POLICY BRIEF

kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

May 2009

Expanding Health Coverage for Low-Income Adults: Filling the Gaps in Medicaid Eligibility

Executive Summary

Discussion continues around the potential for national health reform, with many viewing expanding coverage as a key goal of reform. Low-income adults (below 200% of poverty or $33,200 for a family of three in 2007) account for just over half of the non-elderly uninsured. This brief reviews coverage of non-elderly low-income adults and discusses the implications of broadening their coverage by filling gaps in Medicaid eligibility.

Four in ten (40%) low-income adults lack coverage, and they are more than twice as likely to be uninsured as low-income children. Increasing coverage for low-income adults will help to improve their access to care and provide financial protections; it will also have positive spillover effects of improvements in their children's coverage and care.

Many low-income adults do not have access to employer-sponsored coverage and cannot access or afford private coverage in the individual market. While over half (53%) of low-income adults are in families with at least one full-time worker, they tend to be in low-wage positions and in firms and industries that often do not offer coverage. For those that have an offer of employer coverage, that coverage can often be unaffordable given their limited family budgets. Private coverage on the individual market can be expensive, may have high cost-sharing requirements, and often is not available to people with existing health problems.

Over half of uninsured low-income adults are poor, and a number have significant health care needs. Uninsured low-income adults include adults in a variety of family situations—from young adults, to parents, to "empty nester" couples, to single individuals across the age spectrum. All have limited family budgets, with over half (55%) below the federal poverty level. More than one in three (36%) reports a chronic physical or mental health condition.

Expanding Medicaid provides an effective and efficient strategy for increasing coverage among low-income adults. Medicaid helps protect some low-income adults from being uninsured, but parent eligibility levels are below poverty in 34 states and childless adults are excluded from the program under current federal rules. Given their limited budgets, lack of access to employer-based coverage, and health care needs, Medicaid could be an effective and efficient vehicle for expanding coverage for low-income adults. It is designed to meet the needs of low-income individuals and those with complex health needs and has an existing delivery, financing, and administrative structure. Further, it is a low-cost program relative to the health needs of enrollees and, thus, can serve as a building block for broader coverage targeted to the low-income population. Eliminating the categorical exclusion of childless adults, increasing income eligibility levels, and enhancing the federal financing available to support coverage for adults could enable Medicaid to cover more of the low-income uninsured.

It is likely that any comprehensive coverage effort will include a combination of both public and private strategies to target different segments of the uninsured population. Medicaid coverage for low-income adults could help establish a strong floor of coverage for the low-income population, upon which additional expansion efforts could build.

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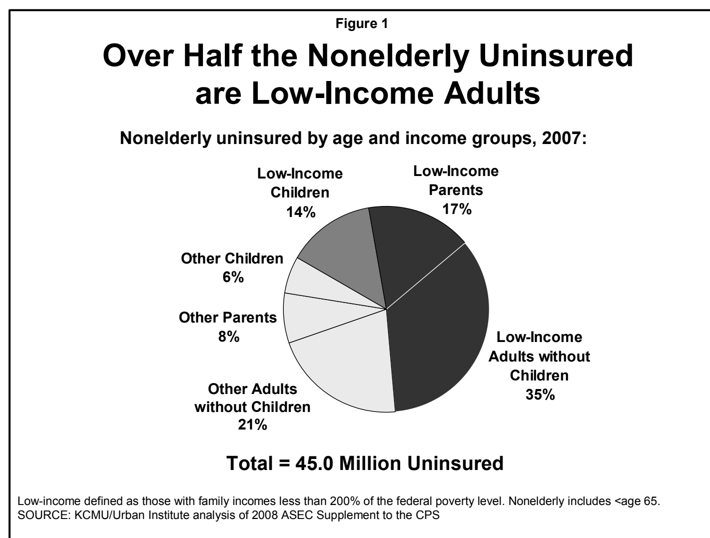
Introduction

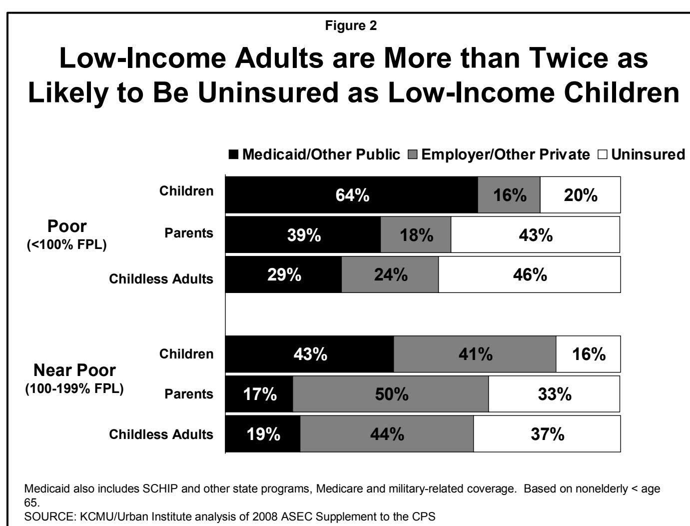
As the nation considers national health reform and broadening coverage of the uninsured, understanding who comprises the uninsured population and the potential role of public programs in broadening coverage can help shape the debate. As of 2007, 45 million non-elderly individuals lacked health insurance coverage, including over 36 million adults and roughly 9 million children. Since then, the number of uninsured has undoubtedly grown due to the recession, corresponding increases in unemployment, and rising health care costs. Low-income uninsured adults (with family income below 200% of the poverty level or $33,200 for family of three in 2007) account for just over half of the non-elderly uninsured and include over 7.5 million low-income parents and 15.6 million low-income childless adults (Figure 1). Efforts to reduce the number of uninsured will likely need to include a focus on covering these adults.



