State Of The States

Title XXI
RIteCare
IHCP
TMC
MediCal
CHIP
BadgerCare
HIPAA

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Foreword

The last decade has seen health policy undergo a dramatic cycle at the national level. The early 1990s saw the newly elected Clinton administration pursue comprehensive reform, intended to lead to universal coverage. With great promises and grand agendas, President Clinton stood before Congress proudly displaying the prototype of what was to become a common health insurance card that would be issued to every American. But some mix of policy flaws, poor timing, and pure politics ultimately relegated the Clinton plan and card to the annals of vague recollections (and probably elevated that one card to unheard heights of value as a collector's item). What did remain intact after the attempt at national reform, however, was a heightened awareness of the need to reform the health care system and improve access for the uninsured. As a result, the federal government eventually passed two significant incremental reforms: 1) the Health Insurance Portability and Accountability Act (HIPAA), which established a floor for insurance market regulatory standards across the country, and 2) the Children's Health Insurance Program (CHIP), which enabled states to expand coverage to children.

As the federal government was going through its evolution to an incremental approach, states remained active, as they had in prior decades, pursuing reforms as far as they could on their own — some incremental, some more comprehensive. In many states, policymakers had become convinced that their potential impact was limited without some help from the federal government. The problems were simply too large for states to handle alone. Many policymakers, therefore, heartily supported and applauded the passage of HIPAA and CHIP. Others may have had less positive reactions, but all state health policymakers felt and had to deal with the impact of the policy decisions made at the federal level.

This report seeks to look back at recent years to gain a sense both of what states have managed to do on their own and what federal action has meant at the state level in terms of access to health coverage and care. The goal is to give credit, learn lessons, and gain insights as to how well the federal-state partnerships of CHIP and HIPAA have worked so far, and where such policies might be pursued in the future.

W. David Helms
Director, State Coverage Initiatives

Executive Summary

Throughout the 1990s states sought to expand health insurance coverage in a variety of ways, ranging from seeking waivers to expand Medicaid to building state-only programs to serve populations of various ages and incomes. In the final two years of the decade, however, federal action in the form of the Children's Health Insurance Program (CHIP) drew the focus of virtually every state to finding ways to cover more children. With its $48 billion authorization, CHIP gives states enhanced reimbursement in comparison with Medicaid. CHIP also targets higher-income families, emphasizing those up to 200 percent of the federal poverty level, and provides states with a great deal of flexibility in structuring their programs.

Although actual numbers of children reached remains well below the CHIP target of covering 5 million additional children, states have responded well to the flexibility and autonomy CHIP affords them, and participation in the program has been universal. Of the fifty state plans that have received federal approval, 21 are Medicaid expansions, 16 are state-designed programs, and 13 are a combination of these two approaches. The District of Columbia's plan and those of the U.S. territories have all been Medicaid expansions. A number of states are expected to amend their plans in the years to come, and with much of the plan set-up work now complete, many plan officials expect to see enrollment grow more quickly over the next year.

Even as children have taken center stage, some states have continued to pursue state-only programs that reach to a wider population in terms of age and, in some cases, in terms of income. Determining how to help uninsured parents of covered children and low-income workers who lack coverage may be the major coverage expansion efforts states will face next.

States have also traditionally carried out the role of regulating their insurance markets. The 1990s saw Congress pass a federal regulatory floor for insurance markets in the form of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA authorized a federal role in insurance markets, made certain standards uniform across all 50 states, and helped ease the problem for some of being unable to change jobs without fear of losing coverage. It did nothing, however, to change the reality that states have no authority to regulate self-insured plans because of the Employee Retirement Income Security Act of 1974 (ERISA). With more than 125 million Americans in self-insured plans, ERISA represents a meaningful barrier to the potential impact of any insurance market reforms. The extent to which HIPAA represents a first step toward state and federal governments being able to work together to overcome such barriers remains an open question.

In addition, as they seek to look ahead and ensure that insurance markets work as well as possible for as many people as possible, state policymakers must evaluate the future viability of the employer-based health system. They must also seek to determine the true potential and capacity of their individual insurance markets as they could face significant growth if major changes occur in the employer-based system.

In all, a review of health policy in the 1990s reveals a collection of efforts that have made meaningful progress, and a look ahead unveils sufficient challenges to ensure that the progress must continue.

Introduction

With the 1994 failure of national, comprehensive health care reform, incrementalism emerged as the preferred policy approach and the one most likely to have an impact on the health care system in the 1990s.

Hardly a new idea, "incrementalism began in the states in the late 1980s," says Patricia Riley, executive director for the National Academy for State Health Policy. "States have been pounding their heads against the incrementalism wall, but they realize they cannot do all that needs to be done without a federal partner."

"The only way to make a dent in the number of uninsured is through federal participation," concurs Judith Arnold, deputy commissioner of Planning, Policy and Resource Development in the New York Department of Health. "We can keep picking away at the problem with state-only dollars, but it is too big a problem for states to take care of on their own."

While many questions remain about how federal and state governments can work together to solve health care coverage access and quality challenges, Riley suggests that the attempt at national reform and the conscious retreat to an incremental approach may have been an essential starting place. "The first step was for people to agree there was a problem," she says. The various efforts made in recent years "have brought us to a place where people see the need for reform."

Recognizing a national consensus was forming around the need for increased health coverage, the federal government passed two significant health policy initiatives in the wake of 1994's failed attempt: insurance market regulation under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the creation of the Children's Health Insurance Program (CHIP), enacted as Title XXI of the Social Security Act under the Balanced Budget Act of 1997. These federal initiatives required or enabled states to act both to change and standardize market regulations and to develop new coverage expansions in ways that reflected their resources and political environment.

The combination of recent federal and state action means that the reforms at all levels have generally sought to resolve health care cost, coverage, and market issues in ways that maximize access to health insurance coverage, but approaches have also reflected each state's distinctiveness and creativity in problem-solving.

Even though recurring themes run through all recent experiences, any state overview provides us with anything but a neat and uniform picture. This report summarizes recent activity at the state level and the impact on the numbers of people who are able to obtain coverage and receive care.

Children's Coverage Expands Across All 50 States

Most efforts at the state level in recent years have sought to expand coverage to children. "Every state has had to focus in the last two years on coverage expansion because every state has had a CHIP program," says Michael Rothman, senior program officer for The Robert Wood Johnson Foundation (RWJF).

"CHIP has been a major focus and has consumed the energies of states who might have worked on different types of reforms." Currently, in just a little more than two years after the program's enactment, 56 states and territories have received federal approval of their CHIP plans, and most have begun to enroll children. Enrollment in state CHIP programs exceeds 1.3 million children and is expected to accelerate as most states implement their programs.

In enacting CHIP in 1998, Congress authorized $48 billion over 10 years to extend coverage to 5 million of the estimated 10 million uninsured children in the United States. At the time CHIP was passed, a number of states, including Minnesota, Pennsylvania, New York, Colorado, Florida, and others, had already established their own children's health insurance programs. CHIP built upon the experience of these states and existing state Medicaid programs by providing enhanced federal resources and the state flexibility necessary to allow states to design their own unique programs.

The federal CHIP program changed the traditional pattern of partnering with states by giving states more flexibility than was common under previous expansion efforts, such as the Medicaid expansions of the late 1980s and early 1990s. Although CHIP mandates minimum program standards regarding benefit structure and enrollee cost-sharing, and requires state maintenance of effort, it also allows states the flexibility to select from a range of program design alternatives. States can: 1) expand their Medicaid programs; 2) create or expand state-only programs; or 3) use a combination of both. As long as they complied with the minimum standards required under CHIP, states could also establish their own cost-sharing rules and design their own benefit packages. While some states — in particular those with existing programs that were not grandfathered into CHIP — had difficulty making their programs conform to federal standards, CHIP did attempt to

HIPPA TANF Balanced Budget Act of 1997 CHIP

Welfare Reform: A Good Thing for Expanding Health Coverage?

All future efforts to expand coverage and maintain enrollment in coverage programs will have to take into account the changes and challenges that result from the passage of welfare reform in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). In severing the long-standing connection between welfare and Medicaid eligibility, some states have seen an unintentional drop in the Medicaid rolls. While some may argue that factors such as the growing economy have caused, at least in part, the decline in Medicaid caseloads, it is clear that the widespread confusion created by the de-linkage of cash assistance (Temporary Aid to Needy Families, or TANF) and Medicaid eligibility is, at least in part, to blame for the drop off in some states.

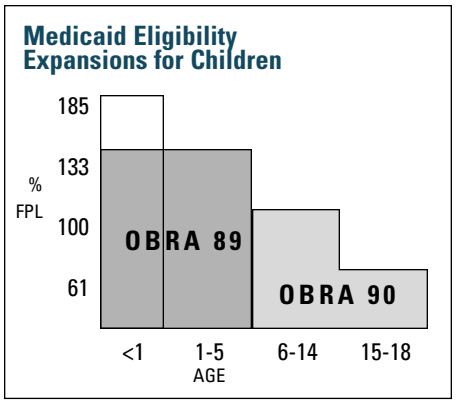
Studies show that in 1997, as many as 675,000 low-income workers lost Medicaid coverage and became uninsured as a result of welfare reform; 62 percent of these newly uninsured were children, and it is likely that many of them were still eligible. Several variables factor into this dramatic drop in enrollment: 1) an increase in income due to employment, often making the family ineligible; 2) a lack of outreach

The federal CHIP program changed the traditional pattern of partnering with states by giving states more flexibility than was common under previous expansion efforts.

strike a balance between the federal role in establishing minimal national standards and the states' desire for design flexibility. "I think CHIP is a good model for federalism," says Debbie Chang, former director of the federal CHIP program and now Medicaid and CHIP director for the state of Maryland. "It is really important that states and the federal government maintain a partnership and a good working relationship."

In addition to program flexibility, CHIP gives states enhanced federal reimbursement. For example, states that qualify for a 50 percent federal matching rate under Medicaid receive a 65 percent match under CHIP. Lower-income states receive even higher federal match rates, up to a maximum of 85 percent of federal money. In addition to the broad political support for providing health insurance to children, this enhanced federal financial contribution helps explain the states' unanimous participation in the CHIP program.

