New York: A Case Study in Childless Adult Coverage

State Report

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OVERVIEW

New York, traditionally progressive in health and social welfare, has covered very low-income childless adults in its Medicaid program since 1966. Responding to an increasing uninsured population, a strong coalition of stakeholders, and a groundswell of public support, the state expanded its Medicaid program in 2001 to cover childless adults with income up to 100 percent of the FPL, as well as parents with income up to 150 percent of the federal poverty line (FPL).[1] The expansion, called Family Health Plus (FHP), was federally authorized through an amendment to the state's existing 1115 waiver, legislated in-state by New York's Health Care Reform Act (HCRA) of 2000, and has used a mandatory managed care delivery system since its inception. HCRA 2000 also legislated Healthy New York, a reinsurance program geared toward making private coverage affordable to small businesses and individuals – including childless adults.

Because Family Health Plus' implementation took place fairly recently and in stages (it was delayed in New York City by the September 11th attacks), it is too early to gauge its impact on cost, utilization, or health outcomes. But based on the high demand for coverage experienced with New York City's temporary Disaster Relief Medicaid (DRM), which was implemented soon after September 11, 2001, the state expects there to be some pent up demand by FHP eligibles. DRM experienced a range of service demands: less costly prevention and screening services for healthy, employed individuals, as well as acute and chronic care services for uninsured individuals with long-held health conditions that went untreated due to lack of coverage.

New York's stakeholders acknowledge that people who have a medical home are more likely to get services earlier, and that those with coverage are more likely to have a medical home than those without. There is widespread understanding that lack of coverage, whether for childless adults or parents, has a cost to society. Indeed, various stakeholders are realizing that there is no discernible difference between parents and non-parents in terms of health care needs, utilization patterns, cost, or "worthiness." As such, they are increasingly calling for these populations to be treated similarly in terms of public coverage and subsidies.

This paper provides an overview of New York's efforts to cover low-income childless adults. It is based interviews with key stakeholders and document reviews, which took place as part of a larger multi-state examination of coverage available to low-income childless adults.

KEY PROGRAM FEATURES

There are three major public programs that provide or subsidize health care for adults without dependent children in New York (see Figure 1 on the next page).[2] This profile focuses on Family Health Plus because it specifically targets childless adults. As a Medicaid expansion program, it also has the broadest target population and the most comprehensive set of benefits for this population.

[1] The Federal Poverty Level (FPL) was $15,260 for a family of three in 2003.

[2] In addition, a number of pilot and local programs serve segments of the childless adult population along with others, but are beyond the scope of this report.

Figure 1. Key Public Health Care Programs Serving Childless Adults in New York

Program Name	Enrollment	Eligibility	Benefits	Cost Sharing
Family Health Plus	148,746 Childless Adults as of May 2004	Childless Adults: up to 100% FPL Adults w/dependent children: 85-150% FPL	Managed care package, comprehensive benefits	None
Healthy New York	55,011 (childless adults and others) in April 2004: 22% in small businesses; 19% sole proprietors; 59% individuals	Small employers: up to 50 eligible employees and at least half participate; 30+% eligible employees earn less than $32k/yr and at least one participates; no coverage or no more than $50/employee/month employer contribution over prior year; employer pays at least 50% single premium. Individuals & Self-employed: employed or sole proprietor; HH income up to 250% FPL; uninsured prior year[3]; no access to employer coverage over prior year.	Streamlined benefits, in-network providers	No direct public subsidies for premiums, copays and deductibles; Indirect subsidy through stop-loss fund that pays 90% of claims between $5k-75k per member/year
Medicaid (for safety net population)	303,570 Childless Adults (non-disabled) as of Nov 2003[4]	Childless Adults: up to about 50% FPL (varies by county); Adults w/dependent children: up to 85% FPL	Comprehensive set of benefits, managed care	None

Family Health Plus

Eligibility and Enrollment

Family Health Plus, legislated by the Health Care Reform Act (HCRA) of 2000, is a managed care program for low-income adults that was created through the expansion of Medicaid coverage. It is available to childless adults with gross family income up to 100% of FPL and for

[3] Or had prior coverage terminated due to loss of employment, death of subscriber, change in residence, other state-determined factors.
[4] New York Department of Health analysis of November 2003 data.

parents living with a child under age 21 with income up to 150% of FPL. Unlike regular Medicaid, no resource or asset tests are used to determine FHP eligibility. In addition to income, applicants must meet the following criteria:

- Permanent residents of New York State;
- Age 19 through 64;
- Citizens or Medicaid eligible qualified aliens;
- Not eligible for Medicaid based on income and/or resources;
- Not in receipt of "equivalent" health care coverage or insurance.

