

Chapter 8.

Options to Expand Medicaid and SCHIP in Texas

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Reducing the number of the uninsured in Texas will likely entail several different approaches, including expansions of both public and private mechanisms; we will concentrate exclusively on solutions that utilize public funds. States have several options for drawing down federal dollars and expanding coverage to their uninsured populations. This paper describes those available under the traditional Medicaid program, Section 1115 waivers, and the State Children's Health Insurance Program (SCHIP). In particular, we present information pertaining to the following options: targeted simplification efforts, which include continuous eligibility, presumptive eligibility, and transitional eligibility; and program eligibility expansion efforts, which include Section 1931, income disregards, the medically needy option, Section 1115 waivers, SCHIP waivers, and premium assistance. Finally, we conclude with a discussion of Medicaid expansion options that focus on the disabled and the elderly.

Simplification

Section 1902(e)(12): Continuous Eligibility

An important option in Medicaid simplification is the concept of continuous eligibility. Continuous eligibility minimizes time and financial burdens and maximizes the retention of health care coverage for low-income families who seek to maintain coverage for their children. It also minimizes the loss of coverage to children in families who experience financial fluctuations as recertification requirements pose barriers to continued health care coverage. Specifically, Section 1902 (e)(12) of the Social Security Act allows states to grant up to 12 months of eligibility to children under the age of 19, even when there has been a change in family income, assets, and/or composition.

Continuous eligibility reduces the administrative work that focuses on checking and rechecking income levels of Medicaid families with state eligibility standards. It also saves families the hassle of navigating the Medicaid system every time they experience a change in their incomes and/or assets. As of July 2000, 14 states currently have adopted continuous eligibility for their children's Medicaid program.¹ This is not the case in Texas.

Currently, in Texas, most changes in family income, assets, or composition must be reported to the state Medicaid officials within 10 days of the change. After six months on Medicaid, families must complete a new Application for Assistance (including up to 14 forms) and provide the necessary verification. The Texas CHIP program currently gives beneficiaries a 12-month continuous eligibility period. The Texas Blue Ribbon Task Force on the Uninsured, an interim committee created during the 76th Texas Legislature to study the problem of the uninsured in Texas, recommended that the Medicaid and

CHIP programs be simplified to create a seamless system; thus, allowing continuous eligibility would be in line with this recommendation.²

The 77th Texas Legislature has introduced bills in the House and the Senate to provide children with Medicaid benefits 12-month continuous eligibility. Representative Patricia Gray along with bipartisan authors have proposed HB 825, and Representative Garnet Coleman proposed HB 1604, which addresses three components of simplification including continuous eligibility. Meanwhile, Senator Judith Zaffirini and Senator Mike Moncrief have authored separate bills in the senate legislating continuous eligibility, SB 43 and SB 374, respectively.

Section 1920A: Presumptive Eligibility for Children

Presumptive eligibility (PE) was first introduced in 1987 as a Medicaid health care option for low-income pregnant women. It allows women to have ambulatory prenatal care, if they are deemed eligible for the program.³ Currently, Texas provides presumptive eligibility care for pregnant women⁴ and their infants up to 12 months old with incomes below 185 percent of the FPL. However, Texas does not currently have a presumptive eligibility option for children one year old or older. The ability to provide such coverage was created through the 1997 Balanced Budget Act. Other states have been slow to adopt the presumptive eligibility option. Currently, eight states have adopted presumptive eligibility and five states have implemented the program.⁵

Presumptive eligibility for children allows states to grant health care providers and other organizations that serve low-income individuals the ability to issue temporary Medicaid cards to children. This policy allows children who live in families with incomes lower than the Medicaid eligibility level to have temporary access to all Medicaid-covered services. To continue receiving the coverage, families must apply for Medicaid using the regular application forms by the end of the month following the month that the temporary eligibility was granted. One of the most important aspects of this option is that it moves Medicaid enrollment into the community.⁶ This increases the families' opportunities to apply for Medicaid.

The providers and other organizations allowed to grant presumptive eligibility are known as "qualified entities." Specifically, they include Medicaid providers, organizations that determine eligibility for Headstart, the Special Nutrition Program for Women, Infants and Children (WIC), and the Child Care and Development Block Grant (CCDBG). SCHIP does not provide specific provisions for presumptive eligibility but states can administer presumptive eligibility in the exact same way they administer Medicaid presumptive eligibility in order to create a seamless system of children's health coverage. States also have the option to have more restrictive presumptive eligibility requirements for SCHIP.

An employee of these agencies asks the family using these services whether their children need health insurance. If a need is identified, the family is given a simple form asking for information about the family's total income. The employee then compares the family's income to a chart listing eligibility for children on Medicaid. If the income is below the level listed on the chart, the children in the family are issued "presumptive

eligibility” documentation. The qualified entity is then required to inform within five days the agency that administers Medicaid/SCHIP in the state. Certain qualified entities have experienced up to an 86 percent final approval rate on those families who follow up and apply for Medicaid/SCHIP.⁷

One of the most important aspects of presumptive eligibility is that the providers are guaranteed payment for the services provided to children deemed presumptively eligible for the Medicaid program. If families that have been issued presumptive eligibility cards apply for Medicaid and do not qualify, providers are not required to reimburse the state for health care services used by the presumptively eligible child. This also is true for families who do not apply for Medicaid services during their presumptive eligibility period. The federal government reimburses the state at the regular Medicaid match rate for presumptive eligibility cases.

Section 1925: Transitional Medicaid

In the case of families no longer receiving financial assistance from the government, “transitional Medicaid” covers health care for those who are leaving the welfare system. Section 1925 of the Social Security Act mandates that states provide extended Medicaid benefits, known as transitional Medicaid, to families who, because of hours of work or income from employment or child support, have lost their Medicaid eligibility under the specifications of Section 1931 (discussed below). It is essential to note that under federal law the loss of coverage under Section 1931, not the loss of Temporary Assistance to Needy Families (TANF), is the trigger for transitional Medicaid coverage

Under Section 1931, states are required to provide an initial six-month period of transitional Medicaid (four months of coverage are automatically available when child support payments trigger eligibility). At this point, individual states become subject to the specific reporting requirements and income limits that are explained in the following section. Certain states provide longer periods of transitional Medicaid under Section 1115 waivers.

In order for families to be eligible for transitional Medicaid, they must have received Medicaid under Section 1931 in three out of the preceding six months before becoming ineligible under the 1931 category.⁸ No income limit applies to families for this initial six-month period of transitional Medicaid. The second six-month period, however, is limited to families whose earned income is less than 185 percent of the Federal Poverty Level for the size of the family (this income limit discounts all necessary child care expenses). Texas offers a full 12 to 18 months of transitional Medicaid coverage under its Aid to Families with Dependent Children (AFDC) 1115 waiver. This waiver expires in 2002 there currently is uncertainty as to what future Texas policy will be regarding transitional Medicaid.

Program Eligibility Expansion

Section 1931

Much flexibility and many options exist within the framework of Section 1931 of the Social Security Act. Section 1931 provides a clear route for states to decrease the number of low-income uninsured adults in families with children. The use of Section 1931 is important because through its authority states may decrease their uninsured without being required to prove cost-neutrality through a federal 1115 waiver.

Adult and Low-Income Family Outreach through Section 1931

The federal welfare reform legislation passed in 1996 directly affected Medicaid recipients and those deemed eligible for the program. The Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) delinked Medicaid and welfare eligibility. Thus, Medicaid eligibility rules are now considered completely separate from welfare (TANF) rules.

Through the use of less restrictive income and assets tests, states now are starting to offer health insurance benefits in the form of Medicaid to low-income parents regardless of whether or not they currently receive welfare benefits. This type of expansion is possible through Section 1931 of the Social Security Act, implemented with PRWORA. Section 1931 was added to the Medicaid program to ensure that those eligible for Medicaid prior to the passage of PRWORA would continue to qualify. Besides allowing those who would have been eligible prior to the new legislation to continue to be eligible for Medicaid, it gave greater flexibility to states in their administration of Medicaid benefits.