In spite of this success, there has been some discussion in Congress about reducing the CHIP allocation because implementation is not perceived to be going fast enough. According to the Congressional Budget Office, in the first two years of the program (federal FY 1998 and FY 1999), states spent only $855 million of the $8.5 billion allocated to the program. For many, this shortfall in state expenditures can be explained by states' need for legislative action and the design and implementation of complex program strategies before the first enrollment of children. "It is premature to take any of that money away," says Chang. "Most programs have less than one year in operation, and they need that first year to ramp up their efforts. Now that most state programs are in place, overall CHIP expenditures should increase significantly." Whatever the cause, Congress and other federal policy leaders will continue to scrutinize any surplus of funds available to CHIP.



Note: States are required to extend Medicaid coverage to pregnant women and infants up to 133% FPL and are permitted to raise eligibility to 185% FPL. At the time CHIP was implemented (October 1997), children through age 14 were covered under Medicaid up to 100% FPL. The older children continue to be phased in up to that level. Currently, older children are eligible for Medicaid under AFDC program rules, which vary by state. The Urban Institute found a median state eligibility threshold of 61% FPL (Zedlewski et al, 1997).

Building on Previous Expansions

CHIP builds on previous coverage expansions for pregnant women and children mandated by the federal government through the Medicaid program. The Omnibus Budget Reconciliation Act of

Medicaid PRWORA RIteCare

to eligible families on the part of welfare administrators and eligibility workers; and 3) the assumption of potentially eligible families that Medicaid enrollment has the same consequences as welfare. The complexity of the Medicaid eligibility and enrollment materials may also be partially responsible for the attrition rates. As a response, states have implemented creative outreach and enrollment strategies that convey a clearer message about the benefits of eligibility and enrollment. This has been accomplished in part by making Medicaid applications available in non-governmental settings and in a pared-down, simplified format.

While some states have experienced administrative challenges because of welfare reform, others have welcomed its impact. For example, officials in Rhode Island report that the RIteCare program has actually experienced an increase in enrollment, due largely to the flexibility provided in Section 1931 with regard to eligibility levels. "Rhode Island has not seen the Medicaid caseload decline as some other states have," says Tricia Leddy, administrator of the Center for Child and Family Health, Rhode Island Department of Human Services. "We have taken the flexibility provided in the welfare reform law to expand Medicaid coverage, and have seen substantial results."

1989 (OBRA 89) required state Medicaid programs to cover children under age 6 living in families with incomes up to 133 percent of the federal poverty level (FPL), or approximately $22,000 for a family of four in 1999. OBRA 90 required that children age 6 to 8 be covered up to 100 percent FPL and initiated a phase-in so that all children under age 19 living in families with incomes below the poverty line will be eligible for Medicaid by the year 2001. All states now cover children through age 16 up to 100 percent of poverty. Coverage for older children (age 17 to 18) varies by state based on eligibility under the previous Aid to Families with Dependent Children (AFDC) program.

One of the states' most immediate responses to CHIP was to accelerate Medicaid eligibility for these older children, known as the "OBRA kids." A number of states, such as Texas and Alabama, initially expanded Medicaid specifically for these older children. Until their initial CHIP expansion, Texas only provided Medicaid coverage to older children whose family income was below 17 percent FPL (less than $2,900 in annual income for a family of four). The CHIP program encouraged Texas and other states, because of the enhanced reimbursement, to expand Medicaid coverage to all previously ineligible children below the poverty line more quickly than they otherwise might have. The enhanced match will be phased out when the "OBRA kids" reach their original phased-in eligibility for Medicaid.

The OBRA expansions have created a "stair-step effect" for Medicaid eligibility. (Illustrated in table on page 5) The "stair-step effect" creates situations in which a younger child in a family might be eligible for Medicaid coverage while an older child is not eligible. In spite of the CHIP expansions, this Medicaid "stair-step" still exists in many states.

Several states have expanded Medicaid to a higher income level and applied that standard to all children under age 19 (e.g., Louisiana:133 percent FPL, Indiana:150 percent, Maryland: 200 percent, and New

Translating FPL Percentages to Dollar Incomes

1999 Federal Poverty Levels (Annual Income)

Family Size	*100%*	*133%*	*150%*	*185%*	*200%*
One (1)	$ 8,240	$10,959	$12,360	$15,244	$16,480
Two (2)	$11,060	$14,710	$16,590	$20,461	$22,120
Three (3)	$13,880	$18,460	$20,820	$25,678	$27,760
Four (4)	$16,700	$22,211	$25,050	$30,895	$33,400
Five (5)	$19,520	$25,962	$29,280	$36,112	$39,040

OBRA 89 FPL

TMA CHPlus

Medi-Cal

Alabama has been able to maintain its Medicaid enrollment numbers as well. In fact, the number of uninsured children in the state dropped from 160,000 in mid-1998 to 100,000 in mid-1999. According to Gwen Williams, former deputy commissioner of policy and strategic planning at the Alabama Medicaid Agency, "Our agency collaborated with the Department of Human Resources [the agency that administers welfare] to determine how to keep enrollment procedures easy," says Williams. "We felt that a total de-linkage of the two programs invited problems, as people will often neglect to follow-up with Medicaid after they've applied for welfare." Alabama also conducts outreach through schools, provides Medicaid applications in Head Start and other offices, and trains providers to help patients complete application forms.

Mexico: 235 percent). A number of states, such as Connecticut, established a level Medicaid eligibility threshold and created a different state program for children at higher income thresholds. Connecticut extends Medicaid coverage to all children under 185 percent FPL (HUSKY Part A) and offers a state-designed program with higher cost-sharing and reduced benefits to children in families below 300 percent FPL (HUSKY Part B). The state uses income disregards to reach more children at the 300 percent eligibility threshold while allowing them to continue to get federal matching funds. Connecticut also offers a full-cost buy-in of the coverage to children in families above 300 percent FPL. (See table on page 6 for federal poverty levels and incomes)

Because the eligibility status of children in low-income families frequently changes due to the changing employment status of their parents, there is the danger that these children will fall through the cracks in transitioning between programs.

Coordination Among Programs

While politically popular in many states, children's coverage programs that are separate from Medicaid bring with them numerous program implementation and coordination problems. Because the eligibility status of children in low-income families frequently changes due to the changing employment status of their parents, there is the danger that these children will fall through the cracks in transitioning between programs. In California, children leaving Medicaid receive an extra month of MediCal coverage while they apply for Healthy Families — the state's CHIP program. New York's Medicaid managed care plans are required under their contracts to enroll children in CHPlus if they become ineligible for Medicaid. Many other states, including Oregon, Florida, and Pennsylvania, inform ineligible applicants about other program options and automatically transfer eligibility information to those programs. Recipients are also individually tracked as they move from one program to another.

Another strategy states have used to ease the transition to a new program and encourage continuity of care is to require health plans serving CHIP enrollees to also serve Medicaid enrollees. Enrollees can then maintain access to the same health network (although not necessarily the same physicians) when changing programs. In Washington, for example, the state Medicaid agency and the Health Care Authority, which administers the Basic Health Plan (BHP), now conduct for both programs a joint procurement, which standardizes health plan contract requirements across state programs and requires plans to offer coverage to both populations. Simplifying the enrollment process for applicants is another priority for many states that want to reduce the number of eligibles who do not enroll. Most states that have separate state-designed CHIP programs have also developed joint applications for both Medicaid and CHIP. Most states have toll-free numbers to assist families with the eligibility and enrollment procedures, and many have outstationed eligibility workers to assist applicants in completing the necessary paperwork. In making the process less burdensome for applicants, states are trying to increase the likelihood that an eligible child will become enrolled in their programs.

Transitional Medical Assistance Availability Often Un-realized

Some eligibles are being left behind sooner than necessary because of poor communication about the availability of Transitional Medical Assistance (TMA). Established under the Family Support Act of 1988, TMA extends coverage to individuals entering the workforce, suspending the need to go uninsured or pay for costly coverage. However, its availability goes largely unknown by many families leaving welfare for work. A South Carolina study found that 44.8 percent of former welfare recipients did not know that adults leaving welfare for work might be eligible for TMA.

TMA generally offers as much as 12 months of coverage to Medicaid enrollees who have become ineligible under Section 1931 due to an increase in earnings. Some states have received waivers to extend the coverage for as long as 24 months. Most notable is Vermont, which extends TMA up to a full three years to adults up to 185 percent FPL, and provides coverage to non-TANF parents with eligible children up to 185 percent FPL.

CHIP Program Design

The decision by state health policy leaders to cover more uninsured children by expanding Medicaid or designing a separate state program has sometimes been a difficult one. Some state lawmakers advocated expanding Medicaid eligibility for kids given the program's comprehensive package of benefits (for example, non-emergency transportation) and its prohibition on cost-sharing for children. However, because CHIP was targeted to higher-income families (emphasizing those up to 200 percent FPL), many other state lawmakers believe the program should more closely resemble the health coverage available in the private market. Expanding Medicaid is administratively simpler and takes less time for states because they can rely on existing administrative structures and health plan contracts. States facing these numerous political and operational challenges have often compromised by establishing a Medicaid expansion in Phase I and creating a state-designed program for Phase II.

In spite of the administrative challenges involved in starting a separate state program, there are states that are wary of expanding Medicaid because of future budget concerns. Expanding the Medicaid entitlement places an obligation on the state to provide coverage to all children who meet the program eligibility criteria. States cannot begin waiting lists if they face budget crises. With the state-designed approach, states can cap enrollment and limit their financial risk. Oregon structured its state-designed CHIP program as a Medicaid look-alike. The program has all the features of a Medicaid CHIP expansion, except that it is not an entitlement and the state can limit or stop new enrollment if the need arises.

Of the 50 state plans that have received federal approval, 21 are Medicaid expansions, 16 are state-designed programs, and 13 are a combination of these two approaches.

