

New Hampshire Adult Coverage Subcommittee

Report to the Governor,
Speaker of the House, and
Senate President

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Report on the Adult Uninsured Issue in New Hampshire [\(Top\)](#)

The 1999 New Hampshire Legislature created a committee of the Healthy Kids Board to study the adult uninsured issue and to make recommendations to the Governor, Speaker of the House, and Senate President. This committee, chaired by Representative John Hunt, met during 1999 and 2000. Among their activities, the committee researched characteristics of the uninsured, explored possible models for coverage expansions, projected costs of those expansions, and identified potential sources of funding.

The Committee gained new knowledge about the rate of uninsurance across the state and characteristics of New Hampshire's uninsured. Data collected through the 1999 New Hampshire Health Insurance Coverage and Access Survey (NH-HICAS) provided detailed information on the uninsured in the state, including access to employer-based insurance and variation across geographic areas and demographic groups.

The survey showed that approximately 91% of the residents of New Hampshire have health insurance coverage, 84% from employer-based or private coverage and 7% from publicly sponsored programs, such as Medicaid and Healthy Kids. The data indicate there are approximately 96,000 uninsured, which consists of 70,000 adults and 26,000 children. At the time of the survey, it is estimated that 65% of the uninsured children were eligible but not enrolled in Healthy Kids. Since the survey was conducted, 7,000 more children have been enrolled in Healthy Kids. Given this success, the uninsured problem becomes primarily an issue of uninsured adults. However, recommendations are included in this report to maximize enrollment in Healthy Kids and extend coverage to underinsured children through enhancements to the State Children's Health Insurance Program (Title XXI).

Based on this information and to focus its work, the committee developed a Statement of Need:

“While most New Hampshire residents are able to take advantage of the state’s strong employment based insurance coverage system, there are a significant number of low income adults in New Hampshire who cannot access or have difficulty accessing insurance coverage through an employer. As un-insurance and under-insurance have an impact on the use of timely and appropriate services and thus on the costs of the health care system as well as worker productivity, lower-income individuals need affordable health care coverage that emphasizes preventive services and care coordination. State policy should promote the development of creative solutions to address this significant need.”

The most significant factor affecting insurance status is the financial ability of individuals to purchase health insurance. Recognizing this, the committee searched for quantifiable data to determine at what income level a family or individual has the resources to pay for health coverage. The committee reviewed research published in a report, “New Hampshire Basic Needs and Livable Wage,” by the Josiah Bartlett Center for Public Policy. The report reveals the level of wages necessary for families in New Hampshire to meet basic needs. Basic needs are identified as food, rent and utilities, basic telephone service, clothing and household expenses, transportation, childcare, health care, and a small allowance for personal expenses. The resulting “livable wage” varies based on family characteristics such as size and the need for outside childcare.

The committee further developed this data by excluding savings and expenditures for health coverage to calculate the minimum income needed before an individual or family can begin to pay for health coverage. The data shows that New Hampshire families need to earn wages at about 200% FPL or higher to meet their basic needs. These findings confirm that low-income households do need financial assistance in purchasing health care insurance. Households with incomes below 185% of the federal poverty level would require a great deal of financial assistance while those with incomes above that level would require less. (See Appendix C for current federal poverty income levels.)

In evaluating current programs and possible models for expansion, the committee established a set of values and guiding principles that should be considered in the design of any program to expand coverage:

- Extend coverage to low income uninsured;
- Foster independence and self-reliance (especially for those transitioning off the TANF program);
- Encourage cost consciousness;
- Respect confidentiality and personal dignity;
- Respond to real life issues of maintaining a household budget on a modest income;
- Build on the current public and/or private system;
- Be administratively simple;
- Emphasize the relationship between children's health insurance and adult's health insurance coverage by requiring any eligible parent to insure their child first;
- Where possible, ensure that lower income parents and their children can be insured through similar funds;
- Leverage resources (federal, private and community based) and maximize federal funding;
- Provide for portable coverage;
- Focus on preventive and primary care services and care coordination.

