Pennsylvania: A Case Study in Childless Adult Coverage

State Report

by
Stan Dorn and
Jack Meyer
Economic and Social Research Institute

August 2004

INTRODUCTION

In June 2001, legislation was enacted that created Pennsylvania's blueprint for using its share of funds to be received through the National Tobacco Settlement Agreement.[1] Included in the services authorized by Pennsylvania Act 2001-77 was a program to provide basic insurance coverage to low-income adults ineligible for Medicaid, which later became known as "adultBasic."[2] The full content of the Act reflected the agreement between then-Governor Tom Ridge and the Legislature that all of the Tobacco Settlement funds should be used to meet health-related needs.

adultBasic is a state-funded and state-designed health insurance program. It is not an entitlement program, and enrollment is limited by the funding made available by the Legislature. Funding available in the first year of implementation (beginning in July 2002) was approximately $79.7 million. In the second year, funding increased to $112 million.[3]

State officials estimate that between 300,000 and 350,000 Pennsylvanians could potentially qualify for the program. However, appropriated funding currently limits enrollment to an average of 44,000 persons monthly over a twelve-month fiscal period. During much of the program's short history, eligible individuals who apply have been placed on a waiting list, unless they choose to pay the full premium, without a subsidy.

Responsibility for administering adultBasic rests with the Pennsylvania Insurance Department, which also runs the state's State Children's Health Insurance Program (SCHIP) program. Designated responsibilities include:

- Entering into contracts with insurers to provide coverage to eligible adults;
- Conducting monitoring, oversight and audits of executed contracts;
- Coordinating outreach; and
- Preparing an annual report to the Legislature regarding program implementation.

This paper provides an overview of Pennsylvania's efforts to cover low-income childless adults through adultBasic. It is based interviews with key stakeholders, a site visit to Harrisburg, Pennsylvania (the state capitol), and document reviews, all of which took place as part of a larger multi-state examination of coverage available to low-income childless adults.

PROGRAM ADOPTION

While proposals to establish this new program received strong bipartisan support in the Legislature, the catalyst for adultBasic's establishment, without doubt, was the strong personal commitment of former Governor Ridge that Tobacco Settlement funds should be used, in substantial part, to expand health coverage for low-income workers ineligible for Medicaid. Consensus around the use of Tobacco Settlement funds was achieved through numerous public forums held around the state. Broad support emerged from consumer groups, hospital groups, and others that some portion of the funds should be used to provide health insurance

[1] Pennsylvania Insurance Department, "An historical overview of the adultBasic Program," prepared for the Senate Democratic Policy Committee, June 2004, http://www.ins.state.pa.us/ins/lib/ins/chip_ab/aB_June2004.pdf
[2] Ibid
[3] Ibid

coverage to low-income adults. This support was sparked, in part, by a 1996 Medicaid cutback that eliminated coverage for approximately 200,000 childless adults with incomes up to 45 percent of the FPL, which exacerbated the problem of uncompensated hospital care.[4]

Support from the employer community was also notable. Employers who covered their workers argued that providing public coverage to the uninsured had the potential of lessening the shift of uncompensated care costs to employers, thereby slowing their increase in health insurance premium costs. Many stakeholders also viewed expanding health coverage as contributing to the state's general economic development.

Some state officials believe that their effort to expand coverage was aided by the broadly shared conviction that low-wage, working adults deserve assistance. These officials found that they could "give a face" to proposed beneficiaries ("this is about the guy who works behind the counter in your dry-cleaner").

A broad range of interviewees stated that adultBasic could not have been adopted if it were structured as a traditional Medicaid program. Many policymakers believed that the entitlement nature of Medicaid would prevent meaningful cost-control. Medicaid expansion was also rejected, despite the appeal of federal matching funds, because of perceptions of stigma and inflexible program design as well as the requirement to provide a scope of benefits . Respondents noted that more comprehensive benefits would have meant covering fewer people, and policymakers consciously chose fewer benefits to cover more uninsured. the trade off between providing comprehensive benefits to fewer people or limited benefits to

In addition, there was tremendous appeal to following, in general terms,[5] the model the state used for its children's health insurance program. Before the 1997 adoption of federal legislation establishing the State Children's Health Insurance Program (SCHIP), Pennsylvania operated an entirely state-funded program to cover children, which was expanded when federal funding materialized. Like adultBasic, the state's child health program uses Blue Cross/Blue Shield insurers to furnish commercial-style coverage, without replicating Medicaid's individual entitlement, fully comprehensive benefits, and prohibition of cost sharing.