After lengthy negotiations with HCFA, Wisconsin received approval for an approach that expands Medicaid, but still allows the state to limit enrollment. BadgerCare, which includes the state's 1115 Medicaid waiver program, uses CHIP funding to extend coverage to families up to 185 percent FPL. However, according to Peggy Bartels, administrator of the Wisconsin Division of Health Care Financing, the program is structured so that "if BadgerCare enrollment is projected to exceed budgeted enrollment levels, a new enrollment income threshold will be established for new applicants." The state will provide 30 days notice regarding any impending program eligibility changes. Those who are already enrolled will be able to stay in the program as long as they continue to meet the eligibility criteria in effect on the date they were enrolled.

Another CHIP design issue for state lawmakers is the negative perception of the Medicaid program. Some low-income families consider Medicaid the same as welfare — placing a stigma on the program that discourages participation. Imposing even minimal cost-sharing on enrollees' families and implementing other private market look-alike strategies may help to counteract this stigma.

Payment rates under Medicaid are typically lower than what providers receive through commercial plans, which often results in low provider participation and access problems for enrollees. Michigan sought to improve access to dentists under MIChild, their CHIP program, by increasing the rates paid for dental services. According to Denise Holmes, director of the Plan Administration and Customer Services Bureau in the Michigan

HCFA

BadgerCare

"Our program automatically enrolls individuals in TMA who are making the transition from TANF to employment," says Paul Wallace-Brodeur, director of the Vermont Office of Health Access. "Although participants are required to report earnings and residency information quarterly, the automatic enrollment process extends their coverage period without placing excessive burdens on the participant." The availability of TMA is allowing 5,700 individuals in Vermont to remain insured with another 1,100 non-TANF parents also covered.

TMC

ERISA

MIChild

California was able to insure approximately 84,000 people in December 1997 through their Transitional Medi-Cal (TMC) program, which is available to families leaving welfare for the initial six-month period, and for a second six months if their income remains below 185 percent FPL. About 62,000 of these individuals were receiving the first six months of TMC, and 22,000 were in the second six-month period.

Although some states provide automatic enrollment in TMA, others require individuals to inform the eligibility worker when leaving welfare that they are going to work. With the onus on the worker to com-

Department of Community Health and Medicine, "We're paying twice as much to dental plans to serve MIChild in exchange for complete access to their networks. Dentists cannot turn people away. We have a number of families who have tried to sign up for MIChild instead of Medicaid. We have also received a large number of calls from distraught parents who are very unhappy about having been accepted into Healthy Kids (Medicaid). One of the reasons they give is that the dental program for MIChild is so much better." The state recently passed a supplemental appropriation of $11 million directed at improving dental services.

States in the past have offered some families a choice of enrolling children in either Medicaid or the separate state-designed program (e.g., Oregon's Family Health Insurance Assistance Program and Washington's Basic Health Plan), and families have often elected to sign up for the separate state program, despite higher cost-sharing and reduced benefits as compared to Medicaid. This is not an option under CHIP. Children who are determined to be eligible for the state's Medicaid program cannot enroll in a separate non-Medicaid program. This requirement has put barriers in the way of state's efforts to enroll all eligible children.

State CHIP Programs

Of the 50 state plans that have received federal approval, 21 are Medicaid expansions, 16 are state-designed programs, and 13 are a combination of these two approaches. The District of Columbia's plan and those of the U.S. territories have all been Medicaid expansions. A number of states anticipate amending their CHIP plans in the coming year, so the CHIP mix of programs is expected to change. In particular, it appears likely that more states will develop combination programs (e.g., Indiana and Texas).

Many states that implemented CHIP using their Medicaid programs had significant expansions already in place through existing waiver authority (e.g., Missouri, Rhode Island, South Carolina, and Tennessee). Minnesota had already expanded Medicaid coverage to families up to 275 percent FPL through an 1115 waiver program. Due to Title XXI's maintenance of effort requirements, the state was not eligible to receive an enhanced federal match under CHIP to cover those children. Minnesota was eligible to use CHIP funds to expand coverage up to 325 percent FPL, but the state legislature did not support this strategy.

"I don't think anybody seriously considered expanding above 275 percent," says Ann Berg, manager of the Federal Relations Unit of the Minnesota Department of Human Services. "There's a general belief that at those income levels, buying your own insurance is feasible." Instead, Minnesota expanded eligibility to children under age 2 in families with incomes up to 280 percent of poverty. This expansion, which was expected to bring no significant new enrollment into the MinnesotaCare program, was designed strictly as a placeholder to secure Minnesota's portion of the CHIP funding. The state is now considering whether to use Title XXI funds to subsidize private health insurance coverage for those below 275 percent FPL currently ineligible for MinnesotaCare because of current program barriers.

Three existing state-designed programs — Florida's Healthy Kids program, New York's CHPlus, and Pennsylvania's CHIP program — were specifically "grandfathered" into CHIP under Title XXI. These states were not required to have their program benefit packages approved by the federal government, but they were still required to make other changes in their programs in order to

Title XXI

Healthy Kids

municate their move into the workforce, the information is often never passed along, and the worker becomes uninsured sooner than necessary. To reduce these avoidable scenarios, advocates for low-income families are encouraging support from a variety of sources. For example, they are asking Medicaid agencies to incorporate TMA information into caseworker/client sessions and to send literature to households with all case-closing notices. Similarly, they are encouraging employers with new welfare-to-work hires to provide Medicaid information at the work site.

conform to the provisions of the law. For example, in order to comply with the requirement that families pay no more than 5 percent of their annual income in out-of-pocket expenditures, New York decided to eliminate enrollee copays altogether rather than develop administrative systems to track these expenditures on a family-by-family basis.

Pennsylvania used the new federal money from CHIP to improve benefits and expand program eligibility. The state extended coverage to all children under 200 percent FPL and provided subsidized coverage to those below 235 percent FPL. The latter portion was initially paid with state-only funds due to Title XXI's restrictions on the target eligible population (children with family incomes below 200 percent FPL). However, Pennsylvania has recently changed its income test to allow more applicants to receive coverage and still allow the state to leverage enhanced federal funding. The new net income test credits $90 per month per employed individual and provides additional credits per child in the household. This change in income calculations allows more CHIP enrollees to be eligible for the 200 percent unsubsidized coverage. According to Pat Stromberg, executive director of the Pennsylvania CHIP program, "Our commitment has been to enroll all eligible uninsured children and take full advantage of the federal funds available."

Outreach and Enrollment Efforts

States have encountered a number of challenges in implementing their CHIP programs. One of the most difficult challenges has been to develop effective outreach and enrollment strategies. For example, families making more than $30,000 per year are often unaware that their uninsured children may be eligible for subsidized health insurance through the state. States have used many strategies to spread the word about these programs, including statewide media advertising, developing information outreach brochures in multiple languages, and outstationing eligibility workers and application assistors in various community locations such as Department of Motor Vehicles offices, local churches, community clinics, hospital emergency rooms, and schools. "It takes a while for people to become aware of the program," says Denise Holmes of Michigan.

In addition to using CHIP funding to market the MIChild program through media advertising and extensive school-based dissemination activities, Michigan also utilized federal funding provided through Section 1931 of the Social Security Act to support community-based outreach and enrollment activities. (See the box above for further explanation of coverage expansions under Section 1931.) The grass-roots organizations receiving the funds have assisted

Section 1931 Allows States to Expand Medicaid in New Directions

Section 1931 of the Social Security Act — passed as part of the welfare reform act known as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 — established a new mandatory Medicaid eligibility group of low-income families with children. Eligibility requirements for the 1931 eligibility group are related to certain requirements in states' Aid to Families with Dependent Children plans that were in effect on July 16, 1996. However, it also provides states several options to make changes to these eligibility requirements.

Section 1931 allows states the flexibility to define what counts as income and resources when determining eligibility. Some states have used the option to disregard an ever larger portion of a family's earning than federally required so that their income remains below the standard for eligibility. Others have used 1931 to omit the assets test — measuring the value of cars or savings accounts — for families applying for Medicaid coverage. Some states do both. Alabama, for example, disregards one vehicle per licensed driver within a household as well as $2,000 of income.

Rhode Island has used Section 1931 to cover parents up to 185 percent FPL if their children are enrolled in RIteCare, the state's Medicaid managed care program. RIteCare now insures approximately 85,000 individuals, 25,000 of whom are parents. "Our recent expansion initiatives focus on covering families," says Tricia Leddy, administrator of the Center for Child and Family Health at the Rhode Island Department of Health Services. "Throughout expansions to cover uninsured children in working families, we often find that the parents were uninsured as well. Since we used the 1931 provision to cover parents, we now encourage the entire family to enroll."

families in filling out the necessary application forms and ensuring that they submit all the required documentation. This allows the state to determine eligibility more quickly.

Pennsylvania, one of the states with a children's coverage program that was grandfathered in under Title XXI, had a fairly easy time with the program design, but is facing challenges regarding outreach. "The primary obstacle for us has been getting the word out about the program," says Stromberg of PaCHIP. Pennsylvania has implemented an extensive outreach campaign and funded an outside organization to evaluate the effectiveness of their efforts. In a survey of low-income residents, researchers found that 41 percent had heard of the CHIP program in Fall 1998, but by Spring 1999 (following the state's advertising efforts), the number increased to 67 percent. The percentage of residents familiar with the Medicaid program grew from 87 percent in Fall 1998 to 90 percent in Spring 1999.

In addition to their outreach efforts, states have made a number of improvements in their eligibility and enrollment requirements to make the process less complex and burdensome for applicants. States have created joint applications that can be used to determine eligibility for both Medicaid and CHIP — and, in some cases, programs such as Women, Infants, and Children (WIC) — and states have also significantly reduced the length of these applications. California's Medi-Cal application was pared from 28 pages to four pages, and many other states have made similar reductions. In Maryland applicants can now self-declare income without providing pay stubs or other documentation, greatly simplifying the eligibility determination process. Most states now offer toll-free numbers to instruct potential applicants on the enrollment process.

