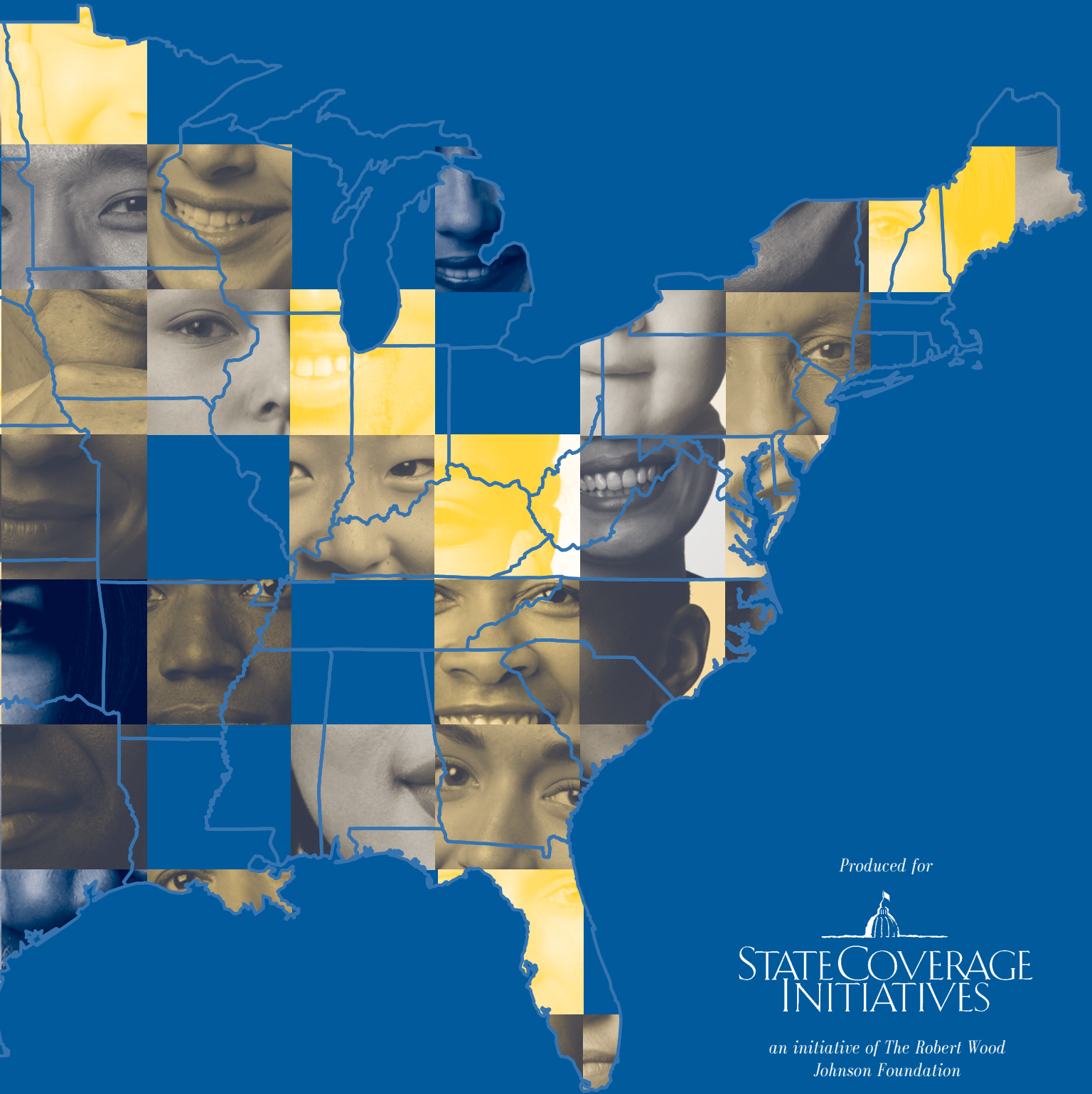


State *of the* States

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★



Produced for


STATE COVERAGE
INITIATIVES

*an initiative of The Robert Wood
Johnson Foundation*

January 2002

TABLE OF CONTENTS



<i>Foreword</i>	<i>1</i>
<i>Introduction</i>	<i>2</i>
<i>Coverage Challenges</i>	<i>4</i>
Budget Pressures Force States to Re-think Coverage Expansions	4
Medicaid Cuts a Tempting Approach	4
States Respond to Bleak Financial Picture	5
SCHIP Enrollment Drives Medicaid Growth	6
States Also Face “SCHIP Dip”	7
Prescription Drug Costs Continue as Budget Driver	8
<i>New Administration, New Focus</i>	<i>12</i>
HHS Gives States More Flexibility to Expand Coverage	12
Building on Employer-Based Coverage	13
Thompson Administrative Actions with State-Level Impact	15
<i>Insurance Market Reforms in 2001</i>	<i>18</i>
New Hampshire Repeals Reforms, Creates Risk Pool	18
Individual Carriers Resume Writing in Washington State	20
Kentucky Opens High-Risk Pool, Legislates Underwriting	20
Healthy New York Makes Its Debut	21
<i>State Planning and Demonstration Efforts</i>	<i>22</i>
The HRSA State Planning Grant Program	22
SCI Demonstration Grants	27
<i>Final Thoughts</i>	<i>32</i>

Written by: LeAnne DeFrancesco, Christina Folz, Madeleine Konig, Carole Lee

Managing Editor: Christina Folz

Contributing Editor: Carole Lee

External Reviewers: Deborah Chollet, John Colmers, John Holahan, Mary Jo O’Brien, Joyce Somsak

Internal Reviewers: Jeremy Alberga, Vickie Gates, Anne Gauthier, Benjamin Wheatley

SCI Program Director: Vickie Gates

Design: Bremmer and Goris Communications



FOREWORD

Last year certainly illustrated the cyclical nature of the economic and political contexts in which health policy decisions are made: finances were rosy, then gloomy; legislators were interested in pursuing coverage expansions, then cautious; public and political consensus on health policy priorities seemed close, then far away. These contrasts were made particularly stark by the September 11 terrorist attacks on the Pentagon and World Trade Center, which shocked and traumatized a country that had been enjoying a long stretch of peace and prosperity. By the end of 2001, the country was in a recession, and national health policy priorities had shifted from patients' rights and prescription drugs to bioterrorism and public health.