The committee also researched and discussed a number of health care issues that confront the state of New Hampshire and the rest of the country.

- The members are acutely aware of the difficulties that many individuals have with purchasing prescription drugs.
- It was recognized that the state is probably at the peak of the insured cycle with predicted increases in health care costs likely to result in a rise in the number of uninsured. It is also anticipated that individuals will pay more out-of-pocket in the form of deductibles, co-insurance and co-pays.
- The committee is aware of the need to keep safety-net providers financially viable as they provide uncompensated or reduced-fee care to the uninsured.
- It was also clear that federal programs are not available to assist in providing coverage to many of uninsured.

The group realized that they could not realistically address all of these issues. Therefore, attention was focused on researching the methods of expanding health coverage that are available to states under current law and regulations.

The committee's research pointed to three primary models of expansion, which meet many of the guiding principles detailed previously. The three models expand coverage to:

- 1) Parents of children eligible for Medicaid/Healthy Kids Gold with income up to 185% of the Federal Poverty Level (FPL – see Appendix E). This model uses Medicaid and Title XXI as a funding source.
- 2) Parents of children eligible for S-CHIP/Healthy Kids Silver with income between 186% and 300% FPL. This model uses Title XXI as a funding source.
- 3) Adults without children eligible for either Medicaid or Title XXI with income first up to 100% FPL, with further expansion to 185% FPL. No federal funding exists for this group.

The first two models are designed to maximize federal reimbursement available under current federal regulations. For New Hampshire, Medicaid federal funding (Title XIX) matches state funds on a 50:50 basis. The State Children's Health Insurance Program (Title XXI) provides an enhanced federal match of 65%. Both programs allow states to cover the parents of eligible children, provided certain requirements have been met. Coverage of parents up to 100% FPL under the Medicaid program is a prerequisite to covering parents with higher income levels under Title XXI. For parents above 100% and up to 300% FPL, Title XXI funding would be available with the enhanced federal match of 65%.

There are currently no federal programs that fund health insurance for adults without children. Therefore, any option to cover adults without children is strictly a state model, and would require 100% state and/or community funding.

The committee believes it would be inappropriate to provide coverage to adults with children at higher income levels for which federal funds are available (parents), without providing coverage for adults without children at lower income levels for which no federal funds are available. Therefore, an expansion for adults without children at low incomes should precede the implementation of a program to cover parents at higher incomes even though a federal funding source is available.

The committee also recommends that, to the greatest extent possible, any expansions should be consistent with current programs in regard to eligibility levels, benefits and cost-sharing. Doing so will streamline program administration and outreach and simplify access for NH citizens seeking assistance.

The following tables provide a summary of the three models including projections of the number of participants and costs, broken down by state and federal sources. The models assume benefits commensurate with the comprehensive package currently provided by Medicaid. The cost projections recognize an 18-to-36 month phase-in of enrollment, depending upon the group, before the anticipated caseload is reached.

In the two models that tap federal resources, the potential impact of crowd-out has been anticipated. Since a program to provide coverage to adults without children would not qualify for federal funding, the state would have greater flexibility in implementing eligibility criteria to prevent crowd-out. Because of this, crowd-out eligibles have not been included in the participation projections for this group.

Crowd-out (as it is broadly defined) occurs when an individual drops private insurance to enroll in a public program or when an employer drops coverage as a result of the availability of public coverage and the employee subsequently seeks the public coverage. Crowd-out is often viewed as a negative occurrence. The committee challenges the notion that all occurrences of crowd-out are to be avoided. Doing so overlooks circumstances where individuals must choose between basic living needs and health care, or where access to preventive and primary care remains an issue because the purchased insurance provides “catastrophic-only” coverage.

Data used to estimate crowd-out are based on national information provided by the Urban Institute. Given a more thoughtful definition of crowd-out as suggested above, it is the consensus of the committee that the crowd-out numbers may be overstated. The committee believes it is essential to develop New Hampshire data to better evaluate the impact of unwanted crowd-out, particularly as it relates to the loss of private comprehensive insurance that covers preventive and primary care and the termination of coverage by employers forcing employees to enroll in public programs. Additional research on this issue will be conducted under a grant from the Health Resources and Services Administration (HRSA is a federal agency) that is detailed later in this report.