Continuous and Presumptive Eligibility Options Reduce Coverage Breaks

An unfortunate reality that plagues Medicaid and probably CHIP programs is the tendency of enrollees to drift in and out of the program, usually as their health requires. Even though an individual may be eligible for a program, they allow their enrollment to lapse, and then re-apply when they are in need of services.

This cycle can be frustrating for officials and health care advocates, as substantial resources are spent by state programs on outreach and education. California, for example, spent $21 million in 1998 alone. In addition, losing coverage even for brief periods can have serious health consequences. The Balanced Budget Act of 1997 provided states with two unique ways to avoid coverage breaks: presumptive eligibility and continuous eligibility.

Presumptive eligibility permits states to make medical assistance available to children under age 19 for a short period — usually between one and three months — without being officially enrolled. Generally a one-page application is administered and if the applicant's information appears to meet the eligibility requirements, the applicant is presumed to be eligible until either the enrollment becomes official, or the application is terminated.

Continuous eligibility reduces, at least for a time, the challenges of re-certification and/or the possibility of being uninsured. This option guarantees children up to 12 months of coverage from the time they first enroll, even if the child's family income increases or other factors render them ineligible during that time. Connecticut has used continuous eligibility to extend coverage to a substantial number of children. The state estimates that at any given time, approximately 5,000 children who would have otherwise become ineligible for Medicaid are covered because of the continuous eligibility option.

"Implementing continuous eligibility was supported by both our governor and state legislature, and has been well-received by advocacy groups, the health plans, and of course, our customers," says Rose Ciarcia, program administration manager for the Connecticut Department of Social Services. "Churning has been an issue in Connecticut as in other states," Ciarcia says, "continuous eligibility remedies both the administrative burden of re-enrollment and reduces the chance that children will be uninsured."

Evaluating State Progress to Date

Although CHIP's 1.3 million children enrolled at the end of June 1999 — and projections of 2.7 million children enrolled by September 2000 — has been disappointing to President Clinton and other federal officials, states expect enrollment to grow even more quickly in future months. Many states, after significant time for development and implementation, have only recently begun to enroll children. In addition, a number of states implemented small expansions initially and are now beginning to implement their larger Phase II expansions.

The Census Bureau's March 1998 Current Population Survey (CPS) estimates 10.7 million uninsured children in the United States. Researchers at the Agency for Healthcare Research and Quality (AHRQ, formerly the Agency for Health Care Policy and Research) estimate that 4.7 million of these children are eligible for Medicaid — making them ineligible for CHIP — but are not enrolled in the Medicaid program. However, when conducting outreach for their CHIP eligibles, states have enrolled a number of previously unenrolled Medicaid eligibles, thus overall reducing the number of uninsured children. Similarly, the Urban Institute and AHRQ estimate that there are approximately 3 million uninsured children under 200 percent FPL who are currently eligible for the new CHIP programs. The remaining uninsured children in the United States exceed CHIP's standard income eligibility threshold or are ineligible for programs due to program barriers implemented to prevent crowd-out (e.g., waiting periods for those who have been enrolled in private insurance). Some of the children above 200 percent FPL and currently ineligible could become eligible for CHIP if states expand their income thresholds through income disregards, as Connecticut and others have already done. AHRQ estimates that there may be 5.2 million uninsured children below 300 percent FPL who could then be eligible for CHIP.

Evaluating the success of the CHIP programs of individual states in enrolling uninsured children is often based on comparing enrollment figures against the estimated target uninsured population based upon CPS national estimates. However, estimates of the target uninsured population at the state level are, in many cases, unreliable. Nancy Cobb, director of the CHIP program in Indiana, notes that her state has had enormous success with outreach and that CHIP enrollment now far exceeds the CPS estimates of the target population. Conversely, several other states have estimates of the target population that appear to be significantly overstated. In Michigan, the CPS estimated 156,000 uninsured children between 150 and 200 percent FPL (the target population for MIChild). However, the Urban Institute, under the Assessing the New Federalism project, estimated the target population to be 47,000 children, which corresponds more closely with the state's own estimates.

As of September 1999, Michigan had enrolled 20,000 children in MIChild. Using the lower target population estimates, Michigan had enrolled almost half of the eligibles in the state and, according to Denise Holmes, "A 43 percent success rate for a brand new program is good." However, when compared against the CPS figure, Michigan had enrolled only 13 percent of those eligible for the program. Given some of the limitations of the CPS, "I'm sure many states are in that same predicament," she adds. The accuracy of the original estimates of uninsured children has meant that states now want to conduct their own surveys in order to obtain more accurate numbers on which to evaluate the success of their programs.

Beyond CHIP and Children: State-only Efforts

Prior to the passage of CHIP, a few states developed state-only coverage programs, which became models for the federal effort. In some cases, these states have chosen to maintain their separate programs in order to continue covering their uninsured low-income families and adults.

These states have used their own resources to design programs that provide health coverage in a way that meets their own unique needs and political environments.

State-only programs — those that do not receive matching funds from the federal government to provide health coverage — have made some limited progress in expanding access to the uninsured through a combination of financial contributions from state general funds, employers, and beneficiaries.

The Washington Basic Health Plan

The Basic Health Plan was created in 1988 to provide subsidized health coverage for Washington state's low-income uninsured people who want to purchase health insurance through a managed care plan. Washington residents not eligible for Medicare, not institutionalized, and who meet the income guidelines can obtain coverage through the program.

Basic Health offers a basic benefits plan through contracts with nine private health plans and has three coverage programs: 1) Basic Health, which covers individuals up to 200 percent FPL, with premiums based on their income, age, family size, and health plan choice; 2) Basic Health Plus, a collaborative effort of Basic Health and Medicaid that provides a broader range of benefits for children under age 19 whose families meet these income guidelines; and 3) the Maternity Benefits Program, which provides free maternity coverage through a coordinated Basic Health/Medicaid program.

While Basic Health is extended to many individuals, it is also offered to employers wishing to cover their employees through a subsidized effort. Employers enrolling their employees in Basic Health group coverage can choose to pay all or part of their employees' monthly premiums. However, they are required to contribute a minimum of $45 for each full-time employee and $25 for each part-time employee.

Although many states have chosen to convert their state-only programs into CHIP plans, Washington has opted to implement both a CHIP plan (effective in 2000), as well as maintain the popular Basic Health. Washington state extended Medicaid coverage to children up to 200 percent FPL in 1994. As of September 1999, there were 130,092 members enrolled in Basic Health, with an additional 80,062 children enrolled in Medicaid coverage through Basic Health Plus and 1,441 pregnant women served through the Maternity Benefits Program.

"Maintaining Basic Health as a state-only program allows us to adjust quickly to benefit design and changes in the market to better serve our enrollees," says Gary Christenson, administrator of the Washington Health Care Authority, the agency that operates Basic Health. "Our enrollees are happy with their benefits and they enjoy contributing toward their insurance premiums. Because Basic Health is not an entitlement program, but an insurance plan that resembles most private insurance, it is very attractive for those seeking health care without the government stigma," he adds.

Most health policy leaders believe that the continuity of health care access and services is enhanced when all members of a family are insured.

In 1994, Basic Health expanded to offer non-subsidized coverage to those whose income is above the guidelines for the subsidized program. Known as the full-premium program, this option requires members to pay their co-payments and deductibles in full. Unfortunately, several health plans that previously offered Basic Health's full-premium program decided not to contract with the program for year 2000. Other plans will continue covering current full-premium members throughout next year, but will not accept new applicants. Therefore, the full-premium program is now closed to new applicants, except in Clark County, where one health plan is still accepting new full-premium members.

"The non-subsidized portion of Basic Health experienced the difficulties you would expect — particularly adverse selection — with many Washington residents losing private coverage as managed care plans withdrew from the private individual

insurance market here," Christenson adds. "Claims costs and premium rates had been escalating. Because of these difficulties, our non-subsidized program is no longer available to new applicants in most areas of the state. Our subsidized program, on the other hand, remains very healthy."

New Jersey's Proposed Equity Program

Although not currently in place, New Jersey has a proposal called the Equity Program, which would provide coverage for working families who meet two criteria: 1) their incomes are between 133 and 200 percent FPL; and 2) they currently pay for "unaffordable" health insurance. For example, two families who have the same number of dependents and the same income make different choices regarding health coverage. One family chooses to purchase insurance for themselves and their dependents, while the other decides it is too expensive. The purpose of the program is to assist those who have done the "right thing" by purchasing insurance for themselves or their family members, as opposed to going uninsured, even if that insurance is considered unaffordable.

The Equity Program would subsidize employer-sponsored health insurance premiums after the employer pays at least 50 percent of the monthly premium and the employee contributes $25. The state will assume the remainder of the premium up to a $45 maximum. Because the state assumes that no matching funds would be available under CHIP, it is not requesting federal approval. The project will cost the state $13.6 million per year, but has the potential, officials believe, to insure and sustain coverage for at least 50,000 low-income employees and their families.

Future Directions in Coverage Expansion

A number of states are exploring options to use funds provided through CHIP to expand coverage to additional low-income uninsured populations. One priority is covering the parents of children participating in the state's CHIP program. Most health policy leaders believe that the continuity of health care access and services is enhanced when all members of a family are insured. By targeting coverage expansions to the adults within a family, enrollment of uninsured children will increase. This should also have a positive impact on utilization of primary care and preventive health care services. Some states are expanding access to coverage through their Medicaid program by allowing medically needy individuals who are income-ineligible to buy-in at full-cost. This coverage is often more affordable than employer-subsidized health insurance and provides them the same Medicaid health benefits that they need.

CHIP allows states to request a family coverage waiver (or "variance") to bring parents of eligible children into the program. To do so, states must demonstrate that the coverage does not substitute for existing private coverage and that it meets the test of cost-effectiveness (i.e., that it does not cost the state any more than it would have to cover just the children).

"Legally it's very difficult to make that happen," says Maryland's Debbie Chang. "The cost of covering families is greater than the cost of covering just the kids. One way to do it would be to leverage employer-based contributions to coverage. I think more and more states will be looking at employer buy-in programs."