At the state level, too, legislatures saw their economies move from healthy surpluses to falling revenues and budget-breaking expenditures. Yet even so, the states remained committed to understanding and addressing their uninsured throughout the course of the year. In 2001, more than half the states participated in public or private grant programs aimed at planning or implementing new coverage models, the majority of which are still under way.

It may be tempting to lose faith in the value of planning to expand coverage at a time when finances are so strained, but we must not do so. In his book *Agendas, Alternatives, and Public Policies*, the social theorist John W. Kingdon offers policymakers some hope, perspective, and insight into the importance of always having options available. In discussing how public agendas are set and met, Kingdon recognizes that social change happens in cycles according to when the economic and political environments are ripe for it. However, in order to act at that critical moment, leaders must have a variety of alternatives already on hand. If they wait until a problem has become a pressing priority to develop solutions, they risk missing their window of opportunity. By continually studying the issues and planning options, policymakers create a kind of "policy soup" that they can use for sustenance when they need it.

Last year, 20 states gathered information to identify the number and characteristics of their uninsured and develop policy options for expanding health insurance through the Health Resources and Services Administration's State Planning Grant program. In addition, four states were awarded grants to design and implement new coverage models under The Robert Wood Johnson Foundation's *State Coverage Initiatives* program. The work of these states is no less valuable because it was conducted during tough economic times. To the contrary, in the stormy history of health care reform, some of the most productive periods have occurred when health care costs were escalating, the number of the uninsured was growing, and the economy was shaky.