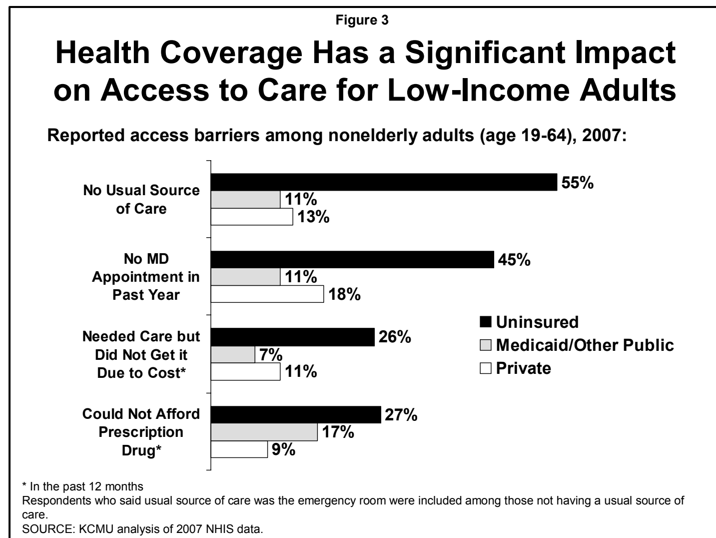
While Medicaid provides a broad base of coverage for our nation's low-income population, many low-income adults remain ineligible for the program. Broader Medicaid coverage of low-income adults could provide a foundation upon which additional public and private expansion efforts could build. This brief reviews health coverage for low-income non-elderly adults and discusses the role Medicaid could play in efforts to cover more low-income adults.

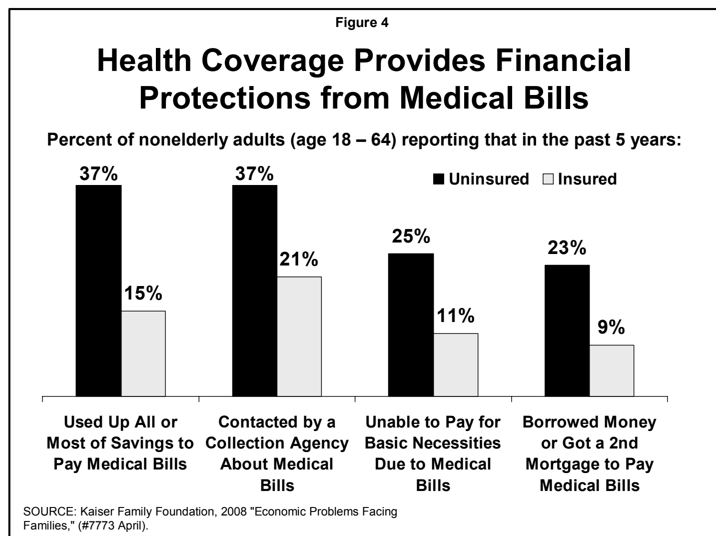
Why is it Important to Address the Uninsured Problem Among Low-Income Adults?

Low-income adults have a high uninsured rate and are more than twice as likely to be uninsured as low-income children. Nationwide, four in ten (40%) low-income adults lacked coverage in 2007, compared to 10% of adults at 200% of poverty or higher. Uninsured rates varied across states, reaching highs of 50% in Florida and 55% in Texas (Appendix Table 1), and reflecting state differences in demographics and coverage policies. Overall, low-income adults were more than twice as likely to lack coverage as low-income children (Figure 2).



Insurance plays a key role in assuring adults' access to care and provides important financial protections from medical bills. Among low-income adults, those who are uninsured are significantly more likely than those with coverage to report a range of access problems (Figure 3). More than half of uninsured adults report no usual source of care, nearly half report not having a physician visit in the past year, and more than one in four report not obtaining needed care or prescription drugs due to cost. Further, compared to insured adults, uninsured adults report more financial challenges from medical bills. Uninsured adults are significantly more likely to use all or most of their savings to pay medical bills, to report being contacted by a collection agency about medical bills, to be unable to pay for basic needs due to medical bills, and to borrow money or take out a second mortgage to cover medical bills (Figure 4).



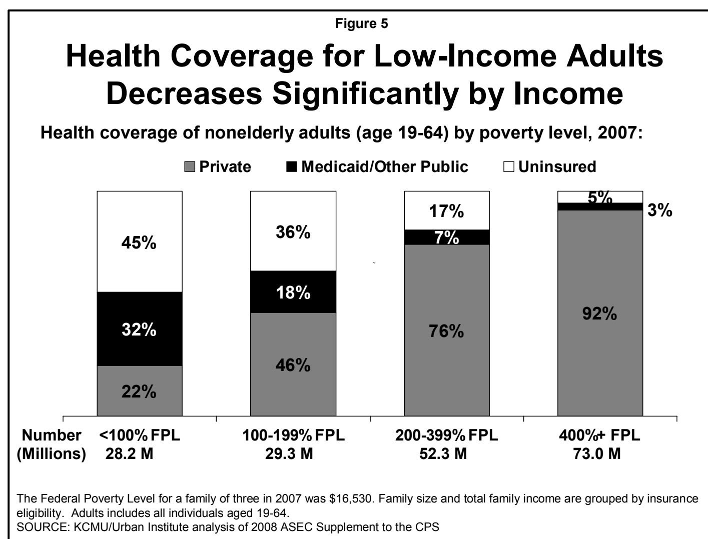


Increasing coverage among low-income adults not only benefits adults themselves but also has positive impacts for their children. Increasing coverage for adults improves their access to care and provides important financial protections. In addition, research and state experience demonstrate that increasing coverage of parents also contributes to increases in children's coverage and improvements in children's access to and use of care.[1] For example, children of insured parents are more likely to see a provider and receive well-child care than those whose parents lack coverage.[2]