Massachusetts is currently one of three states (The others are Mississippi and Wisconsin.) to have received a family coverage variance from HCFA. Under CHIP, Massachusetts provides direct coverage to children from 150 to 200 percent of poverty through its MassHealth program. Families within that income range with access to employer-based coverage can receive subsidies to cover the employee premium contribution, provided it is cost-effective for the state to do so and the employer coverage meets CHIP's benefit and cost-sharing requirements. In cases where the state cannot demonstrate cost-effectiveness, families with access to coverage can receive a partial subsidy equaling the amount the state would pay to cover the children directly under MassHealth. The family is then responsible for the remaining premium.

Curiously, there is now some disagreement between HCFA and state officials from Massachusetts about whether the state did in fact receive a family coverage waiver. State officials note that, while they did initially apply for a variance, the state plan changed significantly during the course of the negotiations with HCFA and classification as a waiver was no longer appropriate.

"We're not allowed to count the parents as covered lives," says Mark Reynolds, acting commissioner of the Massachusetts Division of Medical Assistance. "The whole debate is a funny one, but it matters to other states thinking about doing this. Saying that we have a 'waiver' or 'variance' implies that only we can do it. All we're doing is what many other states could do."

Mississippi and Wisconsin have also received federal approval under Title XXI to institute employer buy-in programs that will extend coverage to parents as well as children. The Wisconsin buy-in program under BadgerCare applies to families up to 185 percent FPL. For families that meet CHIP's cost-effectiveness test, the state receives an enhanced match to purchase the private coverage. For families that do not, the state will conduct a Medicaid cost-effectiveness test (comparing the cost of buying into family coverage against the cost of enrolling the whole family in BadgerCare). Mississippi has also received federal approval to implement a buy-in program up to 133 percent FPL, but the state legislature has not yet approved the measure.

In addition to the stringent cost-effectiveness test, private coverage buy-in programs also pose difficult operational challenges. The benefit packages available in the private market may or may not meet the minimum standards established by Title XXI. Co-pays and other cost-sharing can often exceed the 5 percent of annual income allowed under Title XXI. In order to receive federal approval for a buy-in program, the state must develop a strategy to ensure that the coverage subsidized under Title XXI meets all minimum standards.

"The mechanics are difficult," says Denise Holmes of Michigan. Michigan is currently examining the feasibility of a buy-in program, but "the employer benefits are not exactly the same as the CHIP benchmark, and at this point we're not sure how complicated a wrap-around would be." Despite the administrative challenges and operational complexities associated with establishing employer buy-in programs under CHIP, many states are considering this option to leverage existing private funding and expand coverage to low-income working adults using Title XXI's enhanced federal match.

Buy-ins to Medicaid

Some states have allowed individuals who are ineligible for Medicaid, but unable to pay for the often costly health coverage offered by their employer, to gain insurance through a full-cost buy-in to the state Medicaid program.

This option requires recipients to pay the total expense that the state incurs to cover them, which is usually more affordable than paying a percentage of the employer-based coverage.

Minnesota provides options to its residents to buy into MinnesotaCare, the state's section 1115 Medicaid Waiver program. The state allows enrollees who become ineligible for MinnesotaCare because their gross annual income increases above the income standard to buy into the program by paying the maximum allowable premium for their household size. In addition, starting July 1, 1999, the state provides Medicaid coverage for disabled persons under age 65 who are working, whose net countable income is above the $467/month Medicaid income standard, and whose assets do not exceed $20,000. In the event that a disabled individual's income is above 200 percent FPL — $1,373/month for a household size of one, or $1,843 for a household size of two — the state requires them to contribute only 10 percent of the amount exceeding 200 percent FPL, not to exceed the cost of coverage.

"This opens up new work opportunities for persons with disabilities by allowing them to work as much as they want without sacrificing critical Medicaid health benefits," says Karen Gibson, health care policy consultant for the Minnesota Department of Human Services. "The increase in income and asset limits may enable someone to save modestly for essential needs — a down payment on a house, a lift-equipped vehicle, or a retirement fund. It also opens up a tremendous untapped potential of people with valuable skills, education, and experience to bring to the work place. This is a win-win for all of us," she adds.

Congress and the administration have recently agreed upon a federal law change that builds upon what Minnesota and other states have done. They have agreed to expand Medicare and Medicaid so that people with disabilities can return to work without losing their health insurance benefits. Another part of the agreement allows states to provide Medicaid to workers who are not actually disabled, but have physical and mental impairments that are reasonably expected to become severe disabilities without treatment (i.e., HIV).

Rhode Island provides coverage at no cost for home-based child care providers participating in their subsidized child care program. "We feel that since we are contracting for their services to benefit our enrollees, we are, in a sense, like their employer," says Leddy. "Therefore, it seems only right that we would provide health care for them." The state also extends coverage to pregnant women with incomes between 250 and 350 percent FPL by combining state and enrollee contributions. The enrollee pays approximately one-third of the cost of prenatal care and delivery, and the state pays the remainder. While the arrangement resembles a buy-in, it does not use any Medicaid funds.

State Efforts to Manage Their Health Care Insurance Markets

Even as CHIP has kept children's coverage expansions foremost on their policy agendas, state officials have also grappled with insurance market reforms, in the hope of "lowering costs of coverage for some and enabling an imperfect market to work better for many."[1]

Historically, the states have held sole regulatory authority over health insurance companies, and the federal government held regulatory responsibility for self-insured employee benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA). In 1996, HIPAA authorized a federal role in the regulation of health insurance markets.

Described by some as a major obstacle to meaningful state insurance market reform, ERISA was legislated in 1974 primarily to protect workers and retirees with employer-provided pensions. But ERISA also exempts companies that self-insure from state insurance laws, including employer mandates and assessments to finance state uncompensated care pools. In addition, Gail Jensen of Wayne State University argues that state benefit mandates both decrease small employers' willingness to cover their employees and encourage employers to self-insure to avoid state regulations[2]. With approximately 125 million Americans now in self-insured plans, ERISA thus significantly restricts the potential impact of any insurance market reforms states might pass — whether intended to improve access to coverage, mandate benefits, or redefine patient protections.

The passage of HIPAA marked a first step toward state and federal governments working together to overcome the barriers to regulation that ERISA presents. Intended to reform insurance practices such as denial of coverage to individuals for pre-existing conditions and to reduce "job-lock," which is the phenomenon of individuals remaining in their jobs to ensure coverage for themselves or an (often) ill dependent, HIPAA nationalized the reforms passed by many states from 1990 to 1994, guaranteeing issue, renewal, and portability from group to group plans as well as renewal and portability from group to individual plans. HIPAA's portability provisions are broader than those mandated by most states and supercede state rules, but in other areas many states had already surpassed HIPAA's standards.

In the individual market, HIPAA allowed states to enact "federal fall-back" portability requirements or implement any of four "alternative mechanisms." Eleven states chose the federal fall-back enforcement option, but 21 states chose a state high risk pool as an alternative mechanism to ensure portability from the group market to the individual market.[3] Other states guarantee issue to HIPAA-eligibles (13 states)[4], offer coverage through a state purchasing alliance (one state, N.M.), or operate a special state program.

Effective since July 1997, HIPAA's impact is not yet clear, but most agree that while it has protected those with existing coverage, it has not significantly reduced the numbers of uninsured. Some debate whether the law should have done more. Numerous reports, such as one prepared by the U.S. General Accounting Office, have found that the original goals of HIPAA are elusive because HIPAA is silent about insurance premium rates, and some insurers are charging HIPAA-eligibles 140 to 600 percent above standard rates.

As a group market reform, HIPAA did a good job on portability and regulating self-funded ERISA plans — it leveled the playing field.

Among those who argue that HIPAA's contribution to reform has met Congress's objectives and expectations, Nicole Tapay, formerly of Georgetown University and now CHIP program director at HCFA, says, "HIPAA had limited provisions addressing coverage expansion. Rather, it primarily sought to improve portability and to decrease discrimination based on health status. As a group market reform, it did a good job on portability and regulating self-funded ERISA plans — it leveled the playing field."

While the debate about HIPAA's impact is ongoing, its significance clearly lies in its inauguration of federal insurance standards. The federal law "instituted a federally regulated 'floor' that all employee plans and insurers must adhere to," says Karl Polzer, senior research associate of the National Health Policy Forum. "States may build on these floors for insured group health plans, but they cannot regulate self-insured plans further without additional action at the federal level."

In addition, notes Len Nichols, principal research associate at the Urban Institute's Health Policy Research Center, "Even though it has reached only a narrow class of individuals, HIPAA's implementation, if perceived to be successful, could give Congress the confidence to revisit at a later date the possibility that these standards should be set higher."

Beginning to define the higher standards Congress might pursue later, Deborah Chollet, vice president of the Alpha Center says, "What HIPAA has done must be seen as ineffective unless the states also have enacted rate restrictions in the open market or low limits on rates in the high risk pools. Without rate restrictions in both the small group and individual markets, HIPAA cannot meet its objectives."

A Look Back at State Insurance Market Reforms in the 1990s

State-level insurance market reform efforts began in the 1970s, as some states established high-risk pools to insure people whose health status made them uninsurable. (See box on page 18) A decade later, as policymakers began to recognize that workers and their dependents comprised most of the uninsured population, a few states offered tax credits to encourage employers to insure their employees. In the early 1990s some states enacted market reforms, such as guaranteed renewability, portability, rating limits, and benefit package requirements. Many also enacted a range of mandated benefits, requiring insured plans to cover specific types of services or the services of specific types of providers, such as chiropractors or social workers.