The following tables project costs for each model based upon the current average cost of providing health care in the tri-state area of Maine, New Hampshire and Massachusetts. This data is compiled from the Medical Expenditure Panel Surveys (MEPS) conducted by the Agency for Healthcare Research and Quality (AHRQ). Increases in medical costs of 8% per year are included in the projections.

Table 1
Coverage of Adults with Children in Title XIX and Title XXI
Income Up to 100% of the Federal Poverty Level

	Number of Uninsured Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
					State	Federal	
Year 1	* 506	254	760	\$2,675	\$1.015	\$1.015	\$2.03
Year 2	* 1,306	657	1,963	\$2,889	\$2.835	\$2.835	\$5.67
Year 3	* 1,437	723	2,160	\$3,120	\$3.370	\$3.370	\$6.74

* Assumes an 18-month phase-in of caseload, with a 3% annual growth rate thereafter

Table 1a
Coverage of Adults with Children in Title XIX and Title XXI
Income Between 101% to 185% of the Federal Poverty Level

	Number of Uninsured Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
					State	Federal	
Year 1	* 1,231	621	1,852	\$2,675	\$1.73	\$3.22	\$4.95
Year 2	* 3,191	1,608	4,799	\$2,889	\$4.85	\$9.01	\$13.86
Year 3	* 3,511	1,769	5,280	\$3,120	\$5.76	\$10.71	\$16.47

* Assumes a 18-month phase-in of caseload, with a 3% annual growth rate thereafter

Table 2
Coverage of Adults with Children in Title XXI
from 186% to 300% of the Federal Poverty Level

	Number of Uninsured Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
					State	Federal	
Year 1	* 223	44	267	\$2,325	\$.218	\$.403	\$.621
Year 2	* 633	125	758	\$2,515	\$.666	\$1.240	\$1.906
Year 3	* 1,044	205	1,250	\$2,716	\$1.189	\$2.207	\$3.396

*Assumes a 36-month phase-in of caseload, with a 3% annual growth rate thereafter

Table 3
Coverage of Adults without Children
Up to 100% of the Federal Poverty Level

	Number of Uninsured Participating	Cost Per Person Per Year	Expenditures in Millions		Total
			State/Local	Federal	
Year 1	* 1,612	\$2,675	\$4.31	0	\$4.31
Year 2	* 4,174	\$2,889	\$12.06	0	\$12.06
Year 3	*4,606	\$3,120	\$14.37	0	\$14.37

* Assumes an 18-month phase-in of caseload, with a 3% annual growth rate thereafter

There are several aspects of these models that should be noted. The expansion of Medicaid to parents with income less than 100% FPL is provided for by Section 1931 of the Social Security Act. This allows for a state to expand coverage by amending the Medicaid State Plan. While this is relatively simple compared to a waiver, it does require policy, rule, and system changes that can be time consuming.

Coverage of parents from 101% to 185% of the FPL would be accomplished under the Title XXI program. This would require an 1115 demonstration waiver that must be approved by the Health Care Financing Administration (HCFA). The waiver must show how coverage of the entire family (parents) would increase enrollment of eligible children under Title XXI. The benefits must be equivalent to the benefits and cost sharing must be consistent with Title XXI rules. An 1115 waiver involves a negotiated process with HCFA and approval may take several months to secure. The advantage of the Title XXI program is that federal matching funds are available at 65%, compared to 50% under Medicaid.

Finally, state-only programs provide much greater flexibility to design eligibility requirements benefits and cost-sharing that are consistent with state law without regard to federal regulations. Therefore, the State would have greater control over the costs and the number of eligible participants. For purposes of modeling costs, it is assumed that no individual could enroll in this program unless they have been uninsured for six months. Again, there is no current federal funding available under for these individuals.