[1] Artiga, S. and C. Mann, "Family Coverage Under SCHIP Waivers," Kaiser Commission on Medicaid and the Uninsured, May 2007.
[2] Ku, L. and M. Broaddus, "coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, October 2006; Davidoff, A., et al, "The Effects of Parents' Insurance Coverage on Access to Care for Low-Income Children," *Inquiry*, V.40, 254-268, Fall 2003; and Gifford, Weech-Maldonado, and Farley-Short, "Low-Income Children's Preventive Service Use: Implications of Parents' Medicaid Status," *Health Care Financing Review*, 26(4), 81-94, Summer 2005.

Why Do Low-Income Adults Lack Coverage?

The high uninsured rate among low-income adults is primarily driven by a low rate of private coverage. Low-income adults, particularly those below poverty, are significantly less likely to have private coverage than those at higher incomes. Only about one in five (22%) poor adults has private coverage compared to more than nine in ten with incomes at or above 400% of poverty (Figure 5). Medicaid helps fill some of this gap in private coverage, but it does not fully offset the difference, leading to much higher uninsured rates for poor and near-poor adults.



Many low-income adults do not have access to employer-sponsored coverage and cannot afford or access private coverage through the individual market. Over half (53%) of low-income adults are in families with at least one full-time worker, but they tend to be employed in low-wage positions and in firms and industries that often do not provide coverage to their workers. For example, 43% of working low-income adults are employed in small firms with less than 100 employees, which are less likely than larger firms to offer health coverage. The remaining nearly half of low-income adults are in families with no workers (31%) or only part-time workers (16%). Even when coverage is offered by an employer, it has become increasingly unaffordable for low-income adults given their limited family budgets.[3] The average employee share of annual premiums for individual coverage more than doubled between 1999 and 2008, rising from $324 to $721.[4] Further, the coverage provided by firms that tend to employ low-income workers is more likely to have high cost sharing requirements that would be difficult for low-income adults to cover. For example, 35% of covered workers in small firms with less than 200 workers have a plan with at least a $1,000 deductible compared to 9% in firms with at least 200 workers.[5] Similarly, private coverage on the individual market can be expensive to purchase, may have high cost-sharing requirements, and often is not available to individuals with existing health problems.

Medicaid helps protect some low-income adults from being uninsured, but many remain ineligible for the program. Reflecting the program's historic ties to welfare, states can only cover certain groups of people through Medicaid, including children, pregnant women, elderly and disabled individuals, and parents. States must cover these groups to federal minimum levels and have the option to expand eligibility to higher incomes. The federal minimum for parents is

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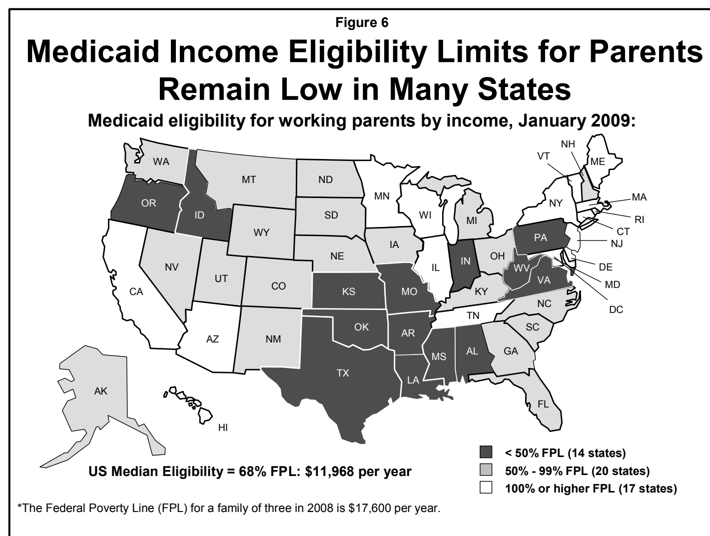
[3] Perry, M.; Cummings, J., Paradise, J. and T. Schwartz, "Snapshots from the Kitchen Table: Family Budgets and Health Care," Kaiser Commission on Medicaid and the Uninsured, February 2009.
[4] Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits 2008 Annual Survey," September 2008.
[5] Ibid.

set by reference to a state's 1996 welfare eligibility levels, which is below poverty in every state and below 50% of poverty in many states. While some states have expanded eligibility above these levels, overall, parent eligibility levels remain low, particularly when compared to children. As of January 2009, 34 states limited parent eligibility to less than 100% of poverty, with 14 limiting eligibility to less than 50% of poverty or about $9,000 for a family of three (Figure 6 and Appendix Table 2). In contrast, 44 states covered children to at least 200% of poverty or roughly $35,000 for a family of three.