In 2001, the new federal administration indicated a new interest in partnering with the states and providing them with greater flexibility to expand coverage. The states, in turn, have done their part by working to maintain the coverage gains they've made over the past decade and using them as building blocks for the future. Although most states were not in a position to implement major expansions last year, they made Kingdon's policy soup a lot richer.

Vickie S. Gates
Director, *State Coverage Initiatives*



INTRODUCTION

Last year, the states demonstrated their continued willingness to find—and fight to maintain—solutions to the problem of the uninsured during a time that was marked by contrasts. The year began in the midst of one of the nation's longest periods of economic growth and ended in a recession that was exacerbated by what some have called the worst terrorist attack in the history of the world. In setting their health coverage priorities, state legislators responded to the changing tide by shifting their focus from expanding public programs to maintaining current coverage levels.

Even before the September 11 tragedy, state and national economies had started to deteriorate by mid-year, as the federal budget surplus shrank considerably and most states reported significant Medicaid budget shortfalls for the first time in years. Across the country, rising unemployment and the return of cost inflation to health care threatened to erode employer-based coverage, with employer health care costs increasing by double digits—11 percent—for the first time since 1992, according to a Kaiser Family Foundation survey released September 6.

At the state level, Medicaid budget problems were largely rooted in successful State Children's Health Insurance Program (SCHIP) expansions, which led to higher-than-expected Medicaid take-up rates. Rising health care costs, particularly with the recent surge in prescription drug expenditures, and the so-called SCHIP dip—a \$1 billion drop in federal SCHIP funding from Fiscal Year (FY) 2002 to FY2004—also contributed to state budget challenges in 2001.

In light of the harsh economic reality that faced states last year, legislators were also forced to play defense in the area of insurance market reforms. Several states, including New Hampshire, Kentucky, and Washington, repealed or struggled to maintain their small group and individual market reforms as carriers left the market. Growth in group markets over the past several years may have contributed to shrinking business among individual carriers, and the recession only made markets more competitive.

The year also brought with it new leaders. Following one of the most contentious (and certainly unusual) elections in U.S. history, George W. Bush became the 43rd president and appointed former Wisconsin governor Tommy Thompson as Secretary of the Department of Health and Human Services (HHS). With two former governors in top federal positions, the new administration quickly communicated a desire to provide the states with

greater federal flexibility to make available state dollars stretch farther. Last year, HHS streamlined the federal review process and approved more than 1,000 state plan amendments and waivers under Medicaid and SCHIP.

