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State Health Insurance Programs for the Uninsured

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Summary

In 2002, six states (Arizona, Massachusetts, Minnesota, New York, Pennsylvania, and Washington) and the District of Columbia offered state-only health insurance programs covering about 238,000 people. About one-half of those individuals, however, were in one state's program – Washington's Basic Health Plan. All but one of those programs directly provides for health insurance coverage of its enrollees through arrangements with providers, insurers, or managed care organizations. Three of those programs also offer subsidies to help pay for employer-provided insurance when enrollees' have such coverage available. New York's "Healthy NY" is a re-insurance program in which the state contracts with certain insurance companies to provide coverage for the program's participants. Then the state shares in the cost of enrollees' health care services by paying for the costs of claims falling within an agreed-upon specified range, in this case between $30,000 and $100,000. This report, summarizing those state programs, is one in a series of short reports describing recent state activities to improve access to health insurance for the uninsured. It will updated as new information becomes available.

Under a contract with the Georgetown University Institute for Health Care Research and Policy, the Congressional Research Service (CRS) has developed a database summarizing state activities related to improving access to health insurance. The database provides characteristics of state-operated high-risk pools, health insurance purchasing cooperatives, and programs for low-income uninsured individuals, as well as small- and individual-market reforms in place in 2002. This data, developed through a combination of literature review and state surveys, includes information on state programs, separate from Medicaid and the State Child Health Insurance Program (SCHIP), for the uninsured that are funded without federal contribution.

In the past, such state-only funded programs were referred to as "general medical assistance." General medical assistance, which usually consisted of Medicaid-like benefits, were offered as a component of some states' "general assistance" programs, programs that extended cash welfare payments to individuals who did not qualify under

the federal rules of the Aid for Families with Dependent Children program. Most general assistance programs were dismantled during the early 1990s. General medical assistance gave way, as well, when (a) the cost of health insurance, generally, and Medicaid costs, in particular, began escalating quickly, and (b) statutory changes began extending Medicaid to many of the individuals who would otherwise receive their health insurance or health care through general assistance programs. Several other general assistance programs were subsumed into Medicaid under the demonstration authority allowed by Section 1115 of the Social Security Act.[1]

In 2002, six states (Arizona, Massachusetts, Minnesota, New York, Pennsylvania, and Washington) and the District of Columbia offered state-only health insurance programs covering about 238,000 people. The individuals covered under the state-only programs are generally not eligible for Medicaid or SCHIP although some of the state-only programs coordinate with Medicaid and SCHIP. For example, one program offers eligibles a choice of Medicaid or the state program. Another program will combine funds for SCHIP-eligible children with state-only funds for the parents who are not SCHIP-eligible.

About one-half of the individuals enrolled in the programs, however, were in one state's program – Washington's Basic Health Plan, which is, by far, the largest of all state-only programs. The state-sponsored insurance plan had over 122,000 individual enrollees in 2002. None of the seven programs are older than10 years and four were implemented since 1997. All but one of those programs directly provides for health insurance coverage of its enrollees through arrangements with providers, insurers or managed care organizations. Three of those programs also offer subsidies to help pay for employer-provided insurance when enrollees' have such coverage available. New York's "Healthy NY" is a re-insurance program in which the state contracts with certain insurance companies to provide coverage for the program's participants. Then the state shares in the cost of enrollees' health care services by paying for the costs of claims falling within an agreed-upon specified range, in this case between $30,000 and $100,000.

The information recorded in the state initiatives data base reflects the features and enrollment in state programs at the point at which surveys were administered (fall of 2002) and spending figures are for the most recent fiscal year available. In most cases, therefore, the enrollment and spending information provided is for state fiscal year 2002. Many states, however, make changes to their programs annually, so the information about program features should be considered to reflect the programs in place in that year. Next year the programs may look quite different from the descriptions below, especially in light of the current budget challenges many states are facing. For example, there are press reports that Washington's Basic Health Plan's enrollment will be cut by half in the coming fiscal year.[2]

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[1] Section 1115 of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration projects which, in the judgement of the Secretary, are likely to assist in promoting the objectives of the Medicaid statute. [http://www.cms.hhs.gov/medicaid/1115/default.asp]

[2] Pear, Robert. "Most States Cutting Back on Medicaid, Survey Finds", *New York Times*, January 13, 2003.