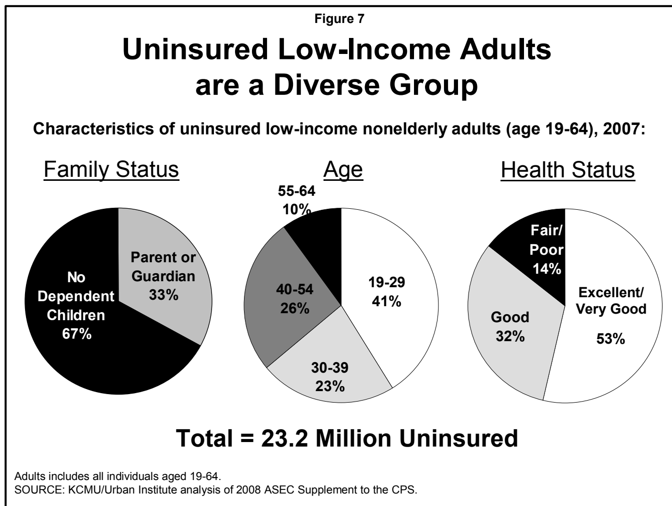


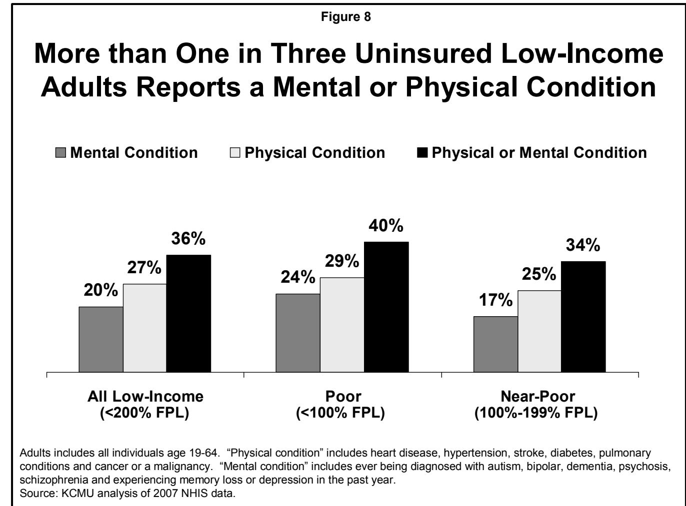
Further, childless adults are not included in the categories of people states can cover through Medicaid under current federal rules, regardless of their income. States can only cover these adults through Medicaid if they obtain a waiver of federal rules, known as a Section 1115 waiver, or they must create a fully state-funded program. Because waivers do not provide states with any additional federal funds and state-funded programs do not benefit from federal matching funds, states have limited ability to expand coverage to childless adults through these vehicles. Reflecting these financing constraints, waiver or state-funded coverage for adults is often limited by enrollment caps and/or provides more limited coverage than available through Medicaid (see Appendix Table 2).

Who Are Uninsured Low-Income Adults?

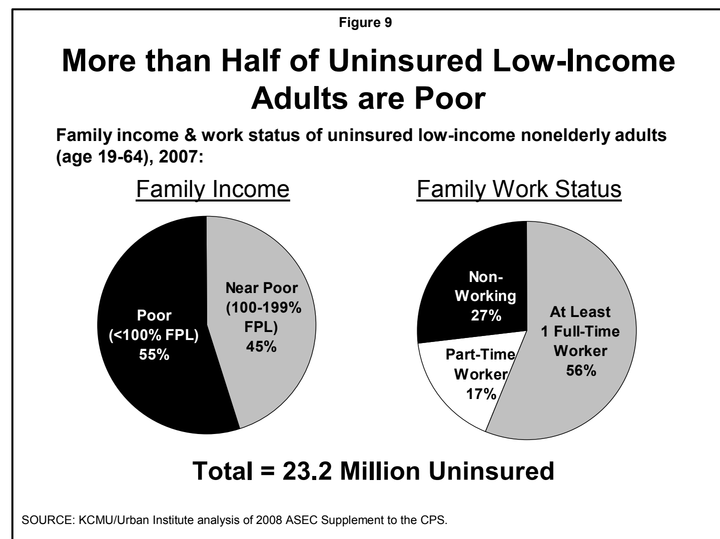
Uninsured low-income adults are a diverse group, ranging in family status and age, and a number have significant health needs. Overall, uninsured low-income adults include adults in different family situations—from young adults, to parents, to "empty nester" couples, to single individuals across the age spectrum. Two-thirds (67%) are adults without dependent children (childless adults), while the remaining third are parents (Figure 7). Four in ten (41%) are between ages 19-29, while over one in three (36%) are between ages 40-64. Some 15% say their health is fair or poor. Further, more than one in four (27%) reports a chronic physical condition, such as hypertension, diabetes, or heart disease; one in five (20%) reports a mental health problem, such as depression, bipolar disorder, autism, dementia, schizophrenia or psychosis; and more than one in three (36%) reports either a chronic physical or mental health problem (Figure 8).[6]

[6] Kaiser Commission on Medicaid and the Uninsured analysis of 2007 NHIS data





Over half of low-income uninsured adults are poor. Some 55% of uninsured low-income adults have family income below the federal poverty level or $16,600 for a family of three in 2007, reflecting that a substantial minority of low-income adults have no or limited connections to the workforce (Figure 9). Compared to their near-poor counterparts, uninsured poor adults are more likely to live in a non-working family, be in a family without dependent children, be African American, be younger (age 19-29) and report fair or poor health (Table 1, next page).[7] Data suggest that this disconnection from the workforce—particularly among poor uninsured adults—may, in part, reflect health problems. For example, two-thirds (67%) of uninsured poor adults who report fair or poor health are not working. Further, non-working poor uninsured adults are more than twice as likely to report fair or poor health as those working on a full-time basis (22% vs. 10%).



