the increased cost for a Medical Assistance program for disabled workers, which is also financed by the Tobacco Settlement funds. As an entitlement program, funding the state matching funds for this Medical Assistance is a higher funding priority than the adultBasic program, which leaves a smaller residual amount for the adultBasic program.²⁶

In recent years, the major source of program financing has been the Community Health Reinvestment Fund which is financed by the four local BlueCross BlueShield insurance plans. These plans originally volunteered to contribute a percentage (about 1.5%) of premium revenues to this fund to support the adultBasic program and several other public health efforts. However, their commitment to this fund expires in 2010 and there is no assurance of a renewal.

Adults are eligible for adultBasic if their incomes are under 200% FPL. They must be uninsured for at least 90 days and can self-attest their residency and citizenship/lawful presence. After determined eligible, individuals are enrolled for 12 months if there are sufficient funds, or are placed on a waiting list. There is a limited benefit package with monthly premiums, copayments and coinsurance. Individuals lose coverage if they fail to pay premiums. If prior to the end of their 12-month eligibility period they pay past-due premiums, they can have their coverage reinstated. However, if they fail to pay prior to the end of their eligibility period they become subject to the waitlist for coverage. A study of those disenrolled from the program found that problems with documenting income were a key reason people failed to renew coverage.

The bulk of enrollees (about 46,000) receive subsidized coverage and pay \$36/month in premiums as of March 1, 2010. About 1,100 enrollees pay “full cost” while on the waiting list by buying into the program. However, because of statutory limits, the amount they pay is actually less than the true full cost of coverage—i.e., true full cost would be about \$1,000 per month, whereas they currently pay about \$600 per month. The state has experienced significant adverse selection, particularly among those paying full cost.

Individuals apply by completing a Family Health Insurance application, which can initiate enrollment in Medicaid, CHIP, or adultBasic. Applications are available online, through county offices, advocacy organizations, and insurers are required to provide an 800 number to assist applicants. If completed online, the application processes information in real-time to determine which program that person is likely eligible for and then requests needed information for determining eligibility for that program.

²⁶ Dorn, S. and J. Meyer. “Pennsylvania: A Case Study in Childless Adult Coverage.” Economic and Social Research Institute for the Kaiser Commission on Medicaid and the Uninsured. August 2004.

About 10-15% of applications are completed electronically independently by the applicant, about 40% are completed electronically in an eligibility office, and about 50% are completed through paper/call center contacts (in which case an application is started, mailed to the applicant, and then the applicant must mail it back with necessary information and documentation).

Demand for the program has always exceeded availability and the program has had a waitlist in place since June 2003. Overall enrollment has generally ranged from between 40,000-56,000 individuals. By July 2004, the waitlist exceeded 100,000. In 2009, the state implemented an “electronic handshake” initiative that improved coordination of applications for Medicaid, adultBasic, and CHIP, by automatically referring applicants between programs. Following implementation of this initiative, there was a large surge in applicants and the waitlist now exceeds over 390,000.

Vermont: Vermont Health Access Plan and Catamount Health Plan

The Vermont Health Access Plan (VHAP) was started in 1994 through a Medicaid waiver expansion to cover uninsured adults who did not qualify for Medicaid. The program covers childless adults up to 150% FPL and parents up to 185% FPL.

In 2006, the state decided to focus on providing more coverage to its population and enacted a comprehensive health reform law that included Catamount Health Plan, which was implemented in October 2007.²⁷ Catamount Health is open to all uninsured residents and is subsidized for individuals with incomes up to 300% FPL. The program is viewed as a public-private partnership with a standard plan of benefits that is currently offered by two private insurers, Blue Cross Blue Shield of Vermont and MVP Health Care. Individuals can enroll in Catamount if they have been uninsured for the past 12 months, although there are several exceptions to this provision such as loss of employment or no longer qualifying as a dependent under an insurance plan of a parent or relative.

