Section III.
Review and Discussion of Possible Coverage Groups

Materials related to the following Coverage Groups will be contained herein:

Coverage Group	✓ = Material provided
Small Business Employees	✓
Premium Subsidy Program	
Pregnant Women	✓
Parents of Title XIX/XXI Children	
Children Aging Out of Foster Care	✓
Transitional TANF	✓
Medically Needy	✓
SSDI	✓
SSI (42 CFT 435.210)	
High Risk Pool	

Health Care Plans for the Small Business Owner

The subcommittee is interested in extending health insurance through employer-based coverage. One possible model to build upon for this coverage extension is the Las Vegas Chamber of Commerce "Health Care Plans for the Small Business Owner" program. This memo gives an overview of that program.

Small business owners, who are members of the Las Vegas Chamber of Commerce, may purchase health plans for their employees through Health Plan of Nevada or Sierra Health and Life. Health Plan of Nevada offers small employers two Health Maintenance Organizations (HMOs) and two Point-of-Service (POS) medical plans. Sierra Health and Life offers a Preferred Provider Organization (PPO).

With the HMO option offered by Health Plan of Nevada, there are no deductibles, claim forms or annual maximum limits for many services. With the POS plan, employees have access to a variety of benefits and covered services within a three-tier design. Each tier mixes flexibility and costs – more flexibility in provider choice equals more out-of-pocket costs. Sierra Health and Life's PPO medical plan provides greater benefits and convenience; however, this equates to higher out-of-pocket costs.

In order for a small employer to be eligible to enroll its employees into any of the plans, it must meet certain criteria:

- Business must have two or more full-time employees
- Have 50 or less employees on the payroll
- If previously insured by Health Plan of Nevada or Sierra Health and Life but coverage terminated, cannot apply for new coverage within 12 months of the termination date
- All businesses/employees must be located within the Southern Nevada area

Eligible employees include all active employees who work at least 30 hours per week. Coverage is also available to dependent spouses and children up to age 19, full-time students to age 24 and handicapped children. Participation by 75% of eligible employees is required for all groups enrolling through the Las Vegas Chamber of Commerce Group Health Benefits Program.

All new groups and those with current Health Plan of Nevada/Sierra Health coverage will be medically underwritten. Groups with 2-19 enrolled employees must complete and sign a detailed Medical Questionnaire. Groups with 20-50 enrolled employees must complete and sign a Simplified Medical Questionnaire.

The group's premium rate for all participants in the plan may be adjusted based on the combined health status of all applicants. This adjustment is known as the Medical Underwriting Rating Factor (MURF). The basic rates quoted may be adjusted for each group by factors that range from .85 to 1.55.

Coverage of Pregnant Women in Medicaid

States must provide Medicaid to all pregnant women with incomes at or below 133% of the Federal Poverty Level (FPL) (mandatory categorically needy). States have the option of covering pregnant women with incomes up to 185% of the FPL (optional categorically needy). A pregnant woman is treated as a family of two for the purpose of determining eligibility.

The following table from the Kaiser Family Foundation ranks the 50 states and the District of Columbia from the highest to the lowest based on the state's 2003 income eligibility levels for pregnant women:

1. Minnesota	275%
2. Maryland	250%
2. Rhode Island	250%
4. Georgia	235%
5. Alaska	200%
5. Arkansas	200%
5. California	200%
5. Delaware	200%
5. District of Columbia	200%
5. Illinois	200%
5. Iowa	200%
5. Louisiana	200%
5. Maine	200%
5. Massachusetts	200%
5. New Jersey	200%
5. New York	200%
5. Vermont	200%
18. Connecticut	185%
18. Florida	185%
18. Hawaii	185%
18. Kentucky	185%
18. Michigan	185%
18. Mississippi	185%
18. Missouri	185%
18. Nebraska	185%
18. New Hampshire	185%
18. New Mexico	185%
18. North Carolina	185%
18. Oklahoma	185%
18. Oregon	185%
18. Pennsylvania	185%
18. South Carolina	185%
18. Tennessee	185%
18. Texas	185%
18. Washington	185%
18. Wisconsin	185%
37. Indiana	150%
37. Ohio	150%
37. West Virginia	150%
41. Alabama	133%
41. Arizona	133%
41. Colorado	133%
41. Idaho	133%
41. Montana	133%
41. Nevada	**133%**
41. North Dakota	133%
41. South Dakota	133%
41. Utah	133%
41. Virginia	133%
41. Wyoming	133%