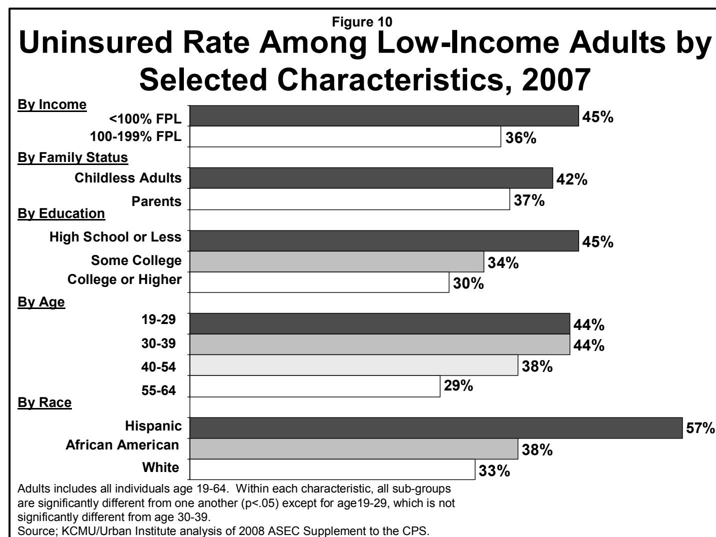
[7] Differences between poor and near-poor adults are statistically significant ($p<0.05$).

Table 1:
Characteristics of Uninsured Low-Income Non-Elderly Adults

	All Low-Income (<200% FPL)	Poor (<100% FPL)	Near-Poor (100-199% FPL)
Gender			
Female	47%	49%	45%
Male	53%	51%	55%
Family Status			
Parent	33%	29%	36%
No Dependent Children	67%	71%	64%
Age			
19-29	41%	43%	39%
30-39	23%	22%	25%
40-54	26%	25%	27%
55-64	10%	10%	10%
Race/Ethnicity			
White	42%	42%	42%
African American	17%	20%	12%
Hispanic	34%	30%	39%
Other	7%	7%	6%
Family Work Status			
1 or 2 Full-time workers	56%	35%	83%
Part-time workers	17%	20%	13%
No workers	27%	45%	4%
Firm Size			
<25	48%	49%	47%
25-99	14%	12%	15%
100-499 workers	10%	10%	10%
500+ workers	28%	29%	28%
Health Status			
Excellent or very good	53%	50%	58%
Good	32%	33%	31%
Fair or poor	14%	17%	11%

Notes: For firm size, <25 workers includes self employed; 500+ workers includes public sector employees.
Source: KCMU/Urban Institute analysis of 2008 ASEC Supplement to the CPS

Among low-income adults, those below poverty are most at risk for lacking coverage. Overall, poor adults are significantly more likely to lack coverage than near-poor adults (45% vs. 36%) (Figure 10). Other low-income adults who are at increased risk for lacking coverage include childless adults, those with no education beyond high school, young adults between age 19-39, and Hispanic and African American adults.



Why Turn to Medicaid to Expand Coverage for Low-Income Adults?

A combination of public and private coverage strategies will likely emerge as part of health reform discussions, and different strategies will likely be most effective for different segments of the uninsured population. An expansion in Medicaid could be an effective and efficient strategy for increasing coverage of low-income adults and meeting their health care needs.

While more than half of Americans have employer based health coverage, many low-income uninsured adults lack access to employer coverage. Further, access to employer coverage for workers has been declining over time, especially among smaller firms and in industries and firms in which low-income adults tend to be employed. Even when coverage is offered, the premium costs are often unaffordable for low-income adults, given their limited budgets. The coverage may also have cost sharing requirements that would be difficult for low-income adults to pay, such as high deductibles. Similarly, private coverage on the individual market can be expensive, may have high cost-sharing requirements, and may not be available for individuals with existing health conditions. These factors create significant challenges to covering uninsured low-income adults through today's structure of employer-based coverage or the individual private market.

Medicaid provides a readily available mechanism for expanding coverage to low-income adults. It has an existing delivery, financing, and administrative structure and is a low-cost program relative to the health needs of enrollees.[8] Further, it is designed to meet the specific needs of low-income individuals and those with complex health needs, as it includes cost sharing protections and comprehensive benefits. Thus, it has been the building block for state expansion efforts, especially for parents, and could be utilized in health reform for broadening low-income coverage.

To date, some states have taken up the option to expand parent eligibility to higher incomes, some have obtained waivers to cover childless adults through Medicaid or created state-funded programs, and, in recent years, several have pursued public/private coverage approaches using Medicaid funds, such as premium assistance programs and new subsidized public coverage options. However, Medicaid's current eligibility structure—particularly the exclusion of childless adults from eligibility for federal matching funds—hinders states' ability to make substantial progress forward in providing broad, stable coverage to low-income adults.

Changes at the federal level could promote broader coverage. Eliminating the categorical exclusion of childless adults from Medicaid could be achieved by providing states a new option to cover childless adults or by determining eligibility based solely on income. States could be given flexibility to provide coverage up to a specified level or a national income floor could be established, as is now the case for children.