When FHP was first proposed, the state estimated that about 720,000 adults would be eligible. Enrollment began phasing in within counties outside New York City in October 2001. Implementation in New York City was delayed about a year due to implementation issues, compounded by the World Trade Center attack in September 2001. As of May 2004, FHP enrolled 407,536 individuals, of whom 148,746 were childless adults.[5]

Affinity Health Plan, a managed care plan in New York City that serves the FHP population, reports that FHP enrollment has been growing rapidly since the Fall of 2002. Prior to that time, large backlogs of applications had accumulated due to processing delays at the county level. Affinity enrollment grew almost tenfold from September 2002 to June 2003. Approximately 40% of Affinity's 21,500 FHP enrollees as of June 2003 were childless adults.

Recent enrollment growth is attributable, in part, to a major outreach and education campaign organized by the State, including television ads, a website (although there is no on-line application), and facilitated enrollment by community based organizations (HMOs, hospitals, lead agencies, others). Applications for the FHP as well as regular Medicaid are accepted through local social services districts, as well as enrollment facilitators within communities available at convenient times for working families and individuals. These facilitators assist individuals in completing a combined and streamlined application for various public programs. The facilitators also help the applicant select a participating plan and a primary care physician. Household members are encouraged, but not required, to participate in the same plan as other FHP, Child Health Plus (CHP) or Medicaid managed care family members. Recertification is on an annual basis and entails an in-person or a mail-in process, with enrollment facilitators available to provide assistance.

Despite this, the enrollment process is considered by health plans and advocates to be unnecessarily complex, discouraging people from applying and recertifying, a situation that was reflected in enrollment declines during the transition from DRM to FHP/Medicaid. Some advocates report that for FHP eligibles in New York City who were originally enrolled in DRM, the transition from DRM to FHP was less than smooth. The state has responded by taking some steps to simplify the enrollment and recertification processes.

Benefit Package

FHP provides a comprehensive managed care package including physician and hospital services, prescription drugs, mental health and substance abuse treatment, dental and vision care, and others. Long-term care services, non-prescription medications (except smoking cessation products) and non-emergency transportation are not covered under FHP. Also,

[5] New York Department of Health.

because all services are provided through managed care plans, there are no "wrap-around" fee-for-service provisions.

There are no co-payments, premiums or other types of cost sharing for FHP. Coverage is available when eligibility is determined and enrollment in a plan has occurred; there is no retroactive coverage. Enrollees are guaranteed an initial six months of coverage regardless of changes in circumstances.

Benefits are identical for childless adults and parents. The only difference between how the two populations are treated is in the income eligibility threshold. Despite New York's progressive tradition of protecting vulnerable people, there seems to be a lingering predisposition to covering families, with childless adults considered less "deserving." Another factor for the more generous income threshold for parents is the greater likelihood of children obtaining health care services if their parents have coverage as well.

Healthy New York

Healthy New York is a commercial product, established through HCRA 2000, that the State mandates must be offered by all licensed HMOs. It was intended to create affordable private health insurance for low-income small businesses and individuals by reducing and limiting the conventional benefit package, requiring use of in-network providers, including premiums as well as service co-payments and deductibles, and providing an indirect state subsidy through a reinsurance mechanism. Originally this mechanism was set to pay 90 percent of claims between $30,000-100,000 per member/year, but after enrollment of a population that was healthier than expected, the stop-loss corridor was adjusted to $5,000-75,000.

This reinsurance mechanism, which also contributes to lowering premiums below conventional commercial levels, had been financed through tobacco tax revenues ($220 million was dedicated through June 2003) but much was not used. Additional funds have been allocated through June 2005.

Healthy New York is offered to small businesses, self-employed, and individuals, and each HMO pools the experience and sets the same premium rates for these three groups of participants. Healthy New York was also designated a qualified health plan under the federal Health Coverage Tax Credit.

Businesses meeting the following criteria are eligible:

- The business must have no more than 50 eligible employees, with at least half of workers participating in the plan;
- At least 30% of eligible workers must have income less than $32,000/year, with at least one of these individuals participating in the plan;
- The employer did not offer coverage during the prior year or contributed no more than $50 per employee per month; and
- The employer contributes at least 50% of the premium of each participating employee's Healthy New York policy.