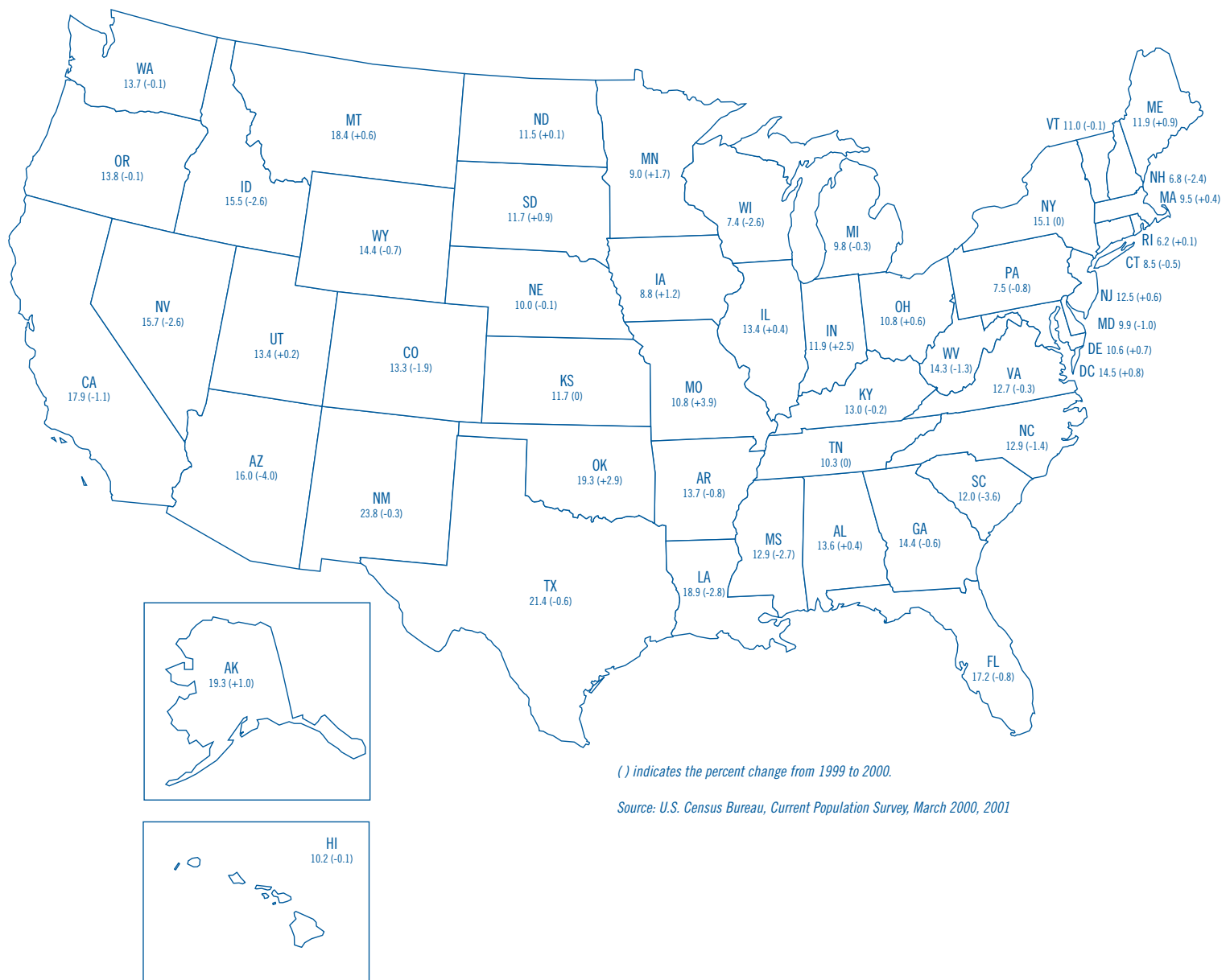
But perhaps the most promising evidence that the new administration will be responsive to states' needs was the Health Insurance Flexibility and Accountability (HIFA) 1115 Demonstration Proposal, which Thompson announced August 4 at the National Governors' Association's annual meeting. HIFA gives states enhanced waiver flexibility to streamline benefits packages and increase cost sharing for optional and expansion populations covered under Medicaid and SCHIP; it also gives states a greater capacity to build on employer-based coverage.

However, the reduced federal surplus and shift in national priorities toward defense meant there was no new federal money available to states last year to help them reach their health coverage objectives, such as prescription drug benefits for seniors, additional SCHIP allotments to cover parents, or federal tax credits directed to the purchase of health insurance. Although greater federal flexibility will no doubt be helpful to states, it's not clear whether it will be enough to compensate for the lack of state and federal dollars available to address the uninsured. Clearly, states will need to be resourceful and innovative to maintain the steady progress they have made over the last decade through incremental coverage expansions.

Fortunately, last year was also characterized by intensive planning and demonstration activities that will make it easier for states to do that. More than half the states were awarded public or private grant funds aimed at planning or implementing new coverage models. Twenty states received one-year planning grants that totaled more than \$23 million through the Health Resources and Services Administration's State Planning Grant program. In addition, The Robert Wood Johnson Foundation's *State Coverage Initiatives* program awarded four states nearly \$5.4 million in large demonstration grants and five states up to \$150,000 each in policy planning grants.