Whether provided at state option or as a new federal requirement, expanding Medicaid to more low-income adults would result in added federal and state costs and would need to be coupled with federal financing to help mitigate the cost impact on states. Consideration would also need to be given to the existing variations in coverage for adults across states.

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[8] Hadley, J. and J. Holahan, "Is Health Care Spending Higher Under Medicaid or Private Insurance?," *Inquiry*, V.40, No. 4, Winter 2003/2004.

Conclusion

As broad health reform discussions move forward, a range of coverage expansion strategies will probably emerge to address the nation's growing uninsured problem. It is likely that any comprehensive health expansion effort will include a combination of both public and private strategies to target different segments of the uninsured population. Medicaid provides a strong base of coverage for our nation's low-income population, but many low-income adults remain ineligible for the program and without affordable coverage alternatives. Given the income, health, and work status of uninsured low-income adults, expanding Medicaid could be an effective and efficient strategy for increasing their coverage rates and meeting their health care needs. This would help to strengthen the floor of coverage for the low-income population, upon which additional reform expansion efforts could build.

This brief was prepared by Samantha Artiga and Karyn Schwartz of the Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

Appendix Table 1:
Uninsured Rates for Low-Income Adults by State, 2006-2007

	All Low-Income (<200% FPL)	Poor (<100%)	Near-Poor (100-199%)
Alabama	36%	44%	29%
Alaska	45%	53%	38%
Arizona	45%	47%	44%
Arkansas	46%	56%	38%
California	45%	48%	42%
Colorado	46%	52%	41%
Connecticut	32%	32%	32%
Delaware	32%	37%	27%
District of Columbia	24%	25%	22%
Florida	50%	53%	47%
Georgia	47%	51%	42%
Hawaii	23%	29%	18%
Idaho	38%	44%	33%
Illinois	40%	46%	34%
Indiana	36%	43%	30%
Iowa	34%	41%	27%
Kansas	37%	41%	34%
Kentucky	38%	46%	30%
Louisiana	46%	49%	44%
Maine	24%	24%	24%
Maryland	44%	46%	41%
Massachusetts	21%	24%	18%
Michigan	33%	41%	26%
Minnesota	28%	32%	25%
Mississippi	46%	55%	34%
Missouri	36%	42%	32%
Montana	41%	43%	39%
Nebraska	37%	43%	33%
Nevada	49%	60%	41%
New Hampshire	38%	44%	34%
New Jersey	45%	52%	38%
New Mexico	49%	51%	48%
New York	34%	36%	31%
North Carolina	41%	47%	37%
North Dakota	33%	41%	27%
Ohio	32%	39%	25%
Oklahoma	45%	55%	36%
Oregon	45%	51%	38%
Pennsylvania	28%	33%	23%
Rhode Island	28%	32%	25%
South Carolina	40%	42%	37%
South Dakota	34%	42%	28%
Tennessee	37%	44%	31%
Texas	55%	59%	50%
Utah	38%	45%	33%
Vermont	28%	31%	26%
Virginia	42%	48%	37%
Washington	36%	38%	34%
West Virginia	36%	41%	31%
Wisconsin	29%	35%	24%
Wyoming	39%	44%	36%

Source: KCMU/Urban Institute analysis of 2007-2008 ASEC Supplement to the CPS.

Appendix Table 2:
Medicaid and State-Funded Coverage Income Eligibility Limits for Low-Income Adults, April 2009

Scope of Benefit Package	Working Parents: Medicaid	Working Parents: More Limited than Medicaid	Childless Adults: Comparable to Medicaid	Childless Adults: More Limited than Medicaid
Alabama	25%			
Alaska	85%			
Arizona	200%		100%	
Arkansas	17%	200%, employment requirement		200%, employment requirement
California	106%			
Colorado	66%			
Connecticut	191%	300%*		300%*
Delaware	121%		100%	
District of Columbia	207%			200%*
Florida	55%			
Georgia	52%			
Hawaii	100%	200%	100%, enrollment closed	200%
Idaho	28%	185%, employment requirement		185%, employment requirement
Illinois	185%			
Indiana	26%	200%		200%, enrollment closed
Iowa	86%	200%		200%
Kansas	34%			
Kentucky	62%			
Louisiana	26%			
Maine	206%	300%*		100%, enrollment closed/ 300%*
Maryland	116%			116%
Massachusetts	133%	300%	133%	300%
Michigan	66%			35%
Minnesota	200%	275%		200%*
Mississippi	46%			
Missouri	26%			
Montana	58%			
Nebraska	58%			
Nevada	91%	200%, employment requirement		
New Hampshire	51%			
New Jersey	200%			
New Mexico	69%	200%		200%
New York	150%		100%	
North Carolina	51%			
North Dakota	62%			
Ohio	90%			
Oklahoma	48%	200%, employment requirement		200%, employment requirement
Oregon	42%	100%/185%, enrollment closed		100%/185%, enrollment closed
Pennsylvania	36%	200%*, enrollment closed		200%*, enrollment closed
Rhode Island	181%			
South Carolina	90%			
South Dakota	54%			
Tennessee	134%	$55,000/year*, employment requirement		$55,000/year*, employment requirement
Texas	27%			
Utah	68%	150%		150%
Vermont	191%	300%	150%	300%
Virginia	30%			
Washington	77%	200%*, enrollment closed		200%*, enrollment closed
West Virginia	34%			
Wisconsin	200%			200%
Wyoming	54%			

SOURCE: KCMU analysis of state policies through program websites and contacts with state officials, April 2009.