Medicaid Coverage for Children Aging Out of Foster Care

The Foster Care Independence Act of 1999 provides states with federal matching funds to provide Medicaid to young people who age out of foster care. If states take full advantage of this Medicaid option, all "independent foster care adolescents" can be eligible for Medicaid without regard to their income status. For the purposes of Medicaid eligibility, The Foster Care Independence Act defines "independent foster care adolescent" as an individual:

(a) who is under 21 years of age;
(b) who, on the individual's 18th birthday, was in foster care under the responsibility of the state; and
(c) whose assets resources and income do not exceed such levels (if any) as the state may establish….[1]

The state can provide coverage for these children until age 19, 20, or 21, at the state's option.[2] The full range of optional and mandatory services provided for by the Medicaid Act, including EPSDT services, must be provided to these children.[3]

If full expansion to the entire population is not financially feasible, the state has the flexibility to provide Medicaid to a subset of this broad group. A state may determine eligibility by:

- Applying an income or resource test in determining eligibility. However, the standards and methodologies cannot more restrictive than those used for low-income families under Section 1931(b)
- Limiting eligibility by age
- Limiting eligibility by foster care status. A state may provide Medicaid to those children who were eligible for foster care maintenance payments or independent living services under Title IV-E of the Social Security Act.

Nevada has not availed itself of this option.

[1] 42 U.S.C. §1396d(v); *See also* HCFA, *Dear State Child Welfare and State Medicaid Directors* (December 14, 1999), HCFA, *Dear State Welfare Director* (December 1, 2000).
[2] 42 CFR § 435.222
[3] 42 USC § 1396a(a)(10)(B).

Medicaid Coverage for Adults Returning to Work

Transitional Medicaid Assistance

The most commonly used option for states to provide insurance coverage for persons who have been on TANF and/or Medicaid who have an increase in their income is Transitional Medicaid Assistance (TMA). TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after they find a job, even though their earnings make them ineligible for regular Medicaid.

TMA is a mandatory Medicaid eligibility category. States must provide TMA to eligible families as a condition of receiving federal Medicaid matching funds. In order to qualify for TMA, a family must have been eligible for Medicaid for at least three of the prior six months as part of the Section 1931 group.[4] TMA primarily serves families who have been receiving welfare and who then get a job.

Eligible families receive TMA for six months. If their earnings stay below 185% of FPL, taking child care expenses into account, states must offer an additional six months of coverage (12 months total).

Under Medicaid rules, individuals on TMA are not disqualified from Medicaid if they have other insurance; Medicaid becomes the payor of last resort. It will pay for services not covered by the plan and help the family pay the premiums, deductibles, and co-payments imposed by the plan. In addition, if a state believes it is cost-effective to purchase available insurance on behalf of an individual or family eligible for TMA, it may do so and provide "wrap around" benefits and cost-sharing protections under Medicaid.

All of the above provisions are only applicable to individuals eligible for TMA under the state plan. However, states may extend the duration of TMA beyond 12 months to a maximum of 24 months and also eliminate the "three out of six months" rule. This may be accomplished either through a demonstration project waiver or an amendment to their state Medicaid plan. Nevada currently offers only 12 months of TMA coverage.

[4] Families are eligible for transitional benefits because they would have been eligible for AFDC based upon the standards in effect on July 16, 1996 (i.e. eligible for Medicaid as part of the 1931 group).

Defining a Medically Needy Population for the Nevada HIFA

Issue

How to define a medically needy eligibility group for the Nevada Health Insurance Flexibility and Accountability (HIFA) demonstration that creates maximum overlap with existing indigent care programs in the state.