This federal legislation mandated that the receipt of TANF benefits no longer entitled individuals to Medicaid benefits, and, conversely, ineligibility for TANF does not necessarily make individuals ineligible for Medicaid benefits. Section 1931 provides states with viable options for creating state standards to determine who is eligible to receive Medicaid. These options are especially powerful because, unlike a demonstration waiver, Section 1931 does not impose budget constraints on the state. Under Section 1931, states have the flexibility to cover more low-income adults and receive the federal match according to the following measures: income disregards, asset disregards, and increasing income and asset limits.⁹

Along with these explicit benefits, 1931 gives states the freedom to simplify their application process. Correspondingly, states may not make Medicaid eligibility standards stricter than they were in July of 1996.¹⁰ Income disregards are also given to families for any child care and child support income based on the July 1996 AFDC level.

Many states have taken advantage of 1931 by aligning their Medicaid program with their TANF eligibility requirements, ensuring automatic Medicaid coverage to those eligible for TANF. Since TANF is available to both single parent and two-parent families, Section 1931 can be used to insure low-income adults in families with eligible children. States are able to determine the level at which the benefit is available to adults.

Rhode Island and the District of Columbia have instituted programs that insure low-income adults, wherein the states are given the regular Medicaid match for adults while children receive the Medicaid-SCHIP match. Section 1931's ability to cover adults may be directly linked to SCHIP benefits, if the state chooses. This allows the entire family to be insured under one plan.¹¹

As previously mentioned, Medicaid's Section 1925 is the mandate that requires states to offer transitional Medicaid coverage for at least six months to families who lose their TANF benefit because of increased hours of work or income from employment. Section 1931 allows states to extend transitional coverage beyond the six-month coverage allotted to families who otherwise would lose Medicaid because of increased earnings. States may also vary the degree of extended coverage by level of increased earnings.

Section 1931 was designed to meet the needs of states by enhancing flexibility. It authorizes them to use phase-in expansion, allowing them to monitor and evaluate the program's success and make necessary program changes. Section 1931 also has the capability to create enrollment limits by allowing states to differentiate between recipients and those currently applying. Finally, states are required to offer the core services, but the scope of those services are up to the state, as is the nominal copay option. These nominal copayments, according to Health Care Financing Administration (HCFA) regulations, may include the following: a nominal deductible of \$2 per month per family, a nominal copayment ranging from 50 cents to \$3, or a nominal coinsurance of five percent of the state's payment rate for service.¹²

Section 1931 of the Social Security Act ultimately can be used to improve health care access in states in different ways depending on the needs of the individual states. Table 8.1 lists the states that have adapted 1931, their allowable income level, and whether or not they have an assets test.

Table 8.1. State Medicaid Expansions to Parents through Section 1931

State	Income Test (percent of FPL)	Assets Test (Yes or No)
California	100 %	Yes
Connecticut	150 %	Yes
Washington, DC	200 %	No
Maine	150 %	Yes
New Jersey*	200 %	Yes
Ohio	100 %	No
Rhode Island	185 %	No

Adapted from: Barbara Lyon, Deputy Director, Kaiser Commission on Medicaid and the Uninsured, "Building on Medicaid and CHIP to Expand Coverage of the Low-Income Population," Presentation at the Families USA Annual Meeting, Washington, D.C., January 27, 2001.

*Granted a SCHIP waiver to cover parents in January 2001.

Section 1931 in Texas

Texas has not taken advantage of many opportunities that are offered through Section 1931. (See Appendix F for descriptions of how California has extended coverage through 1931.) Benefits do exist for states like Texas with substantial populations of uninsured low-income adults. The Center for Budget and Policy Priorities advocates state expansion through 1931 for the following reasons:¹³

Federal Medicaid match—1931 allows states to receive the federal matching funds to expand coverage without the necessity of a waiver.

Coverage promotes work and may reduce the need for welfare—Health insurance will not only ease the transition off welfare, but will also promote job retention by helping workers avoid illness that could potential force them to miss work

It gives low-income working parents the same access to health care as those who are unemployed—This encourages more expedient entry into the workforce rather than dependence on welfare.

Not only are there broad reasons, such as the three listed above, but others exist as well as to why Texas would benefit from expansion through 1931. The following list was developed in part by researchers with funding through The Commonwealth Fund.¹⁴

Scope of benefits—There are no set rules on what medical needs must be covered under the Medicaid benefit for adults. Each state is able to determine the amount, scope, and length of time a patient, particularly an adult receives benefits, although any changes in these limits through Section 1931 will be applied to all adults receiving Medicaid, not only low-income parents. Texas could use this flexibility to insure low-income parents at the most basic level, and then expand to more services, if it sees the need.

Ability to control the cost of expansion—Limiting the scope of benefits is just one way to control expansion costs. Other options exist for Texas in this arena. Specifically, if expansion becomes too fiscally demanding on the state, it may scale back or eliminate optional expansion of coverage, such as the coverage to low-income parents. If this were to happen, coverage to low-income parents already enrolled would continue under the original legislation.

Cost-sharing—Cost-sharing is defined as the out-of-pocket payments Medicaid beneficiaries make in order to receive of covered services. States are allowed to add a cost-sharing option for the adults insured under Section 1931. Cost-sharing takes three main forms: deductibles (specified dollar expenditures), copayments (fixed amounts), and coinsurance (percentage of the cost for service). Cost-sharing may benefit patients considering whether visiting the doctor is medically necessary.

As this brief description of expanded Medicaid options points out, there are ways to decrease the number of uninsured while helping those most in need of health insurance. Texas could follow several different paths, and must be fully aware of all the options it

has to expand health insurance to more low-income families. In fact, the Texas Blue Ribbon Task Force on the Uninsured has recommended that Texas pursue federal options to extend coverage under Medicaid.¹⁵

Section 1902(r)(2)

Section 1902 (r)(2) is another option that gives states the ability to expand Medicaid and decrease the number of uninsured people. Using this alternative, a state may modify its Medicaid income levels to increase coverage on an incremental basis. For example, Minnesota initially used 1902(r)(2) to expand Medicaid coverage to families with children ages one through eight to 185 percent of the FPL (this program was later replaced with MinnesotaCare, a program created through an 1115 waiver, which covers children in families up to 275 percent of the FPL). Other states have used the authority of Section 1902(r)(2) to create slightly different programs. The state of Washington used it to create a program that extended Medicaid coverage to the children of families not receiving cash assistance, with incomes up to 200 percent of the FPL. This program offers the same benefits as Medicaid, but is administered through managed care plans. Section 1902(r)(2) could be used to implement a Medicaid plan in Texas that would reach more uninsured children and their parents.

A second option available through Section 1902(r)(2) is to insure the “medically needy” through its authority. The “medically needy” option uses income and resource standards established by the state. According to federal law, medically needy income standards cannot exceed 133 1/3 percent of the state’s AFDC level.¹⁶ If a potential beneficiary passes the income and resource tests, the state then determines eligibility by deducting medical expenses from the individual’s income over a specified budget period. If the remaining income is less than the set income standard, the potential beneficiary is deemed eligible for Medicaid. Thirty-five states insure the medically needy using such a standard. By extending this program to the disabled and elderly, Texas could decrease the number of uninsured and offer relief to a population who would readily benefit from health insurance.

Section 1115 Waivers

Section 1115 waivers are yet another vehicle under the Social Security Act by which states can expand health insurance coverage to the uninsured. In general, a section 1115 waiver is any experimental pilot project that waives the rules established by the Social Security Act. Section 1115 waivers under the Title XIX Medicaid program or the Title XXI State Children’s Health Insurance Program (SCHIP) must be authorized by the Secretary of the Department of Health and Human Services. These waivers provide states with greater flexibility by enabling them to receive federal funding for trying out new and innovative methods to fulfill the objectives of these two programs. The federal government has traditionally promoted 1115 waivers as a way to encourage states to expand benefits or provide services more efficiently to a larger population, while at the same time reducing, or at least maintaining, current Medicaid and SCHIP expenditures.