To purchase Healthy New York, individuals and self-employed persons must:

- be employed or a sole proprietor;

- have household income no more than 250% of the FPL;
- be uninsured over the prior year[6]; and
- not have access to employer coverage over the prior year.

Early enrollment was slower than expected. The Department of Insurance has been evaluating the program and has made adjustments to reduce premiums further, expand eligibility and promote enrollment. In addition to changing its stop-loss corridor (which effectively reduced premiums about 17 percent), Healthy New York has broadened its employment standards, simplified recertification, no longer requires co-payments for well child visits, created greater flexibility in employer contribution requirements, and offers plans with or without prescription drug benefits. During the first quarter of 2004, enrollment has been growing by approximately 5,000 members per month, reaching about 55,000 in April 2004.

Medicaid for the Adult "Safety Net" Population

The traditional Medicaid program in NY includes elderly, blind and disabled, and very low-income "safety net" adults – those earning less than approximately 50 percent of FPL, with the exact threshold varying by county. The latter category was originally the "Home Relief" population that was funded by state and local funds since Medicaid began in 1966, and was incorporated into Medicaid under an 1115 waiver in 1997.

Disaster Relief Medicaid (DRM)

The September 11, 2001 tragedy, which damaged Medicaid computers in New York City, led to the rapid establishment of a temporary "Disaster Relief Medicaid" (DRM) program. DRM enrolled nearly 350,000 people in less than four months. The large and quick enrollment in DRM is attributed to the simple and expedited application process, lack of documentation requirements or asset test, and new eligibility criteria (tied to FHP) that were higher than existing Medicaid levels. Interestingly, communication about the program was primarily based on word-of-mouth among applicants, rather than a major media or outreach campaign.

Consumer advocates pointed to the easy application process as a model for other public programs, while others feared that inadequate verification might have allowed ineligible people into the program.

Established as a temporary program, DRM was phased out by April 2003. Several notices were sent informing DRM enrollees of the need for an in-person interview in order to assess whether they were eligible to be transferred into another public coverage program. About half did not come in for interviews, presumably because their circumstances changed, they felt they no longer needed the coverage, they moved and did not receive the notices, they were confused about the transfer process, or they were unwilling to go through the more complex and demanding process of applying for regular Medicaid or other public programs. Of those who did attend interviews, about 25 percent were found ineligible for any public program. Among the remainder, two-thirds were transitioned to Medicaid, and one third transitioned to FHP.

[6] Or had prior coverage terminated due to loss of employment, death of subscriber, change in residence, or other state-determined factors.

HISTORY AND BACKGROUND

With a commitment to caring for the needy explicitly stated in its constitution,[7] New York State has been traditionally progressive in social welfare. High uninsurance rates in the early to mid 1990s brought attention to the issue of coverage and access. It was considered most "politically palatable" to start with children, so efforts were focused on the establishment and expansion of Child Health Plus, a program that preceded and became one of several models for the nation-wide State Children's Health Insurance Program (SCHIP).

Once coverage for low-income children was implemented and well-established, consumer advocates and other stakeholders turned their attention to low-income, uninsured adults. The state's existing Home Relief program that provides Medicaid coverage for very poor adults (those with income up to about 50 percent of FPL) does not reach the growing numbers of low-income uninsured, including low-wage workers, above the extreme poverty threshold.

In response, New York City hospitals, a major health workers union, and a broad group of consumer advocates joined forces to help develop and support what became Family Health Plus: a Medicaid expansion for both low-income parents and childless adults. At the same time, the governor's desire to help small businesses and individuals gain access to more affordable private insurance led to the formulation of a state-subsidized commercial program, Healthy New York. Both of these major initiatives were part of the Health Care Reform Act (HCRA) 2000.[8]

A number of additional activities undertaken in New York reflect the state's commitment to improving access to health care among the needy. These include a Regional Pilot Project Program operated by Affinity Health Plan that uses substantial state premium subsidies to provide affordable coverage for low income uninsured individuals and families; demonstration projects aimed at integrating public and private resources to improve coverage; major reforms of both group and non-group insurance markets; the use of an indigent care pool to compensate hospitals for a portion of the free care they provide to the uninsured; and most recently, the rapid establishment of temporary Disaster Relief Medicaid (described above) following the September 11 terrorist attack.

