STATE HEALTH CARE COVERAGE ELIGIBILITY

REPORT 08-8

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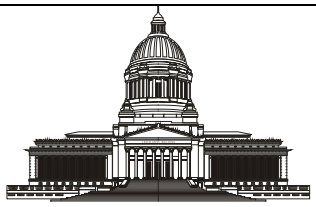

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REPORT SUMMARY

How Does the State Provide Health Care Coverage to Individuals?

The state determines eligibility and participates in funding 73 health care coverage programs in three main categories:

1. The state provides **employment-related** health care coverage to public employees, retirees, their dependents, and certain non-employees.
2. The state provides health care coverage as a **social service** for low-income persons who are members of qualified classes, for example, children, families on assistance, and disabled adults. To receive this health coverage, individuals must fit within specific eligibility criteria related to age, income, and family or disability status. These health care coverage programs are known collectively as Medical Assistance. Federal law establishes boundaries within which many Medical Assistance programs must operate, both in terms of who must be included and the limits beyond which the state may not use federal funds to provide coverage. Most Medical Assistance programs for which federal law provides funding are known as Medicaid.
3. The state provides health care coverage related to **expansion** of the number of persons able to obtain health care coverage, primarily through insurance products, including the Basic Health Plan and the Washington State Health Insurance Pool.

A New Tool for Comparing Health Care Coverage Programs

This report provides information on 73 different health care coverage programs across these three categories. For the first time, legislators and other interested parties have information consolidated into one report on health care coverage program eligibility criteria and the eligibility determination processes. The program information also identifies which criteria are established by federal law or regulation, which by state law or rule, and which by some other process, usually a negotiation or contract.

Each program is summarized on a "Program Summary Page." The report also includes information about how eligibility criteria and eligibility determination processes compare across programs.

What Did JLARC Learn?

In many cases, broad classes of eligibility are similar across programs within a category. For example, public employees must work at least half time, and home care providers must work at least 86 hours per month, which is approximately half of the working hours in a month. Within Social Services programs, enrollees must be low-income and meet age, family, or disability criteria to obtain coverage. In most cases, the enrollee must also be a citizen or eligible non-citizen. Eligibility for non-citizens is illustrated in Appendix 4.

Although income level is typically an eligibility requirement for Social Services programs, the specific criteria and how income is calculated differ among the programs. Each Program Summary Page lists the income limitations, if any, for that program.

The Social Services programs are collectively known as "Medical Assistance" and most of those that have federal matching funds are collectively known as "Medicaid." However, despite the convention of referring to these two categories, they comprise many programs. Medical Assistance includes 54 programs and, among these, neither the eligibility criteria nor the benefits are identical.

The eligibility criteria and the benefits available for social service programs are primarily established in federal and state law. Because these criteria and benefits differ for each program, there is little duplication. Because most criteria are established by federal law, or through negotiation with the federal government, there are large areas where the state has little ability to make changes. In the Employment-Related and Expansion programs, however, the state has more, but not complete, control.

In general, the processes for determining eligibility share similar characteristics across coverage categories. Applicants are required to provide documentation of facts that determine eligibility. Once the application is entered into a computerized system, the determination process is generally automated. The effect of the automation means that, in most cases, applicants are not required to fill out multiple applications or understand the nuances of eligibility requirements—they simply provide one application and receive coverage based on the program(s) for which they qualify.

Opportunities for Improvement

The focus of this report is the compilation of information on the 73 health care coverage programs. However, in the course of assembling this information, JLARC identified an area for needed improvements. It is reflected in the following recommendation:

Recommendation 1

The Department of Social and Health Services (DSHS) should update its administrative rules that relate to the scope of coverage, income limits and eligibility to ensure that they reflect current criteria and are understandable to the general public. DSHS should also ensure that its administrative manuals are consistent with each other and the administrative rules and that its publicly available information is up to date.