Background

In developing a HIFA proposal for the State of Nevada, there is an ongoing process to define a medically needy population. This is important in order to capture the population whose care is currently being paid for with indigent care funds. Since these funds would be used by the state as match in the HIFA, the counties and hospitals have an interest in having the definition of medically needy and existing programs be as close as possible.

The target programs for conversion that provide indigent care are the Indigent Accident Fund (IAF) and the Supplemental fund.

Indigent Accident Fund

This fund pays for hospital care for indigent individuals injured in automobile accidents. The county is responsible for the first $3,000 in expenses, and amounts in excess of $3,000 are paid based on a schedule of charges. Physician services received during hospital stays are paid using a fee schedule. In 2003, IAF expenditures amounted to $9.7 million.

Supplemental Fund

The Supplemental Fund provides subsidies for indigent persons with hospital bills in excess of $25,000. Counties are able to access this fund when 90% of other county indigent funds have been expended. In 2003, this program made $6 million in payments. These payments are paid pro rata, based on available funds.

Discussion

Standard medically needy definition as contained in a state plan

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. Such individuals otherwise have income that is too high for the Medicaid program in their state. They "spend down" to the Medicaid level by incurring medical expenses. Thirty-five states and the District of Columbia have medically needy programs

There are two ways *categorical* individuals can become eligible under the medically needy category. First, individuals with income below the state's medically needy level (which can be no higher than 133% of the maximum state AFDC level as of July 16, 1996 for a family of the same size) but above the Medicaid level are eligible. Second, *categorical* individuals with income higher than the medically needy level that meet a "spend-down" can also qualify. States can choose a spend-down period of one to six months. Once the spend-down is met, the individuals are eligible for the remainder of the applicable period.

States have some flexibility over which categorical groups it chooses to cover if they opt to have a medically needy program. While states must cover pregnant women and children under 18 in this category, they have the option of covering children under 21, parents and other caretaker relatives, the elderly, and individuals with disabilities. States may choose one or a combination of the latter groups. This coverage can be implemented by submitting a state plan amendment. There is also flexibility with respect to benefit packages.

Potential waiver definition

There are a number of approaches the state could consider in defining the medically needy population under the waiver. The two options at either end of the continuum would be:

- Using definitions similar to those used in the state programs, i.e., hospital cases with bills in excess of $25,000 or generated medical expenses as a result of an automobile accident

- Using a definition that would be allowable under a Medicaid state plan amendment, as explained above

The first option would have the advantage of capturing the population currently served by the programs without generating an expansion, which would make a great deal more money available for other groups to be covered under the waiver (The $15.7 million expended in 2003 would yield a savings of $10.8 million in state funds if the federal funds come from SCHIP). This first option has a disadvantage in that CMS has never considered a proposal to limit a medically needy program only to individuals who

experience either a traumatic and/or catastrophic event related to motor vehicles or has incurred a specified amount of medical costs.

It is reasonable to assume that CMS would have some difficulty approving a program that is limited to motor vehicle accident victims. Also, CMS would likely prefer that the program provide more comprehensive benefits than those covered by the two focus programs.

The second option has the advantage of being a pass-through for budget neutrality purposes. However, it has the considerable disadvantage of targeting populations that are not the focus of the current state programs. If the state plan option were adopted, it would leave many individuals who are served by the current programs uncovered. For example, childless adults who are victims of motor vehicle accidents could not be covered. It has the additional disadvantage of being an open-ended entitlement program with limited options available to control expenditures.

A compromise between the two options would be to design a medically needy program that attempts to cover the existing population of the two focus funds and would satisfy CMS policy constraints. Such an alternative could encompass:

- A short spend-down period (e.g., one month)
- Require a specified amount of medical/hospital costs
- Limit eligibility to one segment per year (or a certain number of segments per lifetime)
- Allow non-categoricals as well categoricals to be covered
- A limited benefit package

As an example, a medically needy population could be defined by the waiver to cover individuals that have an income of no more than 150% of the Federal Poverty Level (FPL). In addition, there would only be a one-month spend-down period, which should capture those persons who have experienced some type of catastrophic event such as a motor vehicle accident. Finally, the waiver might be constructed such that individuals eligible for the waiver under the medically needy category must incur at least $15,000 (or some other determined amount) in medical expenses.