Recommendations [\(Top\)](#)

The committee realizes that an expansion of coverage will be incremental in approach, largely due to the financial resources needed. The committee reached consensus on these recommendations to expand coverage and lay the groundwork for future action.

1. **Expand coverage to parents with children eligible for Healthy Kids with incomes up to 185% FPL.** For parents with incomes up to 100% FPL this would be accomplished under Medicaid and the state would receive 50% matching funds. For parents with incomes from 101% to 185% FPL coverage would be provided under S-CHIP/Title XXI to take advantage of enhanced federal matching funds. This program could be phased in by expanding coverage first to families with incomes up to 100% FPL and later to 185% FPL.
2. **Conduct further research and explore innovative options to provide coverage to low-income adults without children.** These activities should be included in the work plan of the State Planning Grant received by the New Hampshire Department of Health and Human Services from the Health Resources and Services Administration (HRSA). This comprehensive grant project is intended to further study the characteristics of the uninsured and develop detailed, operational options for expanding health coverage to the uninsured.
3. **Authorize the committee to continue its work on this issue.** This committee is well informed on the issue of uninsurance and can provide insight and community input to the Governor and Legislature as new information becomes available. The committee will report to the Governor and the Legislature annually on its progress, specifically recommending innovative expansion strategies and exploring ways to leverage additional funds to cover the uninsured. This authorization can be accomplished through an amendment to RSA 126H, the Healthy Kids Act.
4. **Authorize the Department of Health and Human Services, in collaboration with the Healthy Kids Corp., to seek funding and implement a demonstration project under a newly announced Robert Wood Johnson Foundation initiative to expand coverage to the uninsured.** The primary target of this project would be to implement new coverage options for adults that are identified in the HRSA planning grant. Our hope is to develop and implement a public-private partnership that builds on the success and experience of the Healthy Kids model and community-based programs, such as Lakes Region General Hospital's HealthLink program and Seacoast HealthNet, as well as successful public-private partnerships in other parts of the country.
5. **Advocate for federal action to further support efforts to expand coverage.** The committee urges the State Legislature, the Governor's office, the Department of Health and Human Services and all interested stakeholders to work with New Hampshire's Congressional delegation and other federal officials to further the issue of the uninsured and seek additional measures from the federal level to assist the state. Specific action includes requesting that, under Title XXI, states be allowed to:
 - extend coverage to young adults (age 18 to 24)
 - provide preventive and primary care services to underinsured children
 - increase outreach by raising the 10% cap on administrative expenses to 25%
 - make grants to reimburse Community Health Centers (CHC's) for services to people who do not have health insurance coverage.

Appendix A [\(Top\)](#)

SENATE BILL183:

Creation of Adult Coverage Committee – excerpted from Chapter 324

Not available on site. To request a copy of SB183 [click here](#).

Appendix B [\(Top\)](#)

Insurance Coverage in New Hampshire

The 1999 New Hampshire Health Insurance Coverage and Access Survey (NH-HICAS) documents the most recent and reliable information on health insurance in New Hampshire. Of Approximately 91% of New Hampshire residents have health insurance coverage. Eighty-four percent (84%) have insurance coverage through their employer or through direct purchase of insurance coverage. Seven (7%) are covered by publicly sponsored programs, including Medicaid and Healthy Kids. This leaves about 96,000 individuals uninsured, of whom 74% are adults. New Hampshire's overall uninsured rate of 9% for both adults and children, compares favorably to the national average of 17% for adults and 12% for children.

New Hampshire has a higher percentage of individuals that are privately insured, relative to the national average. In New Hampshire 86% of adults and 78% of children are privately insured compared to the national averages of 75% and 69%, respectively. It then follows that New Hampshire would have a lower percentage of individuals covered by public programs. Estimates are that public programs cover 20% of children and 8% of adults nationally, while the numbers for New Hampshire are 14% and 4%, respectively.

