State Of The States

States continue to be sources of **innovation**, and the availability of **federal financial resources** is critical to address **coverage** for the **uninsured**.

Produced for
State Coverage Initiatives
an initiative of The Robert Wood Johnson Foundation

January 2001

Contents

Credits:
This report was prepared by the Academy for Health Services Research and Health Policy under The Robert Wood Johnson Foundation's *State Coverage Initiatives* program, for which the Academy serves as the national program office.

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Cover photo © Susie Fitzhugh

January 2001

Foreword

The environment for health care reform has changed dramatically over the last decade. In 1993, the call for comprehensive health care reform came at the end of an economic recession and in the midst of substantial budget deficits. Today, ongoing efforts to increase the numbers of Americans with adequate health insurance take place in the context of one of this nation's longest periods of sustained economic growth.

Still, the uninsured are persistently with us. Welfare reform brought jobs, but frequently jobs without health insurance. The flood of new immigrants that has sustained our growing service economy and booming construction sites also have been obvious in our uninsured totals. And just as the 2000 Current Population Survey brought news that the uninsured as a percentage of the population had decreased slightly in 1999, concern about a softening economy began to emerge again to control our national conversation about expanding coverage.

Overall, the experience of the last decade suggests that even the best economic times drive only weak improvement in coverage. Rather, improvements in coverage typically have required concerted public efforts to create and expand coverage programs and to legislate insurance market reforms that can make coverage more available or affordable. This report on state activities in health care coverage over the past year — the second in an annual series produced under the *State Coverage Initiatives* program — offers a detailed look at what the states have accomplished over the last year and brings into focus two realities. First, the states are essential sources of innovation, and second, federal financial resources are critical to expanding coverage, public or private. This report gives us an opportunity to look back over the year and learn. It seeks to recognize the leaders of these reform efforts, their innovations, and their hard work, and to provide insights on where and how the federal-state partnership might go in the next few years.

Even as the closing months of 2000 were consumed with one of our nation's most contentious elections, the health care positions of the two major presidential candidates were remarkable not for their differences but for their similarities. The details differed, and the approaches varied, but both of the presidential candidates' health reform proposals were modest and incremental. Both espoused tax credits, building on the success of SCHIP, increased flexibility for states, and tackled special concerns, such as pharmaceutical coverage for seniors and the health of the safety net. These proposals certainly offer significant opportunities for progress in the year ahead.

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Introduction

***W**ith SCHIP coming of age, the last year has brought a clearer focus on the challenges that remain. States continued to use all tools available to them to craft solutions for expanding coverage, and the SCHIP program has been the most powerful and influential of these tools. The federal carrots of incremental match and increased state flexibility, combined with strong local advocacy and activism on behalf of children, have given SCHIP more influence than just the numbers of children brought into coverage. SCHIP has changed the way many states approach health care coverage.*

This change in culture has brought to publicly provided health care coverage a new image and a new way of doing business. Program names that focus on positive images such as Georgia's Peach Care and Indiana's Hoosier Healthwise, outreach at convenient and family-friendly locations, partnerships with local organizations, and streamlined applications have all focused on enrolling children.

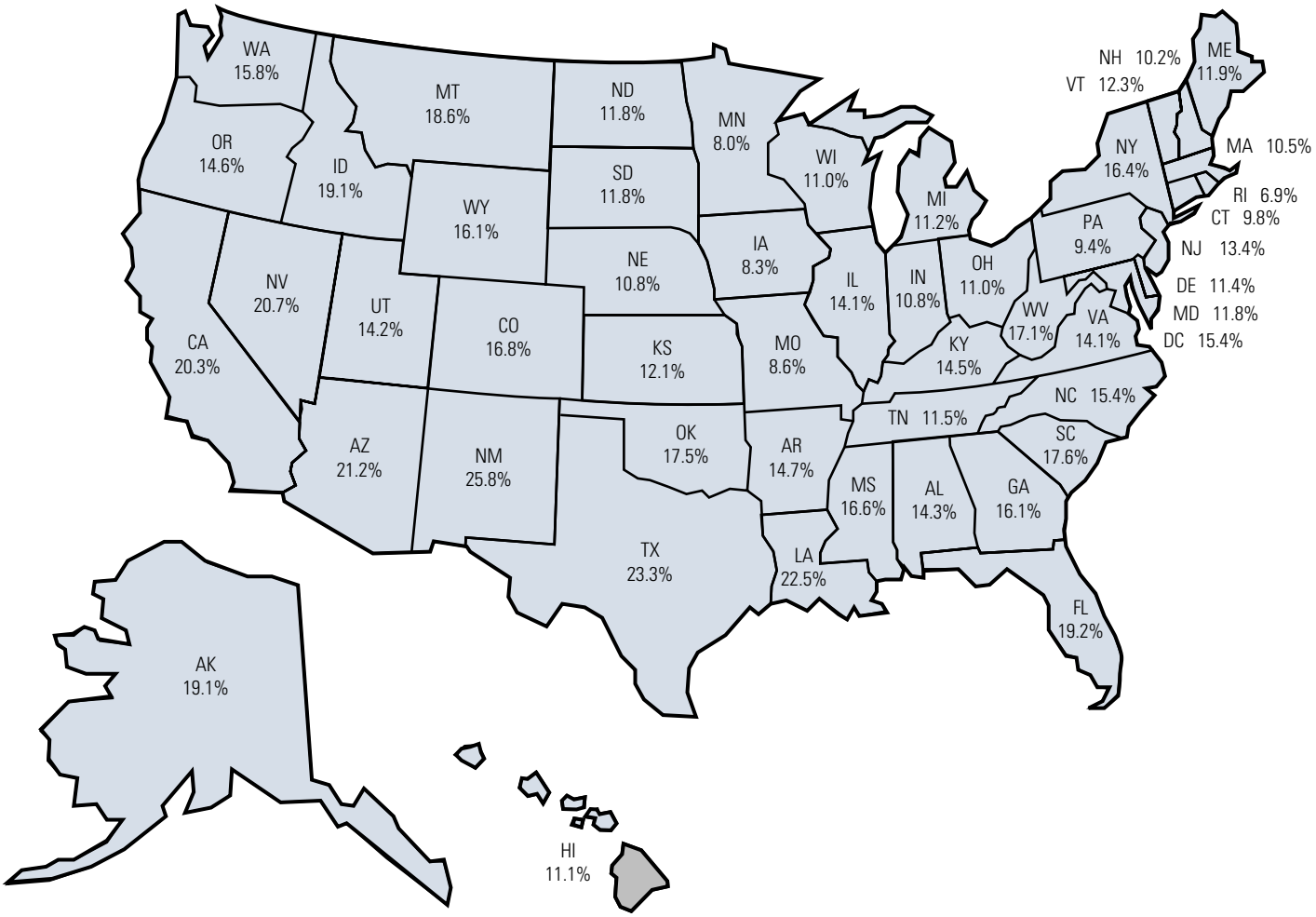
Some governors put their personal stamp on bringing this program to the attention of families and encouraging them to participate. No example of this change in focus is more telling than the debate and concern over the unspent SCHIP allotments. At the center of countless state headlines was the loss of federal money, not the requirement for state matching dollars. Whether the magic was children, enhanced matching ratios, or state flexibility in design and control of the program, it was a stark and welcome contrast to the type of attention public health insurance programs often receive. The SCHIP story in the pages that follow may provide vital clues to more effective federal state partnerships.

If SCHIP was one of 2000's success stories, partnerships with employer-based coverage and supporting working families had to be one of the struggles of 2000. It is not that states haven't found ways to be active and craft programs in this critical arena; it is that federal program limitations, often designed with good intentions, have resulted in states opting for state-only programs or for a tremendous administrative investment to receive the federal dollars. The bottom line has been much smaller numbers actually enrolled in state programs for the working uninsured. Working parents and working adults without children remain a critical challenge, and the states will be exploring the limits of the new SCHIP 1115 demonstration authority to see how flexible a partner the new federal administration will be. Finding ways to maintain and complement private employer coverage for workers is critical to states as they design the next incremental steps in health care expansion.

Also available to help the states explore and develop opportunities for covering the uninsured is a new federal program for 2000 that is providing State Planning Grants from the Heath Resources and Services Administration (HRSA). After a decade of incremental strategies, new federal dollars are going to states to help them better understand and plan for health insurance coverage for all uninsured citizens. The states' response to the offer of a state planning grant was greater than HRSA anticipated, demonstrating both the states' continued commitment to expanding coverage and the power of a federal financial incentive. The infusion of funds for planning and research will encourage states to pursue further the distinctive approaches and creativity that have marked the last decade, and the results may provide new directions for the federal, state, and private partnerships in expanding coverage.

This report provides a look at the themes and directions that characterize the states' work to bring health care coverage to their citizens. The picture is neither always neat nor uniformly positive, but as the pages that follow show, the states continue to make progress marked by growing numbers of people with access to health care coverage.

Percent of All People in Each State Without Health Insurance, throughout 1999



Actual Numbers Reflected in Percentages Above

State	*Number of Uninsured*
Alabama	632,000
Alaska	120,000
Arizona	1,035,000
Arkansas	378,000
California	6,901,000
Colorado	710,000
Connecticut	327,000
Delaware	87,000
District of Columbia	80,000
Florida	2,893,000
Georgia	1,260,000
Hawaii	135,000
Idaho	239,000

State	*Number of Uninsured*
Illinois	1,718,000
Indiana	638,000
Iowa	234,000
Kansas	317,000
Kentucky	566,000
Louisiana	968,000
Maine	151,000
Maryland	597,000
Massachusetts	648,000
Michigan	1,132,000
Minnesota	386,000
Mississippi	458,000
Missouri	473,000

State	*Number of Uninsured*
Montana	168,000
Nebraska	179,000
Nevada	400,000
New Hampshire	128,000
New Jersey	1,090,000
New Mexico	463,000
New York	3,044,000
North Carolina	1,154,000
North Dakota	72,000
Ohio	1,247,000
Oklahoma	571,000
Oregon	498,000
Pennsylvania	1,111,000

State	*Number of Uninsured*
Rhode Island	68,000
South Carolina	673,000
South Dakota	83,000
Tennessee	637,000
Texas	4,665,000
Utah	305,000
Vermont	74,000
Virginia	967,000
Washington	898,000
West Virginia	300,000
Wisconsin	595,000
Wyoming	78.000

Source: U.S. Census Bureau, Current Population Reports, September 2000.

States Extend Coverage Programs in 2000

SCHIP Comes of Age

By far the most common approach states have taken to extend coverage in recent years has been the State Children's Health Insurance Program (SCHIP). In seeking to expand health insurance coverage incrementally, states and the federal government have elected to provide coverage to low-income children as a first step. Encouraged by SCHIP's enhanced federal financial support (relative to Medicaid), all 50 states and the District of Columbia have established SCHIP programs extending coverage to more of these children.

Thirty-eight states now provide coverage to children in families with incomes up to 200 percent of the federal poverty level (FPL).[1] Prior to SCHIP, only four states — Minnesota, Tennessee, Vermont, and Washington — reached that level of coverage for children. Under SCHIP, several states — including Connecticut, Missouri, and Vermont — have raised eligibility as high as 300 percent FPL. New Jersey has extended coverage to 350 percent FPL through its KidCare program.

[1] Currently, federal poverty limits for a family of four correspond to the following annual income levels: 100 percent FPL ($17,050); 150 percent FPL ($25,575); 200 percent FPL ($34,100); 250 percent FPL ($42,625); 300 percent FPL ($51,150); 350 percent FPL ($59,675).

Under Title XXI of the Social Security Act (which established SCHIP), states are technically permitted to extend coverage to 200 percent FPL, or, if they had Medicaid expansions already in place, to 50 percentage points above the eligibility levels in effect prior to SCHIP's enactment. For example, Vermont was able to use SCHIP's federal matching funds to expand eligibility to children from 250 percent to 300 percent of poverty under its Section 1115 Medicaid Demonstration program.

Some states that did not have Medicaid expansions in place prior to SCHIP have increased SCHIP eligibility above the 200 percent FPL limit by using income disregards, an accounting technique that enables states to increase the number of applicants who qualify for the SCHIP program without changing the actual eligibility limit. For example, although the income threshold for the Connecticut HUSKY program technically remains at 200 percent FPL, the state disregards all applicant income between 200 and 300 percent FPL, effectively raising the income limit to 300 percent FPL. State Medicaid programs also use income disregards in determining eligibility, for example by disregarding $90 in monthly income in order to account for necessary work-related expenses. Under SCHIP, all states have the option of increasing eligibility above 200 percent FPL through the use of income disregards although only a few states have done so thus far.

In 1997 when the SCHIP legislation passed, the Census Bureau estimated that approximately 11 million children under age 18 were without health insurance in the United States (see box below). The SCHIP program targeted those children in families with incomes too high to qualify for Medicaid, but too low to afford private

Estimates of Uninsured Children

After steadily increasing during the 1990s, the rate of uninsured children began to decline in 1999. Current Population Survey (CPS) estimates show that, between 1998 and 1999, the percent of uninsured children under age 18 in the U.S. decreased from 15.4 percent to 13.9 percent. These gains in children's insurance coverage followed the nationwide implementation of the SCHIP program, the stabilization of previous declines in Medicaid enrollment resulting from welfare reform, and gains in employer-sponsored coverage.

Data From	*Uninsured Children (<18 years)*	*Percent Uninsured*
1996	10.6 million	14.8%
1997	10.7 million	15.0%
1998	11.1 million	15.4%
1999	10.0 million	13.9%

Source: HCFA Annual Enrollment Reports (http://www.hcfa.gov/init/children)

Note: Including 18 year-olds, the number of uninsured children in the U.S. decreased from 11.9 million in 1998 to 10.8 million in 1999.

SCHIP Enrollment

At the end of each fiscal year, the Health Care Financing Administration releases enrollment figures for SCHIP based on the latest state reports. The enrollment figures represent the unduplicated number of children enrolled in state SCHIP programs during that year (from the beginning of October to the end of September). Each child is counted only once, no matter how many times a child may have been enrolled during the course of the year. However, since the data show the total number of children enrolled during the entire year, the enrollment numbers will generally be higher than the number of children enrolled in SCHIP at any given point in time during the year.