There are certain mandatory rules under Medicaid law that may only be waived by an 1115 waiver. In short, these include statewide application, and equal services and benefits, adequate in duration and scope, for all beneficiaries. Therefore, while what HCFA might allow under an 1115 waiver is somewhat ambiguous, states will be applying to waive one or more of these rules and will be looking to precedents for ideas in developing guidelines for pursuing their proposals. Examples of requirements that have been regularly waived include providing services to specific populations or regions within a state as opposed to serving all eligible populations, offering different benefits to one group but not another, making enrollment in managed care plans mandatory, and expanding coverage to groups like childless adults or parents (since the passage of the 1997 Balanced Budget Act, states can make enrollment in managed care programs mandatory without a waiver).¹⁷

During the Clinton administration, states were given far more flexibility in carrying out the goals of the Medicaid program and, more recently, the SCHIP program, and it has been suggested that such flexibility will continue to be expanded under the Bush administration. New legislation, such as the aforementioned Section 1931, created by the Welfare Reform Act of 1996, or the enactment of the SCHIP program under the Balanced Budget Act of 1997, has provided states with a greater number of options for insuring their uninsured populations. Since Section 1931 enables states to expand coverage to parents through an amendment to their state Medicaid plan, which is both easier and faster than obtaining a waiver, they need only apply for section 1115 waivers if they want to change the rules of their current federally funded public health insurance programs or if they want to expand coverage to new populations not currently covered by these programs, namely childless adults. Thus, if states just wish to add additional optional benefits they do not need an 1115 waiver. States may, however, want to consider a SCHIP waiver to cover parents because they can receive an enhanced match from the federal government for insuring this group.^{18, 19, 20}

The Section 1115 Waiver Research and Demonstration Proposal Process

As mentioned, the proposal process and the specific requirements to be waived are somewhat ambiguous and, therefore, states can turn only to precedent for guidance as to what types of waivers will be granted. There is, however, a typical proposal process for all states, and also several features applicable to all waivers. Therefore, before expanding upon the discussion of the 1115 waiver's features, a state should first understand what is expected of it during the application process. HCFA has provided general guidance about defining the life cycle of a section 1115 waiver. There are five steps in particular to the process, and include the concept phase, proposal review, preimplementation, operational, and evaluation phases.²¹

First, as noted, is the concept phase. During this phase a state provides HCFA with an initial outline of its intent. HCFA then reviews the state's proposed outline and provides comments, thus initiating an ongoing discussion with the state.

The second phase is the proposal phase, during which a state takes HCFA's comments into consideration and then prepares a formal proposal, which it eventually will submit to

HCFA for approval. Once the proposal is submitted, HCFA will review it and then forward it to the secretary's office for review, as well as to the Assistant Secretary for Management and Budget and the Office of Management and Budget (OMB) to review for cost neutrality. Once these parties have reviewed the proposal, the state will be expected to clarify specific aspects of its proposal. States, in cooperation with HCFA, will eventually negotiate the terms and conditions of their waivers; HCFA, however, typically establishes the final operations to be laid out in the 1115 waivers.

It is important to note that while there is no uniform standardized proposal format, there are specific criteria that HCFA looks for when evaluating a proposal. Thus, according to HCFA, each state's proposal should include the following information: the environment, how the services would be administered, who would be eligible for services, the degree of coverage and types of benefits offered, how benefits will be delivered, who can access them, the quality of services, how the services will be financed, a time frame for implementation, and a plan for the evaluating the outcomes of the waiver.²²

The third phase in the proposal process is the preimplementation phase. This is defined as the time between federal approval of a waiver plan and the actual launch of a new project. During this time it is normal for HCFA to conduct a site visit to evaluate whether a state is ready to begin its operations. Once the state is ready to implement its waiver, it enters into the fourth phase, or the operational phase, which is the period when the waiver is underway and providing services to beneficiaries.

Finally, the fifth phase is the evaluation phase, the period under which the demonstration project is examined to assess the degree to which it enhanced access to care or the quality of care, and at what cost.

General Features of the 1115 Waiver Research and Demonstration Projects

In addition to the simplified proposal process discussed above, there also are some common features to all 1115 waiver research and demonstration projects. These general features include budget neutrality, eligibility, time, and evaluation and reporting requirements.²³

The key to a state's being granted any waiver is its ability to demonstrate budget neutrality, which means that the proposed demonstration project will not cost the federal government more than it would have to contribute to a state's program under normal circumstances, throughout the entire life of the project. The cost-neutral requirement is somewhat more complex under SCHIP, however, given that states might choose among three different options in designing SCHIP (creating a new separate SCHIP program, expanding the state's current Medicaid program, or creating a plan that incorporates a combination of these two options). As a result, some budget neutrality terms are unique to SCHIP and do not apply to an 1115 waiver under Medicaid.

Under SCHIP, budget neutrality is referred to as an "allotment neutrality." Thus, under an 1115 waiver, states that created separate SCHIP programs can spend up to their state allotment of Title XXI funds, but if they exceed their federal allotment of monies then no

additional federal matching funds would be provided to them. In the case where a state exhausts its SCHIP resources but its SCHIP program is an expansion of Medicaid, regular Medicaid matching funds could become available under a Title XIX waiver or through a Title XIX state plan amendment. In such situation, Title XIX budget neutrality laws would apply. If a state created a combination Title XIX and Title XXI waiver demonstration project, the budget neutrality terms would have to be worked out from the onset of the demonstration, including how future federal matches for Medicaid would be made.²⁴

Another commonality of Section 1115 waivers is that they extend current eligibility. In particular, Section 1115 waivers enable states to receive federal monies for providing additional benefits or services beyond those currently covered, or expanding current services to a new population not currently served under Medicaid or SCHIP.

Time is another feature inherent in all 1115 waivers. States typically are given five years to operate their waivers, although they may be subject to an annual renewal process for their continuation. It is also possible for states to be granted extension beyond five years to operate their demonstration projects. For example, Arizona has operated its entire Medicaid program as an 1115 waiver since it began in 1983.

Finally, there also is an evaluation and reporting component to 1115 waivers. Each state granted a waiver must evaluate its project and provide the federal government with a report. Such an evaluation should include both specific state- and cross-state analyses of the impact of the expansion on the utilization, insurance coverage, expenditures (both public and private), quality of the services offered, access to these services, and customer satisfaction. Table 8.2 lists the states that have received state Medicaid expansions to cover parents through 1115 waivers, state income levels, and whether an assets test is required.

Table 8.2. State Medicaid Expansions to Parents through 1115 Waivers

State	Income Test (percent of FPL)	Assets Test (Yes or No)
Delaware	100 %	No
Hawaii	100 %	Yes
Massachusetts	133 %	No
Minnesota	275 %	Yes
Missouri	100 %	No
New York ¹	150 %	Yes
Oregon	100 %	Yes
Tennessee ²	400 %	Yes
Vermont	150 %	Yes
Wisconsin ³	185 %	Yes
Washington	200 %	Yes

Source: Barbara Lyon, Deputy Director, Kaiser Commission on Medicaid and the Uninsured, “Building on Medicaid and CHIP to Expand Coverage of the Low-Income Population,” Presentation at the Families USA Annual Meeting, Washington, D.C., January 27, 2001.

¹ Expansion enacted but not yet implemented.

² Enrollment currently closed to adults.

³ Granted a CHIP waiver to cover parents in January 2001.