The advantage of this approach is that it allows for an enhanced overlap with the state programs compared to a more strict Medicaid medically needy definition. In addition, under an HIFA waiver, the state could cap enrollment and/or expenditures for this population.

Issues likely to arise

If the proposed alternative is selected, there are a few issues that will arise, both from the standpoint of the counties and the hospitals and also from the standpoint of securing federal approval from CMS.

County/Hospital Issues

A major issue will be whether the counties and hospitals believe that the waiver will be a "good deal" for them. For the counties, the issue will be whether the proposal absolves them from the responsibility for the groups proposed to be covered, and will the costs of groups that cannot be covered (aliens and non-residents) be a burden on them. For hospitals, the issues will be: 1) what areas of hospital costs that are now covered by these funds will be covered by the proposal; and 2) what other areas of the HIFA waiver will provide reimbursement that are now uncompensated.

Federal Approval Issues

As noted above, CMS has never considered a pure medically needy waiver that dictates a specified amount of medical costs. This type of waiver may receive heighten scrutiny because of its innovative approach, but by following some of the basic standards of a medically needy program, such as a spend-down period and a set medically needy income level, CMS may give the proposal a favorable review.

Also, CMS would most likely prefer that those persons eligible for the medically needy program receive a more comprehensive benefit package than what may be currently offered by the two programs. This would be accommodated by structuring a limited benefit package that includes such services as physician services, inpatient and outpatient hospital, and prescription drugs.

Finally, while defining the medically needy population, the state must be mindful of the budget neutrality implications. The greater the overlap of the waiver definition with the Title XIX medically needy definition, the smaller the impact on budget neutrality. However, budget neutrality issues do not arise in cases where Title XXI (SCHIP) funding is used, as is the plan for Nevada. If XXI funds are used to cover the non-categorical population of the waiver, CMS will only require allotment neutrality. However, if SCHIP funds are exhausted and Title XIX funding is needed, budget neutrality will become an issue.

Conclusion

Because this is an untested issue, all of the policy implications associated with defining the population have not been fully developed. As noted above, several issues arise when considering how to define and structure a medically needy program in Nevada. The defined medically needy population should not only absolve the counties and hospitals of most of their current responsibility under the two focus programs, but it must also address any possible CMS concerns about eligibility and benefits.

More information will be developed based on the ongoing data collection efforts on the individuals served by the existing programs and further exploration of potential CMS reaction.

Expanding Coverage to the SSDI Population

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 (SSDI) 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 if they apply for and receive Supplemental Security Insurance (SSI) payments. SSI is a federal program that provides monthly cash payments to people who do not have much income or many assets. SSI is for elderly people, as well as blind or disabled people of any age, including children. States must provide Medicaid to all persons receiving SSI benefits.

States also have the option to provide coverage to people with disabilities with incomes up to 100 percent of poverty. As of 2002, only 18 states provided coverage to people with disabilities up to or beyond 100 percent of poverty.[5]

A state may also provide coverage for people with disabilities with incomes above the poverty level by disregarding more of their income in determining Medicaid eligibility. Under Section 1902(r)(2) of the Social Security Act, states can liberalize methods of counting income and resources for certain groups of Medicaid beneficiaries. California and Mississippi use liberal disregards to qualify more individuals for coverage.

Finally, states may use the waiver process to cover people who would not ordinarily be eligible for Medicaid. In Massachusetts, the waiver population includes disabled adults with income above 100% FPL not otherwise eligible for Medicaid. The state imposes monthly premiums ranging from $15-$928 for those without third party coverage (TPC). Those with gross income exceeding a published schedule (currently $100,000 annually) without third party coverage, pay 15% of gross income, and those with TPC pay 10%.

An issue to consider would be at what level of income would the state choose to extend coverage. Current SSDI payments can be in excess of 200% of FPL (when calculated on a single person basis).

[5] 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.