Fiscal Year	*Dates*	*Total SCHIP Enrollment*	*Separate Program*	*Medicaid Expansion*
FY1998	10/1/97 – 9/30/98	@ 1,000,000*	N/A	N/A
FY1999	10/1/98 – 9/30/99	1,979,450	1,284,387	695,063
FY2000	10/1/99 – 9/30/00	3,333,879	2,325,079	1,008,800
FY2001	10/1/00 – 9/30/01	To be released December 2001		

** State reporting systems not fully in place*
Source: HCFA Annual Enrollment Reports (http://www.hcfa.gov/init/children.htm)

health coverage (specifically, those in families with incomes below 200 percent FPL). Of the 11 million uninsured children, approximately 7 million were low-income uninsured, but a significant number of those were eligible for Medicaid but not enrolled. They were, therefore, ineligible for SCHIP. Overall, the Congressional Budget Office estimated in 1997 that SCHIP would cover 2.7 million children per year,[2] and an additional 660,000 children would sign up for Medicaid because of SCHIP outreach efforts.[3]

The Clinton administration announced in January 2001 that an estimated 3.3 million children had been enrolled in SCHIP as of September 2000.[4] (See box above.) While enrollment growth was slow initially, enrollment has accelerated. All states have SCHIP programs up and running, and extensive outreach and coordination efforts are underway. Overall, the percentage of children without insurance decreased from 15.4 percent to 13.9 percent between 1998 and 1999. Among near-poor children (those with family incomes between 100 and 199 percent FPL), uninsurance rates declined even more substantially, from 22.4 percent to 19.9 percent.

The success evident from SCHIP enrollment statistics is complicated by the fact that some enrollees were previously covered through employer-based or other private insurance (and, therefore, their enrollment in SCHIP did not reduce the overall number of uninsured children). A formal, national evaluation of SCHIP, including the extent of private market substitution (or "crowd-out"), is underway, and the issue will be taken up in the Report to the Congress that the Secretary of Health and Human Services must submit by December 2001 (see box on page 8.). Overall, however, both increasing SCHIP enrollment and the higher rates of coverage in the private market resulting from the strong economy appears to have helped to reduce uninsurance rates.

Another factor contributing to the reductions in the number of uninsured children in the late 1990s was that Medicaid enrollment declines resulting from the 1996 welfare reform law began to stabilize. As an increasing number of families left the welfare rolls following welfare reform, many families with children left Medicaid coverage, not realizing that they remained eligible. (See Welfare Reform box on page 14.) No doubt, many of these newly uninsured families saw the advertisements for SCHIP and applied to that program.

Because the federal government requires states to screen for Medicaid eligibility before enrolling children in SCHIP, many were eventually re-enrolled in Medicaid. Still, while Medicaid is an entitlement program with a highly comprehensive package of benefits, the program continues to carry a welfare stigma that deters many eligibles from enrolling. States such as Washington that allow families to choose between Medicaid and a separate state-designed program (the Washington Basic Health Plan — BHP) have found that many families prefer BHP, despite being required to pay premiums and receiving "less generous" benefits than Medicaid.

[2] These estimates assumed a participation rate of 55 percent among eligible uninsured children. See "Budgetary Implications of the Balanced Budget Act of 1997," CBO Memorandum, December 1997.

[3] Title XXI also increased Medicaid enrollment by affording states an opportunity to implement presumptive eligibility and 12-month continuous eligibility for children under Medicaid.

[4] HCFA enrollment figures represent that unduplicated number of children who were covered through SCHIP during the course of the entire year. The figures are therefore higher than current program enrollment figures, but lower than a count of all children ever enrolled in SCHIP.

In October, New York was cited for enrolling a sizable number of Medicaid-eligible children in its SCHIP program, called Child Health Plus (CHPlus). State and insurer estimates found that between one-fourth and one-half of New York's 538,000 CHPlus enrollees were actually eligible for Medicaid. The state is working to resolve the issue by moving children who were inappropriately enrolled in CHPlus into Medicaid, but this transition has disrupted coverage for many families. The federal government is working with the state to try to ensure that no children lose coverage during the transition between programs.

Taken together, the Medicaid and SCHIP programs cover a sizable proportion of the nation's uninsured children, and current law enables states to cover significantly more children under these programs if they

Enrolling Children

States have implemented a wide variety of outreach strategies to bring more eligible children into the SCHIP program. Listed below are examples of specific outreach strategies — compiled by The Robert Wood Johnson Foundation's *Covering Kids* program — that are currently being employed by states and local communities.

Outreach Type	*Specific Examples–*
School-based	Free or reduced lunch programs, Parent-Teacher Associations (PTAs), school registration materials, report card inserts
Printed materials	Brochures, flyers, postcards, posters
Broadcast media public service announcements	Donated or purchased
Toll-free help lines	Accept applications over the phone, triage referral service
Web-based	Online application form, Listserv
Identification of uninsured through data matches	Immunization registries, hospital discharge/newborn packets, hospital charity care databases, school lunch programs
Targeted population efforts	Rural, immigrant/migrants, Hispanic/Latinos, Tribal/Native Americans, teenagers/adolescents, African-Americans, Asians, homeless, low-income
Provider-based	Clinics, hospitals, physicians' offices, pharmacies, mobile health units, health trade associations, mental health/addiction centers, nurse midwives
Employer-based	Labor unions, city and state chambers of commerce, factories, seasonal employers, worksite enrollment events
Training	Provider, volunteer/peer, clergy, agency caseworkers, school personnel, employers
Retail-based	Shopping and outlet malls, grocery and convenience stores, discount stores, flea markets, thrift stores, and automated kiosks
Informational/promotional inserts	Utility bills, shoeboxes, store bags, employee paychecks, phone bills, church bulletins, or bank statements
Special events	Door-to-door canvassing, community meetings, gala state SCHIP launch, special "enrollment days" at schools
Non-conventional locations for posting outreach workers and/or distributing print materials	Housing authorities, fast food restaurants (tray liners, menus, packaging), homeless shelters, bus and subway stations, vehicle and video rental locations, laundromats, little league games, police stations, welfare-to-work classes, bingo halls, mobile dental care units, domestic violence shelters, and food banks
Non-conventional conduits for distributing information	School district English as a Second Language (ESL) programs, nurse midwives associations, YMCAs and 4-H clubs

Source: Southern Institute on Children and Families, Covering Kids program website: http://coveringkids.org/outreach-ideas.html

choose. In September, the Clinton administration announced that, of the remaining uninsured children that had been identified, two-thirds could have coverage under existing law if states enrolled all children eligible for Medicaid and SCHIP. In addition, a study released in December by the Center on Budget and Policy Priorities showed that nearly 95 percent of low-income uninsured children are eligible for coverage under these public programs.

Reaching Out for SCHIP Enrollment

Today, extensive outreach efforts are underway to bring in more children who are eligible but not enrolled. In 2000, the federal government awarded $700,000 in grants to states to investigate the effectiveness of specific outreach and enrollment simplification strategies. Florida is now piloting a new electronic application process aimed at reaching minority children served by day care centers. Ohio and Pennsylvania are examining whether allowing self-declaration of income — so that the applicant does not have to provide pay stubs or other proof of income — is effective in increasing take-up rates. In addition, The Robert Wood Johnson Foundation's *Covering Kids* program continues to support state efforts to expand outreach and increase SCHIP and Medicaid enrollment. The Foundation has awarded grants in all 50 states to support outreach activities under the *Covering Kids* program, supplementing the outreach efforts being made individually by the state SCHIP programs.

Indiana's Outreach Efforts for Medicaid and SCHIP

Indiana is one state that has sought to improve outreach for its Medicaid and SCHIP programs and to make the two programs seamless. Indiana now covers all children up to 200 percent of the poverty level under their Hoosier Healthwise program, covering the lowest income children through Medicaid, and the higher income eligible children through SCHIP. "We're trying to reduce the stigma of Medicaid by making the programs seamless," says, Nancy Cobb, director of the Indiana SCHIP program. "We feel that members don't care what their funding source is, they just want health coverage they can participate in, and they want to be treated with dignity."

Indiana — like many other states — has created a joint application for Medicaid and SCHIP, which helps ease the application process. It offers a toll-free number that provides callers with information about both programs. In addition, the state has combined the identification cards for Medicaid and SCHIP, and has spruced up their appearance. The old cards were grey and read "Medicaid and Other Public Assistance Programs" along the front. Cobb says, "Now, it's a pretty blue and gold card that says 'Hoosier Health Card.'" With these cards, she says, "There is no stigma when you pull it out of your purse at the doctor's office."

In order to achieve buy-in and improve program outreach at the local level, Indiana estimated the number of eligible uninsured children in each county and required the directors of the local Division of Families and Children (DFC) offices to submit plans detailing how they would cover that number of children. The state then provided the DFC directors with additional funding to assist with outreach. Though they were aware that the county uninsured figures were very rough estimates, the state published a scorecard each month measuring progress toward the goal. This provided the county offices with an incentive to increase enrollment in contrast to the past when the DFC offices were encouraged to bring down the welfare rolls and ensure that ineligible applicants were not accepted into state programs. "To meet their goals, county offices had to become a lot friendlier," says Cobb. "It also required them to reach out to partners in the community."

SCHIP Allotments

The Balanced Budget Act of 1997 established Title XXI of the Social Security Act and allocated $40 million to the SCHIP program over 10 years. Due to outyear budget constraints, funding levels for the program vary over time, shrinking to $3.15 billion beginning next year and increasing to $5 billion by FY2007. Title XXI initially allowed states to have just three years to spend their allotments for a given fiscal year, after which those funds would be reallocated to other states. In December, Congress provided states with additional time to spend these allotments.

Fiscal Year	*Total SCHIP Allotments*
FY1998	$4.275 billion
FY1999	$4.275 billion
FY2000	$4.275 billion
FY2001	$4.275 billion
FY2002	$3.15 billion
FY2003	$3.15 billion
FY2004	$3.15 billion
FY2005	$4.05 billion
FY2006	$4.05 billion
FY2007	$5 billion
Total	$39.65 billion

NOTE: The federal fiscal year begins on October 1 and ends on September 30. FY2001 began on October 1, 2000.

Evaluating the SCHIP Program

States must submit annual progress reports to the Secretary of Health and Human Services after each fiscal year (due January 1). These reports assess the operation of the state's SCHIP program over the year, including the progress made in reducing the number of uninsured children. In addition, Title XXI required states to submit a formal evaluation to the secretary by March 31, 2000. The specific components of the evaluation were detailed in the Title XXI law, including an assessment of the program's effectiveness in increasing health coverage; a description of the elements of the state plan (including eligibility criteria, benefits and cost-sharing, and program coordination activities); and recommendations to the federal government on how to improve the SCHIP program overall.

The individual state evaluations will be used to prepare a report to Congress, which is due by December 31, 2001. That report will provide an overview of state SCHIP programs, discuss specific achievements and ongoing challenges, and identify best practices in areas such as outreach and enrollment simplification.

In addition, the Balanced Budget Refinement Act of 1999 directed the secretary to conduct a new $10 million federal evaluation of SCHIP focusing on the experience of ten states. The evaluation will include surveys of the target population, an assessment of various outreach strategies, a review of Medicaid and SCHIP program coordination, an analysis of the impact of cost-sharing requirements on enrollment, and an evaluation of retention issues. This new report will also be due to Congress on December 31, 2001.

States have found that many applicants are wary of coming in to local welfare offices to apply for coverage. This, together with application sites' inconvenient hours of operation, produces a barrier to enrollment. To address these problems, most states now have mail-in applications for both Medicaid and SCHIP, with follow-up telephone interviews. This ensures that applicants do not need to come to the welfare offices in person. Some states that maintain in-person interviews have changed their hours of operation to accommodate applicants' work schedules. The states' greater attention to customer service for SCHIP enrollees, who represent a higher income population than Medicaid, is also changing the culture of many state Medicaid programs.

For its part, Indiana has established in-person application centers for Medicaid and SCHIP at locations other than the local welfare offices. According to Cobb, "We knew that a lot of families wouldn't want to go to their local DFC office, so we now have around the state 500 enrollment centers that have participated in enrollment training, but the most effective enrollment centers were the ones with vested interest in getting people enrolled, such as community health centers and hospitals."

Of all the outreach and enrollment simplification efforts made in Indiana, Cobb says that "one of the most successful outreach projects was the radio and TV ad campaign." Those ads included a jingle with the Hoosier Healthwise 800-number. In a story about the success of the ads in increasing enrollment, a *Chicago Tribune* journalist called the jingle "maddeningly indelible." Cobb says that "a lot of people complained that they couldn't get the jingle out of their minds," which of course meant that the commercial succeeded in helping people to remember the number to call. The ad prompted a flood of enrollment applications. "We were overwhelmed, and I don't know that we've caught up with the backlog yet," Cobb said. "We were absolutely overwhelmed by the number of responses."

Cobb observed, however, that the ads "wouldn't have been as successful if we hadn't done some of the other groundwork before that." She recommends that states be sure to have adequate administrative structures in place before launching a large advertising campaign. "If there are states out there that think that people don't want health insurance, that's just not the case."

The Unspent SCHIP Funds Controversy

Title XXI authorized states to receive $40 billion over 10 years to provide coverage under SCHIP (see box on page 7). States receive an allotment each year based both on the number of low-income uninsured children in the state and on health care cost factors.[5] The original legislation provided states with a three-year period within which to spend the allocation for a given fiscal year, and on September 30, 2000 (the end of the federal fiscal year 2000), the clock ran out on unspent SCHIP funds from FY98. In December, the Congress decided to provide states with some additional time to spend those allocations, but in late September, many states (and low-income families) were concerned that SCHIP funding was on the verge of being cut.

[5] Beginning in FY2001, SCHIP allocations will be calculated based on a ratio of low-income children and low-income uninsured children in the state. This allows a greater percentage of the SCHIP funds to be allocated to states that are succeeding in bringing down the number of low-income uninsured children.