The state has taken significant steps toward covering children through the Healthy Kids program. Children in families with incomes up to 300% of the FPL are eligible for coverage under Medicaid/Healthy Kids Gold and S-CHIP/Healthy Kids Silver. There were approximately 26,000 children who were uninsured at the time of the study in 1999. Of those, it is estimated that 16,500 were eligible but not participating in these publicly sponsored programs. Since that time, nearly 7,000 children have been enrolled.

The Healthy Kids initiative does not address health care access for uninsured adults. While the data indicate that 85% of the uninsured live in a family with at least one family member working full or part-time, their income levels are relatively low. Approximately 45%, or 32,000 uninsured adults live in families with incomes less than 200% of the FPL.

There are regional variations in health insurance coverage in New Hampshire. Seventy percent (70%) of uninsured residents live in the southern, more urban areas of the state. However, rural areas have a higher percentage of uninsured. In these rural areas of the state, including Colebrook, North Conway, Littleton, Haverhill, Wolfeboro, and Claremont, the uninsured rates range from 13% to as high as 21%.

Uninsured individuals in the state report a lack of access to insurance through their employment. Approximately 58% of working uninsured adults indicated they work in a firm that does not offer insurance coverage. However, the percentage without access jumps to 72% when employees are either not offered insurance coverage, or are ineligible for coverage as a result of length of employment, part-time status, or pre-existing medical conditions. Thus, most uninsured adults in New Hampshire do not have access to employer-based insurance. Those who have access but decline employer-based coverage cite cost as the single most important reason they are uninsured.

There are safety-net providers that provide care to the uninsured. However, this does not provide an adequate substitute to health insurance. Individuals without health insurance typically are unable to improve their health through preventive care. Studies show that the uninsured delay needed medical services and are less likely to receive follow-up care. The lack of coverage has implications for individuals, families, and communities. Individuals without health insurance are generally in poorer health. A serious illness or injury can mean financial disaster for their family. The community suffers from a loss of job productivity and the cost of uncompensated care.

As previously noted, New Hampshire has a relatively low rate of uninsured when compared to national averages. However, it is not realistic to believe that the 9% of residents who are uninsured will ultimately be covered by employer-based or non-group insurance without intervention by public programs. Unemployment is currently at record lows, with projections pointing to the many jobs being created in service industries, which traditionally do not provide access to health insurance for all employees.

With the uninsured rate at its lowest level ever, and considering the factors above, the logical conclusion is that the state is likely at or near the peak of insurance coverage. An economic downturn and expected increases in the cost of health insurance will increase the number of uninsured, perhaps significantly.

The full report on the uninsured in New Hampshire is available by contacting the Office of Planning and Research at the Department of Health & Human Services.

Appendix C [\(Top\)](#)

2000 Federal Poverty Level Guidelines All States (Except Alaska and Hawaii) and DC

Income Guidelines as Published in the Federal Register on February 15, 2000

Effective Date: February 15, 2000

ANNUAL GUIDELINES

Family Size*	100% Poverty	150%	185%	200%	250%	300%
1	\$8,350.00	\$12,525.00	\$15,447.50	\$16,700.00	\$20,875.00	\$25,050.00
2	\$11,250.00	\$16,875.00	\$20,812.50	\$22,500.00	\$28,125.00	\$33,750.00
3	\$14,150.00	\$21,225.00	\$26,177.50	\$28,300.00	\$35,375.00	\$42,450.00
4	\$17,050.00	\$25,575.00	\$31,542.50	\$34,100.00	\$42,625.00	\$51,150.00
5	\$19,950.00	\$29,925.00	\$36,907.50	\$39,900.00	\$49,875.00	\$59,850.00
6	\$22,850.00	\$34,275.00	\$42,272.50	\$45,700.00	\$57,125.00	\$68,550.00
7	\$25,750.00	\$38,625.00	\$47,637.50	\$51,500.00	\$64,375.00	\$77,250.00
8	\$28,650.00	\$42,975.00	\$53,002.50	\$57,300.00	\$71,625.00	\$85,950.00