Expanding Coverage through the State Children’s Health Insurance Program

States might choose to apply for an 1115 SCHIP waiver rather than an 1115 Medicaid waiver because they receive an enhanced federal match under the SCHIP program. The U.S. Department of Health and Human Services (DHHS) has indicated that it will consider waivers for proposals to expand health insurance coverage, improve enrollment, improve health care outcomes, and increase access to needed health care services. For example, a state might want to provide a health care-related benefit to SCHIP enrollees that is not currently covered under either Medicaid or SCHIP, such as respite care for special-needs children. Or, a state might choose to create a public health care initiative that focuses on the needs of a specific group such as a state’s Hispanic population, although this initiative does not replace any existing state public health services. A state might also choose to expand SCHIP to cover parents so that it can receive an enhanced federal match.²⁵

In the State Medicaid Directors letter dated July 31, 2000, however, DHHS specified that any state applying for an 1115 waiver under SCHIP must first meet certain requirements. These include the following:

- the state’s SCHIP program must have been in operation for at least one year;
- states must conduct evaluations of the SCHIP program and must have submitted the required reports pertaining to these evaluations;
- each state must have submitted its enrollment reports;

- the state must prove that it has met the primary objective of the SCHIP program, which is to insure children up to age 19 in families with incomes up to 200 percent of the federal poverty level; and
- if granted a waiver, states cannot have a waiting list nor can they close registration and enrollment of eligible children during the life of their demonstration projects.²⁶

It is important to clarify that DHHS will not consider proposals that would allow any of the following:

- expansion of coverage to childless adults using SCHIP funds;
- reduction in benefits;
- cost-sharing above what is established under law;
- coverage of a group if there is a high risk of substitution;
- enabling Medicaid eligible children to be enrolled in SCHIP; and
- elimination of the 10 percent limit for administrative expenditures.²⁷

Expanding Health Insurance to Parents through SCHIP

While the majority of uninsured children are eligible for some form of public health insurance, a large number are still uninsured. Research has indicated that when parents are insured children are more likely to be enrolled and therefore more likely to get the care that they need. For example, a recent study by Ku and Broaddus found that family-based Medicaid expansions increased the Medicaid enrollment of Medicaid-eligible children who are not enrolled.²⁸ Given the research, it would seem prudent to extend public health insurance coverage to parents. Since January 2001, 16 states have expanded Medicaid coverage by utilizing different approaches, such as 1115 waivers and Section 1931, to provide health insurance to families who earn 100 percent of the Federal Poverty Level or higher.²⁹ In addition, as of January 18, 2001, three states, New Jersey, Rhode Island, and Wisconsin, have been granted SCHIP waivers. All three states will expand coverage to low-income parents with incomes above 100 percent of FPL.³⁰ Two of these states, New Jersey and Rhode Island, will expand the income eligibility guidelines for pregnant women.³¹

Initiatives that target populations other than children, such as parents, must adhere to the purposes of the SCHIP program and be designed with the end goal of insuring a greater number of children. Therefore, any waiver proposals to cover populations not targeted by SCHIP must provide evidence indicating that the state has adopted at least three of the following five policies and procedures, none of which have been adopted by Texas, in the health programs it offers to its children (including SCHIP and Medicaid):

- joint mail-in application and similar application procedures for both SCHIP and Medicaid;
- no assets test;

- 12-month continuous eligibility;
- presumptive eligibility; and
- a simplified redetermination and renewal process that allows renewal for eligibility by mail. In addition, for those states with separate SCHIP programs, if eligibility status changes states must facilitate an effortless transfer between Medicaid and the separate SCHIP program so that families are not required to fill out separate applications and children will not experience gaps in their coverage.³²

In addition, those states which want to cover additional populations must cover the lower-income individuals in the group targeted by the waiver before including those with higher incomes. Also, populations other than low-income children cannot be covered at income levels higher than those applicable to children in a state. Therefore, since states must first cover the lower-income individuals in a group targeted by a waiver before including those with higher incomes, and because Medicaid eligibility levels for parents are generally low, states like Texas would first have to expand Medicaid for parents using either the section 1931 authority or a Medicaid 1115 waiver before expanding their separate SCHIP programs to higher-income parents whose children are enrolled in the separate SCHIP program. According to new federal regulations, once this has been accomplished states could then apply for a waiver to use their SCHIP funds to provide health insurance to a family. There is, however, a caveat. States applying for family waivers must first demonstrate that covering a particular family would be cost-effective.³³

Furthermore, a state must show that the cost of providing family coverage would be equal to or less than the cost of providing coverage to an individual child. Cost-effectiveness will be assessed not only in a waiver request, but annually in the state's annual report. According to the regulations, states can compare these costs either on a case-by-case or an aggregate basis. If a state were to choose the aggregate cost method and fail to prove cost-effectiveness in its annual assessment, however, then from that point forward it would be required to prove cost-effectiveness on a case-by-case basis. This cost-effectiveness test makes it difficult to use SCHIP funds to provide health insurance to parents. As a result, several states are attempting to provide health insurance coverage to families through premium assistance programs, discussed in greater detail below.³⁴

If a state meets the SCHIP criteria, but has already implemented an expansion to parents on or before March 31, 2000, states may be eligible for the enhanced SCHIP matching funds, but only for those parents whose incomes are above 100 percent of the federal poverty line. The state would receive Medicaid matching funds for those parents below 100 percent of the poverty line.³⁵

Table 8.3. Covering Adults with Children through SCHIP

State	Expansion Method	Income Eligibility Level
New Jersey	SCHIP Waiver	200 % FPL
Rhode Island	SCHIP Waiver	100-185 % FPL
Wisconsin	SCHIP Waiver	100-185 % FPL

Adapted from: Department of Health and Human Services, "HHS Approves First SCHIP Waivers," Washington, D.C.: HCFA Press Office, January 18, 2001 (press release).

As demonstrated in the above discussion, states have begun expanding health care coverage to parents using Medicaid and SCHIP funds. Specifically, some states have used Section 1931 to implement these expansions, while other states have pursued Section 1115 waivers under Medicaid, and, most recently states have begun to use SCHIP waivers. The Blue Ribbon Task Force on the Uninsured has recommended that the State of Texas pursue a federal waiver to extend family coverage under both Medicaid and SCHIP. Coverage can already be extended to families under Section 1931 of Medicaid, without applying for a waiver, however. To extend coverage to families using SCHIP dollars, the state would in fact have to apply for a federal waiver under SCHIP. This particular recommendation goes on to urge that the waiver would specifically request that family coverage be provided under employer-sponsored insurance, if family coverage is cost-effective when compared to the coverage for the SCHIP eligible child alone. The premium assistance coverage option, using Medicaid and SCHIP dollars, will be discussed more thoroughly later in this paper.

Expanding Coverage to Childless Adults

Forty-eight percent of low-income childless adults are uninsured.³⁶ Seventy-one percent of these low-income adults work, but do not have employer-based health insurance.³⁷ As mentioned earlier, the only way for a state to expand health insurance to its childless adult population and receive any type of federal funding is through a Section 1115 waiver. States also have the option of using state funds to expand coverage to this group. As of January 2001, eight states have used an 1115 waiver to expand coverage to childless adults, and all have expanded coverage to at least 100 percent of the FPL. Several of these states have gone so far as to not have any income thresholds, although enrollees must pay a premium once they reach a set income level. Furthermore, one state has used state funds to provide coverage to this demographic group. Table 8.4 lists the states that have obtained 1115 waivers to cover childless adults, their methods of expansion, and their income eligibility levels.

Table 8.4. Covering Adults without Children

State	Expansion Method	Income Eligibility Level
Delaware	Section 1115	100% FPL
Hawaii	Section 1115	100% FPL
Massachusetts ¹	Section 1115	133% FPL
Minnesota	Section 1115/State funded	175% FPL
New York	Section 1115	100% FPL
Oregon	Section 1115/State funded	100% FPL
Tennessee	Section 1115	No income threshold ²
Vermont	Section 1115	150% FPL
Washington	State-funded	No income threshold ³

Source: Barbara Lyon, Deputy Director, Kaiser Commission on Medicaid and the Uninsured, “Building on Medicaid and CHIP to Expand Coverage of the Low-Income Population,” Presentation at the Families USA Annual Meeting, January 27, 2001.