Under the original provisions of Title XXI, any unspent funds from FY98 would be reallocated to states that had used up their FY98 allocations by the September 30, 2000, deadline. In September, *The New York Times* reported that almost 50 percent of the $4.3 billion provided by Congress for fiscal year 1998 remained unspent three years after SCHIP's enactment.[6] California and Texas, the two states with the largest unused SCHIP allocations, accounted for more than half of the unspent money ($590 million and $446 million, respectively). Overall, the *Times* reported, only 10 states had spent all of their FY98 funds.[7] Under the provisions of law initially established in Title XXI, those 10 states were projected to receive almost $2 billion in redistributed SCHIP funds.

Before December, when Congress provided the states with an additional two years to spend their FY98 allocations, it looked as though as many as 40 states could lose significant amounts of federal funding. Most were under pressure to explain why the money had not been spent, and, in some cases, to calm the fears of parents who heard that their children might lose coverage. In September, a statewide newspaper in Georgia ran a front-page article with the banner headline: "Children Losing Coverage." Jana Leigh Key, director of the Peach Care for Kids program, said, "two thousand parents called because they had heard that Peach Care was losing funding."

In reality, the loss of unspent SCHIP funds would not have caused any Georgia families to lose coverage, a point not made clear in early press accounts. In Georgia, as in many other states, the reallocation would have meant only that further expansions of coverage would have been more difficult.

A number of factors prevented states from spending their full FY98 allotments within the first three years of the program. While some states, including New York and Pennsylvania, had state-only children's coverage programs already in place when SCHIP was passed in 1997, most states had to create programs from scratch. Those states had to make numerous program design decisions (about eligibility, benefits, and cost-sharing requirements) and to create an infrastructure and procedures to administer the program — including application processes, enrollment staff, contractual arrangements with plans and providers, and outreach.[8]

Many states implemented their coverage expansions in phases so that they could begin enrolling some children while making further design decisions and putting the administrative structures in place to expand coverage to additional children. For example, Alabama and Arkansas expanded coverage to all children under age 19 living in families with incomes of up to 100 percent FPL as a first step in implementing their SCHIP programs, and later implemented expansions to all children up to 200 percent FPL.[9] Because the eligibility increases were phased in over time, however, the expansions brought in relatively few children during the early months of the program, which was one factor in SCHIP's slow initial enrollment.

Georgia Seeking to Accelerate Enrollment and Spending

Georgia is one of the 40 states that had not expended all of its FY98 funds. In its initial SCHIP plan, Georgia expanded coverage to all children up to 200 percent FPL. Since the Peach Care for Kids program was implemented in September 1998, the state has conducted extensive outreach efforts and has enrolled more than 100,000 children in the program. Peach Care's advertising campaigns have received numerous accolades, including a PR Week Magazine award for the best public service campaign and a National Health Information Award.

SCHIP Director Jana Key notes that since the start of the program, Peach Care advertisements have used the slogan: "Now you can afford peace of mind." The effectiveness of this message was recently validated in a study sponsored by The Robert Wood Johnson Foundation's *Covering Kids* program, which found that emphasizing the peace of mind that comes from having health coverage is one of the most persuasive outreach strategies that states can use to reach eligible families.

Georgia also conducted focus groups with parents of eligible but not enrolled children to find out why the families had not signed up for coverage. The state found that "the reason why they hadn't applied was because they didn't think they'd be eligible," says Key. In response, Peach Care now states specifically on its posters and other materials that families of four with incomes under $40,000 per year qualify for the program.

[6] These spending figures were based on financial data provided by states in March 2000. Later financial reports revealed that a higher percentage of SCHIP funds had in fact been spent by the September deadline.

[7] The financial reports submitted by the states in the late fall are expected to reveal that additional states had spent their entire FY98 allotments.

[8] Moreover, SCHIP provided very little financial support for those start-up costs. Title XXI permitted states to devote only 10 percent of program expenditures on administrative expenses. Because there were few children enrolled in the early stages of the program, 10 percent of program expenditures did not extend very far.

[9] When SCHIP was passed, Medicaid eligibility for these older children below the poverty level was already being phased in. A number of states elected to speed up the phase-in using enhanced federal matching funds under SCHIP.

In addition to the time it took to ramp up the state SCHIP programs, another reason that some states were unable to expend all of their allotted funds is that the allotments were too large relative to the size of the eligible population. Under Title XXI, state SCHIP allotments are based on uninsurance estimates from the Current Population Survey (CPS), which is conducted annually by the Census Bureau. The CPS is a national survey, but is not designed to provide reliable state-level estimates. In linking allotments to the CPS estimates — still the best measure currently available for all 50 states — Title XXI overestimated the amount of money some states would need and underestimated the amount for others.

"CPS really underestimated the number of uninsured children in Indiana," says Cobb. The inaccurate estimate of the uninsured produced a lower FY98 allotment, which Indiana was able to expend within the three-year period. Although Indiana has enrolled 140,000 children in Hoosier Healthwise (both Medicaid and SCHIP), a state survey found that 55,000 children in families below 200 percent FPL remain without health insurance.

As described above, Indiana was able to do a number of things to accelerate program enrollment, such as improving its administrative systems, reducing the stigma often attached to Medicaid, and effectively advertising the program. Still, Indiana only implemented the second phase of its expansion in January 2000, meaning that for most of the three-year period, SCHIP eligibility in Indiana extended only to children in families with incomes below 150 percent FPL.

Covering the Parents of Enrolled Children

Partially because many states have unexpended SCHIP funds still available, a number of states have begun to examine the possibility of extending coverage to the parents of eligible children. Research has also begun to show that by extending coverage to parents, states are more likely to bring in children who are eligible but not enrolled. In addition, now that states have expanded eligibility to most low-income children, many believe that covering low-income parents represents the logical next step in expanding health insurance.

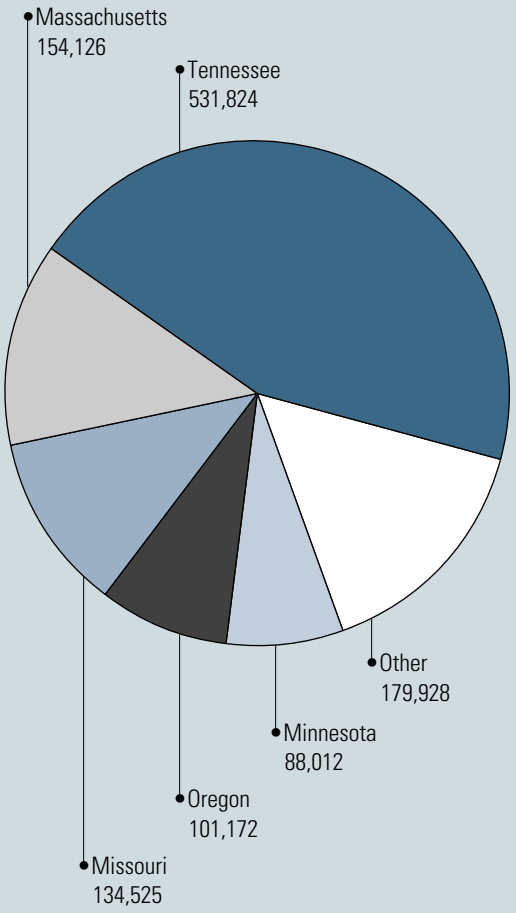
Title XXI contains a waiver provision for providing family coverage through SCHIP. Over the first three years of the program, three states received federal approval to use SCHIP funds to purchase coverage for eligible families through employer-based plans. In July 2000, HCFA provided guidance for states seeking to obtain broader waivers of SCHIP regulations, and by early January 2001, seven states had submitted SCHIP waiver applications, four of which sought to expand coverage directly to parents (see pages 13-15).

Over the last decade, many states have relied on Medicaid Section 1115 Research and Demonstration waivers to extend health care coverage to families and other working adults. More recently, states have begun also to expand coverage through Medicaid Section 1931 income disregards, and some states (including Washington and Oregon) have designed their own programs using only state funds in order to avoid the constraints that come with federal funding.

Medicaid Section 1115 Research and Demonstration Programs

Prior to the availability of enhanced federal matching funds through SCHIP, many states used Section 1115 Research and Demonstration waivers to achieve significant expansions of coverage through their Medicaid programs (See chart below). These waivers allowed states to eliminate certain requirements of the traditional

Number of Enrollees in Section 1115 Demonstrations (by State)



Source: Current Enrollment in Approved Section 1115 Demonstrations (9/29/00). Health Care Financing Administration.

Note: Figures represent the number of new persons enrolled due to the state Section 1115 Demonstration waivers as of September 29, 2000.

Medicaid program (e.g., freedom of choice of providers) to achieve cost savings and expand program eligibility. A number of states used this waiver authority to implement Medicaid managed care in order to reduce program costs. Some states applied these savings toward new programs to expand coverage, such as MinnesotaCare, TennCare, RIte Care, and the Oregon Health Plan.

Although federal executive authority to waive some requirements of the Medicaid program has existed since the 1960s, states began to implement federal waivers in significant numbers only in the last decade. In 1993, the Clinton administration eliminated a significant barrier to Medicaid waiver programs by easing the budget neutrality test, which required states to show that federal costs over the period of the demonstration program would not exceed projected costs under the smaller, pre-waiver program. A series of states then applied for and received approval to implement Medicaid demonstration programs, including Tennessee (1994), Oregon (1994), Hawaii (1994), Rhode Island (1994), Minnesota (1995), Vermont (1996), and Delaware (1996). Some of these programs covered children, some extended coverage to families, and others covered all adults up to particular levels of income, eliminating categorical eligibility for the program.[10]

"States have used 1115 authority to expand coverage in ways that wouldn't otherwise be possible," says Theresa Sachs, technical director at the Center for Medicaid and State Operations at HCFA. For example, Minnesota used its 1115 waiver authority to extend coverage to all families with incomes up to 275 percent FPL through the MinnesotaCare program. The program offers coverage with sliding scale premiums to families with incomes up to $46,900. In addition, adults with no children are eligible for MinnesotaCare coverage up to 175 percent FPL.[11]

Using 1115 waivers, Delaware and Oregon eliminated categorical eligibility and extended Medicaid coverage to all non-elderly residents with incomes below 100 percent of poverty. Sachs notes that "Oregon has been very innovative with their 1115 demonstration. In order to afford the expansion, Oregon created a priority list of benefits or list of conditions and treatments that would be covered. Oregon departed from the standard Medicaid benefit package while other states maintained that same benefit package." She notes that "Tennessee was innovative just in terms of the sheer size of their expansion." Sachs adds that the savings in TennCare stemmed partly from lowering provider payments.

Tennessee implemented TennCare — the largest of the 1115 Medicaid expansions — in 1994, but the program has faced difficulties since its inception because it attempted a rapid shift of all Medicaid enrollees from fee-for-service health plans into capitated managed care arrangements. The providers and the plans serving the program have repeatedly said that payments were too low and some have stopped participating. Tennessee's federal Medicaid waiver is scheduled to expire December 31, 2001, and the state is now considering whether to let the program close — potentially leaving 350,000 state residents without coverage — or to modify and stabilize the existing program. In November 2000, the Governor's Commission on the Future of TennCare produced its final report, which recommended maintaining the current program with a number of modifications. For example, the commission proposed that TennCare be divided into three distinct programs — separating traditional low-income Medicaid eligibles from the chronically ill and establishing a buy-in program for TennCare eligibles with access to employer-based coverage. Governor Sundquist supports the commission's recommendations, but it is unclear how the state legislature, which will take up the issue during its 2001 session, will respond.

Expanding Medicaid Eligibility through Section 1931 Income Disregards

States may also use the flexibility provided under Section 1931 of the Social Security Act to expand Medicaid coverage to working families. Section 1931 allows states to disregard any portion of an applicant's income when determining eligibility, thereby increasing the number of applicants that qualify. The provision is designed to expand Medicaid coverage to families; it extends eligibility to the parents of children already eligible for Medicaid — whether that coverage is financed through Title XIX Medicaid or Title XXI's enhanced match — but not to adults without children or to parents of children eligible for a free-standing non-Medicaid SCHIP program.

Rhode Island Extending Coverage to Parents

Rhode Island is one state that has extended coverage to parents using Section 1931. Under the state's Medicaid 1115 program, RIte Care, children are covered up to 250 percent FPL. In addition, in 1998 the state began providing coverage under RIte Care for the parents of eligible children with incomes up to 185 percent of poverty using authority provided under Section 1931. RIte Care has been tremendously successful in enrolling eligible families, but this sizable enrollment increase has burdened the state budget beyond predictions.

Concerned that the expanded public coverage was in part substituting for coverage that was previously provided by the private market, (and therefore having less impact in reducing the overall number of uninsured) the state commissioned United Healthcare of New England to investigate

[10] Categorical eligibility for Medicaid includes poverty-related groups (such as low-income pregnant women and children), the disabled, and low-income seniors.

[11] This portion is funded without federal financial support.

the extent to which enrollees in its commercial products were switching directly into its RIte Care product. United conducted a one-year study and found that 4,200 of its 13,000 new RIte Care members in 1999 had switched directly from one of its commercial products. Families with incomes below 185 percent FPL accounted for 95 percent of the substitution. According to Tricia Leddy, administrator of the Center for Child and Family Health in the Rhode Island Department of Human Services, "We're seeing significant substitution and, under 1931 rules, we're not able to implement affordability tests or firewalls [such as a waiting period], which would be effective deterrents to substitution."

During the time period investigated in the study, Rhode Island's insurance markets underwent significant turmoil. One of the few insurance plans serving the state, Harvard Pilgrim Health Care of New England, left the market; insurance rates in Rhode Island climbed steadily, and many residents were looking for alternative sources of coverage. Families faced with high increases in their contribution to employer-sponsored coverage were attracted to RIte Care, which is available to families of four earning up to $30,000 per year, because the program offered a generous package of benefits, minimal cost-sharing, and no waiting period for applicants under 185 percent FPL. This combination of factors contributed to high crowdout rates for the state.

In July 2000, the state responded to the instability in Rhode Island's insurance market and to RIte Care's resulting substitution problem by enacting Health Reform RI 2000. This legislation established a new RIte Share premium assistance program designed to support — rather than replace — existing private coverage. Pending federal approval, the law also will establish a six-month waiting period for RIte Care applicants and increase cost-sharing to enrollees over 150 percent FPL. The law also instituted small-group insurance market reform and amended some insurance regulations, for example, requiring exiting plans to provide at least six months notice before leaving the state.