Table 1. Summary of State-Only Programs Providing Health Insurance to Individuals Not Eligible for Medicaid[a]

State	Name of program	Type of program[b]	Number of covered individuals	Spending for health care services
Arizona	Premium Sharing Program	Direct coverage	3,623	$20.2 million
District of Columbia	Healthcare Alliance	Direct coverage	28,360	Not available
Massachusetts	Children's Medical Security Plan	Direct coverage	25,680	$11.5 million
Minnesota	MinnesotaCare	Direct coverage or subsidy	32,915	$373.0 million
New York	Healthy NY	Re-insurance	13.430	$106.0 million
Pennsylvania	AdultBasic	Direct coverage	11,937	$97.0 million [c]
Washington	Basic Health Plan	Direct coverage or subsidy	122,250	$219.0 million

Source: Georgetown University, Institute for Health Care Research and Policy. State initiatives database created under contract to the CRS.

[a] State survey respondents were asked to provide data presented for the most recent fiscal year. In all cases the data provided are for 2002. Not all data, however, refers to the same 12-month fiscal period.

[b] Direct coverage denotes a program that directly provides for health services for enrollees through arrangements with providers, insurers or managed care organizations. Subsidy denotes a program that contributes toward the cost of employer-sponsored insurance coverage. Re-insurance denotes a program in which the state subsidizes health insurance coverage for enrolled individuals and small businesses when claims fall within a certain specified range, in this case between $30,000 and $100,000.

[c] Includes administrative costs. Pennsylvania was not able to provide spending for health services separate from program administration.

Table 2. Eligibility Groups Targeted by State-Only Programs

State	Target group
Arizona	– Arizona residents with family income below 250% of the federal poverty level[a] (FPL). – Chronically ill (with at least one of 19 specified conditions) with family income below 400% of FPL.
District of Columbia	– Uninsured D.C. residents with family income below 200% of FPL.
Massachusetts	– Uninsured residents not eligible for Medicaid with family income below 400% of FPL.

State	Target group
Minnesota	– Children under age 21 with family income below 150% of FPL. – Pregnant women with family income below 275% FPL. – Parents with family income below 275% FPL. – Childless adults with family income below 175% FPL.
New York	– Uninsured working individuals with family income below 250% FPL. – Self-employed individuals with income below 250% FPL. – Small employers with one-third of employees earning less than $31,000 per year.
Pennsylvania	Adults under age 65 with family income below 200% FPL.
Washington	– Uninsured workers with family income below 200% FPL. – Unemployed people with family income below 200% FPL needing transitional health insurance. – Individuals with family income below 200% of FPL who do not qualify for other federal health assistance.

Source: Georgetown University Institute for Health Care Research and Policy. State initiatives database created under contract to the CRS.

[a] The federal poverty level was set at $18,100 for a family of four in 2002.

Table 1 provides basic characteristics of each of the seven programs and **Table 2** summarizes their eligibility criteria. The above information does not include programs established under Medicaid Section 1115 demonstration waivers. A total of 19 states[3] plus the District of Columbia have comprehensive demonstration waivers, many of which extend coverage to certain groups of people who are not traditionally eligible for Medicaid. Although the data are weak, we know that those programs together cover at least five times the number of individuals covered through the seven above-described programs.[4] In fact, New York's Medicaid demonstration program alone covers almost twice the number of those covered in all of the above seven programs combined. While most states have abandoned their state-only programs to establish demonstration waivers under Medicaid, and more recently SCHIP, the above seven programs have held on to the state-only approaches, and some of those have both a state-only program and a waiver program in place. This is likely to be because those states not wish to change program features in order to obtain federal approval under the demonstration waiver authority. It remains to be seen if those programs can withstand a budget environment that may make the matching payments available under Medicaid and SCHIP waivers relatively more attractive than the state flexibility.

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[3] Arizona, Arkansas, California (LA County), Delaware, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, Missouri, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Vermont, Wisconsin, New Jersey, and Utah.

[4] In the past, states were not required to report enrollment or expenditures under waiver programs separately from other enrollees and spending. Recently, CMS has begun collecting such information. It is likely that as states become used to the new reporting format, data related to these characteristics will improve.