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MEDICAID FOR LOW-INCOME ADULTS AND CHARTER OAK HEALTH PLAN

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You asked a series of questions about the Medicaid Low-Income Adults (LIA) and Charter Oak Health Plan programs.

With respect to LIA, you want to know (1) if the program is part of Medicaid, (2) if enrollees pay premiums, (3) if people with pre-existing conditions can enroll, (4) the program's eligibility criteria, and (5) how enrollees receive their health care (e.g., managed care versus fee-for-service). For Charter Oak, you are interested in the program's (1) eligibility criteria, (2) benefit structure, (3) cost sharing requirements, and (4) service delivery.

SUMMARY

The LIA program offers Medicaid-funded health care to adults with very low incomes; there is no asset test. It is available to anyone who meets the program's eligibility criteria, regardless of whether the person has a pre-existing medical condition. Enrollees pay no premiums or co-payments, and they receive their health care from medical practitioners who have provider agreements with the Department of Social Services (DSS).

Currently, LIA enrollees' benefits are the same as those of other state Medicaid recipients. But 2011 legislation (PA 11-44) allows the DSS

commissioner to offer an alternative benefit package to them, which could be less generous than what is available now.

The Charter Oak Health Plan (COHP) offers less comprehensive health insurance to individuals and families who (1) do not qualify for public health insurance; (2) generally have been uninsured for at least six months; and (3) beginning September 1, 2011, are ineligible for the Connecticut Pre-Existing Condition Insurance Plan (CT-PCIP). There is no income or asset limit. Certain individuals with incomes under 300% of the federal poverty level (FPL, 300% of the FPL is \$2,724 per month) receive premium assistance if they were receiving this assistance in mid-2010. The program requires other cost sharing, such as deductibles, and does not cover certain benefits (e.g., dental).

Beginning in January 2012, DSS will transition all of its medical assistance programs (including LIA and COHP) from either a managed care or fee-for-service delivery system to one that uses an administrative services organization (ASO) combined with person-centered medical homes. DSS released a request-for-proposals (RFP) for the ASO in April 2011 and continues to work through the procurement process.

MEDICAID FOR LOW-INCOME ADULTS (LIA)

Legislative History

For several years, the legislature considered making the state-funded, State-Administered General Assistance (SAGA) program a Medicaid-funded coverage group (entitling the state to a 50% federal match for its expenditures). Before the 2010 federal health care reform legislation (Patient Protection and Affordable Care Act, P.L. 111-148, as amended by P.L. 111-152), the state would have needed a federal waiver to do this since traditionally, Medicaid has not paid for childless adults who are not elderly or disabled.

The Affordable Care Act offered states an easier way by requiring them by 2014 to offer Medicaid to all adults up to age 65 with incomes up to 133% of the FPL (133% of the FPL is \$1,206 monthly in 2011). And it gave states the option to implement the change as early as April 2010.

The General Assembly directed DSS to seek a Medicaid state plan amendment to convert SAGA to Medicaid in early 2010. In April 2010, DSS submitted the plan and the federal Centers for Medicare and Medicaid Services approved it in June 2010, retroactive to April 1, 2010 (CGS § 17b-261n).

Eligibility Criteria

Although the state could have included any adult with income up to 133% of the FPL who was otherwise Medicaid-ineligible in the new LIA program, DSS limited it to those individuals who met the SAGA program's eligibility limits, with one exception: there would be no asset test, since the federal law prohibits states from imposing one.

Hence, the income limit for SAGA medical assistance is \$506 per month for someone living in most parts of the state. This is equivalent to 56% of the FPL, or about half of the amount individuals can have starting in 2014. Additionally, individuals who are working have \$150 of any monthly earnings disregarded, bringing their allowable income up to \$656 per month. Individuals with higher incomes may also qualify if they have high out-of-pocket medical expenses.

Services

LIA recipients are entitled to the same benefits that other Medicaid recipients receive, including nonemergency transportation to medical appointments. But [PA 11-44](#) (§ 116) permits the DSS commissioner to amend the Medicaid state plan to (1) establish an "alternate benefit package" for individuals eligible for LIA and (2) pay providers lower rates for these services. It specifically allows DSS to limit a number of services, such as (1) office and emergency room visits and (2) pharmacy.

Service Delivery

Unlike the HUSKY and Charter Oak programs, which currently are run by DSS-contracted MCOs, LIA is run by DSS. LIA enrollees can go to any medical provider with a DSS provider agreement. The provider bills DSS directly and is reimbursed by the department using its fee-for-service fee schedule. The state's federally qualified health centers, which previously were the main source of health care delivery for the SAGA medical assistance population, have provider agreements with DSS.

CHARTER OAK HEALTH PLAN

The Charter Oak Health Plan (COHP) offers managed health care to individuals between the ages of 19 and 65 who (1) do not qualify for other public health insurance programs and (2) have been uninsured for at least six months, regardless of any pre-existing condition.