MONTHLY GUIDELINES

Family Size*	100% Poverty	150%	185%	200%	250%	300%
1	\$695.83	\$1,043.75	\$1,287.29	\$1,391.67	\$1,739.58	\$2,087.50
2	\$937.50	\$1,406.25	\$1,734.38	\$1,875.00	\$2,343.75	\$2,812.50
3	\$1,179.17	\$1,768.75	\$2,181.46	\$2,358.33	\$2,947.92	\$3,537.50
4	\$1,420.83	\$2,131.25	\$2,628.54	\$2,841.67	\$3,552.08	\$4,262.50
5	\$1,662.50	\$2,493.75	\$3,075.63	\$3,325.00	\$4,156.25	\$4,987.50
6	\$1,904.17	\$2,856.25	\$3,522.71	\$3,808.33	\$4,760.42	\$5,712.50
7	\$2,145.83	\$3,218.75	\$3,969.79	\$4,291.67	\$5,364.58	\$6,437.50
8	\$2,387.50	\$3,581.25	\$4,416.88	\$4,775.00	\$5,968.75	\$7,162.50

Appendix D [\(Top\)](#)

New Hampshire Basic Needs and a Livable Wage

The Josiah Bartlett Center for Public Policy published a study in June 2000 that identified the basic needs of the residents of New Hampshire and the income that is required to meet those needs. The study incorporated New Hampshire specific data and calculated how much each working adult in the family would have to earn to meet the basic needs of the family.

A livable wage is defined as income sufficient to meet a household's basic needs, including:

- Food, but not restaurant meals;
- Rent, and utilities such as heat, lights, and water, but not cable TV service;
- Basic telephone service;
- Clothing and household services;
- Transportation;
- Child care,
- Health care;
- A small allowance for personal expenses (3% of income);
- Savings (5% of income).

The costs of these basic needs were estimated for seven different household types:

- Single person;
- Single parent and one child;
- Single parent and two children;
- Two parents with one child and one parent working;
- Two parents with one child and both parents working;
- Two parents with two children and one parent working; and
- Two parents with two children and both parents working.

The committee was interested in the study to ascertain the income levels needed to provide for the essentials of living; such as food, rent, utilities, and clothing. By excluding expenses for health coverage and savings, the committee was able to determine what income is required to meet basic needs before there are dollars available to purchase health insurance. Such information is seen as useful in determining appropriate income eligibility levels and cost-sharing for uninsured adults. The results of the study as shown in the following table.

New Hampshire Basic Needs and a Livable Wage [\(Top\)](#)

Living Wage represents the average annual salary below which individuals have to make choices about basic necessities as defined by the Josiah Bartlett Center.

Family Unit	Annual Livable Wage not including Healthcare and Savings	Percent of FPL
Two parents & two children (both parents working)	\$40,655.20	238%
Two parents & two children (one parent working)	\$28,555.20	167%
Two parents & one child (both parents working)	\$34,655.20	245%
Two parents & one child (one parent working)	\$26,532.00	188%
Single person & two children	\$34,505.60	244%
Single person & one child	\$28,713.60	255%
Single person	\$16,880.80	202%

These results essentially show that households require incomes that range from 167% to 255% FPL to meet basic needs. These findings confirm that low-income households do need financial assistance in purchasing health care insurance. Households with incomes below 185% of the FPL would require a great deal of financial assistance while those with incomes above that level would require less.

**Presentation to the
New Hampshire Adult Coverage
Subcommittee**

October 16, 2000

**Table 1
Coverage of Adults with Medicaid or S-CHIP
up to 185% of the Federal Poverty Level**

	Number of Eligibles	Participation Rate	Number Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
							State	Federal	
Year 1	10,480	45%	* 1,737	875	2,612	\$2,675	\$2.745	\$4.235	\$6.980
Year 2	10,480	45%	* 4,497	2,265	6,762	\$2,889	\$7.685	\$11.845	\$19.530
Year 2	10,794	45%	* 4,948	2,492	7,440	\$3,120	\$9.130	\$14.080	\$23.210

Service Delivery System: The Medicaid and Healthy Kids process, which currently determines eligibility, would be used to determine eligibility for parents, and the current provider network of Medicaid and S-CHIP would be used to deliver services.