¹ Applies only to unemployed adults without insurance.

² Above 100 percent FPL, enrollees must pay premiums, deductibles, and copayments; enrollment frozen since 1995, except for limited adult populations.

³ Above 200 percent FPL, enrollees must pay the full premium.

Premium Assistance

States have three options for pursuing premium assistance programs. Specifically, they can make an amendment to their state Medicaid plans under Section 1906, which Texas has already done; pursue a section 1115 waiver under Medicaid; or pursue a waiver under Section 2105(c)3 of Title XXI SCHIP. Some states actually have implemented a premium assistance plan that incorporates a combination of these three options.

Premium assistance is designed to utilize private employer funds to provide health insurance to low-income working families. States can fund such as program using a combination of state and federal funding, or create a program entirely sponsored by the state. Premium assistance potentially could enable states to provide coverage to a greater number of children using a smaller pool of resources, or enable them to insure a larger number of people by extending coverage not only to children but to their parents using its original available resources.

Both Section 1931 and the new SCHIP regulations have provided states with new opportunities to expand coverage to those at higher income levels. Given that families at higher income levels are more likely to have a working parent with access to employer-based insurance, these families would be more likely to qualify for premium assistance. The CHIP law also allows states to apply for a “variance” from HCFA that permits the purchase of family health insurance through a group plan that includes coverage for the children targeted by CHIP. Texas, as well as other states, may be interested in subsidizing private coverage for working families for the following reasons:^{38,39}

- Employed Medicaid/SCHIP-eligible individuals and families could take advantage of their employer-sponsored health plans, which would enable states to stretch their limited public funds by sharing the cost of health care coverage with employers and taking advantage of the money employers already are willing to spend on health insurance.
- Since premium assistance builds on mainstream, employment-based coverage, it may be able to reach children whose parents want to avoid the stigma of participating in a public program.
- Insuring families under a single health plan may increase the likelihood that children in these families will access health care services.
- Premium assistance is consistent with the goal of welfare reform, which is to encourage self-sufficiency through employment. Employment-based benefits help strengthen attachment to the workforce by parents with modest incomes.

Eligibility for Premium Assistance Programs

To be eligible for private coverage buy-in programs individuals must, at the minimum, be:

- eligible for the public program (SCHIP, Medicaid, or a state-only program);
- have access to employer-based coverage or other private coverage that is comparable to the public option; and
- finally, children applying for SCHIP must have been without insurance for six months before they can benefit from the premium assistance program.

It should be noted, however, that under the new SCHIP final regulations states have been given some flexibility to formulate exceptions to this six-month requirement of uninsurance. Exceptions to the rule could include economic hardship, job changes to employers who do not offer health insurance, and involuntary losses of health insurance.⁴⁰ In addition, the secretary of health and human services has the authority to modify the six-month waiting period requirement if deemed necessary.⁴¹ It is also important to note that the six-month waiting period is not applicable to children insured through Medicaid under section 1906 of the Social Security Act.

Section 1906

The Health Insurance Premium Payment Program (HIPP), created under Section 1906 of the Social Security Act, allows states to subsidize employer-sponsored plans when it is cost-effective for them to do so. States must pay premiums, but they are not required to pay for deductibles or copayments, although they can use Medicaid funds for all cost-sharing elements. The key to this program is cost-neutrality. Specifically, states cannot spend more to subsidize an individual than they would have spent to cover them under

the state Medicaid program.⁴² Additionally, given Medicaid's extensive benefits and low cost-sharing, states must bring employer-sponsored insurance up to the same standards by providing wraparound benefits and cost-sharing, both of which are factored into the cost-effectiveness test. Texas is one of the few states currently operating a HIPP program; it currently serves 3,000 people.⁴³

Premium Assistance Programs under Medicaid Section 1115 and SCHIP Waivers

States also may choose to implement premium assistance programs using an 1115 Medicaid waiver or SCHIP. Before they can implement one of these programs, however, they must meet several requirements. These include a benefits benchmark, cost-sharing, and cost-effectiveness requirements.⁴⁴

Benefits

Premium assistance programs first must provide coverage that matches the benefits offered under Medicaid/SCHIP health plans. The state must provide the same benefits that beneficiaries receive under the state's regular Medicaid program, including those services required by law as well as any "optional" benefits states have chosen to cover under their Title XIX State Plans. With respect to SCHIP, health plans must be equivalent to one of the following options:

- the commercial HMO plan in the state with the largest enrollment;
- the state employee plan;
- the Federal Employees Health Benefit Plan standard option PPO; or
- coverage deemed "benchmark-equivalent."⁴⁵

Cost-Sharing

Second, coverage under a premium assistance program must meet the same cost-sharing stipulations required under regular Medicaid and SCHIP programs. Under Medicaid rules, states cannot impose any cost-sharing on children under age 18, and only nominal cost sharing can be required of nonpregnant adults. Under SCHIP, the following requirements apply to premium assistance programs:

- no cost-sharing for well-baby, well-child, and immunization visits;
- families with income under 150 percent of the Federal Poverty Level may pay no more than the Medicaid-level of copays (including \$3 office visits); and
- families covered by SCHIP that have incomes under 150 percent of the federal poverty level may pay no more than 5 percent of their total income for cost sharing in a given year.⁴⁶

Cost-Effectiveness

Third, states must provide evidence that their premium assistance proposal is cost effective or budget neutral. More specifically, states must show that providing health insurance under the premium assistance option does not cost the federal government more money than it would have spent under traditional circumstances. Under Medicaid, states may include adults as well as children, or families, in the cost-effectiveness equation, whereas under SCHIP only children are included in that equation (i.e., it cannot cost the state more money to insure both parents and children than it would have cost the state only to insure the children). Included in this equation is the cost of wrap-around benefits that must supplement a private plan that fails to meet the standards of the public plans. As a result, to determine whether the purchase of employer-sponsored coverage meets the cost-effectiveness test, states need information on the benefits covered by the private plan and the amount of the premium that employers expect employees to contribute. (See Appendix H for a description of the design of the premium assistance programs of two states, Iowa and Massachusetts).⁴⁷

In some instances it can be economical for the state to buy into a family plan that would cover noneligible family members as well as eligible ones. For example, if the cost of buying into an employer family plan (employee, spouse, and two children) is less than subsidizing the cost of two children in a public program, then the state could extend a subsidy to the individual (the spouse) who is technically not eligible. Conversely, problems arise pertaining to the cost-effectiveness of the premium assistance option for smaller families (such as an employee and only one child).⁴⁸

Concerns about to the Creation of Premium Assistance Programs

Several concerns arise when creating a premium assistance program, including crowd-out, administrative burdens associated with paying the subsidy, and employer concerns, such as unequal treatment of families with similar incomes, lack of confidentiality, and reluctance on the employer's part regarding a partnership with the government.

Crowd-Out

One problem often associated with premium assistance is known as "crowd-out." It pertains to the substitution of public funds for private funds. Substitution can occur in two ways: insured employees may drop private coverage to enroll in a Medicaid or SCHIP program, and/or employers may reduce their contribution toward the cost of dependent coverage or drop dependent coverage altogether because of high costs or there being a viable public option for health insurance available to families. For example, employers with low-wage workers may decide to cut costs by eliminating dependent coverage, as medical assistance programs likely would cover their employees' children. Higher-wage workers or higher-income families in that same company, however, would no longer be able to get coverage, either through the company or the government.

In the short term, decisions resulting in crowd-out will likely take place at the individual level. For example, when faced with the option of paying for their children to have

insurance through their employer, or applying to place them in the SCHIP program, a family with children might choose the latter because it would more than likely cost the family less money. In the long term, crowd-out could occur at the industry level. As new and existing firms reevaluate their financial positions, fewer employers may choose to provide health insurance benefits to their employees' dependent children or may reduce their contributions.⁴⁹

To deter crowd-out under the SCHIP premium assistance programs, children must have been without insurance for six months before they can receive benefits. It should be noted, however, that under the new final regulations, states have been given some flexibility to formulate exceptions to this six-month requirement. Exemptions to that rule could include economic hardship, job changes to employers who do not offer health insurance, involuntary losses of health insurance, and modification of the six-month waiting period by the secretary of health and human services if deemed necessary.⁵⁰ Additionally, the six-month waiting period does not apply to children insured through Medicaid under section 1906 of the Social Security Act.