As the legislative debate around the distribution of Tobacco Settlement monies proceeded, the proportion of funding devoted to adultBasic fell from the 40 percent originally proposed by the Governor to approximately 22.5 percent in the final legislation. In addition to health care for adults, funding was designated for such things as grants to hospitals for uncompensated care, health research conducted in Pennsylvania universities, expansion of the state's pharmaceutical program for the elderly, home and community based care, and tobacco prevention and cessation efforts. While avoiding the need to raise taxes, this financing strategy relied on resources that will last only as long as the revenue made available by the Tobacco Settlement.

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

[5] Of course, adultBasic departed from the earlier model by covering fewer benefits and imposing higher consumer costs, further extending the departure from Medicaid. Notwithstanding these critical differences between adultBasic and SCHIP, Pennsylvania's policymakers saw the non-Medicaid, state-funded structure of adultBasic, with its extensive use of Blue Cross/Blue Shield insurers, as following, at a fundamental level, the precedent set by the state's child health program in the form in which it preceded adoption of the national SCHIP program.

PROGRAM DESIGN

adultBasic seeks to provide a basic set of benefits to low-income adults who are otherwise uninsured and ineligible for Medicaid. State officials have the authority to keep spending within appropriated levels by stopping new enrollment. In such cases, qualifying adults are placed on a waiting list for coverage. Adults on the waiting list can purchase coverage "at cost" by paying the full premium, without any subsidy. However, the price of single coverage purchased in this manner can exceed $200 per month, which is a considerable expense for people with income low enough to qualify for the program. Altogether, only 7.8 percent of individuals on the waiting list take advantage of this option, according to state officials.[6]

Eligibility

To qualify for adultBasic, an individual must:

- Be between the ages of 19 and 64, inclusive;
- Have income at or below 200 percent of the Federal Poverty Level (FPL);
- Have no other health coverage (including Medicaid);
- Have had no health coverage within 90 days before applying for adultBasic;[7]
- Be a resident of Pennsylvania Commonwealth for at least 90 days; and
- Be a U.S. citizen or legal permanent resident.

Benefits and Cost-Sharing

The defined and limited funding available for the program placed policymakers in a dilemma. Crafters of the legislation believed they were faced with a choice of either (a) serving more enrollees with fewer benefits; or (b) covering fewer enrollees with a more expansive benefit package. While the Ridge Administration originally hoped to cover prescription drugs, the cost projections of such coverage were sufficiently high that prescription drug coverage would have reduced the number of beneficiaries appreciably. Ultimately, medications were excluded from the adultBasic benefit package, as were mental health services, to increase the number of beneficiaries served.

Some stakeholders suggest that adultBasic's limited benefit package also resulted from fears that generous benefits could cause employers to drop coverage or that employers using fairly limited health coverage to recruit workers would be undercut if the state offered more generous coverage through adultBasic.

Benefits covered under adultBasic include:

- Physician services
- Lab and x-ray services
- Emergency care
- Maternity care
- Rehabilitation and skilled care in cases of extended hospitalization

[6] Pennsylvania Insurance Department, op cit.
[7] This waiting period does not apply to adults who lost insurance when they became unemployed.

- Hospitalization (unlimited number of days)

Because of a state law requiring certain benefits for all health insurance, whether funded publicly or privately, adultBasic also covers diabetic supplies and transplant-related immunosupressives.

Consumers must pay $30 per month in “premium” payments for subsidized coverage. This requirement is enforced strictly. One late payment terminates coverage; consumers must then re-apply for adultBasic. If this takes place while the program has a waiting list (as it does currently), the consumer terminated from adultBasic joins the waiting list at the back of the line.

Point-of-service cost sharing includes $5 per physician visit, $10 per specialty visit, and $25 for any Emergency Room visit that does not result in a hospital admission, regardless of whether the individual’s condition was emergent.

Filing an Application

Applications can be filed via paper application (through the mail) or through the Internet. An integrated application process can result in eligibility for either adultBasic or Medicaid. If an applicant is found ineligible for adultBasic because income is within the Medicaid range, the application is forwarded to the appropriate County Assistance Office for a determination of Medicaid eligibility. Conversely, applicants for Medicaid are also screened for potential eligibility for adultBasic. Reciprocal protocols are in place with the Insurance Department, which administers adultBasic, and the Department of Public Welfare, which is responsible for Medicaid eligibility. Such protocols place the burden of appropriate program enrollment on the respective agencies rather than the applicant. Preexisting CHIP and Medicaid application forms were adapted to include for adultBasic and to accommodate parents and children applying together for coverage. As with CHIP, adultBasic applications are filed with the insurer servicing the applicant’s county of residence.