An uninsured individual who is employed and who applies for VHAP or Catamount Health may be required by the state to enroll in their employer's plan if the state determines that the ESI plan is comparable in cost and benefits to VHAP or Catamount Health. Employees with incomes below 300% FPL may qualify for subsidies to help pay their share of premiums for the employer's plan. If the individual is eligible for VHAP, wraparound coverage is provided for any VHAP benefits not covered by the ESI plan and cost sharing in excess of VHAP limits.

Copayments in VHAP include a \$25 copayment for use of the emergency room and \$1 and \$2 pharmacy copayments for enrollees with income above 100% FPL. Individuals with incomes below 50% FPL do not pay premiums; premiums for those above this income level range from \$7 per person per month to \$49 per person per month, based on income. Catamount Health has higher cost-sharing amounts with deductibles for individuals at \$250 and \$500 for families. The annual in-network, maximum out-of-pocket costs for deductibles and co-insurance combined are \$800 for single coverage and \$1,600 for a family plan. Catamount Health also has a \$10 office visit fee, as well as prescription co-payments that range from \$10 for each generic drug prescription to \$50 for a brand-name drug that is not on the preferred brand-name drug list (\$30 for brand-name drugs on the preferred brand-name drug list). Out-of-pocket costs are waived for patients who need clinically recommended treatment for a chronic condition or disease.

As of June 2010, there were around 35,700 adults covered by VHAP (including around 1,000 adults who receive premium assistance for employer-sponsored insurance and VHAP wraparound benefits). The subsidized portion of Catamount Health covered about 10,700 adults (with around 700 of these adults receiving premium assistance for employer-sponsored insurance). The state had anticipated that the average age of enrollees would be around 35 but the actual average has been closer to 45, which has led to higher premiums overall. Enrollment has increased due to the recession, with enrollment between January and May 2009 growing faster than anticipated for Medicaid, VHAP and Catamount Health.

²⁷ Kaiser Commission on Medicaid and the Uninsured. "Vermont Health Care Reform Plan." December 2007

Washington: Basic Health

Basic Health began as a pilot demonstration program in 1988 (established in 1987 as part of The Health Care Access Act of 1987), open to 4,000 residents in King and Spokane counties. Benefits for the program initially included preventive care, hospital and physician services, emergency room, ambulance, and maternity (through the state's DSHS Medicaid program). The program became statewide in 1993.²⁸

Adults living in Washington who have incomes at or below 200% FPL are eligible for Basic Health. There is no asset test and no citizenship documentation requirement. The overall benefit package for Basic Health is more limited than Medicaid, with the most notable differences being higher premium and cost sharing charges. For example, Basic Health enrollees with family income between 0-125% FPL are charged up to about 6% of family income in premiums and those between 125-200% FPL pay up to between 6-24% of family income. Further, there is a \$250 annual deductible with a \$1,500 out-of-pocket maximum. An individual is "suspended" from the program if he or she is non-compliant with paying premiums for one month, and if premiums are not paid for two consecutive months an individual is locked-out of the program for 12 months and moved to the waitlist.

In 2003, the state reduced the benefit design of the program by 18%, primarily through increases in member cost-sharing. The state legislature recently approved a 43% reduction in the program enrollment for the 2009-2011 budget cycle and cost-sharing was increased for members of the program. In 2009, the average enrollee paid \$34 a month while the state paid the remaining \$211. For 2010, the average member pays \$60 a month, and the state's portion decreased to \$177. Additionally, the annual \$150 deductible increased to \$250 but members did not see any modifications to their benefits package. The program had covered up to 107,000 members in the 2007-2009 biennium, but that number was reduced to the current 65,000 enrollees due to rate increases.