While some states had received federal approval to increase enrollee cost-sharing and institute waiting periods under their 1115 demonstration programs, HCFA was not eager to allow such a waiver for the 1931 expansion group in RIte Care and RIte Share. Rhode Island submitted a Medicaid waiver request in August 2000, but, according to Leddy, "HCFA was very discouraging about our Medicaid waiver request, even though similar waiting period and cost-sharing provisions had been approved in other states such as Minnesota and Wisconsin. In particular, they don't like the idea of an affordability test or waiting period to deter substitution under 1931."

Around that same time, however, HCFA released guidance for states seeking to obtain waivers under the SCHIP program. This provided another approach for Rhode Island, which submitted a SCHIP waiver request in early November 2000 seeking to move all 1931 expansion parents enrolled in RIte Care into SCHIP family coverage. Still under review, the SCHIP waiver could allow Rhode Island to receive enhanced match to cover these parents, apply both SCHIP's required waiting periods, and impose cost-sharing provisions to this group.

Leddy says that this "highlights the differences in policy between Medicaid and SCHIP rules. Medicaid rules are designed to protect families in poverty; only minimum cost-sharing is allowed, such as $2 co-pays, and no waiting periods to deter substitution. SCHIP is a more recent program, and it targets a different population — children in working families who may have access to employer-sponsored coverage. SCHIP not only allows but requires a waiting period to deter substitution and allows cost-sharing consistent with commercial insurance."

Given Rhode Island's experience with Medicaid Section 1931 — both the substitution problem and HCFA's unwillingness to permit either waiting periods or enrollee cost-sharing requirements to deter substitution — Leddy concluded that "states should progress cautiously with 1931 expansions, evaluate the state's private insurance market, and consider incremental expansions while watching for substitution." Meanwhile, a number of states, including Pennsylvania, New York, and the District of Columbia,[12] are continuing to operate coverage expansions using Medicaid Section 1931.

[12] Pennsylvania disregards 50 percent of applicant income in determining Medicaid eligibility; New York disregards $90 in monthly income, plus 46 percent of remaining income; the District of Columbia disregards all income above its Aid for Families with Dependent Children limit and 200 percent FPL.

SCHIP Waivers: A New Approach to Family Coverage and Employer Buy-Ins

Five states — Massachusetts, Wisconsin, Mississippi, Virginia, and Maryland — have received federal approval to pay for private coverage using SCHIP funds in cases where it is cost-effective. Mississippi, Maryland, and Virginia have approval to pay only for coverage of children while Massachusetts and Wisconsin have approval to cover entire families if cost effectiveness can be demonstrated. To prove cost-effectiveness for family coverage, states must show that the cost to the federal government of covering the parents and the children under the private plan does not exceed the cost of covering the children alone under the public program.[13] Typically, this can only be accomplished through employer buy-in programs where the employer is paying a significant portion of the premiums. The SCHIP family coverage programs currently in operation do not count parents as program enrollees; rather, their coverage is considered an ancillary benefit of supporting employer coverage for children.

In July, HCFA released guidance to states seeking broader waiver authority to extend eligibility to parents under SCHIP, or to waive other provisions included in the Title XXI law. In a Dear State Health Official letter dated July 31, 2000, Tim Westmoreland, director of the Center for Medicaid and State Operations at HCFA, stated that "the purpose of SCHIP 1115 demonstrations is to allow states to illustrate how state-initiated innovations, not otherwise permitted under the law, will help them accomplish the goals of the program."

HCFA sought to gain experience in implementing the early SCHIP programs before granting waivers to selected provisions of Title XXI. With more experience accumulated under the program, the federal government is now implementing a waiver process that builds on the Medicaid Section 1115 waiver model. In doing so, the federal government appears to be giving tacit approval of the innovations states have made through their Medicaid waiver programs. Sachs says that "the implementation of SCHIP 1115 does show that the Medicaid waiver programs have been successful."

As of early January 2001, seven states — California, Minnesota, New Jersey, New Mexico, Oregon, Rhode Island, and Wisconsin — had submitted SCHIP 1115 waiver requests to HCFA. Four states — California, New Jersey, Rhode Island, and Wisconsin — are seeking to extend coverage to the parents of children eligible for SCHIP or Medicaid. In addition, SCHIP waivers will allow states to receive an enhanced match to cover parents with incomes above 100 percent FPL who were already eligible for public coverage prior to March 31, 2000. States may also use the SCHIP waivers to add benefits not currently offered under the program, such as respite care for special needs children.

Cobb of Indiana reports that "HCFA has said that they will expedite those waivers in order to the speed the process and make it more efficient and useful." This addresses one of the concerns of states: that the application process for Medicaid 1115 waivers has been unduly long and complicated. HCFA has released a draft template for SCHIP demonstration applications. According to Cobb, HCFA has "made it very clear that they are really interested in having states cover parents this way. They are looking at data showing that if you cover the parents, you will get more kids."

In order to qualify for an SCHIP waiver to cover populations other than targeted low-income children, a state must meet several requirements. It must already have expanded coverage to all children with family incomes up to at least 200 percent FPL, and the SCHIP program must be enrolling children on a statewide basis without a waiting list. In addition, it must have adopted at least three of the following policies and procedures: elimination of assets tests; presumptive eligibility for children; 12-month continuous eligibility; use of a joint mail-in application form and common application procedures if the state has separate Medicaid and SCHIP programs; procedures (e.g., mail-in forms) that simplify redetermination; and other efforts to promote seamlessness between programs (e.g., no new application form required when transitioning between programs and no gap in coverage).

Although SCHIP waivers will not change federal requirements that employer benefits meet a benchmark standard and that employers make a significant premium contribution, the waivers may enable states with existing premium assistance programs to expand beyond current enrollment levels. To date, states that have been leaders in establishing employer buy-in programs under SCHIP — Massachusetts and Wisconsin — have enrolled relatively few families in that portion of their programs although they have had great success in overall program enrollment. This is primarily due to eligibility restrictions under SCHIP, such as the federal requirement that employer benefits meet a benchmark standard and that employers make a significant premium contribution in order for the employee to qualify for a subsidy.[14] SCHIP 1115 waivers could potentially allow states to eliminate these barriers to enrollment. Rhode Island's waiver, for example, requests a simplified cost-effectiveness methodology under SCHIP intended to streamline administration of the RIte Share premium assistance program.

[13] In addition, the state must show that the private plan meets other SCHIP requirements, including that it provides an adequate level of benefits and ensures that cost-sharing requirements does not exceed 5 percent of the family's annual income.

[14] New SCHIP regulations released by HCFA in January 2001 eliminated a previous requirement that employers contribute at least 60 percent of the premium cost in order for the employee to qualify. States are now able to identify their own reasonable employer-contribution level, based on state-level date and experience.

The Aftermath of Welfare Reform: States' Efforts Diminish Medicaid Drop-offs

Prior to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the receipt of cash assistance through Aid to Families with Dependent Children (AFDC) guaranteed automatic eligibility and enrollment in Medicaid. Welfare reform de-linked Medicaid and welfare eligibility, thus making Medicaid available to low-income families not eligible to receive cash assistance (now known as Temporary Aid to Needy Families—TANF).

Despite efforts and intentions to the contrary, welfare reform has had a negative effect on Medicaid rolls. A study conducted by Families USA in June 2000 shows that from January 1996 to December 1999, low-income parents' enrollment declined an average of 27 percent over the states studied. Georgia, for example, experienced a 50 percent decline in enrollment of parents, while Tennessee experienced an 11 percent decline. Causes for the large drop-offs in enrollment have been identified as: 1) administrative problems from the incomplete de-linkage of Medicaid and welfare (e.g. dated computer systems, caseworkers unfamiliar with the new law, and unrevised application policies determining eligibility); 2) lack of communication and outreach about what the de-linkage really means; and 3) an increase in income due to employment, often making the family ineligible.

Another report, produced by the Kaiser Commission on Medicaid and the Uninsured in April 2000, showed a 2.7 percent decline among states studied, from June 1997 to June 1998, and a decrease of only 1.4 percent over the following year. The states studied in this report, however, included three states with large increases in enrollment. Massachusetts, Arkansas, and Oklahoma experienced increases in enrollment of more than 20 percent from June 1997 to June 1999. These three states have been particularly active in combating the effects of welfare reform. Their approaches have included eligibility expansions, streamlined enrollment, and outreach campaigns. States are also updating computer systems, and conducting staff training to lessen the problems occurring from de-linkage.

Other states are using the flexibility of the Medicaid eligibility category, Section 1931, to cover low-income families that may not qualify for TANF. Section 1931 requires states to continue to provide Medicaid to families who meet the state AFDC income and eligibility requirements that were in effect at the time of the enactment of the PRWORA. Through Section 1931, states were also given broader flexibility to expand eligibility to higher income low-income families through Section 1931. California and Ohio have used Section 1931 flexibility to increase their eligible income levels to 108 percent of the federal poverty level, while the District of Columbia has used Section 1931 to increase its eligible income level to 200 percent of the federal poverty level. Some states, including Massachusetts and Mississippi, have also used Section 1931 to eliminate asset limits, and others, such as Alabama and Rhode Island, have used it to drop the family composition rule.

Both reports show a positive trend that states' efforts are decreasing the effects of welfare reform. Medicaid rolls are still dropping, but the rate of that fall is subsiding. An issue brief from the National Health Policy Forum suggests states may need to examine and perhaps redesign their Medicaid programs to make sure that low-income people do not become lost in the maze of new rules associated with welfare and Medicaid eligibility. It is apparent that many states are responding to the task and succeeding in their efforts to reverse the loss of eligible families from Medicaid.

For more information on the reports mentioned above, visit the following websites:

Go Directly to Work – Do Not Collect Health Insurance: Low-Income Families Lose Medicaid
Families USA, June 2000
http://www.familiesusa.org/pubs/gowrk.pdf

Medicaid Enrollment in 21 States: June 1997 to June 1999
Kaiser Commission on Medicaid and the Uninsured, April 2000
http://www.kff.org/content/2000/2190/pub2190.pdf

Welfare Reform and Its Impact on Medicaid: An Update
National Health Policy Forum, February 1999
http://www.nhpf.org/pdfs/8-732+(web).pdf

Tricia Leddy notes that states with premium assistance programs thus far have generally had low enrollment and limited cost savings. "But," she says, "what I find really interesting is that if you go to meetings with other states, you hear that this is where [they] are going." Many states are now moving in the direction of premium assistance, primarily because of the financial contribution that employers can provide toward coverage, as well as the widely held belief that states should support, rather than supplant, private coverage. "I am excited about the fact that we have asked for authority to try some new things under the SCHIP waiver to create an effective premium assistance program," Leddy says.

Oregon's Innovative Premium Assistance Program

Oregon's Family Health Insurance Assistance Program (FHIAP) was established in 1997, before SCHIP was enacted. The program has been operating since July 1998 and now serves approximately 5,000 enrollees. Funded entirely by the state, the program subsidizes the premiums that low-income families pay for employer-based or individual coverage. Families with incomes below 170 percent FPL are eligible to receive premium subsidies of 70 percent, 90 percent, or 95 percent, based on income. In addition to the current program enrollees, another 12,000 to 14,000 applicants are on the program's waiting list. "FHIAP is clearly addressing a need," says Robert DiPrete, director of the Oregon Health Council. "There is more demand for the private coverage option than there is funding."

State legislators have been concerned about the expense of the program and its exclusive reliance on state funds. Several Oregon lawmakers have advocated that the program seek federal matching funds to bolster its finances. Executive branch officials from Oregon have now been in negotiations with HCFA for more than a year seeking to address the challenges in bringing the FHIAP program into compliance with Title XXI.

To meet federal approval, the state would be required to develop ways to keep employer premium contributions, enrollee benefits and cost-sharing, and other program components in line with federal requirements. For example, the state would be required to verify that the benefit package offered through each applicant's employer plan meets the Title XXI benchmark although insurance plans typically do not define their benefits in uniform ways. If the employer plan is found to meet most of the benefit requirements but not all, the state would need to provide wrap-around coverage for those other benefits. John Santa, administrator of the Office for Oregon Health Plan Policy and Research, says that, in Oregon, "neither Medicaid nor FHIAP look forward to the complexity involved in administering the program that would meet HCFA approval."

Oregon submitted its SCHIP state plan amendment to HCFA in August 1999, but thus far, the two parties have not been able to reach an agreement. Oregon officials believe that with the added SCHIP funds, they could bring 2,000-3,000 more children into the program and also cover uninsured parents where Title XXI's cost-effectiveness rules permit. Still, Santa notes, "it's an incredibly tough fight for a few thousand kids at best. If we were getting 25,000 kids enrolled through SCHIP that would be different." Whether HCFA will provide states with more flexibility through the new SCHIP waivers is yet unclear. Still, a number of states have expressed interest in obtaining SCHIP waivers and are continuing their negotiations with HCFA. The Bush administration has also indicated that it may provide states with additional flexibility.

Hybrid Coverage Expansion Programs

Many states are expanding coverage through a combination of funding mechanisms. Several are using Medicaid programs together with SCHIP to extend coverage to both parents and children. Some, like Oregon, are using a combination of Medicaid, SCHIP, and separate state-designed programs. Key of Georgia says that the state is developing a coverage expansion proposal that includes parents and "combines everything."

To expand coverage to parents and children living in families with incomes less than 185 percent of poverty, Wisconsin works through its BadgerCare program, a hybrid SCHIP and Section 1115 Medicaid program with an employer buy-in component.[15] Enrollees sign up and experience the program the same way regardless of whether they are in Medicaid or SCHIP. Meanwhile, the state receives the regular Medicaid match or the enhanced SCHIP match, depending on the enrollee's age and income level. In cases where employer-based coverage is available, the employer plan must meet Medicaid or SCHIP standards (including benefits, cost-sharing, and cost-effectiveness) to draw the federal match.[16] Generally, the state receives an enhanced match to cover the children and a regular match to cover the parents. According to Wisconsin Medicaid Director Peggy Bartels, "the beauty of the program is its seamlessness; the enrollee doesn't need to know which they are applying for. We know that this is the way to go because these kids are going back and forth between Medicaid and SCHIP all the time."