Administrative Burdens

There also are administrative burdens inherent in the premium assistance option, which create new costs to state Medicaid and SCHIP budgets. For example, in order for states to use Medicaid or SCHIP funds to buy into employer-based insurance, mechanisms must be in place to pay these funds to enrollees. States can choose to make subsidy payments to employees, employers, insurance carriers, or intermediaries, such as purchasing groups or brokers.⁵¹

Making payments to any of these entities will likely result in new costs and/or barriers. In particular, in such cases, employers who do not directly benefit from the program could incur additional costs arising from additional administrative duties. Or, employees' disposable income could be negatively affected in the short run if they are required to pay deductibles and then wait for reimbursement. Some fear that under this option employees could abuse the system by claiming to have insurance, when in fact they do not, in order to receive payments from the government. (To address this fear, some states require employees to turn in photocopies of their paycheck stubs to verify the deduction of health insurance premiums.) Regardless of who takes on the administrative duties and what type of safeguards are put into place, such a program will carry with it additional administrative costs that must be considered by state governments when they develop their proposals.

Inequities

Employers have several other concerns with the premium assistance program apart from the administrative burden. First, some employers see premium assistance as unfair discrimination among employees with similar wages. More specifically, because of the six-month uninsurance requirement, employees who currently were or at some point within the past six months were covering their children would be denied entry into the program.⁵²

Lack of Confidentiality

Another concern that has been raised is lack of confidentiality. Employers who offer the premium assistance option would be aware of a family's income levels and their public subsidy program status.⁵³

Fear of Government Partnership

Additionally, some employers fear having to forge a partnership with the government, and as a result may be hesitant to participate in the premium assistance program.⁵⁴

In conclusion, it should be noted that there are benefits and drawbacks to premium assistance programs. Overall, states with implemented premium assistance programs find the effectiveness of such programs to be generally limited. This is fundamentally true because most of the parents of uninsured children do not have access to employer-sponsored insurance. Those parents with access often have premium costs too high for effective premium assistance.

Expansion of Medicaid to the Disabled and the Elderly

The Social Security Administration's State Partnership Initiative

Increasing access to health insurance for the disabled has been an area of growing concern and action for federal administrators and legislators. The Social Security Administration (SSA) took the first major step in this area by carrying out President Clinton's Executive Order 13078, "Increasing Employment of Adults with Disabilities." This order aimed to help states develop innovative and integrated programs of service and support for residents with disabilities throughout the state. The SSA began the State Partnership Initiative as a direct result of this order. Under the initiative, 12 states entered into five-year cooperative agreements to develop projects that would increase job opportunities, enhance the coordination and delivery of rehabilitation, employment, and other support services available to adult recipients of Supplemental Security Income, SSI (these programs are designed for SSI beneficiaries who are either blind or disabled) or Social Security Disability Insurance, SSDI. The overriding objective of this program is to assist these individuals in returning to work, or working for the first time, and in the long run to reduce their dependence on SSI and SSDI benefits.⁵⁵

The first set of research and demonstration waivers under this act was enacted in January of 2001. These waivers, known as the SSI Work Incentive Demonstration Project, are being carried out in California, New York, Vermont, and Wisconsin. These projects seek to discover ways to give states more flexibility with their SSI programs as they tackle barriers to employment such as health care faced by the disabled in a particular state. Increasing Medicaid benefits through a buy-in and health care support are integral elements of Vermont and Wisconsin's demonstration waivers. The four pilot programs show the diversity in states' needs; none of the demonstration projects are exactly the same because of differences in the state's Medicaid program, supplement to SSI, workforce policy, or interpretation of the Ticket to Work and Work Incentives

Improvement Act of 1999 (TWWIA). The SSA's initiative encouraging disabled individuals to enter or return to work predates TWWIA, the major legislation on this issue. Keeping the demonstrations within this initiative flexible will be a challenge as states implement their version of TWWIA. If better programs are developed through the State Partnership Initiative, all states, including Texas, will benefit.⁵⁶

Ticket to Work and Work Incentives Improvement Act of 1999

The Balanced Budget Act of 1997 allowed states to provide Medicaid coverage to working individuals with disabilities who did not qualify for Medicaid because of their earnings through a provision, known as Section 4733, which permitted states to create a new optional categorically needy Medicaid eligibility group. The TWWIA legislation passed in 1999 expanded on the 1997 provision by creating two new optional categorically needy Medicaid eligibility groups: 1) the Basic Coverage Group and 2) the Medical Improvement Group.

The Basic Coverage Group

Similar to the group coverage created through the 1997 BBA, the Basic Coverage Group allows states to provide Medicaid to working individuals with disabilities who would not otherwise qualify because of their income. However, the Basic Coverage Group goes beyond the original provisions, as it allows states to cover disabled individuals whose families earn more than 250 percent of the federal poverty level. It also allows states to establish their own income and resource standards.⁵⁷

The Medical Improvement Group

The second optional group, known as the Medical Improvement Group, can also be created in a state through TWWIA. This group would consist of individuals with medically improved disabilities who lose their SSI coverage because of their improved condition. A states opting to create a Medical Improvement Group must cover the same benefits for individuals in this group as it covers for those individuals in the Basic Coverage Group.

Provisions of TWWIA

States are allowed to impose sliding-scale premiums and other cost-sharing mechanisms based on the participant's income from the Basic Coverage Group and the Medical Improvement Group. If a covered individual makes over \$75,000 in income a year, the state is required to charge the recipient 100 percent of the premium for the state's Medicaid coverage.⁵⁸

TWWIA in Texas and Other States

Texas is currently reviewing legislation to enact some of the provisions of the Ticket to Work and Work Incentives Improvement Act. The bill, HB 1087, introduced by Representative Garnet Coleman in the 77th Texas Legislature, will allow Texas to create

a demonstration project that includes both optional groups, the Basic Coverage Group and the Medical Improvement Group, through 2003. Several states have already enacted similar legislation and have been approved by the Health Care Financing Administration.

The federal government has also provided states the opportunity to build upon the basics of TWWIIA by allowing them to develop and apply for a Demonstration to Maintain Independence and Employment and/or a Medicaid Infrastructure Grant. The Demonstration to Maintain Independence and Employment allows states to provide health care services and support for individuals with physical and mental impairments before the onset of a disability.⁵⁹ Specifically, it will enable individuals with chronic conditions to obtain the care they need without having to quit their jobs. This program will alleviate their fear of losing health insurance if they continue to work. Rhode Island and Mississippi are the first two recipients of this demonstration grant. Congress has authorized \$250 million to be spent on demonstrations in the next six years.

Twenty-four states and the District of Columbia have been granted the Medicaid Infrastructure Grant for 2001. The Infrastructure Grants were designed to help states create a mechanism for individuals with disabilities to purchase health coverage through Medicaid. A common fear among individuals with disabilities is that they will lose their health coverage if they choose to return to work. This program seeks to alleviate this barrier to work. Grant money can be used to provide disabled individuals with personal assistance or supports. It can also be used by the state to help employers develop ways to gain better access to disabled workers, train staff in new employment opportunities, and/or improve transportation and other similar supports that individuals with disabilities must rely upon.⁶⁰

Medicaid and the Elderly and Disabled

When discussing issues of the uninsured, the elderly often are a forgotten group (all programs discussed in this section apply to the disabled if they are eligible for SSI or Medicare because of their disability). Few individuals over 65 are considered uninsured because a vast majority are entitled to Medicare benefits. Certain individuals 65 and over are not eligible for Medicare. Specifically, if neither the individual nor his/her spouse participated in employment long enough to contribute for the required number of quarters, they are not covered by Medicare Part A, although it is possible for these individuals to buy into Medicare Part A. Part B is available to all individuals over 65 who pay the monthly premium.