Rules of Issue and Rating Restrictions for Small and Individual Markets

REFORM	DESCRIPTION
Guaranteed Issue	The "take-all-comers rule" mandates that an insurer must sell a benefit plan to any eligible party regardless of claims history or health status
Guaranteed Renewal	Policies in force must be renewed (regardless of claims experience) as long as the insurer remains in the market and the policyholder meets the terms of the contract (such as timely payment)
Limit on Pre-existing Conditions	The maximum time period that insurers can exclude existing medical conditions. Limits refer to both the "look back period" (the period prior to the beginning of the contract during which a medical condition may have arisen) and the "waiting period" (the period following the beginning of the contract during which services related to the condition are not covered).
Portability	Individuals who maintain continuous coverage are exempt from a new policy's pre-existing conditions exclusions
Rating Restrictions	*Community Rating:* Rating based on health status or claims experience is prohibited. *Pure Community Rating:* Rates may be set only based on geographic location, benefit package, and family size. *Modified Community Rating:* Those in different age, work type, or gender categories may pay different premiums, thus moderating potential adverse selection of pure community rating. *Durational Rating:* Insurers may not re-rate groups or individuals solely because of the length of time they have held the policy.

Standard Benefit Packages

States can also use benefit package mandates to regulate their health insurance markets. Proponents of mandated benefits argue that consumers must be protected, especially those in small businesses and the individual market, which do not have the same purchasing leverage as do large businesses. Mandates can provide needed coverage for certain illnesses and conditions not regularly included in benefit packages.

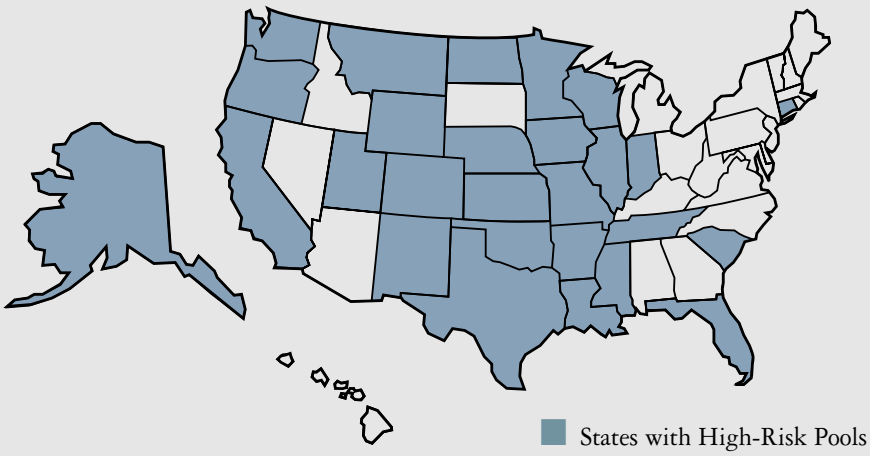
Opponents of mandated benefit laws refer to an oft-cited statistic on the cost of mandated benefits derived from a six-state study conducted by the General Accounting Office (GAO) in 1996. The study found that between 5 and 22 percent of claims were for mandated benefits, with the concomitant rise in cost passed on to consumers. Other studies suggest that mandates increase the number of uninsured. One estimate is that at the end of 1998, 25 percent of the uninsured were priced out of the market by 1,260 state mandates.

High-Risk Pools

In many states, high-risk pools are the sole health insurance option for individuals who have been denied health insurance because of a medical condition. Minnesota and Connecticut started the first risk pools in 1976, but HIPAA, enacted in 1996, allowed states to form high-risk pools as an "acceptable alternative mechanism" to assure access to health insurance coverage for HIPAA eligibles.

Although insurance benefits vary from state pool to risk pool, benefits offered tend to be comparable to those in basic private market plans. Each state caps risk pool premiums, typically between 125 to 200 percent of the average cost for comparable private coverage in the same state. According to Communicating for Agriculture, an advocacy group that monitors risk pools, most states offer coverage at approximately 150 percent of the average rate. To cover pool losses, some states assess all insurers in the market; others appropriate funds from general tax revenues, use special funding sources, or levy a health care provider surcharge.

Twenty eight states operate high-risk pools: AL (for portablility only), AK, AR, CA, CO, CT, FL, IL, IN, IA, KS, LA, MN, MS, MO, MT, NE, NM, ND, OK, OR, SC, TN, TX, UT, WA, WI, WY.



States with High-Risk Pools

Small Group Market

In most states in the 1990s, insurance premium instability has been a major problem for buyers in the small group market, which consists of employer groups of fifty and less and comprises approximately 25 percent of private insurance. "Insurer practices, such as medical underwriting and rating practices were threatening to destroy the market," explains Polzer. "As a result the insurance industry itself actually suggested moderate reforms." By 1997, 47 states had enacted guaranteed issue and renewal, portability, pre-existing condition limits, and premium rating reforms.

Initial studies have indicated that small group reform efforts have had some measure of success. For example, Mark Hall of Wake Forest University, having studied insurance market reforms in 12 states, found that small group reforms have helped create more stable insurance markets, measured by: 1) increased enrollment; 2) average insurance prices; 3) market competition; and 4) regulatory administrability.

Purchasing Cooperatives

Among their various efforts in the 1990s to help increase consumer choice and contain the cost of coverage in their small group markets, some states passed legislation to create or to facilitate purchasing cooperatives.

"Purchasing cooperatives represent a complex area of policy," says Polzer. "Some of these pools have succeeded — including association and chamber of commerce plans — but many have proven to be financially unstable and prone to adverse selection, mismanagement, and fraud."

Also, the states have launched these coops on very unequal footings. Some states have authorized the cooperative to negotiate with insurers for price and quality, excluding insurers that cannot meet the cooperative's terms; other states require the cooperatives to accept all licensed insurers.

Approximately 12 states have attempted to launch state-sponsored cooperatives, but perhaps the most significant example of the purchasing cooperative's potential lies in the experience of the Health Insurance Plan of California (HIPC). HIPC was enacted during the debate over the Clinton administration health reform plan, and covers over 140,000 employees in over 7,000 businesses. Although encompassing only 2 percent of small group employers in the state, HIPC reports that 20 percent of its enrollees were previously uninsured. "This cooperative has had a desirable impact and has been very well managed, but now enrollment has slowed," says Polzer.

Last year the Pacific Business Group on Health (PBGH) assumed ownership and management of HIPC in accordance with HIPC's authorizing legislation, which required that it be privatized three years after its inception.

California's success, while modest, compares well to other states' experience. The cooperatives in Florida and Texas faced particularly tough years in 1999. Florida's eight Community Health Purchasing Alliances (CHPAs) were created in 1993 and by 1998 covered a large portion of

all Floridians in small-group policies. Collective enrollment dropped, however, in 1998-1999 from (93,000 to 68,000), and some cite the CHPAs' inability to negotiate price or choose health plans that provide competitive prices and benefits as the most important reasons for the decline. In Texas, the last remaining carrier dropped out of the Texas Insurance Purchasing Alliance (TIPA) on July 31, 1999, leaving 7,600 enrollees without coverage. In recent years, TIPA experienced annual rate increases of 32 percent, as well as a severe compromise of its benefit packages.

Despite such struggles purchasing cooperatives continue to be discussed as viable policy options — especially at the federal level where HealthMarts received significant attention this past year. Described as a kind of private supermarket of health plans where employers would send their workers for health coverage rather than providing it directly, HealthMarts would be modeled after the Federal Employees Health Benefits Program. Employees could choose from a menu of fully insured coverage options offered at group rates. HealthMarts proponents argue that such cooperatives would improve choice and access for employees of small businesses, and at the same time avoid a high-cost, high-risk pool because companies would have to bring all their employees in at once. Then enrolled workers and their dependents could remain or go as they choose, with the result, according to proponents, being a diverse risk pool reflective of the broader populations. Policymakers and health policy researchers have had mixed reactions to the HealthMarts idea. Some, such as Gary Claxton, of the U.S. Department of Health and Human Services, warn that HealthMarts would not be able to control adverse selection over time "because you cannot define a population exclusively at the front end and say that only these people get to buy insurance from now on." Others, such as Nicole Tapay, question the need for and desirability of the federal government's involvement at this level. "Federal legislation authorizing pools might undermine existing state reforms and destabilize state insurance markets."

Ultimately, whatever form they take, voluntary purchasing cooperatives may never be able to attract sufficient numbers of employers to realize the economies of scale that could enable them to drive prices down. Some have argued that the solution may be to require all small employers that buy coverage to do so through a purchasing alliance like HIPC[5].

Individual Insurance Market

As the debate continues about how to reduce the numbers of uninsured employed in small groups, the individual insurance market also is experiencing significant instability — increasing premium costs and unpredictable enrollment — and so also demanding the attention of researchers, health administrators, and insurers. As Hall explains, the individual market comprises approximately 10 percent of the private market nationally. It is characterized by a lack of group cohesion, few economies of scale, strong adverse selection, intensive medical underwriting, and volatile medical loss ratios[6].

Adverse selection is particularly acute in the individual insurance market, where individuals can decide to buy coverage based on their anticipated health care needs. Insurers respond with aggressive medical underwriting in the form of coverage denials, premium variations, and individualized coverage exclusions, called riders. State efforts to reform individual insurance markets, have been significantly fewer and less successful than small group market reforms.

Chollet explains that, "many states view these markets as too fragile to regulate, but in fact it may be that they

Washington State's Individual Market Reform Experience

Washington's current problems in its individual insurance market, where 6 percent of the state's population purchases insurance, can be traced back to the 1993 passage of the Health Services Act. The legislation included the implementation of guaranteed issue and renewal, required portability, and a limitation on pre-existing conditions of three months for both look-back and waiting periods — one of the shortest in the country. Over the next few years, insurers complained about losing money in the individual market and battled with the Insurance Department over regularly denied rate hikes. In 1997, a legislative effort to limit guaranteed issue to an annual open-enrollment period was vetoed. In November 1998, one of the largest insurers in the state (60 percent of market share), and the only one to sell individual market policies state-wide, announced that it would no longer sell to individual purchasers.