BadgerCare was implemented in July 1999 and has had tremendous success in enrolling new members. After 15 months, the state had covered 91 percent of the target population. "The program obviously met a need," says Bartels. By the end of October 2000, "we had more people enrolled in BadgerCare than we expected to

[15] Families enrolled in BadgerCare remain eligible until their incomes reach 200 percent FPL.

[16] As described above, in order to be cost-effective under SCHIP, the cost to the federal government of covering the entire family under private coverage (including the employer contribution) cannot exceed the cost of covering the children alone under the SCHIP program directly. Proving cost-effectiveness under Medicaid is easier in Wisconsin because the parents are eligible through the 1115 waiver. The cost-effectiveness test therefore compares the cost of private coverage for the entire family (including employer contribution) against the cost of covering the family directly through Medicaid.

have by June 30, 2001," she says. "The feedback we get from all parties involved is that this is a very popular program."

The program has been so successful in enrolling new members that it has strained the state's budget. "The program is costing more money than is budgeted because the enrollment is higher than the budgeted amount," says Bartels. "For the program to continue at its present level, the legislature will need to take specific action," during the state's 2001 legislative session, which runs from January through December.

BadgerCare was established following extensive negotiations between Wisconsin and the federal government over enrollee cost-sharing requirements and other significant provisions, such as whether the state would be allowed to cap program enrollment. HCFA initially denied the Medicaid waiver on the grounds that a participation cap is inconsistent with the entitlement nature of the Medicaid program. In the final agreement, however, HCFA approved Wisconsin's requested trigger curbs on enrollment if it grew beyond a certain level. Under the agreement, the state can decrease the income eligibility limit for new applicants while retaining eligibility up to 200 percent FPL for existing enrollees.

Although BadgerCare is exceeding its budget, Wisconsin is seeking alternatives to curbing enrollment. Encouraged by the Clinton administration's budget proposal to extend SCHIP eligibility to the parents of eligible children, the state submitted a waiver request in March 2000, seeking enhanced federal matching funds to cover parents through BadgerCare. Later in the year, the state entered discussions with

Planning for Universal Coverage: Eleven States Receive HRSA Grants

In September 2000, the Health Resources and Services Administration (HRSA) announced that 11 state agencies had been selected to receive funds through the new State Planning Grant Program (SPG), which is providing one-year grants to help states develop plans for providing uninsured citizens access to affordable health insurance. Thirty-five states and U.S. territories applied for funding under the SPG program.

The immediate goal of the SPG is to "assist states as they collect and analyze data, develop coverage options or design programs that provide health insurance coverage to all uninsured citizens in the state through expanded state, federal, and private partnerships." Grantee states will design approaches that provide affordable health insurance benefits similar in scope to the Federal Employees Health Benefits Plan, Medicaid, coverage offered to state employees, or other similar quality benchmarks. HRSA's Office of the Administrator is managing the program.

The SPG program shares some of the same goals and focuses of The Robert Wood Johnson Foundation's *State Coverage Initiatives* program and the Health Policy Studies Division of the National Governors' Association Center for Best Practices. Thus, whenever possible, the SPG program and their grantees are coordinating with these groups to share information about insurance trends, data and analyses, and technical assistance.

Grantees will use their funding to gain a clearer understanding of who the uninsured are in their state and what mechanisms may work best to enroll them in appropriate programs. In many cases, this will entail conducting surveys of individuals who are uninsured, as well as hosting focus groups in the employer, insurer, and provider communities. Massachusetts will synthesize data from a variety of research sources, including survey data and market data. "We have less knowledge about employers than we do about households," notes Prema Popat, project director at the Massachusetts Division of Medical Assistance.

Greater than just identifying the uninsured, however, is the need to understand why they are uninsured. The HRSA grants will allow some states to pursue this question. As most states are heavily invested in their Medicaid and State Children's Health Insurance Programs (SCHIP), a logical step in exploring coverage expansions will involve evaluating the programs' strengths and determining where weaknesses are. Minnesota, for example, will evaluate the effectiveness of MinnesotaCare and Medicaid in reducing the number of uninsured people in the state and make recommendations for adjustments to the program.

"The HRSA grant funds will be used primarily to fill some gaps in our knowledge of the uninsured," says Scott Leitz, director of the Health Economics Program at the Minnesota Department of Health. The state will also expand their knowledge of health insurance status for populations of color and rural communities and use this knowledge to adapt current programs and/or create new initiatives designed to reduce the number of uninsured people within these populations.

The Wisconsin Department of Health and Family Services will use their grant funds to improve their household survey by including a broader sample than the Wisconsin FHS

telephone survey. "The HRSA grant will help us to understand who the uninsured are, and why some employers elect not to provide coverage," says Peggy Bartels, administrator of Health Care Financing at DHFS. Based on the finding from this research, the state will "develop policy guidance on what might be a reasonable next step" for coverage expansion.

Some states are considering the partnering track on the road to improved coverage. "We're going to examine a variety of different models to reach the remaining uninsured," says Lori Real, director of the Office of Planning and Research at the New Hampshire Department of Health and Human Services. "Specifically, we are looking at approaches to maximize public and private dollars." The state seeks to implement health care reforms that will expand coverage and access to health care services for the uninsured based on a public/private process of collaboration and education.

Other grantees are putting what they know already into action. Considering that a large percentage of the uninsured are employed — usually self-employed or working in small firms — Kansas has among their objectives the development of program rules, policies, and structures necessary to reach uninsured workers in small firms. Oregon recognizes that a significant amount of care is delivered through their safety-net clinics. One of their goals under the HRSA grant is to improve the capacity and capability of these clinics to provide needed care to the uninsured.

Grantee states will submit the results of their study and analysis in the form of a report to the Secretary of Health and Human Services that identifies the characteristics of the uninsured within the state and their approaches for providing them with access to health insurance coverage. These reports, which will present the states' roadmap for achieving significant expansions of coverage, are due to the Secretary by September 30, 2001.

State	*Lead Agency*	*Grant Award*
Arkansas	Arkansas Center for Health Improvement (ACHI)	$1,393,322
Delaware	Delaware Health Care Commission	$ 800,900
Illinois	Department of Insurance	$1,200,000
Iowa	Department of Public Health	$1,303,731
Kansas	Department of Insurance	$1,298,205
Massachusetts	Division of Medical Assistance	$1,069,195
Minnesota	Department of Health	$1,630,931
New Hampshire	Department of Health and Human Services	$1,033,315
Oregon	Office for Oregon Health Plan Policy and Research	$1,253,264
Vermont	Agency of Human Services	$1,288,892
Wisconsin	Department of Health and Family Services	$1,249,846

For more information about the State Planning Grants program, visit the HRSA Web site at: *http://www.hrsa.gov/stateplanning.*

HCFA regarding a possible SCHIP waiver. To this point, however, HCFA has not been willing to grant an SCHIP waiver and appears to be particularly concerned that Wisconsin not curb the enrollment.

Pris Boroneic, deputy administrator of the Wisconsin Division of Health Care Financing, reported last fall that they were "talking it through."

Covering Families in New York and New Jersey

During 2000, both New Jersey and New York worked to design and implement major coverage expansions. In July, New Jersey enacted the FamilyCare Health Coverage Act, which extends coverage to uninsured parents with gross family incomes up to 200 percent FPL and to adults without children up to 100 percent FPL. New Jersey, which offers Medicaid coverage to children up to 133 percent of poverty through its KidCare program (Part A), uses Section 1931 income disregards to extend Medicaid coverage to their parents. Parents with gross family incomes between 133 and 200 percent of poverty are now eligible for a benefit package equivalent to the most widely sold HMO plan in the state. This portion of the FamilyCare program is currently funded by the state without federal match.

After the enactment of the FamilyCare program, HCFA released the federal guidance on SCHIP waivers; New Jersey submitted an application for a waiver in late September. If approved, the state would qualify for enhanced federal match to cover the parents enrolled in FamilyCare. Federal funds would extend only to the limits of the state's SCHIP allocation, however, at which point the regular Medicaid match would be applied to the parents with incomes below 133 percent FPL. State funds would cover parents between 133 and 200 percent FPL. To pay for the program, New Jersey will use funding from the state's tobacco settlement and premium contributions from enrollees with incomes above 150 percent FPL.

New Jersey now covers adults without children up to 50 percent FPL under Medicaid. Adults with incomes between 50 and 100 percent of poverty are eligible for coverage that is provided through a commercial managed care plan and pay no premiums. The latter portion of the program is not an entitlement, and

Legislatures Debate Tobacco Settlement Funds

Tobacco Settlement Yields Millions for Coverage Expansion Efforts

The $206 billion Master Settlement Agreement (MSA) signed between the country's four largest tobacco companies and 46 states represents an unprecedented opportunity to expand and improve health-related programs. Lacking specific details on how the money should be allocated, the MSA created a virtual free-for-all in 2000 legislative sessions. The Health Policy Tracking Service (HPTS) reports that as of October 2000, over 140 bills were introduced in 41 states to allocate settlement funds for health care programs.

Despite the vast range of proposals put forth to spend the money — more than 550 bills ranging from tax reduction to building roads to assisting tobacco farmers — state legislatures across the country gave health care programs priority for funding. Lee Dixon, director of HPTS notes that legislation largely reflects the demands of the public, "In many cases the process of discussing the allocation of these funds was a very public one. Over time, I think we will see that funds will be increasingly allocated to health care and human services areas such as education."

In addition to the funding of long-term care (including pharmaceutical assistance for low-income seniors and the uninsured, see story page 24), youth smoking cessation programs, and community health centers, 38 states allocated $3.5 billion to indigent care programs, coverage expansions, and improvements to existing programs for the uninsured. According to the HPTS, 13 states appropriated some portion of tobacco settlement monies to SCHIP and 12 states allocated some portion to Medicaid.

One of the most notable examples is New Jersey, which committed $100 million to expand coverage to parents through its FamilyCare program. This initiative will provide free or low-cost insurance to 125,000 uninsured parents up to 200 percent of the federal poverty level (FPL) and adults without children to 100 percent FPL. In addition, the Partnership Program, a premium assistance program, is being developed to leverage qualified employer-sponsored insurance. According to Margaret Murray, director of New Jersey's Division of Medical Assistance and Health Services, this allotment is part of Governor Christine Whitman's commitment to affordable health care for all New Jersey residents, "The governor has always had a strong commitment to children and by covering parents, the FamilyCare program will facilitate better health care for the whole family." The state's $100 million allotment is projected to attract an additional $106 million in federal and state matching funds and in employer and employee contributions.

Through a combination of a 55-cent cigarette tax increase and over $300 million of its share of the tobacco settlement, New York passed the Health Care Reform Act (HCRA) 2000. The three-year package of coverage expansions for low-income parents and poor adults without children also provides subsidies for working adults to purchase coverage. The Healthy New York initiative assists small employers, workers whose employer does not offer insurance coverage, and individuals purchasing coverage in the direct pay market with subsidies to purchase insurance. The Family Health Plus program expands Medicaid coverage to parents with incomes below 150 percent FPL and for individuals with incomes of up to 100 percent FPL.

In a number of states, citizens forced the issue of allocating tobacco funds to ballot initiatives on November 7. In Arkansas, citizens overwhelmingly approved the Tobacco Settlement Proceeds Act, a plan to earmark the entire $1.62 billion settlement to fund health care and health improvement in the state. The act includes $62 million in annual funds for programs, including an incremental Medicaid expansion for adults to 100 percent FPL, funds to cover pregnant women with Medicaid to 200 percent FPL, and prescription drug coverage to Medicaid eligible senior citizens. The expansion will make 100,000 of the state's 400,000 uninsured eligible for Medicaid coverage. Dr. Joseph Thompson, author of the ballot proposal notes, "With bi-partisan support, this non-partisan issue was taken out of the hands of the politicians and ultimately succeeded in the voting booth with the pens of the citizens. With both short and long-term strategies incorporated, Arkansas will address the health crises of today and avoid the illnesses of tomorrow."

In Arizona, voters approved the state's share of $3.2 billion to Proposition 204 — Healthy Arizona 2, a copy of the Healthy Arizona initiative approved by voters but not legislatively implemented in 1996. Successful despite a better financed counter proposal, Proposition 204 will bring 130,000 adults into the state system by raising the Medicaid income limit from 34 percent to 100 percent FPL. The plan will require a Medicaid waiver; if the waiver receives approval, the program would cost less than $100 million per year, with funds to come from the settlement. If the waiver is denied, however, the initiative would cost the state roughly $231 million a year.

Although the tobacco settlement has been a windfall to states looking to expand services, the continued financial viability of coverage expansion initiatives may be vulnerable if the economy falters or cigarette production decreases. The MSA protects the tobacco companies by decreasing annual payments to the states if cigarette production decreases. Because of a cigarette production decrease in 1999, Texas is facing a $75 million to $90 million SCHIP funding shortfall in the current biennium, which will have to be covered by general revenue funds.

Anecdotal evidence shows that cigarette production will be down 3 or 4 percent next year which will probably be canceled out by adjustments for inflation built into the MSA — the Consumer Price Index (CPI) or 3 percent, whichever is higher. However, Lee Dixon notes that states have been wary of this and have moved cautiously, "States have been careful of how to spend their allotments and have not gotten too far in front such that potential decreases in cigarette production will hurt them." Two states, Alaska and South Carolina have chosen securitization — the process of selling bonds that are backed by settlement payments. In effect, selling bonds provides budgetary certainty in the event of inflationary, economic, or cigarette production fluctuations over time.

enrollment is limited to the amount of state funds available.

New Jersey is also preparing to implement a premium support program to encourage private market coverage. FamilyCare applicants who qualify for the program and have access to employer-based coverage will be eligible to receive premium assistance through the program. In fact, to encourage enrollment in employer-based plans, out-of-pocket payments will be less for enrollees in the premium support program than for those covered directly through FamilyCare. To qualify, the employer plan must meet program requirements (e.g., benefits and cost-sharing), and must be cost-effective to the state. The state expects this program to be operational in early 2001.

In New York, the Health Care Reform Act of 2000 (HCRA) broadly expands coverage for state residents and addresses a series of other health-related issues, including funding for safety-net providers and graduate medical education. Signed by Governor George Pataki, the centerpiece of HCRA 2000 is the establishment of the new Family Health Plus program, which builds on the state's existing SCHIP program, Child Health Plus. Family Health Plus will cover parents of eligible children up to 150 percent FPL, and non-elderly adults without children up to 100 percent FPL.