Medicare benefits are entitlements offered to most elderly people due to age and work history, unlike Medicaid benefits, which are means-based. Although most low-income elderly individuals have the basic benefits of Medicare, they often do not have sufficient coverage to allow them to receive expensive and specialized extensive health services, and are forced to spend large percentages of their income on health care.

Medicaid offers two general forms of medical coverage to help low-income elderly and disabled individuals. The first is the basic Medicaid benefit package or full benefit eligibility; this includes physician, hospital, nursing facility, prescription drug, and other

services, as well as assistance with the Medicare premium and cost-sharing requirements. The second form of medical coverage offered to Medicare beneficiaries through Medicaid includes assistance with their premiums, deductibles, and coinsurance. Table 8.5 gives an overview of these program and eligibility levels.

Full Benefit Eligibility

Federal law stipulates that full benefit eligibility is to be achieved through the Supplemental Security Income (SSI) Medicaid Benefit. Thus, Medicaid automatically covers individuals who are eligible for SSI. Those with incomes of less than 74 percent of the federal poverty level are eligible for the SSI benefit in Texas, and therefore receive full Medicaid benefits, which, for someone already on Medicare, include prescription drugs, long-term care, and Medicare Part B premium and cost-sharing. This population is known as the dual-eligible.

For those not eligible for full benefits, the federal government offers four programs collectively called the Medicare buy-in to help low-income seniors and disabled receive the health care they need. These programs, which offer a range of services from broad coverage to premium assistance, are a means-tested entitlement that are more difficult to begin receiving than the automatic Medicare health care coverage. These programs include the Qualified Medicare Beneficiary (QMB) program, Specified Low-Income Medicare Beneficiary (SLMB) program, and Qualified Individuals 1 and 2 (QI-1 and QI-2).

Although the cost-assistance programs provide a needed benefit, participation rates are low. In short, they are not reaching everyone who qualifies and needs these programs. In 1998, Families USA estimated that approximately 684,000 low-income Texan Medicare beneficiaries were eligible for an aspect of the QMB or SLMB buy-in based on their incomes, but between 370,000 and 404,000 were not receiving the buy-in.⁶¹ This means that 54 to 59 percent of eligible low-income Texans are forced to pay for or go without medical services they are entitled to receive.

Table 8.5. Texas Medicaid Eligibility for Low-Income Medicare Beneficiaries, 2001

<i>Beneficiaries Receiving Full Medicaid Benefits</i>				
	Income Test (Monthly)		Assets Limit	
SSI Medicaid Beneficiaries*	Gross \$550 (Individual) Gross \$816 (Couple)		\$2000 (Individual) \$3000 (Couple)	
Nursing Home Medicaid	Gross \$1,590 (Individual) Gross \$3,180 (Couple)		\$2000 (Individual) \$3000 (Couple)	
Medically Needy	[not provided in Texas]		[not provided in Texas]	
<i>Beneficiaries Receiving Medicaid Assistance with Medicare Premiums and Cost-Sharing</i>				
Category	Family Income	Resource Test	Medicaid Test	Entitlement
QMB	≤ 100% FPL	\$4,000 (Individual) \$6,000 (Couple)	All Medicare premiums and cost-sharing	Yes
SLMB	100%-120% of FPL	\$4,000 (Individual) \$6,000 (Couple)	Medicare Part B monthly premium	Yes
QI-1	120%-135% of FPL (first come, first served basis)	\$4,000 (Individual) \$6,000 (Couple)	Medicare Part B monthly premium	No (subject to annual federal funding cap)
QI-2	135-175% of FPL (first come, first served basis)	\$4,000 (Individual) \$6,000 (Couple)	2.5% of the Medicare Part B monthly premium (pays \$1.25 per month)	No (subject to annual federal funding cap)

Adapted from: Area on Aging of the Capital Area, *Eligibility Table* (Austin, Texas: Area on Aging of the Capital Area, 2001), p. 1; Ellen O'Brien and Diane Rowland, *Medicare and Medicaid for the Elderly and Disabled Poor* (Washington, D.C.: The Henry J. Kaiser Family Foundation, 1999), p. 8; and Andy Schneider, Kristen Fennel, and Patricia Keenan, *Medicaid Eligibility for the Elderly* (Washington, D.C.: The Henry J. Kaiser Family Foundation, 1999), p. 13.

*Individuals on SSI are automatically eligible for Medicaid. The SSI eligibility level is below 74% of the FPL in Texas.

Federally Provided Benefits

The federal government pays for 60.6 percent of the deductible for the QMB and SLMB benefit in Texas. The federal-state match program in the state pays the remaining 39.4 percent. The QI benefits are paid for entirely by the federal government (the QI programs are federally funded through a block grant created in the BBA of 1997). This program is funded through FY 2002. The premium for Medicare Part B is deducted from the recipients' Social Security checks, but for those who qualify for QMB, SLMB, and QI-1 benefits, no money is deducted from their monthly Social Security benefit. QI-2 beneficiaries have a reduced premium deduction taken from their benefit.

Providing Medicaid to More Elderly and the Disabled

Several options exist to provide more Medicaid coverage to low-income Medicare recipients in Texas. One federally matched method would be to grant Medicaid eligibility to all elderly and disabled at or below 100 percent of the FPL with assets at the SSI level of \$2,000 per individual or \$3,000 per couple. Increasing this eligibility level would provide the QMB population with full Medicaid benefits. This would ensure prescription and long-term coverage to elderly and disabled individuals who fall between 74 and 100 percent of the FPL. This methodology is less restrictive than the 1972 Income and Resource Standard currently in use. States can also use Section 1902(r)(2) to create less restrictive measures of income and assets to further expand full Medicaid benefits to low-income populations (for example, if a state disregarded \$50 of monthly income, eligibility to seniors would expand to those who have monthly income \$50 above the poverty line).⁶²

This same tactic can be used with the SLMB program that aids beneficiaries with income between 100 percent and 120 percent of the FPL. Texas could eliminate the resource test to ensure that those with incomes within the SLMB bracket are assured assistance in paying for the Medicare Part B premium. Another possible option to be applied to the SLMB income level would disregard certain types of income, making individuals between 100 to 120 percent of the FPL eligible for more generous entitlements such as cost-sharing or full Medicaid benefits. These income disregards would have a domino effect and allow some Medicare beneficiaries with incomes above 120 percent of the FPL eligible for SLMB.

Another option to help seniors obtain health care at lower cost is to supplement their monthly SSI payments with state payments. If Texas were to utilize this option, it could also opt to continue to offer Medicaid coverage to these individuals. As of 1999, 24 states offered this benefit to their low-income seniors and disabled individuals receiving SSI. The monthly supplements vary from a few dollars in some states to \$364 in Alaska. States can opt to supplement only specific groups, such as individuals living in group facilities, or to supplement all recipients of SSI in the state.⁶³

A Federal Problem with Medicaid for the Elderly and the Disabled

A final option to help the elderly and the disabled receive health insurance through Medicaid would be to increase the “medically needy” level. In Texas, individuals are required to spend at least 24 percent of the federal poverty level per month to be eligible for Medicaid through the medically needy pathway. Texas is limited by federal law, which permits states to set spend-down levels up to 133 1/3 percent of the state’s 1996 AFDC (Aid to Families with Dependent Children) payment level.⁶⁴ Thus, action must be taken on the federal level because of the 17 percent of federal poverty level income standard used in Texas for AFDC eligibility in 1996. This problem needs to be addressed as it creates the problem of inequity between those eligible for SSI and those who have incomes just above the SSI level and are therefore ineligible for Medicaid.