Federal Requirements: Coverage to 100% of the FPL would be accomplished through a Medicaid expansion allowed for under Section 1931 of the Social Security Act. The state would be allowed to use “less restrictive methodologies” to compute a family’s income or assets. This would provide coverage for adults with children in Medicaid to 100% of the FPL. To cover parents from 101% to 185% under S-CHIP, approval would be required by HCFA under an 1115 demonstration project. The demonstration must be designed to foster the coverage of children by enrolling the entire family (parents). Several requirements must be met in regard to eligibility. The state must address how expanded coverage will be improved or promoted through the demonstration. States must provide coverage for parents to 100% of the FPL under Medicaid before covering parents above the FPL under S-CHIP.

Benefits: For parents under the FPL, the Medicaid benefit package would be used. For parents from 101% to 185% FPL, a benefits package with equivalent value to the current Healthy Kids Silver package must be provided. Benefits will possibly differ, e.g. EPSDT not required, perhaps mammograms and prostate screenings will be covered. Agreement with HCFA on the package would be part of the demonstration approval process.

Other: Medicaid provides federal matching funds at 50% of total expenditures and does not require a Medicaid waiver, can be accomplished through a state plan amendment. The program does become an entitlement for adults with children enrolled in Medicaid. Eligibility could be set at various income levels, such as 80% or 100% of the FPL, at the state’s discretion. If the state wishes to cover parents under an S-CHIP waiver at higher incomes, parents must be covered first under Medicaid up to 100% of the FPL. S-CHIP provides for federal matching funds of 65%. Approval requires an 1115 Demonstration waiver, which must be approved by the Health Care Financing Administration. This would allow the state to use more of the federal allotment for S-CHIP. Cost sharing would be allowed, subject to Federal approval.

*Assumes 18- month phase-in of caseload.

Table 1a
Medicaid Coverage of Uninsured Adults
with Children Enrolled in or Eligible for Medicaid/Healthy Kids Gold
(0-100% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		Total
			State	Federal	
Year 1	760	\$2,675	\$1.015	\$1.015	\$2.03
Year 2	1,963	\$2,889	\$2.835	\$2.835	\$5.67
Year 3	2,160	\$3,120	\$3.370	\$3.370	\$6.74

Detail of Caseload Growth

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	117	234	351	468	585	702	819	936	1,053	1,170	1,287	1,404	760
Year 2	1,521	1,638	1,755	1,872	1,989	2,097	2,102	2,107	2,112	2,117	2,122	2,127	1,963
Year 3	2,132	2,137	2,142	2,147	2,152	2,157	2,162	2,167	2,172	2,177	2,182	2,187	2,160

Assumes 18-month phase-in of caseload and 3% annual increase thereafter.

Assumes 8% increase in costs per year.

Table 1b
S-CHIP Coverage of Uninsured Adults with Children
Enrolled in or Eligible for Medicaid/Healthy Kids Gold
(101-185% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		Total
			State	Federal	
Year 1	1,852	\$2,675	\$1.73	\$3.22	\$4.95
Year 2	4,799	\$2,889	\$4.85	\$9.01	\$13.86
Year 3	5,280	\$3,120	\$5.76	\$10.71	\$16.47

Detail of Caseload Growth

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	285	570	855	1,140	1,425	1,710	1,995	2,280	2,565	2,850	3,135	3,420	1,852
Year 2	3,705	3,990	4,275	4,560	4,845	5,130	5,142	5,154	5,166	5,178	5,190	5,202	4,799
Year 3	5,214	5,226	5,238	5,250	5,262	5,274	5,286	5,298	5,310	5,322	5,334	5,346	5,280
Assumes 18-month phase-in of caseload and 3% annual increase thereafter.													
Assumes 8% increase in costs per year.													