HCRA relies on several funding sources, including the state's tobacco settlement funds, a new 55-cent per pack increase in the state's cigarette tax, and federal financial support. The state has applied for two federal waivers that would enable the state to expand its Medicaid program. Family Health Plus was scheduled to be phased in over three years beginning January 1, 2001, but was still awaiting federal approval at press time.

In addition to expanding coverage through Family Health Plus, HCRA 2000 sought to address the affordability of coverage through market reforms, which are discussed in more detail in the next section.

A Tale of Two Summits

In September 2000, both Oregon and Florida hosted health care summits to bring together lawmakers, consumer, provider and plan representatives, advocates, and other interested parties to assess the problem of the uninsured and to discuss possible remedies. Though neither summit resulted in a finalized coverage expansion strategy, both served to lay the groundwork for future action.

In Oregon, the Governor's Health Care Summit was held in Eugene on September 13. Governor John Kitzhaber, who was instrumental in enacting the Oregon Health Plan (OHP), the state's innovative Medicaid demonstration program that covers all non-elderly residents with incomes below the poverty line, led off the day's discussion. The governor said his goal was to begin a dialogue about improving the OHP and reducing the number of uninsured, rather than to agree to specific solutions during the one-day meeting.

Spending increases in the Oregon Health Plan have put the program under cost pressures in recent years, and the state is seeking possible cost savings. Summit participants heard a range of recommendations from an OHP advisory group for resolving the plan's current challenges.

Bruce Goldberg, vice-chair of the state's Public Health Advisory Board, said that OHP has led to "dramatic increases in access" for children, adults, and persons with chronic illnesses. While inequities do still exist, he said that OHP has increased the use of preventive services and decreased emergency room use among low-income populations in Oregon. Overall, the OHP enjoys broad political support in the state but will need to address the outstanding budget issues.

In Florida, the Governor's Health Care Summit on Solutions for the Uninsured was held in Miami on September 21-22. The Agency for Health Care Administration (AHCA) released the results of the Florida Health Insurance Study, a state-financed household survey that provided county-level estimates of the uninsured. The study found that 2.1 million Floridians were without health insurance in 1999, down from 2.6 million in 1993. Still, the state's uninsurance rate remained high at 16.8 percent. Scott Hopes, director of health policy at AHCA, noted that the problem of uninsurance is concentrated primarily in seven of Florida's 67 counties, and is especially prevalent among low-income individuals, Hispanics, and persons working in firms of less than 50 employees.

Florida has been an innovator in expanding health coverage, establishing one of the first children's coverage programs, Healthy Kids, seven years in advance of the national State Children's Health Insurance Program. The state also developed a comprehensive coverage expansion strategy called the Florida Health Security Act in the early 1990s, but the program — though it received federal approval — was never implemented. The one component of that program that was put in place — the Community Health Purchasing Alliances (CHPAs), to bring small businesses together to purchase health insurance — closed down in 2000.

Panelists at the Florida summit presented coverage expansion approaches that have been undertaken in other states. Florida is now examining expansion alternatives, including targeted solutions for the pockets of the population with the highest rates of uninsurance. State officials hope that the summit discussions will assist in moving that process forward.

Insurance Market Reforms

Even as SCHIP and other coverage expansions dominated policy news over the last year, insurance market reform remains an essential component in many states' efforts to reduce the number of uninsured. Ensuring compliance with the federal Health Insurance Portability and Accountability Act is an ongoing priority, and a few states have also pursued new market regulations and pooling initiatives in their attempts to help the small group and individual markets work more effectively for populations seeking coverage there.

New York Creates Stop-loss Fund

Very progressive over the years in reforming its health insurance markets, New York has continued to battle the fluctuation and adverse selection common in individual (direct-pay) markets across the country. With more than 700,000 people in its individual market, New York has turned to stop-loss insurance in an effort to increase stability there. Stop-loss insurance is most often purchased by self-insured employers, physicians organizations, and health care facilities to protect against unpredictable financial liability. Also called reinsurance, the coverage limits the insurer's responsibility to absorb the cost of catastrophic diagnoses or unexpected increases in overall use by partially reimbursing for medical services provided. California and Washington have experimented with stop-loss initiatives to soften premium increases in their individual insurance markets.

New York instituted its Direct-Pay Stop-Loss Fund in its broad Health Care Reform Act of 2000 (HCRA). The legislation actually creates two stop-loss funds to offset premium increases in the individual market. One fund is for health maintenance organizations (HMOs) that provide standard coverage to individuals; the other is for HMOs that provide out-of-plan benefits in this market. HMOs may be reimbursed for 90 percent of claims paid between $20,000 and $100,000 per member per year. Participation for HMOs is mandatory; it is voluntary for other insurers.

Rather than design the Direct-Pay Stop-Loss Fund as a full stop-loss, which protects plans against all catastrophic claims above a specific level, the HCRA 2000 subsidy is a "corridor" initiative, assisting insurers with claims between $20,000 and $100,000. Above this corridor, the carrier bears all risk. The $80,000 corridor does not truly indemnify plans for high loss. Rather, it is designed to keep plans engaged. "Health insurers are amazingly responsive to small subsidies," notes Deborah Chollet, senior fellow at Mathematica Policy Research.

Also in HCRA, New York instituted some small group market reforms. Under the new law, managed care plans may offer to small firms insurance products that exclude the mandated benefits that apply to other insurance products sold in the state. In addition, the state will assume some of the financial risk of covering employees within these small groups. For individuals with high medical expenses, the state established a stop-loss fund to reimburse HMOs, Blue Cross plans, and commercial insurers for 90 percent of claims paid between $30,000 and $100,000 in a calendar year. By providing this stop-loss protection, New York hopes to reduce the premiums that these plans can offer to small businesses, thereby increasing coverage of employees in small firms. This program was implemented January 1, 2001.

Washington Passes Law to Draw Insurers Back

After several insurers departed its individual and small group markets, Washington state passed S.B. 6067 in April 2000, titled "Engrossed Second Substitute." According to Governor Gary Locke (D), the legislation "allows the insurance system to work like an insurance system" by providing rules that encourage people to buy insurance before, not after, they need coverage.

The new law increased from three to nine months the waiting period that applies to enrollees with pre-existing conditions newly seeking coverage in the individual or small group markets and for consumers enrolling in the state's health insurance pool (in either case, except as they are protected under HIPAA). The new law also reconstituted the state's guaranteed insurance coverage at a higher cost to people denied coverage by private insurers, but private insurers are allowed to deny no more than 8 percent of those who apply. Finally, the legislation mandated that

maternity and prescription drug benefits be offered in all comprehensive (non-supplemental) plans, but it no longer requires carriers to obtain state approval for proposed premium increases in the individual market.

By the end of 2000, insurers had begun to return to Washington's individual market with Primera Blue Cross resuming acceptance of individual applications on December 1, and Regence BlueShield on December 4. Regence Chief Executive Officer Mary McWilliams specifically cited the new law as a reason for the plan's return. "It allows us greater flexibility in meeting people's needs," she says.

Primera Blue Cross Chief Executive Officer Brereton "Gubby" Barlow also applauded the new law, saying the legislature "took the steps necessary to revive an ailing market."

Pooling Small Businesses

To expand rates of coverage among small firms, at least 10 states have developed small-group purchasing pools that allow these employers to band together to purchase insurance, and several other states are examining whether to establish purchasing pool arrangements. Wisconsin implemented its statewide Small Business Health Insurance Pool (SHIP) on January 1, 2001. SHIP will allow groups of two employees or more to join together in hopes of obtaining administrative economies of scale in purchasing health insurance and stable insurance prices.

California and Florida established two of the oldest and largest purchasing pools in the United States. California's program, PacAdvantage (originally the Health Insurance Purchasing Cooperative), was established in 1993 and now covers over 9,500 small-employer groups with 2-50 employees. The program has been reasonably successful in stabilizing insurance premiums and also increasing the number of health plan choices available to small groups.

In contrast, Florida closed its purchasing pools, the Community Health Purchasing Alliances (CHPAs) in 2000, after a number of large health plans left, citing high administrative costs and low profit margins in insuring small groups. The CHPAs once offered coverage to 25,000 small businesses with as many as 90,000 employees and dependents. But as premiums offered through the CHPAs began to escalate, CHPA enrollment had begun to drop precipitously. The CHPAs were never allowed to use their purchasing leverage to negotiate with health plans, and this design element limited their impact in reducing premium prices.

State Health Policy Agendas in 2001

Officials Share How the 2000 Elections May Shape the Year Ahead

Although the 2000 Presidential contest overshadowed virtually all else, the state races certainly were not short of either excitement, or, in some cases, controversy. Dubbed by some as the "jackpot" election,[17] much was at stake. Twelve new governors were elected — five winning by a margin of 5 percentage points or less — and the control of six state chambers changed from one party to another, leaving 15 split legislatures across the country.

Both tax issues and education influenced campaigns, but with an aging American population and seniors living longer than ever, health care won significant attention. For example, in coverage of the highly charged New York senate race between Hillary Rodham Clinton (D) and Rick Lazio (R), the *Rochester Democrat and Chronicle* called health care "one of the policy areas that really distinguishes" the two candidates.

In Nebraska, Ben Nelson (D), a former two-term governor, featured Medicare prescription drug coverage, patients' rights, and his record of helping cover children under SCHIP in his successful bid for election to the U.S. Senate.

Likewise, in the gubernatorial races, successful candidates Mike Easley of North Carolina, Ruth Ann Minner of Delaware, and John Hoeven of North Dakota committed to address health care issues ranging from prescription drug coverage for seniors to medical privacy. Losers also contributed ideas that are expected to play into some state debates. For example, Republican candidate John Burris of Delaware stated during his campaign that he wanted to create a state-funded pool to expand coverage to low- and moderate-income families; he also proposed to improve screening and treatment programs to lower the state's cancer mortality rates. Although Burris lost the race, state officials anticipate that his issues will continue to receive attention, particularly those related to cancer, which were common themes for both parties in the election.

To gain a sense of where all these campaign promises and debates may lead in 2001, *State Coverage Initiatives* submitted a questionnaire to more than 100 officials in all 50 states and the District of Columbia. Officials representing state Medicaid departments, departments of health, medical services, offices of the governor, and more responded to questions regarding

- how election results will affect the health policy environment;
- what are the most important health coverage problems to be faced;
- what specific initiatives to expand coverage are under consideration and which might be enacted this year; and
- what challenges stand in the way of the initiatives?

[17] Source: National Conference of State Legislatures, *State Legislatures*, "Election 2000 – the States are Crucial," by Karen Hansen, September 2000.

Review of Selected Reports Released in 2000

State Strategies for Covering Uninsured Adults
Urban Institute, Assessing the New Federalism
January 2000

Since the implementation of the State Children's Health Insurance Program (SCHIP), most of the focus on the uninsured has been towards children. The Urban Institute has shown, however, that parents and childless adults present a greater likelihood of uninsurance than do children. Recent data show that 17 percent of adults at all income levels lacked health insurance compared to 12 percent of children. This report provides state-level strategies to expand health coverage to uninsured adults. State strategies examined include Section 1931, state-only programs, and Medicaid Section 1115 waivers. Programs such as Washington's Basic Health Plan and Massachusetts' MassHealth are shown in detail in relation to the three main strategies presented. This report provides a comprehensive view of states implementing these strategies to reduce the number of uninsured adults.

This report may be viewed at:
http://newfederalism.urban.org/pdf/discussion00-02.pdf

Medicaid and Children. Overcoming Barriers to Enrollment. Findings from a National Survey.
The Kaiser Commission on Medicaid and the Uninsured
January 2000

It is estimated that 4.7 million children are eligible for Medicaid but remain uninsured. This national survey was conducted by the Kaiser Commission on Medicaid and the Uninsured to determine the barriers to Medicaid enrollment by low-income parents. Currently uninsured, Medicaid-eligible children were found to come from two-parent, working families with little welfare participation. These children were shown to have less access to health care services. The survey found that their parents valued Medicaid, but difficulties in the enrollment process served as strong barriers to participation. Changes to Medicaid policy such as streamlined enrollment processes; expanded outreach and better communication of program information; simplification of eligibility criteria; and better Medicaid

Officials from 26 states indicated that health care in general, and coverage and access in particular, would surface in the upcoming legislative sessions. Respondents indicate varying levels of determination and optimism about seeing significant health measures passed, but the extent of interest in health policy issues suggests that state policymakers in much of the country will wrestle with important health issues this year.

Prescription Drug Coverage for Seniors Direction Many Expansions are Taking

Just as it gained prominence in the national debate, prescription drug coverage topped the list of policy priorities for nearly all state officials who responded to the survey. Prescription drugs for the elderly was the most prominent health issue in the campaign, according to an official in the Office of Public Health at the Nebraska Department of Health and Human Services. An Arizona official indicated that medical inflation and prescription drug coverage were in the top three health coverage problems that state faced.

"Prescription drug coverage and the cost of prescription drugs are significant issues with which we're currently grappling," says

"product" (which relates to quality of care and provider participation) were cited as keys to greater Medicaid enrollment.

This report may be viewed at:
http://www.kff.org/content/2000/2174/MedicaidandChildren.pdf

Déjà Vu All Over Again: The Soaring Cost of Private Health Insurance and Its Impact on Consumers and Employers
National Coalition on Health Care
May 2000

Health insurance premiums are now rising at four times the inflation rate compared with two times the rate of inflation over the past decade. In addition to the traditional forces increasing costs such as new medical technology and cost-shifting among payers, emerging factors include longer and deeper insurance underwriting cycles, Wall Street pressure on for-profit health plans to raise profits, and escalating prescription drug costs. The rising cost of premiums is directly related to the number of the uninsured. Increasing numbers of uninsured patients create a situation where providers try to shift their costs to employers and employees who are able to pay. Higher insurance premiums result, and employees, especially low-income employees, find themselves unable to afford coverage. In the end, more people end up uninsured. This report stipulates that the lowest projected increase in premiums (9 percent) for the year 2000 translate to an addition of 600,000 uninsured to the more than one million who already become uninsured each year.