Outreach Options for Low-Income Elderly

The preceding state expansion options describe a variety of approaches Texas and the federal government could use to further reduce the number of low-income Texans who go without eligibility for necessary services in their state-provided health insurance. A concerted outreach effort must be made to reduce the number of individuals eligible for but not receiving benefits. Such an effort should inform and simplify the buy-in application process for this aging population. The Social Security Administration and the Health Care Financing Administration are the agencies that would be most closely involved. This outreach effort should include three main components: 1) identification and notification, 2) simplification of the application, and 3) enrollment through Social Security offices.

In 1998, the SSA created a Medicare buy-in demonstration project resulting from a congressional mandate that included different administrative models which were used to test six targeted outreach procedures. For example, two models examined the effects of enabling seniors to receive Medicaid information through Social Security rather than through county Medicaid offices, which tend to have a welfare stigma. The models were developed to test their effectiveness in inducing eligible elderly and disabled populations to enroll in the Medicare buy-in programs. These pilot programs yielded modest results. The targeted individuals often had income or assets that precluded their eligibility for the buy-in. The demonstrations also found that application requests did not necessarily matriculate into program participation, although the individuals who utilized the phone-in option were a source of substantial enrollment, particularly when SSA or state workers assisted respondents with the application process.⁶⁵ It therefore may be beneficial for individuals eligible for the buy-in in Texas to have the state establish a means of distributing information connected to call centers, which would provide guidance throughout the buy-in application process.

Conclusions

This paper has described some of the federal options available to the state of Texas for addressing the problem of the uninsured: targeted simplification efforts, including continuous eligibility, presumptive eligibility, and transitional eligibility; and program eligibility expansion efforts, which include Section 1931, income disregards, the medically needy, Section 1115 waivers, SCHIP waivers, and premium assistance. The final section of this paper discussed Medicaid expansion options that focus on the disabled and the elderly. Additionally, recommendations from the Texas Blue Ribbon Task Force on the Uninsured were presented.

A number of states have implemented at least one approach to covering their uninsured populations, and some have used a combination of approaches. Furthermore, many of the options discussed throughout this paper would only require an amendment to the Texas State Medicaid Plan or the Texas SCHIP Plan and therefore could be implemented more easily than those which expand coverage through Section 1115 waivers.

According to a 2000 report released by the Council of Economic Advisors to the President and a recent issue of *Health Affairs*, a combination of both private and public incentives would insure the greatest number of people who are currently without insurance coverage. Private options include tax credits and medical savings accounts. The council found, however, that while tax credits likely would affect the greatest number of people, this option also would cost the government the most money. Direct provisions, such as insuring parents under Medicaid or SCHIP, would be the most efficient option because these programs reach the lower-income uninsured for a relatively small cost compared to the benefits being offered.^{66,67}

Expanding coverage through public programs like Medicaid and SCHIP has its advantages, especially when the public policy goal is to expand coverage to low-income vulnerable populations, those who would benefit from specific types of public expansion. Using such information of this nature, Texas must continue the dialogue and choose the most effective options as it strives to increase the number of insured individuals in the state.

Notes

¹ Donna Cohen Ross and Laura Cox, *Making it Simple: Medicaid for Children and CHIP Income Eligibility Guidelines and Enrollment Procedures* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2000), p. 5.

² Texas Blue Ribbon Task Force on the Uninsured, *Report to the 77th Legislature* (Austin, Texas, February 2001), p. 39.

³ Children's Health Campaign, *Promising Ideas in Children's Health Insurance* (Washington, D.C.: Families USA, 2000), p. 4.

⁴ The Texas Blue Ribbon Task Force recommended that services to this population, specifically, limited, non-entitlement family planning be added to Medicaid benefits through a federal waiver. Texas Blue Ribbon Task Force on the Uninsured, *Report to the 77th Legislature*, p. 40.

⁵ Ross and Cox, *Making it Simple*, p. 5.

⁶ Children's Health Campaign, *Promising Ideas in Children's Health Insurance*, p. 2.

⁷ Ross and Cox, *Making it Simple*, p. 9.

⁸ Department of Health and Human Services, *Supporting Families in Transition: A Guide to Expanding Health Coverage in the Post-Welfare Reform World*. Online. Available: <http://www.acf.dhhs.gov/news/welfare/welfare.htm>. Accessed: February 6, 2001.

⁹ Michael Birnbaum, *Expanding Coverage to Parents through Medicaid Section 1931* (Washington, D.C.: The Robert Wood Johnson Foundation, 2000), p. 1.

¹⁰ Marilyn Ellwood, *The Medicaid Eligibility Maze: Coverage Expands, But Enrollment Problems Persist* (Washington, D.C.: The Urban Institute, 2000), p. 8.

¹¹ Birnbaum, *Expanding Coverage to Parents through Medicaid Section 1931*, p. 4.

¹² Andy Schneider and Rachel Garfield, *Medicaid Benefits* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, 2000), p. 18.

¹³ Jocelyn Guyer and Cindy Mann, *Taking the Next Step: States Can Now Expand Health Coverage to Low-Income Parents Through Medicaid* (Washington, D.C.: Center on Budget Policy Priorities, 1998), pp. 3-4.

¹⁴ Jocelyn Guyer and Cindy Mann, *A New Opportunity to Provide Health Care Coverage for New York's Low-Income Families* (Washington, D.C.: The Commonwealth Fund, 1999), p. 11.

¹⁵ The Task Force recommends a waiver to extend family coverage under Medicaid, but this is not necessary if the state utilizes Section 1931. Texas Blue Ribbon Task Force on the Uninsured, *Report to the 77th Legislature*, p. 39.

¹⁶ Families USA, *Expanding Medicaid State Options: Could Your State Do More?* (Washington, D.C., 1999), p. 5.

¹⁷ Families USA, *Expanding Coverage for Low Income Parents: An Action Kit for State Advocates*. Online. Available: <http://www.familiesusa.org/html/expansion/actionkit.htm>. Accessed: February 2, 2001; and National Association of State Medicaid Directors, *Medicaid 1115 Waivers*. Online. Available: <http://medicaid.aphsa.org/waivers/1115waivers.htm>. Accessed: January 8, 2001.

¹⁸ The Title XXI SCHIP program was created to insure children; therefore, the focus of the program is the expansion of health insurance to kids, and states must apply for waivers if they want to extend coverage to parents. In addition, under no circumstances will states be granted the authority to cover childless adults under a Title XXI waiver.

¹⁹ Jocelyn Guyer, "Financing Expansions" (presentation to Families USA Health Action 2001, Washington, D.C., January 24, 2001).

²⁰ Families USA, *Expanding Coverage for Low Income Parents: An Action Kit for State Advocates*.

²¹ Health Care Financing Administration, *1115 Waiver Research and Demonstration Projects*. Online. Available: <http://www.hcfa.gov/medicaid/hpg5.htm>. Accessed: January 7, 2001.

²² Health Care Financing Administration, *Steps in the 1115 Waiver Demonstration Proposal Process*. Online. Available: <http://www.hcfa.gov/medicaid/hpg6.htm>. Accessed: January 7, 2001.

²³ Health Care Financing Administration, *1115 Waiver Research and Demonstration Projects*.

²⁴ Timothy M. Westmoreland, Health Care Financing Administration, "Letter to State Health Officials: Guidance on Proposed Demonstration Projects Under Section 1115 Authority" (July 31, 2000). Online. Available: <http://www.hcfa.gov/init/ch73100.htm>. Accessed: January 7, 2001.

²⁵ Ibid.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Leighton Ku and Matthew Broaddus, *The Importance of Family Based Insurance Expansions: New Research Findings about State Health Reforms* (Washington, D.C.: The Center on Budget and Policy Priorities, 2000), p. 14.

- ²⁹ Families USA, *Expanding Coverage for Low Income Parents: An Action Kit for State Advocates*.
- ³⁰ U.S. Department of Health and Human Services, *HHS News: HHS Approves First SCHIP Waivers*. Online. Available at <http://www.hhs.gov/news>. Accessed: February 2, 2001.
- ³¹ Ibid.
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