



OLR RESEARCH REPORT

February 7, 2007

2007-R-0170

MEDICAID COVERAGE OF CHILDLESS ADULTS

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You asked if there are potential obstacles to offering Medicaid coverage through an 1115 waiver to childless adults who are not aged, blind, or disabled.

SUMMARY

If the legislature wants Medicaid to cover these particular childless adults it will need to direct DSS to seek a federal Section 1115 waiver to create a new coverage group for them. States that have 1115 waivers generally set an income limit for this coverage at 100% of the federal poverty level (FPL), but at least one state (Maine) goes up to 125% of the FPL.

The main obstacle to obtaining such a waiver is the cost neutrality test, which means that every additional federal dollar spent must be offset by a corollary reduction in other federal Medicaid spending. Some states have met this requirement by redirecting some of their unspent federal disproportionate share hospital (DSH) payments. Others have departed from Medicaid rules and limited the benefits offered or have required cost sharing. Often, states have employed multiple strategies. Massachusetts had an easier time showing neutrality as it made the adult coverage part of a much broader public health care expansion.

According to a 2004 Kaiser Commission report, *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Eight States*, 11 states provided childless adult coverage through 1115 waivers

as of January 2004. (New York operated both waiver- and fully state-funded programs.) A few others, including Connecticut, offered this coverage using state funds only.

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Federal Limits

Since its inception, Medicaid has been available only to certain groups of low-income people. Enacted in the 1960s, it was meant to serve as an adjunct to cash assistance programs created during the Depression (e.g., Social Security, Aid to Dependent Children). While the program has been expanded over the years to cover more and more children and adult caretakers, childless adults have continually been excluded from these expansions, leading some to suggest that policymakers view them as less deserving than other groups.

Given these limitations, states have had two options for covering these adults: use state funds or seek 1115 waivers. In fact, some states, including Connecticut, have offered health care coverage to very low-income childless adults in state only programs for many years. Faced with growing budget deficits, several of these states have applied for the waivers to get federal matching funds to help offset program costs.

Unlike regular Medicaid, which is an entitlement (states must cover everyone who meets the program's eligibility criteria, regardless of cost), the 1115 route allows states to limit enrollment and impose cost sharing, by "waiving" federal rules that generally prohibit these restrictions. But because federal law requires that these waivers be budget neutral, that is federal costs under the waiver cannot exceed a state's projected federal spending "baseline" without the waiver, simply capping enrollments and imposing cost sharing may not be enough.

Thus, the states that have used 1115 waivers to offer this coverage have typically employed several strategies, including shifting disproportionate share hospital (DSH) payments, capping enrollment, requiring cost sharing, and limiting benefits.

Maine

Maine has a fully developed adult coverage program with matching federal Medicaid funds for individuals with income up to 100% of the FPL. (Although state law and the state's 1115 waiver permit coverage up

to 125% of FPL, it has never done so.) Previously, it had a state-funded program. The legislature pushed for Medicaid coverage as part of a larger effort for universal coverage begun in 2001.

To address cost neutrality, the state chose to tap unspent Medicaid DSH payments (this became the federal match). A 2004 paper by the Economic and Social Research Institute (ESRI) reported that a portion of the state's DSH allocation that had been divided up among psychiatric and community hospitals had not been used and neither group opposed the fund transfer. In fact, they had been pushing for the above coverage for years, in part because the lack of coverage was driving increases in emergency room use for nonemergency care.

Ultimately, a larger group of parties (e.g., hospitals, advocates, legislators, mental health agencies) proposed the DSH fund shift, mainly because of the rising number of uninsured workers and the nearly complete lack of commercial individual health coverage. They also believed that the community would pay the high cost of caring for the uninsured in the long run, either in the form of higher commercial coverage costs or hospital service shortages.

The outgoing governor's dislike of the law and the incoming governor's (Baldacci) budget concerns nearly ended the expansion in 2002 and 2003. But Governor Baldacci's commitment to health care, as seen by his Dirigo Health Universal Health plan, has ensured its sustainability for the time being, although the program is now closed (see below).

The ESRI paper also discussed the state's waiver discussions with the federal Centers for Medicare and Medicaid Services (CMS), which ultimately must approve these waivers. The authors characterized them as smooth, despite the fact they alerted federal policymakers to the unspent DSH funds. These discussions occurred as the Bush administration was introducing its Health Insurance Flexibility and Accountability (HIFA) initiative, which invited states to expand health care coverage using unspent DSH and State Children's Health Insurance Program (SCHIP) funds. (The Deficit Reduction Act of 2005 now prohibits states from covering childless adults with SCHIP funds.) ESRI characterized the state's proposal as "uncomplicated," which may also have helped it gain CMS' approval.

ESRI described anecdotal reports by hospitals that the childless adult expansion increased their costs due to a greater utilization of outpatient and specialty care services. But at the same time, these institutions receive higher payments than when they wrote these services off as

charity care. (More concern was expressed about costs to rural hospitals, often the only health care provider available, since they were providing all services, not just inpatient and outpatient care.)

Maine's waiver authorizes an expenditure cap, which allows it to limit enrollment. According to a 2005 interview with Trish Riley, director of the governor's Office of Health Policy and Finance, adult coverage was highly popular and enrollees were high service users. This resulted in the state reaching its DSH cap and ultimately forced it to cap program enrollment at about 13,000 (*State Coverage Initiatives, May 2005*). The cap has been in place ever since, according to state legislative staff. (In part, this may be due to the fact that these adults receive the same benefits as other Medicaid enrollees with no premiums and nominal co-payments.)

Massachusetts

Childless adult coverage in Massachusetts was part of a major public health insurance push begun in the early 1990s. The state submitted its 1115 proposal in 1994, the federal government approved it the following year, the legislature adopted it in 1996, and it began in 1997. (At that time, the Clinton Administration was encouraging states to expand coverage with 1115 waivers.) In addition to the childless adult coverage, the waiver expanded coverage for children and pregnant women, created several Medicaid coverage groups under a new umbrella MassHealth program, and integrated care for the uninsured by the state's two big safety net hospitals.

The legislature agreed to shift DSH funds and increased the state's tobacco tax to obtain the state's share of Medicaid funds for the expansion. To get the federal match, the state showed budget neutrality by transferring the Medicaid population into managed care.

In designing the childless adult coverage, the state acknowledged that not all childless adults were the same and created categories that some could suggest deemed certain adults more deserving of coverage than others. For example, adults with disabilities were covered if their income was up to 133% of FPL with full benefits, while childless working adults could get premium assistance only if they had access to employer sponsored coverage. Budget constraints in recent years forced the state to tighten eligibility for this group and limit benefits further.

Massachusetts' new universal coverage initiative which, among other things, creates the Commonwealth Care Health Insurance Program (managed care for all residents through state-procured plans), continues

the state's coverage for childless adults. The state will pay full premium costs for adults with income up to 100% of the FPL and partial premiums for people with incomes up to 300% of the FPL. The state had to renegotiate its 1115 waiver with CMS so that Medicaid matching funds will be available for all these subsidies.

Childless adults with incomes less than 100% of FPL must still meet MassHealth's nominal co-payment requirements.

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