Response to Economic Downturn

As the economic situation worsened across the nation in the early 2000's, New York also struggled with major budget shortfalls. There have been various proposals to address the state's current budget deficit. The Governor's budget proposal included reductions in the income eligibility under FHP for parents from 150% to 133% of the FPL; a shift of some children

[7] Article XVII, Section 1 states: The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine. (Adopted by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938.).

[8] For a more detailed description of the factors behind the development, passage, and implementation of HCRA 2000, see: Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont. (Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer. The Commonwealth Fund's Task Force on the Future of Health Insurance, January 2003, http://www.cmwf.org/publist/publist2.asp?CategoryID=4).

age 6-19 from Medicaid to SCHIP; and establishment of nominal copays for managed care beneficiaries in Medicaid, CHP, and FHP. These were not enacted as of July 2003.

In general, it appears that the FHP income eligibility level for childless adults is safe from cutbacks, at least in the next fiscal year. While some claim that childless adult eligibility is safe because, at 100 percent of FPL, "the bar is already set so low," others point out that coverage for adults below the poverty line has been "on the chopping block" in other states. Therefore, it appears that the combination of political and traditional support for providing health coverage to childless adults remains alive, for the time being, in New York.

IMPACT OF COVERAGE

How the FHP population obtained services or what their patterns of care were before enrollment is not well-documented. Moreover, FHP's recent implementation makes it is too early to gauge the program's impact; the state is currently collecting data, and maintains that it needs more time before there is enough evidence to adequately assess cost and utilization patterns. However, one state official expects there to be evidence of some pent up demand, with new FHP enrollees having health care needs they had not addressed while they were uninsured. She points to the large volume of dental care provided under DRM (see below) as evidence of this pent-up demand for specialized services. Although pent-up demand may result in increased up-front costs, she notes that over time, someone who has a medical home is more likely to get services earlier, so care is less costly overall in the long term. She also expects that the working childless adult population will have similar cost and utilization patterns as working parents, because employment generally requires functionality and relatively good health. Rather than seeing significant differences in costs and utilization between childless adults and parents, the state expects to see those contrasts between the working population and the safety net population – i.e., those under 50% FPL, who are typically long-term unemployed and suffer from serious alcohol, substance abuse, or mental health conditions.

Similarly, a representative of one health plan serving the FHP population points out that as the literature and common sense suggest, providers can do more for people with coverage than without. "Coverage affects employability and productivity. Lack of coverage has a cost to society, regardless of whether the uninsured are parents or childless adults."

On an anecdotal basis, coverage has made an important difference in many lives. For example, there is a report of a woman at an eyeglass center telling the person next to her how thrilled she was that she could finally get needed glasses, having just been approved for FHP.

The president of New York City's public hospitals reports that the number of uninsured using their safety net system has been declining in recent years, and he expects this trend to continue this coming year. He attributes this to expansions in coverage combined with active enrollment. While it is too soon to tell whether or how patterns of care are affected by FHP coverage, he expects that the FHP population will be primarily persons in their 30s, 40s, and 50s, many of whom are beginning to develop chronic illnesses, and who could benefit greatly from early screening. Without coverage, he contends, these people would likely not access the system until much later when their conditions worsen. He also expects emergency room use to decline as FHP gears up.

The success in improving patterns of care and ultimately health outcomes may depend largely on stability of coverage. One of the state's biggest challenges is helping people to retain

coverage once enrolled. It recently began a mail-in recertification process so enrollees do not need to come in for a face-to-face interview. But advocates point out that the new process is not "passive," i.e., it requires enrollees to actively return documents and information to the state, resulting in tremendous fall off. For example, in one recent month, one FHP/CHP/Medicaid health plan added 12,000 new members, but 5,000 members disenrolled involuntarily because they did not recertify appropriately. Such volatility undermines the full benefits of coverage.

LESSONS LEARNED

Lessons from DRM

Focus groups with DRM enrollees, sponsored by the Kaiser Commission on Medicaid and the Uninsured and the United Hospital Fund, revealed a number of findings with implications for coverage of childless adults and other low-income populations. The study found the following:[9]

- The DRM population included both chronically ill and healthy people;
- There was evidence of pent up demand; DRM enrollees sought medical services that they were postponing or doing without because they could not afford them before they had coverage; these include visits to specialists, diagnostic testes, medications, and treatments for chronic conditions such as diabetes;
- There was high use of screening, check-ups, mammograms, and other preventive services, indicating that these services are important to these low-income populations but that obtaining them without insurance is difficult;
- Childless adults, able to enroll because of higher income eligibility limits, valued coverage and appreciated that they could now qualify for an insurance program.