The loss of Premera Blue Cross left 15 of the state's 39 counties with no insurer selling new policies. Following Premera's decision, Regence BlueShield, and Group Health Cooperative also moved to stop selling individual policies. The only option for these individuals was to seek coverage in the unsubsidized portion of the Basic Health Plan (BHP). However, in September 1999, some 3,000 members of the unsubsidized BHP were notified by the state that their coverage will end January 1, 2000. Little other progress was made in 1999, as legislation to attract insurers back into the market met considerable political and interest group resistance. In mid-1999 a proposal to allow individuals without access to private insurance into the state's high-risk pool, the Washington State Health Insurance Pool (WSHIP), was accepted in September.

require even stronger constraints on insurer and consumer behavior than the small-group market does in order to thrive or even to survive."

Concurring with Chollet that the individual market will not respond to the same reform measures as the small group market, Hall explains that "states don't see an easy route to reforming the individual market and have therefore backed off from extending small group reforms."

Kentucky and Washington are among the states with experience in how attempts to apply to the individual market reforms that worked for the small-group market can be ineffective. (See box on Washington on page 19.) Though many aspects of Kentucky's and Washington's experiences were unique to their political and regulatory environments, their efforts still offer lessons that could prove valuable as other states seek to shore up and strengthen their individual markets. Broadly, Hall suggests, "First, we've learned that you can't take small group reforms and automatically transplant them to the individual market. Second, requiring community rating and guaranteed issue without also stabilizing demand causes adverse selection, which scares away insurers."

Alpha Center's Adele Kirk notes that factors other than Kentucky's core insurance market reforms may have contributed to the exit of most insurers from that state's individual insurance market. A series of rate freezes, a rigid rate approval process, repeatedly postponed implementation of key aspects of reform and partial repeal of the reform legislation combined to create an atmosphere of chaos and uncertainty. "Likewise, in Washington," Kirk explains, "the individual market reforms were part of an ambitious, system-wide health care reform effort, and the state repealed many of its reforms before they went into effect."

Although the dramatic experiences of Kentucky and Washington have generated most of the headlines related to individual market reform, other states have had positive experiences.

Massachusetts' Individual Market Reform Experience

In 1996 Massachusetts passed comprehensive individual market reforms that reflected the input of a unique coalition that included representatives from the state's HMOs, Massachusetts Blue Cross and Blue Shield, small business groups, and consumer groups. The law requires small-group insurers to offer at least one standardized product in the non-group market, implements modified community rating that limits rate variations to a maximum of 2:1, and prohibits pre-existing waiting periods. At the same time, the law regulates entry into the non-group market: persons eligible for group coverage, including self-employed individuals, are not permitted to buy non-group products, and individuals can only buy coverage during an annual 60-day enrollment period or during a 63-day period following a qualifying event such as loss of group coverage.

Enrollment during the first open enrollment period in late 1997 was lower than expected, but increased substantially during the second year of reform. Rates offered by different insurers for the same product varied considerably during the first year of reform, leading to speculation that some insurers were using high rates to discourage potential enrollees. Although rates have varied less in the subsequent years, two insurers active in the individual market prior to reform, Blue Cross and Blue Shield and Harvard Pilgrim, continue to draw the vast majority of enrollees. The reforms have also prompted a strong move towards HMO products, with approximately 90 percent of enrollees in HMOs. Massachusetts' nongroup market had a strong HMO presence prior to the reforms, but the high rates for PPO and especially traditional indemnity products may have accelerated that trend. The reforms have remained controversial, and there have been multiple legislative attempts to modify them, but the domestic insurers that helped draft the reforms have remained supportive.

Some states, such as New Jersey and Massachusetts, have strictly limited benefit packages in the individual market and required insurers in the group market also to sell individual products. (See box on New Jersey on page 21; box on Massachusetts above.)

According to Harvard University's Katherine Swartz, who has studied New Jersey's Individual Health Care Program extensively, the result in New Jersey has been a market with 21 companies selling to individuals and evidence that "a state can get competition going and losses shared."

"This type of reform can also allow for some short-term cross-subsidization between group and individual markets, decreasing insurers' financial vulnerability to accepting bad risk at the margin," says Chollet.

Polzer counters and emphasizes what a delicate balancing act market reform can be, asking, "Would this policy run the risk of weakening the small-group market in the long-run as small groups already experience some adverse selection from the large-group market?"

Seven states require guaranteed issue of all products; another eight states require guaranteed issue of a standard product only. However, relatively few states limit rate variations in their individual insurance market. HIPAA requires health plans to guarantee renewal of individual coverage. Other characteristics of state individual markets are detailed in the chart on page 21.

New Jersey's Individual Market Reform Experience

By 1992, few carriers in New Jersey offered individual health insurance policies to people who lacked employer- or government-sponsored health benefits. Individual policies did not provide adequate coverage and restricted the types of persons that would be insured; 175,000 persons were covered and the one major carrier of individual policies generated losses of $20 million. Determined to make significant changes in the market, the New Jersey Legislature created the Individual Health Coverage Program (IHCP) in 1993. The IHCP guaranteed issue of health coverage under standard health benefit plans for individuals and their families regardless of age or health status through a play-or-pay mandate that required small-group insurers to either participate in the individual market or help cover the losses of insurers who did. As a result, 28 carriers were actively selling policies within the first two years of the program's start and enrollment increased to 192,000 people by the end of 1995. However, according to Ellen DeRosa, deputy executive director of IHCP, enrollment dropped to 147,000 persons by mid-March 1998 and fell to 121,000 by mid-1999. DeRosa is unsure of the reasons for this, although she explains that the combination of the strong economy and rising premiums are major factors.

New Jersey's program demonstrated that there are ways for a state to implement effective health reform legislation. The program's success is attributed to the participation and leadership of the major carriers in the market. More people were able to enroll in individual plans and consumers were given the opportunity to choose a plan that would best meet their health care needs.

State Individual Market Insurance Reform Laws

Reform (number of states)	States
Guarantee issue all products (7)	MA, ME, NH, NJ, NY, VT, WA
Guarantee issue some products (8)	IA, ID, MD, NC, NV, OH, SD, UT
Pure community rating (2)	NY, NJ
Modified community rating (6)	MA, ME, ND, OR, VT, WA
Rating bands (9)	ID, IA, KY, LA, MN, NM, NV, SD, UT
Limit preexisting conditions (30)	CA, CT, FL, GA, ID, IN, IA, KY, LA, ME, MD, MA, MI, MN, MS, MT, NH, NJ, NM, NY, ND, OH, OR, RI, SD, UT, VT, VA, WA, WY
No individual market insurance reforms other than guaranteed renewal (12)	AL, AK, AZ, AR, DE, HI, IL, KS, MO, OK, TN, WI

Source: Alpha Center.

The Structurally Uninsured

Coverage Expansions Unable to Reach Everyone

While coverage expansions and insurance market reforms have been aggressive in their attempts to reduce the number of uninsured, it has become clear that policy changes and outreach efforts can only do so much.

Universal coverage is a near-impossible goal, as public perceptions about access to insurance, whether accurate or unfounded, promote behavior that lead many Americans — currently more than 43 million — to the ranks of the uninsured.

Several factors unrelated to policy contribute to the number of uninsured Americans, including the following:

- Low-income working families may not realize that their children qualify for Medicaid;
- Medicaid enrollment processes can be difficult to understand and require extensive documentation; and
- Families may delay enrolling their children until they need health services.

Many individuals neglect to participate in regular health care, even when it is affordable, but Elliot Wicks of the Economic and Social Research Institute argues that the affordability of health insurance remains the number one obstacle for the uninsured. "At the margin, some reforms being considered, such as more generous tax deductions or eliminating mandated benefits, may make coverage more affordable, but not affordable enough to bring in large numbers now outside the marketplace. The real problem is that many small employers and their workers can't afford even *reasonably priced* coverage."

Observing the rise in the numbers of uninsured in the late 1980s and early 1990s, researcher Greg Acs of the Urban Institute found that falling family incomes — as opposed to rising unemployment and changing patterns of industrial employment — account for much of the decline in overall insurance coverage.[7]

In addition, Philip Cooper and Barbara Steinberg Schone found that although "the number of workers offered coverage increased between 1987 and 1996, the proportion of workers holding a health insurance plan from their main job declined in the same period." Cooper and Schone also point to declining real incomes and increasing costs in health as major factors in workers' decisions not to take up insurance when it is offered.[8]

Finding a way to put new subsidies into the system seems an essential component for dealing with the unaffordability obstacle many low-income workers face. Because explicitly funding subsidies tends to be politically difficult, if not impossible, tax credits have gained attention among policymakers and researchers as a viable vehicle for making subsidy dollars available to those who need them. Some of the proposals that have been placed on the table focus on changing the tax system to help people afford their employer-based options, but this approach neglects many of the people who lack coverage, particularly those seeking coverage in the individual market, according to Lynn Etheredge of the Insurance Reform Project at George Washington University.

"For the most part, participants in the individual market lack access to an employer-sponsored plan; therefore, the proposed tax preferences would really have no value to them," Etheredge says. "If you are out there on your own without employer-based coverage, you get no help from the government to buy health insurance. We definitely need to at least give the same kind of tax preference to people who buy coverage on their own." Any tax credit proposal must, therefore, seek to help those with and without access to employer-based coverage in order to eliminate current inequities in the system.

Further, argues Alpha Center President David Helms, "the success of any tax credit will depend on the commitment of the federal government. Experience has shown us that states have a hard time sustaining subsidies solely funded at the state level. CHIP has also shown us that federal dollars can generate extensive state activity. Revising the tax code may be the way to go to make meaningful progress toward reducing both inequities in the system and the numbers of uninsured."

Safety Net Has Sought to Guarantee Care

To date, safety net facilities have been trying to provide sufficient access to ensure that even those who cannot afford coverage can receive care.

Therefore, health centers, emergency rooms, federally qualified health centers (FQHCs) and other community clinics must serve as the health care safety net, or providers of last resort. Because some states have experienced substantial drops in Medicaid enrollment — in some cases due to the welfare de-linkage mandated in 1996 legislation — many previous Medicaid beneficiaries are now uninsured and must access care through the safety net. In addition, as employer-sponsored health care declines and health premiums rise, these centers serve crucial roles in the health system, because they may be the only way an individual can or will access needed services.