As of June 2010, about 65,000 adults were enrolled in Basic Health and enrollment was closed. On average, approximately 300 individuals are added to the waiting list for coverage every day, and over 110,000 people were on the list as of June 2010. The majority of individuals enrolled in the program have incomes under 125% FPL (around three-quarters of the enrolled population). The population demographics have generally remained consistent since 1995, including low-income, low-wage workers, the self-employed, or migrant farm workers.

When the program is open for enrollment, individuals can apply on-line but have to mail in supporting documents to the agency. Currently, individuals can register for the waitlist on-line. There is also coordination between Basic Health and Medicaid programs in the application process. If an individual enrolled in Basic Health is determined to be eligible for Medicaid, he or she will be notified that they are eligible for Medicaid and the state can then shift the individual to Medicaid. There is also an ongoing effort by the state to have application materials adequately translated, including monthly forums to deal with these issues.

²⁸ Dorn, S. and T. Alteras. "Washington State: Pioneer and Innovator in Covering Low-Income Workers." Economic and Social Research Institute for the Kaiser Commission on Medicaid and the Uninsured. August 2004.

Wisconsin: BadgerCare Plus Core Plan and Basic Plan

The state enacted the BadgerCare Plus program in 2007, merging the three distinct Medicaid programs for children, parents, and pregnant women, into one comprehensive health coverage program while also expanding eligibility for these three populations. The Badger Care Plus program for children, parents, and pregnant women was implemented in February 2008. In January 2009, the state expanded coverage to childless adults with incomes up to 200% FPL, beginning only with those already enrolled in the General Assistance/General Relief Medical Program (GAMP). In July 2009, the BadgerCare Plus Core Plan was opened up statewide to other childless adults who met the income requirement and have not had private coverage in the previous 12 months. The childless adult expansion is primarily financed with a 5-year dedicated funding stream from DSH allocated funds and an assessment on hospitals.

Childless adults at or below 200% FPL are eligible to enroll in BadgerCare Plus Core Plan, with no income disregards or asset tests. The Core Plan for childless adults contains a more limited benefit package than what is offered through Medicaid, covering doctor visits, hospital services, and some generic prescription drugs, among other services. There are no premiums, other than a one-time \$60 application fee and cost-sharing is nominal for individuals between 0-100% FPL with slightly higher charges for those with incomes between 100-200% FPL. Within the first 3 months following implementation, the state received around 80,000 applicants and implemented a waiting list in October 2009. As of June 2010, 56,500 childless adults were enrolled in the BadgerCare Plus Core Plan.²⁹ The demographics of the enrollees overall has tended to be a higher percentage of females (almost 50/50 split) and younger than anticipated with almost a third of the population under 30.

A majority of the applicants have come through the online application (83%) and the rest by phone (there is no paper application). Traditionally, enrollment in public programs has been county-based, but the state decided to centralize the eligibility and enrollment process for the BadgerCare Plus Core Plan program because of concern about overburdening the counties' workload, especially during the economic recession. There is an integrated application for medical assistance, food assistance, and TANF. Individuals have been primarily coming into the system for assistance with health care coverage but many have found that they are also eligible for food benefits, and therefore the state has seen a significant increase in Food Share participation.

Currently, there is a cap on enrollment into the BadgerCare Plus Core Plan and there are up to 30,000 on the waitlist. In an effort to offer coverage to people on the waitlist, Governor Jim Doyle proposed the BadgerCare Plus Basic Plan, which would allow those on the wait list to buy-into a health plan at full-cost. Legislation creating this new program was enacted on April 30, 2010. The Basic Plan offers more limited benefits than the Core plan and includes up to ten physician visits, one hospital visit, and five outpatient visits per year, as well as access to generic prescription drugs. The premium for the Basic Plan will cost \$130/month. Enrollment began June 1, 2010 with coverage beginning in July 2010.

²⁹ Kaiser Commission on Medicaid and the Uninsured. "Wisconsin's BadgerCare Plus Program: Moving Forward on Health Reform Amid a Recession." June 2010.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8087) is available on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.