APPENDIX TABLE 2 NOTES:

This table reflects income eligibility limits as a percent of the federal poverty level for Medicaid and state-funded programs for parents and childless adults that provide direct coverage or premium subsidies. It does not reflect other state coverage strategies such as purchasing pools, reinsurance programs, or changes in insurance market regulations.

Medicaid income thresholds for working parents take earnings disregards, when applicable, into account. Computations are based on a family of three with one earner. States may use additional disregards in determining eligibility. In some states, the income eligibility guidelines vary by region. In this situation, the income guideline in the most populous region is used. In some states, the earnings disregards used to determine eligibility are applied only for the first few months of coverage. Thus, the eligibility limits for most beneficiaries would be lower than the levels that appear in this table.

A program's scope of benefits is categorized as ***"More limited than Medicaid"*** if it provides more limited benefits and/or charges higher cost sharing than the state provides to parents covered through its regular Medicaid program.

"Employment requirement" denotes that eligibility for the program is limited to individuals who work for specified qualified employers or meet other employment-related eligibility requirements. See state-specific notes for more information on each state's employment-related requirements.

"Enrollment closed" denotes that enrollment in the program is closed to new applicants as of April 2009.

***** denotes that a program is financed solely with state dollars.

Arkansas: Parents and childless adults up to 200% FPL are eligible for more limited coverage through the ArHealthNetworks waiver program; individuals must meet income eligibility requirements and work for a qualifying, participating employer.

Arizona: Parents and childless adults are covered under the state's broad 1115 waiver.

Connecticut: Parents and childless adults up to 300% FPL are eligible for the fully state-funded premium subsidy program called Charter Oak.

Delaware: Parents above Section 1931 eligibility limits and childless adults are covered through a Medicaid waiver that offers a benefit package identical to the state's traditional Medicaid benefits package with the exception of dental and vision benefits.

District of Columbia: Childless adults are eligible for the more limited fully district-funded DC Healthcare Alliance program. As of March 2009, 52,273 adults were enrolled in the program. In addition, the District has a Medicaid waiver program for non-disabled childless adults age 50-64 with income below 50% of poverty. Enrollment in the waiver program closed in 2005; as of 2009, there are about 1,000 adults enrolled.

Hawaii: Parents and childless adults up to 100% FPL are covered under the QUEST Medicaid managed care program, which operates under a waiver. Enrollment in QUEST is currently closed except for certain groups, including individuals receiving TANF or General Assistance or those below AFDC standards. (Adults enrolled in QUEST or Medicaid fee-for-service who become ineligible due to increases in income can continue to receive more limited coverage under QUEST-NET, which is available to adults with incomes up to 300% FPL.) Parents and childless adults up to 200% FPL are eligible for more limited coverage under the QUEST-ACE waiver program.

Idaho: The state provides premium assistance to parents and childless adults up to 185% FPL under a waiver. Individuals must meet income eligibility requirements and work for a qualified small employer. Total enrollment in the program is capped at 1,000 adults; 365 adults were enrolled as of March 2009.

Illinois: Parents up to 185% FPL are covered under FamilyCare waiver program. The state covers some non-disabled childless adults through its State Hemophilia Program and catastrophic coverage program, Illinois Comprehensive Health Insurance Program (ICHIP). These programs for childless adults are not depicted on the table because they are limited to individuals who qualify on the basis of specific medical conditions.

Indiana: Parents and childless adults up to 200% FPL are eligible for more limited coverage under the Healthy Indiana waiver program. As of April 2009, 43,535 adults were enrolled in the program. Enrollment in the program closed for childless adults on March 12, 2009; as of April 10, 2009, there were 6,778 childless adults on the waitlist for coverage.

Iowa: Parents and childless adults up to 200% FPL are eligible for more limited coverage under the IowaCare waiver program. As of March 2009, 28,667 adults were enrolled in the program.

Maine: Childless adults up to 100% FPL are eligible for more limited coverage under the MaineCare waiver program. Enrollment in the program is closed. As of March 2009, there were 9,886 childless adults enrolled in the program and as of April 2009, there were 14,779 adults on the waitlist for coverage. Additionally, the state offers a fully state-funded subsidized coverage plan, called Dirigo Health, to parents and childless adults up to 300% of poverty.

Maryland: Childless adults are eligible for coverage of primary care services under the Primary Adult Care waiver program. As of April 2009, 29,250 adults were enrolled in the program.

Massachusetts: Parents and childless adults up to 133% FPL are covered under the MassHealth Medicaid waiver. Additionally, the state offers a subsidized coverage plan, called Commonwealth Care, to parents and childless adults up to 300% FPL, for which it receives federal Medicaid financing to support some program costs.

Michigan: Childless adults are eligible for more limited coverage under the Adult Benefit Waiver program. As of April 2009, there were approximately 55,000 adults enrolled in the program. Enrollment in the program is capped at 62,000 adults.

Minnesota: Parents receive coverage under the MinnesotaCare waiver program, and childless adults receive coverage under the fully state-funded portion of MinnesotaCare. Parents up to 200% FPL receive full Medicaid benefits with the exception of some optional services (e.g., non-emergency transportation, private duty nursing, personal care, orthodontic services, targeted case management, and school-based services) and institutionally-based long-term care services. If parents were in need of long-term services, they would likely get switched to a different Medicaid eligibility category that covers these services. Parents above 200% FPL and childless adults are categorized as receiving more limited coverage because they have a $10,000 annual limit on inpatient hospital care. The inpatient hospital limit for parents will only apply to parents above 215% FPL effective July 1, 2009. As of April 2009, 27,452 parents and 49,391 childless adults were enrolled in MinnesotaCare. Under state legislation, childless adult eligibility is scheduled to increase to 250% FPL in July 2009.