"The safety net in Alabama improves health care by putting providers in settings — particularly rural communities — where they might not have otherwise practiced," says Dale Walley, acting commissioner of the Alabama Medicaid Agency.

Unfortunately, however, safety-net providers often are uncompensated for the care they provide, or are reimbursed at rates far below the actual cost of treatment. Federal and state funds help off-set the cost of treating patients who are unable to pay for their care through disproportionate share hospital (DSH) payments, which level the playing field to some degree for centers in areas with larger uninsured populations. Federal law sets a minimum standard for these payments, and gives states flexibility to expand upon them. Alabama's DSH payments, approximately $390 million in fiscal year (FY) 1999, provide the maximum allowed. In addition to the hospital disbursements, the state pays FQHCs an encounter rate — adjusted at year-end to actual cost — which costs Alabama approximately $11 million a year. The Balanced Budget Act of 1997 enacted mandatory reductions in DSH payments for "high-DSH" states, like Alabama, which pushed the envelope in both payment amounts and definition of qualifying hospitals. Their DSH expenditures are, therefore, considerably higher than those states that chose to provide only minimum payments. Alabama's DSH payment for FY 2000, for example, will decrease to $353 million.

Managed Care Threatens Safety Net Solvency

In addition to shrinking subsidies from the government, the shift in most states to Medicaid managed care has diverted subsidized dollars away from community clinics, leaving primarily uninsured patients behind. As with most risk pools, in order to shift costs to provide care for the poor and uninsured, a certain level of paying — or Medicaid-subsidized — patients must be maintained for a center or hospital to remain solvent. Therefore, community providers and clinics must contract with Medicaid managed care plans to continue serving this population and receiving the government grants that sustain them.

A partnership between the two entities can be a positive course of action, as each brings strengths to the table. For example, clinics are familiar with processes such as outreach, helping patients keep appointments, and other enabling services, and MCOs can provide the administrative support, management expertise, and special care equipment needed to provide for patients.

Massachusetts Uncompensated Care Pool Remains Stable

In 1985, Massachusetts established the Uncompensated Care Pool, which pays for medically necessary services provided by acute care hospitals and community health centers to low-income uninsured and under-insured people. The Pool is funded in three ways: 1) An assessment on hospitals' private sector charges contributes $215 million; 2) a surcharge on payments from private-sector payers to hospitals and ambulatory surgical centers contributes $100 million; and 3) a state contribution of $30 million. In 1996, the Uncompensated Care Pool covered approximately 60,000 inpatient admissions and 1.5 million outpatient visits.

The Pool provides coverage for individuals in the following categories:

Full free care: Provides care at no cost for families with incomes below 200 percent FPL. This category accounts for approximately 77 percent of the total pool.

Partial free care: Provides care for families with incomes between 200 percent and 400 percent FPL. The funds may cover patient contributions at community health centers — calculated on a sliding scale — or the deductibles required by hospitals. This category assumes only 1 percent of the total pool.

Medical hardships: Extends coverage to individuals at any income level whose medical expenses are such that they cannot afford to pay them; however, the application does account for the patient's available assets. Less than 1 percent of the pool is covered by this category.

Emergency bad debt: Targeted at the uninsured; pays for emergency bad debt as a last resort to ensure the hospital directs its efforts toward enrolling the patient into the

most appropriate program of care. Providers must assist the patient in completing a MassHealth or free care application, bill the patient, or pursue collection action before billing the Pool for the emergency services rendered. This category makes up 22 percent of the pool.

In addition to the formal categories stated above, the Uncompensated Care Pool also provides funds to help those who have high health care expenses through the individual market or their employer-sponsored plan. "While we aim to reduce the number of uninsured people in the Commonwealth, we must also realize that many people who are insured may be paying for unaffordable insurance," says Katharine London, policy development manager at the Massachusetts Division of Health Care Finance and Policy. "The Uncompensated Care Pool helps cover the cost of deductibles and co-payments for those individuals who contribute substantially to their insurance costs. Our goal is to provide access to the uninsured, as well as the under-insured, residents in Massachusetts."

Safety Net Always Likely to Have a Role

While the number of uninsured Americans continues to grow, the pressures on state safety-net providers to provide uncompensated care will only increase. Although some states have been able to maintain a stable safety-net system, FQHCs, teaching hospitals, and community centers that provide care for indigent populations are less solid in other states.

"A long range goal, of course, is that those people moving from welfare into work get jobs that provide employer-sponsored coverage," says Gretel Felton, associate director of Family Certification at the Alabama Medicaid Agency.

"Unfortunately, most of these individuals are employed at minimum-wage levels. Therefore, the safety net must remain solvent to ensure that everyone who seeks health care can receive it."

Looking Ahead

The demographic and economic faces of the uninsured, especially uninsured adults, are likely to remain the same as they have for decades. Similarly, the nature of the discussion about the uninsured may remain much the same.

Finding small opportunities to expand coverage and improve the function of insurance markets will continue to define the nature of policy pursuits. Budget realities and political battles will continue to determine much of the pace of change, and the opportunities, budgets, and politics will continue to vary among the states. Still, some common themes are emerging, and policy leaders across the states can expect to face a number of common issues in the coming months.

Emerging Issues

At the top of the list is the rising cost of providing unlimited *access to pharmaceuticals.* Nationally, growth in spending on pharmaceuticals has been at double-digit rates since 1995. Spending on prescription drugs in all state-sponsored programs has increased more rapidly than spending on most other health services. This is especially true of the Medicaid programs. States are attempting to rein in the cost increases by putting controls around unlimited access without endangering patient utilization of needed medications. Given the pipeline of new, more expensive and effective pharmaceuticals in the next few years, this pressure on state resources will only increase. Access to needed pharmaceuticals could likely become the focus of initiatives to expand coverage to the uninsured and the underinsured low-income persons who are elderly or have continuing medical needs.

Access to oral health services for low-income families, persons with disabilities, and minority populations is so severe that it has become a public health crisis. States will be under pressure to increase reimbursement to dental service providers and to implement other strategies to increase the number of dental providers that serve these populations. (See further discussion on page 25.)

There is also a growing emphasis on *sustaining the enrollment of eligible persons in Medicaid and CHIP* programs. This becomes especially important as we approach timelines that demand recertification of children's eligibility for CHIP expansion programs. It makes little sense to put so much effort into outreach and enrollment of new children when even more children may leave the program for failure to meet information needs necessary to verify continued eligibility.

The exact direction of change in insurance market reforms is harder to specify, but two sets of questions are emerging clearly. First, should the current employer-based system be sustained? Can it be improved in ways that would expand coverage, contain costs, and maintain quality, or has the time come for it to be replaced? Second, what is the individual market's potential for growth? Can it serve the greater numbers that could seek coverage there if the employer-based market declines?

Access to Oral Health Services for Low Income Children and Families: A Public Health Crisis

Access to oral health services for low-income children and their families throughout this country has become a public health crisis. In spite of state and federal efforts to increase health coverage for these low-income families, including dental coverage, access to dental services has remained elusive. This crisis has prompted the Surgeon General to recognize access to oral health services as a priority and he will be releasing a report this winter to highlight the problem and to identify strategies the department will pursue to increase access.

Access to oral health services is essential to improving and maintaining the overall good health of both children and adults. Tooth decay is the most common chronic disease of children and 25 percent of all children suffer 80 percent of all tooth decay. Yet often children with the greatest dental treatment needs have the least access even when they are covered under Medicaid and CHIP programs.

States have tried several different strategies in order to increase the number of dentists who are willing to see Medicaid and CHIP families. These efforts have included increases in reimbursement and requirements that dentists serve both Medicaid and CHIP enrollees. The impact of the different strategies on access to oral health services has been mixed. Increasing the willingness of dental providers to serve low-income families will most likely require a menu of strategies including education and support of families and providers. Those states that have designed different oral health access plans under their CHIP than under their Medicaid programs provide a natural experiment from which to examine the effectiveness of these plans.

States often have laws and rules that may interfere with the state's ability to experiment with different strategies to increase access to oral health services. These laws include the prohibition of the corporate practice of dentistry and limited scope of practice laws for dental hygienists. The supply of dental providers can also have a negative effect on the state's ability to increase access to dental services. Many states have a significant number of counties that have been designated as federal dental shortage areas. Efforts to improve the supply of providers and incentives to locate providers in shortage areas must be coordinated with provider training and education programs.

Or will it remain a residual market, serving relatively few people without group coverage?

As state policymakers work through whether and how to reform markets and expand coverage, national elections also will influence this year's policy activities and outcomes. If the initial months of the presidential campaign are any indication, all candidates seem likely to be drawn into a new discussion of health policy. The actual impact of this discussion may become clear only as a new president attempts to draft and pass legislation. In the meantime, the ongoing debate may contribute to greater public awareness of the issues in ways that alternatively support or challenge state policymakers' desire and ability to act.

Notes

[1] Linda Blumberg and Len M. Nichols, "Health Insurance Market Reforms: What They Can and Cannot Do." The Urban Institute.

[2] Gail A. Jensen and Michael A. Morrisey, "Employer-Sponsored Health Insurance and State Regulations," *Milbank Quarterly,* December 1999.

[3] Deborah Chollet, Alpha Center vice president, notes that "HIPAA-eligibles" is so narrow that few individuals will benefit from the guaranteed issue and portability provisions when moving from group plans to individual coverage.

[4] CA, CO, FL, IA, KY, MN, NM, NC, OH, SC, TX have established state-sponsored HPCs.

[5] Karl Polzer, "Should We Dare to Make Them Big?" (Discussion Draft), August 24, 1998.

[6] Mark Hall, "The Geography of Health Insurance Regulation: A Guide for Minimizing, Exploiting, and Policing Market Boundaries," An Unpublished Paper, December 1999.

[7] Gregory Acs, "Explaining Trends in Health Insurance Coverage Between 1988 and 1991," *Inquiry,* Spring 1995.

[8] Philip F. Cooper and Barbara Steinberg Schone, "Trends: More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs,* December 1997.

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