This report may be viewed at:
http://www.nchc.org/releases/Pemiums_4-24-00.pdf

Using SCHIP to Subsidize Employer-Based Coverage: How Far Can This Strategy Go?
National Health Policy Forum
June 2000

SCHIP was created to help states cover low-income uninsured children. States can also use SCHIP funding to subsidize employer-sponsored insurance for children alone or families that include eligible children. States must apply for a waiver allowing them to use SCHIP funding to subsidize employer-sponsored insurance. States have argued, however, that the Health Care Financing Administration's (HCFA) requirements for the waiver are overly complex, restrictive, and inconsistent with private-sector benefit plans. Three states, (Massachusetts, Mississippi, and Wisconsin), have received HCFA approval but only Massachusetts and Wisconsin have been able to implement their programs. This report examines the experiences of these three states, plus the experiences of Maryland and Oregon. Oregon has been unsuccessful in gaining approval from HCFA due to difficulties with the cost-sharing limits imposed and the requirement that children apply for Medicaid before applying for SCHIP. Maryland will be implementing its subsidy program in July 2001, covering children-only between 200 and 300 percent of the federal poverty level.

This report may be viewed at:
http://www.nhpf.org/pdfs/bkgr/1-107+(SCHIP_6-00).pdf

The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms
Center on Budget and Policy Priorities
September 2000

According to the research conducted by the Center on Budget and Policy Priorities, extending insurance coverage to low-income parents through Medicaid can increase Medicaid enrollment among children who are eligible, but not enrolled. Through broad Medicaid expansions that include parents, states can improve health care access and utilization among adults and children with minimal crowd-out of private insurance coverage. This report compares the effect of different types of parental expansions among states. States with broad, early expansions, including Tennessee, Hawaii, and Oregon, were shown to have increased Medicaid participation rates among young low-income children by 13 percent over states with no expansions. Mechanisms employed by these states to expand family coverage are Medicaid Section 1931, Section 1115 Demonstration waivers, the State Children's Health Insurance Program, and state-funded expansions.

This report may be viewed at:
http://www.cbpp.org/9-5-00health-rep.pdf

Mary Jo Fox, communications director for the Office of the Governor of Montana.

"Increasing health care costs, particularly with regard to prescription drugs in the Oregon Health Plan, will be big issues in 2001," echoes John Santa, administrator at the Office of Oregon Health Plan Policy and Research. "Governor Kitzhaber will be pushing for stabilization of the current plan and control of health care costs in general, especially prescription drugs." He adds that universal coverage remains Oregon's overarching goal.

New Hampshire will be pursuing a new effort to establish a tri-state purchasing pool for prescription drugs. In Massachusetts, a new pharmacy insurance program, funded entirely with state funds, will serve low-income persons with disabilities (less than 188 percent FPL) and all seniors, according to the Massachusetts Division of Medical Assistance. The cost of the monthly premium and co-payments will be subsidized for low-income populations; coverage of prescription drugs will be unlimited after a deductible has been met, and formularies may be used.

In North Dakota, pharmaceutical coverage stands some chance of funding with tobacco dollars. Ten percent of the state's tobacco settlement funds have been allocated to public health, "but the governor and the legislature will determine how the money will be spent," explains Murray Sagsveen, state health officer at the North Dakota Department of Health. "The gubernatorial candidates discussed state subsidies for prescription drugs, but it is unlikely that the legislature will fund such an effort."

Other states simply indicated that they needed to do more to provide adequate drug coverage. "We need expanded drug coverage for those who don't qualify for full Medicaid," says Mary H. Finch, policy advisor for the Alabama Medicaid Agency.

Legislatures Tackle Prescription Drug Costs and Access

Many States Create or Expand Prescription Drug Access Programs in 2000

Legislative activity on prescription drug coverage was one of the year's biggest health care stories in the states. Susan Laudicina, director of research at the Blue Cross Blue Shield Association, explains that "the explosion of state activity in some states and expansion of programs in others," can be attributed to three factors: "the need has never been greater due to costs and new drugs; consumers have been more aware than ever of pharmaceutical treatments and they have transferred these needs to their legislators; and the inactivity factor at the federal level."

The extraordinary progress made in the last decade in pharmaceutical treatments has resulted in price increases that have forced many elderly, low-income, poor and uninsured people to ration or do without needed prescription drugs. Observers agree that price increases are the result of direct-to-consumer advertising ($1.8 billion in 1999), the "substitution effect" of more expensive drugs for existing therapies, patent protections that delay generic products from entering the marketplace, and the growing belief that pharmaceuticals provide an effective substitute for other forms of health care. Drug benefits are the fastest growing cost component of both private and public insurance programs. Since 1991, drug prices in the United States have increased 6.7 percent a year, more than double inflation.

Medicare does not cover outpatient prescriptions and an estimated 35 percent of beneficiaries do not have supplemental coverage from any source (including Medicaid). Although Medicaid is an important source of coverage for the poorest Medicare recipients, Medicaid covers fewer than half of all Medicare beneficiaries living below the poverty level. In addition, many non-elderly individuals with insurance coverage face high deductibles and copayments. The result has been a divisive debate, both in Congress where Republicans and Democrats vigorously contested the issue but failed to pass legislation, and at the state level. State legislators across the country set up task forces, held town hall meetings, and passed a litany of legislation to assist low-income and elderly pharmaceutical consumers. In 2000 alone, 10 states created new programs or expanded existing ones. According to Laudicina, although prescription drug benefits was high on the agenda in state legislatures, this is not a new issue for all states, "Many states are not newcomers to the issue and have run prescription drug programs for the elderly for years."

One of the boldest legislative measures in 2000 was Maine's Act to Establish Fairer Prescription Drug Prices, which created the Maine Rx Program to assist the state's 325,000 residents without drug benefits. The law requires the state to serve as a pharmaceutical benefit manager (PBM) for residents and to monitor fair pricing by pharmaceutical manufacturers. The state is empowered to set maximum retail prices for drugs sold in Maine if prices are judged to be unreasonably high (compared to the lowest prices paid in the state). The state leveraged participation in its Medicaid and elderly drug programs to force compliance although in late October a federal judge struck a blow to the state's efforts by siding with the Pharmaceutical Research and Manufacturers of America's (PhRMA) challenge to the law.

In mid-December, Vermont also prompted legal action from PhRMA. The state's Pharmacy Discount Program allows Medicaid beneficiaries and non-elderly adults below 300 percent FPL without prescription drug coverage access to discounted prices through Medicaid. PhRMA has sued HCFA — but not the state — to block implementation. PhRMA challenges the legality of the U.S. Department of Health and Human Services' granting a Medicaid waiver for a program that benefits non-Medicaid eligibles. Despite PhRMA's action against HCFA, the state forged ahead with the program opening enrollment on January 1, 2001. Approximately 70,000 Vermont residents are eligible for the Pharmacy Discount Program, which has negotiated discounts averaging 17.5 percent.

Other states formed bulk purchasing alliances, such as the Northeast Legislative Association on Drug Prices, which includes all six New England states and New York and Pennsylvania. The alliance was created to use collective buying leverage to negotiate lower prices. Iowa and Washington created "buyers clubs," allowing seniors to benefit from the state's buying power in the form of lower prices. In Washington, the AWARDS program will allow participants to receive up to 50 percent off the retail prices for drugs. An estimated 275,000 citizens over the age of 55 are eligible for the program.

Some states bordering Canada have begun investigating joint ventures with Canadian pharmacies to take advantage of lower prices north of the border. In New Brunswick, for example, some drugs are 50 to 80 percent cheaper than the same ones sold in neighboring Maine. Many of these state efforts, including Maine's price control law, face legal challenges that could delay implementation in 2001.

The massive injection of funds from the tobacco settlement (see box page 18) encouraged states to focus on subsidizing prescription drug coverage. According to the National Governors' Association, 16 states allocated some portion of tobacco settlement monies to programs for the elderly, including prescription drug programs. As Phil Bremen, press secretary for Indiana Governor Frank O'Bannon explains, "There are always more needs than there is money, especially in health care, but the tobacco settlement funds gave us the opportunity to help seniors most in need."

In Indiana, where all non-trust fund investments were dedicated to health care causes, the General Assembly allotted $20 million to HoosierRX. Eligible seniors must have family income below 135 percent FPL and may not have other prescription drug insurance coverage, including Medicaid. The program reimburses seniors for half their prescription drug costs and for between $500 and $1,000 of benefits, depending on income. Indicative of the need for such a program, in the first month of HoosierRX, 1,600 seniors called the toll-free line to ask for applications and information about the program, and more than 400 seniors submitted their eligibility information. Grace Chandler, director of the program, explains that the program serves a need state administrators have been trying to fill for years, "We are starting the program off as a rebate program in order to get benefits out to people as quickly as possible. We have seen an ongoing need for this type of assistance for years; better prescription drug coverage is the number one request our seniors make."

With this program, Indiana joins 20 other states providing prescription drug assistance to seniors, disabled, and low-income or poor individuals. Other state programs created in 2000 include Alabama's Seniors' Safety Net, which creates a Medicaid Trust Fund with earmarked tobacco revenue that will allow seniors on Medicaid to continue receiving medicine through the rest of this decade. Florida's Governor Jeb Bush signed legislation that provides up to $80 monthly to low-income dual-eligible seniors to purchase prescription drugs and requires Medicaid-participating pharmacies to provide discounts to Medicare beneficiaries, resulting in an average savings of up to ten percent per prescription, brand name or generic. Other states that created or expanded prescription drug programs in 2000 include Illinois, Kansas, Maryland, New Jersey, New York, Rhode Island, and South Carolina.

As Congress and state legislatures reconvene in early 2001, they will surely pick up where they left off in 2000 — concerned about the price of drugs for the elderly and low-income, and heavily divided on the issue. Should Congress create a prescription drug program for Medicare beneficiaries, states will be forced to examine how this may affect existing programs and how they can fill needs federal legislation does not address.

Expanding Services to Children Remains High on Agenda

Beyond prescription drugs, the 2001 focus for most states appears to be largely an extension of last year's efforts to find ways to reach more children and their families. "We're working on expanding SCHIP, specifically to provide expanded coverage for special needs children and more mental health benefits," says Paul Perruzzi, director of the Division of Medical Assistance, North Carolina Department of Health and Human Services. "We are hopeful that HCFA will approve our SCHIP Phase 2 waiver plan so that we can offer a richer scope of benefits. However, budget shortfalls make all these pursuits very questionable." In North Dakota, SCHIP eligibility may be raised from its current 140 percent FPL to closer to 200 percent.

In Maryland, the incremental approach to expanding insurance coverage will continue. The most immediate and important health coverage problems facing the state include: 1) making managed care work; 2) exploring community-based long-term care alternatives and implementing waivers; 3) expanding health coverage for pregnant women between 200 and 250 percent FPL under Medicaid; and 4) getting precise estimates of the number of uninsured children and adults in the state, where these individuals live, and why they lack coverage. Maryland will also be working to implement a SCHIP expansion to children between 200 and 300 percent FPL, which includes providing coverage to children through employer-sponsored insurance when appropriate. This expansion is scheduled to go into effect on July 1, 2001.

Parents of Eligible Children are Increasingly a Priority

A few states will begin to try to reach parents. In Indiana, the Health Insurance for Indiana Families Committee (HIIF), representing leadership from a broad cross section of the community, is studying ways

to expand coverage for parents of Medicaid and SCHIP children. A proposal for the short-term was sent to the legislature in January. In Connecticut, goals include an expansion of SCHIP to include parents of children up to 150 percent FPL.

In its last legislative session, Maryland expanded its SCHIP program eligibility to 300 percent FPL, effective July 1, 2001. "Some in the legislature and in advocacy groups are talking about options to provide some coverage to some, if not all, SCHIP parents," says John Colmers, former executive director of the Maryland Health Care Commission and now with the Milbank Foundation. There will also be a great deal of discussion about access to prescription drugs, particularly for seniors on Medicaid who recently lost their drug coverage.

Florida will be concentrating efforts on the "hard to reach" segments of its SCHIP-eligible population, which include families in rural areas, immigrant families, and Native Americans and Native Alaskans. Many of these populations are distrustful of the government in general, and Florida will need to develop an environment of trust and cooperation with them. "This often requires investing a great deal of time and establishing ties with community leaders," says Santiago Sanchez, medical health care program analyst at the Agency for Health Care Administration's MediKids Program.

Targeting Adults is Gaining Political Viability

Adults in general are getting more attention as a potential target population. The Montana Governor's office reported that coverage for low-income adults, particularly those who are self-employed, is the most important health coverage problem they are facing. The Kansas Department of Social and Rehabilitation Services responded that covering individuals who are employed but not able to afford health insurance premiums tops their list of challenges.

Over the last three years, Massachusetts implemented major health care reform expansions, reducing the statewide rate of uninsurance from 8.2 percent in 1998 to 5.9 percent in 2000. Despite this success, some populations remain largely uninsured, most notably low-income single adults without children, but also more generally Hispanics, African-Americans, and immigrants. Massachusetts intends to focus its outreach and expansion efforts in 2001 on these "gap" groups.

Covering adults is also claiming the spotlight in other states. New Hampshire plans to convene a study committee to explore options for coverage for low-income working adults, and New Jersey will be working on expanding coverage to non-parents above 100 percent FPL. In addition, Pennsylvania will be working on providing stand-alone coverage for transitionally uninsured adults — those who move from job to job, from employed to unemployed, or in and out of eligibility categories. As with many other states, Pennsylvania hopes to fund this initiative with dollars from the state's tobacco settlement.

Funding Emerges as Most Significant Challenge to Expanding Coverage

Many states have done a good job of identifying which populations need help and figuring out ways to fill those needs. Still, to make expansions a reality, financial support must be available. Almost all states identified funding as a significant barrier in achieving expansion goals.

"The election results will have virtually no bearing on our state health policy environment," says Bobbie Graff-Hendrixson, senior manager of health care delivery systems at the Kansas Department of Social and Rehabilitation Services. "The state budget and lack of funding will have the most impact on what we are able to accomplish for 2001."