Fragmented System

Despite the fact that childless adults are enrolled in the same program as parents, there are complaints that the separate administration and/or different rules for multiple public programs available in New York – FHP, traditional Medicaid, and Child Health Plus – results in a system that is fragmented and difficult for applicants and enrollees to navigate. These programs use different information systems, providers (although some managed care plans use the same provider network for all three programs), rules, and eligibility guidelines, in part because they are based on different funding streams. This adds a layer of complexity to administrators, health plans, providers, and the public that results in waste, delays, and ultimately reduced access to care. Many stakeholders call for greater integration of New York's various programs. Some would prefer children and adults – both parents and childless adults – be treated together in one program with one set of benefits and providers.

There is acknowledgement at the state level that the system is complicated, but it is a challenge to present the rules for the various programs in a clear way. The state is attempting to have one entry point for all coverage programs, with decisions about appropriate funding streams taking place "behind the scenes," while being transparent to the applicant. All agree that there needs

[9] Perry, Michael. *New York's Disaster Relief Medicaid: Insight and Implications for covering Low-Income People.* Kaiser Commission on Medicaid and the Uninsured in collaboration with the United Hospital Fund, Washington, DC, August 2002.

to be a better focus on the 'big picture,' with the goal of ensuring greater access to coverage and care to vulnerable people.

Implications for Federal Policies

Many stakeholders contend that it makes sense to expand coverage through Medicaid as opposed to state-only programs in order to capture federal funds. But the complexity and bureaucracy of Medicaid, especially in New York where each county has different rules and processes, can be detrimental to participation. An alternate model is that of the "UniCare Program," a pilot project, funded through indigent care funds that the state redirected, and operated by Affinity Health Plan since 1990. The program provides comprehensive coverage for uninsured individuals and families with gross household incomes less than 200% FPL. To assure affordability for enrollees, the state pays approximately 87% of the monthly premium with enrollees paying the balance. This program, with relatively simple eligibility criteria and without the need to interact with the social service system, is "unfettered" by Medicaid's reputation, bureaucracy, and complexity. Given the limited funds appropriated for this pilot project, however, the UniCare Program has been closed to new enrollment for many years, and has a gradually declining enrollment now totaling only a little over 1,400 persons.

While most stakeholders deem the federal contribution essential, the requirement of budget neutrality under an 1115 waiver is a difficult challenge for states, particularly those wishing to expand coverage to adults, who are more costly than children. As opportunities to increase the cost-efficiency of service delivery through managed care begin to wane, it may not be realistic to maintain budget neutrality when expanding coverage, and there were suggestions that this federal policy be reconsidered.

Some advocates support expansion of SCHIP to include childless adults, pointing out that SCHIP expansion involves fewer hurdles than Medicaid. One way to do this is by allowing SCHIP to both cover non-parents and move up the income scale, while requiring higher cost sharing at higher income levels.

No Difference between Parents and Non-parents

State officials, providers, advocates, and other stakeholders are realizing that there is no discernible difference between parents and non-parents in terms of health care needs, utilization patterns, cost, or "worthiness." As such, they are increasingly calling for these populations to be treated similarly in terms of public coverage and subsidies. This understanding was behind the inclusion of childless adults along with parents in FHP. These groups receive the same benefit package, although as noted above, the income eligibility threshold remains lower for childless adults.

Problem is Not Solved

Advocates point out that one must not become complacent in light of the progress New York has made with its coverage programs. Additional groups of childless adults remain "out in the cold." They include: 1) single disabled adults whose only income is disability insurance and who have not been disabled long enough to qualify for Medicare; 2) employees working part time or

full time who earn more than 100% FPL but who cannot afford private insurance or the Healthy New York premiums; 3) persons in late adulthood (age 50s-60s) who are not yet eligible for Medicare and who are early retirees or who have lost employer-sponsored insurance. Overall, stakeholders remain aware of the unmet needs of these populations and will continue to work on strategies to fill the gaps in the uninsured population.

SOURCES

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