Insurers

Four insurance companies provide adultBasic coverage, each serving a separate area of the state. The companies are:

- Highmark (Western PA)
- Capital Blue Cross (South Central PA)
- Independence Blue Cross (South Eastern PA)
- First Priority (North Eastern PA)

Care is provided through both traditional HMO and PPO managed care networks. The networks used by the insurers to provide service are the same as those used by each company for its commercial subscribers and CHIP. In addition to providing coverage, each insurer is also contractually responsible for eligibility determination, enrollment, reenrollment, outreach, and quality management activities. Insurers play similar roles with CHIP.

PROGRAM IMPLEMENTATION

Request for Proposal (RFP) and Other Administrative Activities

Formal development of the program began with the August 2001 issuance of an RFP for the purpose of contracting with insurers to provide coverage and to carry out other responsibilities. The four insurers listed above responded to the RFP, and all were determined to be qualified. Three-year contracts became effective in March 2002. Per member per month rates were negotiated with each insurer. The negotiated rates were set in place for the first two years of the contract. The rates are slated to be evaluated and potentially renegotiated in the third year of the contract.

Early Experience

Although legislation authorizing adultBasic passed in June 2001, implementation was delayed until July 2002 for budgetary reasons. Funding originally slated for adultBasic's use in fiscal year 2001-02 was reallocated to cover shortfalls in funding for other services (principally Medicaid).

Most observers expected that, when the program began, the application volume would be substantial. However, the degree of demand surprised both state officials and the insurers responsible for processing applications. As many as 6,000 applications statewide were received in some weeks, even though only modest radio advertising, regional kick off events, and outreach through community-based programs publicized adultBasic. Approximately one third of applications came through screening protocols put in place with Medicaid agencies for adult applicants who did not qualify for Medicaid.

Both consumer groups and state officials identified the following as among the program features about which consumers expressed the strongest concerns: the waiting list, the absence of any coverage for prescription drugs and mental health services, and the requirement that adults must "go bare" without insurance for 90 days before receiving adultBasic. According to some informants, these policies may be especially troubling to consumers because they represent departures from CHIP, which is well-understood and liked by many Pennsylvanians, and which, as noted above, is the general model for adultBasic. Despite these concerns, many adults have welcomed the opportunity to participate in adultBasic, including so-called "medically uninsurable" adults unable to afford nongroup coverage because their health history causes insurers to increase premium charges substantially.

Enrollment and Waiting List

Although enrollment did not begin until July 2002, applications for enrollment were made available beginning in April 2002. In the first six months of application processing, the program received over 70,000 applications. As a result of this volume, some insurers developed significant application processing backlogs, notwithstanding the state's requirement that each application should be processed within 15 days of receipt. Ultimately, state officials required that all insurers meet that requirement by November 2003.

Enrollment grew steadily from July 2002 (5,992 enrollees) through February 2003 (50,258 enrollees). To prevent adultBasic spending from exceeding appropriated levels, the state established a waiting list in March 2003. Placement on the waiting list is determined by the date of filing a completed application. As of July 2003, over 55,000 persons were on the waiting list.

Approximately 1,800 of them purchased coverage "at cost," while retaining their place on the waiting list for purpose of insurance subsidies. The price of single coverage purchased in this way can exceed $200 a month. Because of funding augmentations that occurred in July 2003, two offerings of enrollments have been made to over 15,000 persons on the waiting list.

According to recent information provided by state officials, as of May 2004 40,416 people were enrolled in adultBasic; 90,878 were on the waiting list; and 3,159 of those wait-listed individuals were purchasing coverage at the full cost negotiated by the state.[8]

Who is Enrolled?