In Tennessee, where health care issues clearly influenced the state elections, funding was regarded simultaneously as the most important issue surrounding coverage expansions and the largest barrier. "Although the State General Assembly supports the TennCare program, funding the program has been curtailed due to a bleak state revenue picture," reports Mary Ann Calahan, director of Medicaid eligibility at the Tennessee Department of Human Services. "The medical community is reluctant to participate in TennCare without additional funding."

In Montana, finding enough resources to provide better coverage is a significant concern. According to Fox, if a funding source could find enough support in the legislature, then all of the other components to a successful program would likely fall into place, including enrollment, networking with pharmacies and health care providers, and an efficient reimbursement system.

The story is the same in Nebraska, where covering parents of SCHIP children is a policy goal among those who wish to expand coverage. With the state's Medicaid program running a budget deficit, however, covering parents may be difficult unless

there is a federal effort or incentive to expand coverage. Other issues, such as ways to pay for care for the state's growing elderly population, are expected to take precedence in the near term.

Despite the funding shortfalls that many states have experienced or are expecting in the coming year, there is good news to tell in other states. Minnesota's Governor Jesse Ventura has made the goal of children's health care coverage a priority in his "Big Plan for Minnesota," according to Mary B. Kennedy, Medicaid director/assistant commissioner of Health Care for Minnesota's Department of Human Services (DHS). While the money issue is at play, Kennedy notes that over the past decade Minnesota's elected officials have supported legislation to establish an accessible, high-quality, affordable health care program. This support, Kennedy says, has been reflected in the amount of dollars allocated to the DHS budget for health care. Each year, Minnesota spends more than $2 billion in state funds, with an additional $2 billion in federal dollars, to meet the health care needs of low-income families, disabled individuals, elderly individuals, single adults, and residents of nursing homes. Still, the goals always outpace the resources.

Ironically, Minnesota's innovation with coverage for children and the several maintenance-of-effort requirements have prevented the state from using its SCHIP allocation. Now, as it tries to find ways to cover all kids, Minnesota must use more state dollars, due to its early commitments to insuring kids.

The Delaware Health Care Commission has secured new funding sources to help achieve its goals of reducing the number of uninsured and strengthening and integrating the direct delivery care system. The commission won a Health Resources and Services Administration (HRSA) State Planning Grant, which will provide resources to develop a successful plan to ensure access to affordable coverage for the remaining uninsured in the state. The commission will also receive some funds from the state's tobacco settlement to address issues of the uninsured.

Finally, the commission won a grant through HRSA's Community Access Program, which will be used to achieve the commission's second objective for 2001: enhancing integration and coordination among safety-net providers to improve access to primary and preventive care. This effort will focus on enrolling eligibles for existing programs; those who are not eligible will be referred to a primary care provider and will receive follow-up to ensure access to appropriate care. The objective is a statewide, integrated, and user-friendly safety-net system.

Other Barriers

While the problem of funding is at the forefront of many states' needs, others states are finding that their primary need is much more basic: information. In Connecticut, expanding coverage means enrolling people already eligible for coverage. Identifying the uninsured and enrolling eligibles are the most important health coverage problems Connecticut faces, but they are only the first steps; maintaining coverage to eligibles as they move through coverage categories or on and off welfare is equally important and equally difficult.

According to Colmers of Maryland, the lack of accurate sub-state level estimates of the uninsured hampers the state's ability to develop targeted programs. "There is a crying need to have accurate estimates of the uninsured below the state level to succeed in developing consensus on policy changes," says Colmers. Debbie Chang, deputy secretary at the Health Care Finance Administration at the Maryland Department of Health and Mental Hygiene, concurs. "Administrative issues such as estimating the number of eligible children at the county level and hence the program budget is a challenge, since we do not currently have information at the county level on the number of uninsured children by poverty level," Chang says. "Moreover, evaluating how successful we have been in terms of enrolling all of those who are eligible is a challenge, again because of our lack of information." Colmers says Maryland will be fielding a survey in early 2001 to address these information gaps.

In some areas, enrolling eligibles is not the principal issue at all — allowing more people to qualify for public programs is. "We have a huge number of uninsured people in New Mexico, including a large population of undocumented families who do not qualify for Medicaid," says Barak Wolff, director of the Public Health Division at the New Mexico Department of Health.

Ballot Initiatives

Several initiatives that appeared on state ballots in 2000 addressed health care issues. Montana, for example, passed a legislative referendum that allocates 40 percent of the state's tobacco settlement to a permanent trust fund. The referendum requires that 90 percent of these dollars be used for health care benefits, services, or coverage, as well as tobacco disease prevention.[18] Similarly, Oklahoma passed a legislative referendum creating the Tobacco Settlement Endowment Trust Fund, which will use the state's tobacco settlement for, among other things, health care, children's services, and programs for seniors.[19]

Arizona's ballot included two successful initiatives to expand Medicaid coverage to

[18] Source: National Conference of State Legislatures Web site.

[19] Source: Ibid.

100 percent FPL for both categorical individuals (the aged, blind, disabled, pregnant, a parent, or a child) and non-categorical individuals. Arizona's previous eligibility threshold was 34 percent FPL for categorical individuals; non-categorical individuals were ineligible.

"The passage of Proposition 204 will increase the number of individuals eligible for the state Medicaid program," says Doug Hirano, bureau chief of the Arizona Department of Health Services. "Even with its passage, our biggest problem is still the number of Arizonans without health insurance."

Not all such initiatives were successful, however. In Oregon, Measure 4 would have created the Oregon Health Plan Trust Fund, which would have appropriated all earnings on tobacco settlement monies to be spent only to finance medical, dental, and other remedial care services for low-income children and low-income adults. (The use of monies under the tobacco settlement agreement is currently unrestricted.)

"Since this measure would have allocated funds to the Oregon Health Plan, its failure will raise concerns about support for the plan, particularly in the current budget shortfall," Santa says. The Oregon ballot also included several tax cutting measures,

State Coverage Matrix

State	Medicaid				State Children's Health Insurance Program						State-only
	Section 1115	Section 1931	HIPP	TMA	Eligibility ≥200% FPL	Employer Buy-In	Section 1115	Full Cost Buy-In	Coverage Program	High-risk Pool	Tax Incentives
Alabama					■					■	
Alaska		■			■					■	
Arizona		■		■	■						
Arkansas	■	■			■					■	
California		■		■	■					■	■
Colorado										■	■
Connecticut		■		■	■			■		■	
Delaware	■			■	■						■
District of Columbia		■			■						
Florida		■			■			■		■	
Georgia					■						■
Hawaii	■				■						
Idaho											■
Illinois									■	■	■
Indiana					■					■	
Iowa		■	■		■					■	■
Kansas		■			■					■	■
Kentucky					■					■	
Louisiana										■	
Maine					■						■
Maryland		■			■	■					
Massachusetts	■				■	■			■		■
Michigan					■						
Minnesota	■	■			■					■	
Mississippi					■					■	
Missouri	■		■		■					■	■
Montana		■								■	
Nebraska		■		■						■	
Nevada		■			■						
New Hampshire		■			■						
New Jersey		■		■	■						■
New Mexico	■	■			■					■	■
New York		■			■			■			
North Carolina				■	■			■			■
North Dakota		■								■	
Ohio		■			■						
Oklahoma		■								■	
Oregon	■	■							■	■	
Pennsylvania		■	■		■						
Rhode Island	■	■		■	■				■		
South Carolina		■		■						■	
South Dakota											
Tennessee	■			■	■					■	
Texas			■	■	■					■	
Utah				■	■					■	■
Vermont	■	■		■	■						
Virginia			■		■	■					
Washington		■			■				■	■	
West Virginia					■						
Wisconsin	■	■	■			■				■	■
Wyoming		■								■	
All States	**12**	**29**	**6**	**13**	**38**	**5**	*****	**4**	**5**	**29**	**16**

* Approved by HCFA, but implementation has been put on hold indefinitely.

The State Coverage Matrix: A New State Resource

This fall, the State Coverage Initiatives program unveiled a new web-based resource for tracking state coverage expansion programs. The new State Coverage Matrix provides information on coverage programs in all 50 states and the District of Columbia. It traces state coverage expansions made through Medicaid, the State Children's Health Insurance Program, and other state-designed and -funded programs. Detailed information on particular expansion strategies (e.g., Medicaid Section 1115 waivers, SCHIP employer buy-in programs, and high-risk pools) are also available.

The State Coverage Matrix allows you to:

(1) View the entire national picture to see the mechanisms states are using to expand coverage.
(2) Compare state approaches within a particular expansion mechanism, such as SCHIP employer buy-in programs.
(3) Link directly to the web pages of state coverage programs and to additional sources of information about those programs.

To view the entire State Coverage Matrix, log on to the *State Coverage Initiatives* web site at http://www.statecoverage.net .

The following are the coverage expansion mechanisms that are tracked through the State Coverage Matrix, along with definitions for each category.

Medicaid

Section 1115	States that have implemented an 1115 demonstration program that includes an eligibility expansion
Section 1931	States using earnings disregards that exceed the July 16, 1996 AFDC standard (including the customary $90 earnings disregard)
HIPP	States with Health Insurance Premium Payment programs in operation under Medicaid. These states have employer buy-in programs that are available to the Medicaid population broadly, not only to specific groups (e.g., people with AIDS)
TMA	States that have extended eligibility for Transitional Medicaid Assistance beyond the required 12 months

State Children's Health Insurance Program

Eligibility ≥ 200% FPL	States that cover all children under age 19 in families with incomes greater than or equal to 200 percent of the federal poverty level
Employer Buy-In	States that have implemented programs that provide premium assistance to families that are covered through employer-based insurance using SCHIP funding
Section 1115	States that have obtained federal approval to implement a SCHIP 1115 demonstration program
Full Cost Buy-In	States that allow higher income families to purchase coverage through SCHIP at the full premium price (with no state subsidy)

State-only

Coverage Program	States that provide direct, major-medical health insurance coverage, or premium assistance for private insurance coverage, through programs that are state-designed and state-funded (without federal support)
High-risk pool	States that operate a high-risk pool to cover residents whose medical costs preclude them from obtaining coverage at affordable prices in the private market
Tax Incentives	States that provide tax relief, either through tax deductions or credits, to an employer or individual who purchases health insurance for themselves, their family, or their employees

most of which failed. "One did pass, however," he adds, "and as a result there will be continued stress on budget resources, likely moderating any enthusiasm for expanding coverage."

According to Santa, Oregon hoped to expand SCHIP to 200 percent FPL, and coverage for poverty level medical (for pregnant women) up to 200 percent FPL. "These goals are of course up in the air unless we can fund them," he says. "In 2001, we will be asking for a [HCFA] waiver to allow more benefit/eligibility flexibility, SCHIP flexibility for safety nets, and dual eligible issues," he says.

In Massachusetts, voters considered an Initiative Petition (Question 5) to provide universal health insurance for all residents of the commonwealth by 2002. The initiative also would have put in place an improved patients' bill of rights to protect HMO patients, making sure that necessary medical services cannot be withheld, and prohibiting for-profit companies from taking over the commonwealth's non-profit health care institutions. In July 2000, however, the Massachusetts legislature passed a managed care reform bill that included consumer protections and expanded state oversight of managed care. Fearing that passage of the Initiative Petition might delay implementation of the July bill, which met many of their needs, many of its own sponsors campaigned against the Initiative Petition, causing it to fail. Massachusetts is now in the process of implementing the managed care reform bill, which did pass.

Looking Forward

States vary in their issues, priorities, and opportunities. But even the most diverse states have many common concerns as they pursue options for expanding health insurance coverage. One early lesson from the SCHIP experience is that nearly all states will respond when federal funds are made available and federal programs are flexible. Convinced by the research that shows parents are more likely to enroll their children when coverage is available to the entire family, many states would welcome even more federal flexibility, allowing them to launch demonstration programs to serve adult populations with federal and state funds. Other states are focusing also on helping working adults without children.

All states, however, must operate within the constraints of their own economic realities. In recent years healthy economies and the availability of tobacco settlement funds have allowed many states to expand coverage without changing their priorities or reducing their commitment of funds to other areas. But accelerating health care costs and a "soft landing" of the nation's robust economy could again force state policymakers to make difficult choices among priorities that compete for funding and action. States that have succeeded in bringing low-income workers and children into coverage may find their situation particularly difficult, should the economy soften, state surpluses evaporate, and health care costs continue to rise sharply.

Employers also may find themselves in a difficult predicament. For all its flaws and detractors, employer-based coverage remains the dominant and preferred source of coverage for most Americans. Like state insurance programs, employer-based plans also are struggling with sharp increases in health insurance costs, driven especially by the rising cost of pharmaceuticals. All employers — but especially employers who have responded to the tight labor markets by newly offering health insurance, even to part-time and temporary workers — will face stark choices in a softening economy: to drop or reduce coverage or require their workers to pay higher premiums. These choices are likely to force a new erosion of employer coverage in every state.

In the 1990's, many states enacted reforms to protect and strengthen their small group markets. While all states could face significant pressure to assist their small-group markets further, in many states, the pressure to reform individual markets is ongoing. New York's stop-loss strategy, enacted in 2000, offers an interesting example of one new initiative to assist both markets in tandem.

Finally, pharmaceutical coverage will clearly remain an issue for both states and for private sector health plans. No plan sponsor — public or private — views double-digit growth in pharmaceutical costs as sustainable. Controlling pharmaceutical costs and guaranteeing that low-income seniors and others have access to prescription drugs are issues that will command ongoing attention, as they did both in the Presidential election and in at least several gubernatorial and congressional races last year.

For all its controversy, the recent election should help refocus the electorate on the issue of health insurance coverage. Congressional leaders are considering a range of innovative ideas, and thoughtful proposals continue to emerge, such as that offered by Families USA, the Health Insurance Association of America, and the American Hospital Association. That proposal would drop categorical limitations for Medicaid, so that low-income adults could also become eligible for public coverage.

Still, the ultimate success of any proposal requires a firm commitment by both state and federal policymakers to solve problems. As the Congress and state legislatures embark on their 2001 legislative agendas, they will confront familiar constraints: tighter state budgets and rising health case costs. Further progress in reducing the ranks of the uninsured will depend on the ongoing creativity of many states as they address this problem, learn from each other, and explore new options. As they have proven themselves in the past to be effective policy laboratories and leaders in innovation, states will again have to help lead the way to solutions for the challenges that will fill the year ahead.

Notes

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