Table 2
Coverage of Adults with S-CHIP Children
from 185% to 300% of the Federal Poverty Level

	Number of Eligibles	Participation Rate	Number Participating	Crowd-Out Eligibles	Total Participation	Cost Per Person Per Year	Expenditures in Millions		Total
							State	Federal	
Year 1	4,335	28%	* 223	44	267	\$2,325	\$.218	\$.403	\$.621
Year 2	4,335	28%	* 633	125	758	\$2,515	\$.666	\$1.240	\$1.906
Year 3	4,465	28%	* 1,044	206	1,250	\$2,716	\$1.189	\$2.207	\$3.396

Service Delivery System: The Healthy Kids process, which currently determines eligibility, would be used to determine eligibility for parents, and the current provider network of S-CHIP would be used to deliver services.

Federal Requirements: Approval would be required by HCFA under an 1115 demonstration project. The demonstration must be designed to foster the coverage of children by enrolling the entire family (parents). Several requirements must be met in regard to eligibility. The state must address how expanded coverage will be improved or promoted through the demonstration. States must provide coverage for parents to 100% of the FPL under Medicaid before covering parents above the FPL under S-CHIP/Title XXI.

Benefits: An equivalent benefits package used under current S-CHIP/Title XXI must be provided to the parents. Benefits will possibly differ, e.g. EPSDT not required, but perhaps mammograms and prostate screenings will be. Agreement with HCFA on the package would be part of the demonstration approval process. There is a \$20 per member per month cost sharing requirement for individuals in the 186-250% of FPL group and \$40 for those in the 251-300% group.

Other: This provides for federal matching funds of 65%. Approval requires an 1115 Demonstration waiver, which must be approved by the Health Care Financing Administration. This would allow the state to use more of the federal allotment for S-CHIP. Cost sharing would be allowed, subject to Federal approval.

*Assumes 36-months phase-in of caseload.

Table 2a
S-CHIP Coverage of Uninsured Adults with Children
Enrolled in S-CHIP or Eligible for S-CHIP
(186-250% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		Total
			State	Federal	
Year 1	150	\$2,435	\$.128	\$.237	\$.365
Year 2	425	\$2,630	\$.390	\$.727	\$1.117
Year 3	701	\$2,840	\$.697	\$1.294	\$1.991

Detail of Caseload Growth

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	23	46	69	92	115	138	161	184	207	230	253	276	150
Year 2	299	322	345	368	391	414	437	460	483	506	529	552	425
Year 3	575	598	621	644	667	690	713	736	759	782	805	826	701
Assumes 36-month phase-in of caseload.													
Assumes 8% increase in costs per year.													

Table 2b
S-CHIP Coverage of Uninsured Adults with Children
Enrolled in S-CHIP or Eligible for S-CHIP
(251-300% of FPL)

	Average Participants	Cost Per Person Per Year	Expenditures in Millions		Total
			State	Federal	
Year 1	117	\$2,195	\$.090	\$.166	\$.256
Year 2	333	\$2,370	\$.276	\$.513	\$.789
Year 3	549	\$2,560	\$.492	\$.913	\$1.405

Detail of Caseload Growth

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	Average
Year 1	18	36	54	72	90	108	126	144	162	180	198	216	117
Year 2	234	252	270	288	306	324	342	360	378	396	414	432	333
Year 3	450	468	486	504	522	540	558	576	594	612	630	649	549

Assumes 36-month phase-in of caseload.

Assumes 8% increase in costs per year.

Covered Benefits for Adult Expansions [\(Top\)](#)

Major Benefits

- Physician Services
- Hospital Inpatient Services
 - Limited to Medically Necessary Days
- Hospital outpatient Services
 - Limited to 12 per year
- Prescribed Medicine
- Lab and X-Ray Services
 - Limited to 15 X-Rays per year
- Family Planning Services and Supplies
- Home Health Care Visits
- Dental
 - Limited to treatment of acute pain or infection
- Hearing Aid Services
- Vision Care (Eyeglasses)
 - Limited to one refraction per year
- Durable Medical Equipment
 - Prior Authorization Required

Estimated Costs by Category of Service