Eligibility, Cost Sharing, and Service Limits

There is no income or asset limit for COHP. Individuals with incomes under 300% of the FPL receive subsidies for their care if they were receiving them as of June 1, 2010. Otherwise, participants, regardless of income, pay \$307 per month.

Program beneficiaries must meet a deductible which, by law, cannot exceed \$1,000 annually. The highest deductible COHP imposes is \$900, which applies to individuals with incomes above 300% of the FPL. Enrollees are also responsible for co-payments for most services (excluding preventative care office visits), and coinsurance cannot exceed 20% once the deductible is met. There is a \$1 million lifetime limit on benefits and an annual benefit cap of \$100,000. The program does not pay for dental, vision, and chiropractic care, among other services.

Enrollees with incomes above 300% of the FPL and those who enrolled in the program after April 30, 2010 (May 31 under PA 11-44, see below) pay premiums of \$307 per month. Individuals enrolled in the program before April 30, 2010 who have income below 300% of the FPL receive premium assistance. (The state premium subsidies are reduced by PA 11-44.)

2011 Legislative Changes. PA 11-44 (§ 80) makes significant changes in the program. First, as of September 1, 2011, it limits COHP access to only those individuals ineligible for the state’s high-risk pool, the CT-PCIP.

The act also reduces the state’s premium subsidies for individuals with incomes under 300% of the FPL who were receiving them as of May 31, 2010. Table 1 shows the premium assistance and coinsurance requirements for a one-person household before and after September 1, 2011.

Table 1: Charter Oak Cost Sharing for a One-Person Household

<i>Income Level</i>	<i>Current State Subsidy</i>	<i>Proposed Subsidy</i>	<i>Enrollee Premium Contribution (pre 9/1/11)</i>	<i>Enrollee Premium Contribution (9/1/11 and after)</i>	<i>Annual Deductible</i>
<150% of the FPL	\$175	\$115	\$129	\$189	\$150
150% -185% of the FPL	150	100	172	222	200
185%-235% of the FPL	75	50	202	227	400

<i>Income Level</i>	<i>Current State Subsidy</i>	<i>Proposed Subsidy</i>	<i>Enrollee Premium Contribution (pre 9/1/11)</i>	<i>Enrollee Premium Contribution (9/1/11 and after)</i>	<i>Annual Deductible</i>
235-300% of the FPL	50	35	239	254	750
>300% of the FPL	0	0	307	307	900

Source: OLR analysis using COHP website information from June 2010

Services

In addition to the lifetime and annual benefit caps, COHP offers a more limited benefit package than other DSS medical assistance programs. Table 2 lists the program's benefits, co-pays, and limits. Coverage is first-dollar, after co-pays and any required deductible.

Table 2: COHP Benefits and Coverage Limits

<i>Medical Benefit</i>	<i>Coverage</i>
Primary care office visit	\$25 co-pay
Specialist office visit	\$35 co-pay
Preventive care office visit	No co-pay
Emergency room visit	\$100 co-pay (waived if an emergency)
Prescription drugs	Three-tiered co-pays, lowest \$10; \$7,500 annual limit
Durable medical equipment	\$ 4,000 limit, no co-pay
Behavioral health	\$35/\$25 co-pay
Outpatient rehabilitation	\$35 co-pay, 30 visits per year
Maternity—pre- and post-natal care	No co-pay
Inpatient hospital visits	90% coverage after deductible met
Inpatient rehabilitation/skilled nursing	14 days per year, 80% covered after deductible met
Outpatient surgical	80% coverage after deductible met

Source: Charter Oak website, last updated May 2010

CONVERSION OF HEALTH PROGRAMS TO ASO AND INTEGRATION OF PERSON-CENTERED MEDICAL HOMES

By law, DSS can contract with one or more ASOs to provide, among other things, care coordination, provider credentialing, customer service,

and grievance remedies for individuals enrolled in Medicaid, HUSKY B, and COHP (CGS § 17b-261m).

In April 2011, DSS issued an RFP to entities interested in serving as ASOs to run DSS' medical assistance programs (including Medicaid and the COHP). Under the RFP, the ASO will provide a number of administrative functions, including care coordination, operating a centralized customer call center, provider profiling, and enrollee referrals and appointment scheduling.

Unlike MCOs, which assume the entire risk of providing health care to DSS medical assistance enrollees, under the ASO model, DSS will assume most of the risk and health care providers will contract directly with DSS rather than the MCOs.

Four bidders submitted proposals, and DSS was expected to begin evaluating them last week.

In conjunction with the ASO conversion, DSS is developing a person-centered medical home model to be implemented in 2012. A Provider Advisory Group is looking at model standards and DSS anticipates issuing a request for applications from medical practices in September 2011. Under this model, which expands on the state's primary care case management pilot program, care is centered around the person and his or her circumstances. Care is coordinated, typically by a primary care provider (e.g., pediatrician), who makes referrals to specialists when needed and helps control any chronic health conditions (e.g., asthma).

To ensure no service disruption for DSS medical assistance program clients, the department is negotiating with the three MCOs to extend their contracts through the end of 2011.

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