COVERAGE GROUP OPTIONS FOR CONSIDERATION

The Technical Work Group has identified seven potential coverage groups for consideration by the Subcommittee. These coverage groups fall into two basic categories:

- New Expansion Populations. These are coverage groups which are not currently addressed by any state or locally funded program.
- Conversion Coverage Groups. These coverage groups are addressed, **in part**, by current programs and may offer an opportunity to draw federal match for individuals already served.

The Technical Work Group will develop estimates of the number of individuals potentially served under each coverage group for the Subcommittee's consideration in May. In addition, the group will examine:

- The administrative requirements associated with each coverage group
- The impact on the uninsured and stakeholder groups
- Financing required
- The service delivery vehicle
- The benefits to be covered

New Expansion Populations

Small employers 2-50 who currently do not offer health insurance

While we do not have this exact breakdown, we do know that 43.1 percent of employers with fewer than 50 employees offer health insurance. The remainder do not. We also know that 66.7 percent of employees are offered health insurance by employers with 2 to 50 employees, the remainder are not. Preliminary estimates suggest that 78,500 employees are not offered health insurance by their employer.

Employees of small employers with incomes below 200% of the FPL who currently have health insurance offered but do not enroll

While we do not have this exact breakdown, we do know that 17.3% of employees who are offered *and are eligible* for insurance by employers with 2 to 50 employees do not accept coverage, or 21,000 employees. While we do not know the income levels precisely we do know that the majority of uninsured Nevadans are below 200% of the FPL.

Pregnant women between 133% and 185% of the FPL

Nevada Medicaid currently extends coverage to pregnant women up to 133% of the FPL. This is the minimum percentage states must cover under federal law. Thirty-six states

extend coverage to at least 185% of FPL. Based on available data, moving the eligibility threshold for pregnant women would result in an additional 2,236 women. If the income threshold was raised to 200% of FPL an additional 2,684 women would be eligible. DHR is examining the accuracy of these estimates.

Nevada (CPS 2001-2003 Pooled)

% of FPL	Number of Pregnant Women
<=133	6,232
134-185	2,236
186-250	2,684
251+	11,600
Total	**22,752**

Parents of Medicaid and SCHIP children

This group would include parents of Medicaid eligible and SCHIP children who have incomes above 31% of the federal poverty level and are, therefore, not now eligible for TANF. This group would include parents of:

- Parents of Medicaid eligible children with incomes above 31% of FPL and below 100% of FPL
- Parents of Medicaid eligible children ages 0 to 6 with incomes between 100% and 133% of the FPL
- Parents of SCHIP children with income up to 200% of the federal poverty level

The DHR is estimating the number of parents that fall into these groups.

Conversion Coverage Groups

Individuals who are medically needy as a result of a catastrophic health care event

In brief, medically needy is a Medicaid eligibility mechanism that allows states to cover individuals who meet income guidelines only after deducting the cost of their medical care. Because Nevada would grant eligibility to those with medically needy status under a demonstration rather than through the state plan, there would be a great deal of flexibility in how the eligibility group and the benefit package would be structured. It could be structured to mirror as closely as possible the criteria typically used in Counties today for the episodic care they support, or it could be more expansive. This group could also be structured as a high risk pool.

We do not have an estimate of the number of medically needy today. Hospitals and counties are working on the data needed to develop an estimate.

Individuals who are receiving Social Security Disability Benefits but who are not eligible for Medicare until they have received such benefits for 24 months

Under Section 206 of the Social Security Act, individuals under the age of 65 who are classified as "disabled" under the statute are eligible to receive Medicare. In order to receive Medicare benefits, the person must have received Social Security Disability Insurance for 24 months. However, because they must wait 5 months before receiving disability insurance benefits, in effect, they must be disabled for 29 months before they have Medicare coverage.

To qualify for SSDI, an individual must be unable to engage in "substantial gainful activity" because of a medically determined physical or mental impairment expected to last at least 12 months or until death.

During the 29 month waiting period some of these individuals may be eligible under Medicaid. States have the option when providing coverage to people with disabilities who have incomes up to 100 percent of poverty or even above. As of 2002, only 18 states provided coverage up to or beyond 100 percent of poverty.[1]

We will need to work with SSI to develop an estimate of the number of individuals who may be eligible under this coverage group.

Individuals who would be eligible for SSI if they applied and had the eligibility determination process completed

The "210" category, or more specifically the category contained in regulation at 42 CFR 435.210, is a pathway to Medicaid eligibility for individuals "who meet the income and resource requirements of the appropriate cash assistance program for their status."

This category is a way for states to cover disabled individuals who have not applied for SSI but would qualify based on both disability and financial criteria, or individuals who have applied for SSI but whose disability status has not been determined. In order to provide coverage under 210 for disabled individuals, the state must use the SSI definition of disability as specified in regulation. In the event that a subsequent determination is made by the Social Security Administration (SSA) that is contrary to the state's determination, the SSA determination prevails, but not retroactively.
Hospitals and counties are working on the data needed to develop an estimate.

If Nevada covered the 210 category as 31 states currently do under a waiver or state plan, federal matching funds would be available for individuals who would otherwise have their care paid for by hospitals, as the liability for payment currently remains with hospitals (or is paid for by counties) until SSI determinations are made. This will be particularly helpful with the severely mentally ill, who often do not cooperate with the

[1] DC, IL, ME, MA, MI, MN, NJ, NE, NC, ND, OK, PA, RI, SC, SD, and UT. California expanded eligibility to those individuals up to 110% FPL. Mississippi expanded up to 142% FPL. Virginia increased coverage to 80 percent of poverty in July 2001.

SSI disability determination process but do receive services from the state-funded behavioral health system. There are also benefits to coverage of this group in ensuring that they can access appropriate services.

Hospitals and counties are working on the data needed to develop an estimate for this category of eligibility.