Early data regarding enrollment reveal the following demographic profile:

Age Ranges	**Percentage**
19 to 24	11.2%
25 to 44	48.0%
45 to 55	23.3%
56 to 64	17.5%

Income Ranges	**Percentage**
0-100% FPL	39.0%
101-150% FPL	36.0%
151-200% FPL	25.0%

Gender	**Percentage**
Male	36.7%
Female	63.3%

LESSONS LEARNED

The experience of Pennsylvanians enacting and implementing adultBasic can inform other policymakers considering health coverage for childless adults. Potentially useful lessons from the Pennsylvania experience include the following:

First, the process of seeking public input through community forums, while time consuming, ultimately proved beneficial. In Pennsylvania, such a process helped generate strong and widespread support for using tobacco settlement funds for a defined set of health-related purposes, including coverage for the low-income uninsured.

Second, the Pennsylvania approach of using insurers to determine eligibility for adultBasic and CHIP coverage is unusual among state health programs. This role for insurers provides an immediate connection to consumers and replicates, in many ways, the "look and feel" of commercial coverage, thus avoiding the stigma sometimes experienced with other public programs. Care should be taken, however, to consider adequate funding to cover the administrative expenses associated with this function. Because of legislative requirements, reimbursement for these expenses is presently limited to 11% of the per member per month payment made by the state for each enrolled person. Some insurers contend that this level of administrative reimbursement covers approximately one-third of their administrative costs.

[8] Pennsylvania Insurance Department, op cit.

State officials note that each participating insurer is contractually bound to provide the same benefit package and to abide by the same rules regarding eligibility. Prior to program implementation, the state conducted readiness reviews with each insurer and conducted staff training regarding the determination of eligibility. Despite these efforts to promote uniform administration, some stakeholders have expressed concerns that different insurers, serving different parts of the state, have provided varying levels of service to beneficiaries and, in some cases, seemed ill prepared to handle the large, initial surge in applications. This suggests that there may be some challenges involved in achieving uniformity among multiple private contractors performing traditional public functions, such as eligibility determination.

Third, policymakers could consider replicating the state's practice, both in adultBasic and CHIP, of contracting with insurers to use the same provider networks and coverage systems for commercial and publicly funded enrollees. For both state agencies and insurers, such an approach avoids the administrative costs of creating new systems for publicly covered enrollees. For subsidized consumers, this strategy also gains access to mainstream health care.

Fourth, the limited scope of the adultBasic benefits package illustrates an important consequence for consumers when state policy makers feel they have no choice but to depart from Medicaid's model of guaranteed coverage for all eligible persons, matching federal funds, and with comprehensive benefit requirements.[9]

Fifth, the ongoing redirection to other purposes of tobacco settlement revenues originally designated for adultBasic illustrates the importance of timing. If a designated, specific revenue source is available for a long period before a new health coverage program is up and running, other interests may be well-positioned to divert the revenue to their own purposes, since beneficiaries of the new health program do not yet exist.

Finally, and perhaps most important, the enactment, implementation, and expansion of adultBasic despite significant state budget problems illustrates the potential broad appeal of health coverage programs that benefit uninsured workers, including childless adults.

INTERVIEWEES

We are grateful for the information provided by a broad range of Pennsylvanians involved in the design and implementation of adultBasic. None of these interviewees is responsible for the contents of this report.

In alphabetical order, our informants included the following:
Erik Arneson, Chief of Staff to Senate Majority Leader
Melia D. Belones, Director, Bureau of Management Consulting, Governr's Office of Administration (formerly Senior Policy Analyst, Governor's Policy Office, then-Governor Tom Ridge)
Geoffrey Dunaway, Director, Insurance Department
Stephen Fera, Senior Director for Government Programs, Keystone Health Plan East
David Gates, Managing Attorney, Pennsylvania Health Law Project

[9] Of course, federal Medicaid funding is no guarantee of a program that consumer advocates will find sufficient. Recent years have seen dramatic cutbacks in eligibility and services in many states' existing Medicaid programs, and Medicaid expansions have increasingly proceeded via federal approval to waive many traditional Medicaid rules, including those pertaining to benefits and cost sharing.

Lowware Holliman, Operations Manager, Insurance Department
H. Scott Johnson, Executive Director, Senate Public Health and Welfare Committee
Donna Memmi Malpezi, Chief Counsel to Senate Majority Leader
Niles Schore, Minority Chief Counsel/Executive Director, Senate Public Health and Welfare Committee
Sandy Segal, Progarm Analyst, Children's Health Insurance Program
Patricia H. Stromberg, Deputy Insurance Commissioner for CHIP and adultBasic Coverage
Evonne Tisdale, Assistant Director, Philadelphia Unemployment Project
Geoff Webster, Executive Director, Consumer Health Coalition