Nevada: The state provides premium assistance to parents up to 200% FPL under the Check Up Plus waiver program. In addition to meeting income eligibility requirements, parents must work for a qualified small business. The program is capped at 100 enrollees. As of April 2009, 3 parents were enrolled in the program.

New Jersey: Parents are covered under the FamilyCare waiver program.

New Mexico: Parents and childless adults up to 200% FPL are eligible for more limited subsidized coverage under the State Coverage Insurance waiver program. Individuals must meet income eligibility requirements and work for a participating employer; if they do not work for a participating employer; they must cover both the employer and employee share of premium costs. As of April 2009, there were 23,558 childless adults and 12,316 parents enrolled in the program; the state was processing about 6,500 applications from its waitlist and accepting new applications.

New York: Parents up to 150% FPL and childless adults up to 100% FPL are covered under the Family Health Plus waiver program, which provides full Medicaid benefits with the exception of long-term care services. (If adults were in need of long-term care services, they would likely get switched to a different Medicaid eligibility category that covers long-term care.) As of April 2009, 284,551 parents and 125,561 childless adults were enrolled in the program.

Oklahoma: Parents and childless adults up to 200% FPL are eligible for more limited subsidized coverage under the Insure Oklahoma waiver program. In addition to meeting income eligibility requirements, adults must also work for a small employer, be self-employed, be unemployed and seeking work, be working disabled, be a full-time college student, or be the spouse of a qualified worker. As of April 2009, 18,643 adults were enrolled.

Oregon: Parents and childless adults up to 100% FPL are eligible for more limited coverage under the OHP Standard waiver program, and the state provides premium assistance to parents and childless adults up to 185% FPL through the Family Health Insurance Assistance Program (FHIAP). There were 26,998 adults enrolled in OHP Standard as of March 2009 and 33,766 adults enrolled in FHIAP as of November 2008. (More recent enrollment data for FHIAP are not currently available from the state.) OHP Standard enrollment has been closed since July 1, 2004 except for a limited open enrollment period in January 2008. FHIAP enrollment has been closed since November 2007.

Pennsylvania: Parents and childless adults up to 200% FPL are eligible for more limited coverage under the fully state-funded adultBasic program. As of April 2009, 43,615 adults were enrolled in the program. Enrollment in the program is currently closed.

Rhode Island: Parents are covered under the RIte Care and RIte Share waiver programs.

Tennessee: The state offers a subsidized limited coverage plan, called CoverTN, to workers of qualified businesses, self-employed individuals, and recently unemployed workers earning (or who earned) up to $55,000 per year. For

businesses to qualify, at least 50% of employees must earn $55,000 or less per year. Once a business qualifies, all eligible employees, regardless of income may enroll. Eligible local county governments and their employees may also enroll as well as spouses of enrollees. As of March 2009, 17,397 adults were enrolled and 19,211 applications had been approved and assigned a future effective coverage date.

Texas: Since 2002, the state has been in the process of transitioning to a new computer system to process applications. The earnings disregard under the new system is slightly more generous than that under the old system. The policy reflected in the table is that applied under the new system because the state intends for all applicants and recipients eventually to be processed under this system. However, the great majority of those parents currently enrolled in Texas's Medicaid program are evaluated under the old system in which the income threshold for a working parent is $308 per month rather than $402 per month.

Utah: Parents and childless adults up to 150% FPL are eligible for coverage of primary care services under the Primary Care Network waiver program or can receive premium assistance through the Utah Premium Partnership for Health Insurance program. Enrollment in the Primary Care Network is closed except for limited open enrollment periods.

Vermont: Parents up to 191% FPL and childless adults up to 150% FPL are covered under the Vermont Health Access Plan (VHAP) waiver program. VHAP benefits mirror traditional Medicaid with a few exceptions. Additionally, the state offers a premium subsidy plan, called Catamount Health, to parents and childless adults up to 300% FPL, for which it receives federal Medicaid financing to support some program costs.

Washington: Parents and childless adults up to 200% FPL are eligible for more limited coverage under the fully state-funded Basic Health program. As of April 2009, just over 102,000 adults were enrolled in the program. Enrollment in the program closed on May 4, 2009. There are over 17,000 applicants already on the wait list for the program, as applications were being held and delayed prior to the official closure of enrollment.

Wisconsin: Parents up to 200% FPL are covered under the BadgerCare Plus waiver program. (Certain farmers or other self-employed parents with a gross family income of more than 200% of FPL can also enroll in BadgerCare Plus if their net income, excluding their tax deduction for depreciation, is less than 200% FPL. These parents receive a more limited benefit package.) As of March 2009, 179,859 parents and caretaker relatives were enrolled in the BadgerCare Plus program. Childless adults receive more limited coverage under the BadgerCare Plus Core Plan for Childless Adults. In January 2001, the state transitioned approximately 13,000 childless adults who were participating in state- and county-funded general assistance/general relief medical programs into the new BadgerCare Plus Core Plan for Childless Adults. The state will begin accepting new applications for this program in June 2009, with benefits beginning in July 2009.

Wyoming: The earnings disregard is based on marital status and whether one or both parents are employed. The figures in this table represent the income thresholds for families with unmarried parents with one earner.

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This publication (#7900) is available on the Kaiser Family Foundation's website at www.kff.org.

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