Although these grant programs were created during stronger economic times, the timing of the awards may prove fortuitous. They have given the states an opportunity to adjust to the new reality and develop strategies for holding onto the hard-fought coverage gains they made during the 1990s.

Percentage of People without Health Insurance by State in 2000



Number Uninsured by State, 2000, Current Population Survey

Alabama	588,000	Illinois	1,687,000	Montana	166,000	Rhode Island	53,000
Alaska	118,000	Indiana	646,000	Nebraska	159,000	South Carolina	436,000
Arizona	805,000	Iowa	239,000	Nevada	289,000	South Dakota	79,000
Arkansas	371,000	Kansas	287,000	New Hampshire	76,000	Tennessee	575,000
California	6,372,000	Kentucky	505,000	New Jersey	1,066,000	Texas	4,501,000
Colorado	518,000	Louisiana	821,000	New Mexico	435,000	Utah	296,000
Connecticut	253,000	Maine	138,000	New York	2,842,000	Vermont	62,000
Delaware	80,000	Maryland	476,000	North Carolina	993,000	Virginia	869,000
Dist. of Columbia	72,000	Massachusetts	607,000	North Dakota	67,000	Washington	743,000
Florida	2,666,000	Michigan	1,001,000	Ohio	1,285,000	West Virginia	250,000
Georgia	1,149,000	Minnesota	406,000	Oklahoma	634,000	Wisconsin	372,000
Hawaii	112,000	Mississippi	370,000	Oregon	441,000	Wyoming	69,000
Idaho	200,000	Missouri	561,000	Pennsylvania	920,000		

COVERAGE CHALLENGES

Budget Pressures Force States to Re-think Coverage Expansions

Responding to nearly a decade of rising budget surpluses, many state legislators put new incremental health coverage initiatives on the table in early 2001, and they enjoyed some initial success. Even before the September 11 tragedy, however, the economic outlook had changed for the worse for nearly all states, and about a third had budget shortfalls in FY2001 for the first time since the early 1990s. As the year wore on, states began to slow their push for expansions and focus instead on maintaining initiatives already in place.

"We assumed we still had a reasonably strong economy at the beginning of our [two-year legislative cycle]," said Barbara Edwards, deputy director for the Office of Ohio Health Plans, at an Alliance for Health Reform event on November 8. The state increased Medicaid eligibility to include children up to 200 percent of the federal poverty level (FPL), pregnant women to 150 percent FPL, and parents to 100 percent FPL, among other expansions. (For HHS's 2001 Poverty Guidelines, see table below.) But, by year's end, state revenues were down dramatically, enrollment had exceeded expectations, and the state faced a \$1.5 billion shortfall for the FY2002-03 biennium.

"This is a dramatic and frightening change in state tax revenues," Edwards says. "If trends continue, we are in deep trouble in terms of our budget."

At a National Health Policy Forum meeting on October 30, Ray Sheppach, executive director of the National Governors' Association (NGA), said that state revenues have not kept pace with spending for a decade, but that the resulting structural deficits were camouflaged by unprecedented economic growth during the 1990s. In part, the success of state efforts to expand eligibility and enrollment in Medicaid and the State Children's Health Insurance

Program (SCHIP) led to states' overspending their budgets as greater-than-expected enrollment generated higher-than-expected costs. The rising costs of prescription drugs and the so-called SCHIP dip—a \$1 billion drop in federal SCHIP funding that extends from FY2002 to FY2004—also contributed to the current budget challenges. And, of course, September 11 and the events that followed forced states to focus more of their spending on public health, security, and readiness initiatives.

Medicaid Cuts a Tempting Approach

State revenues are unlikely to rebound quickly, particularly in states that depend heavily on consumption taxes, such as Tennessee. In the near term, therefore, states want to make big-item cuts. Medicaid programs, which account for roughly 15-20 percent of states' spending, are their natural first targets.

"In this era of fiscal accountability and fiscal stress, states are really hard-pressed to look at where we can save money, and that creates particular challenges for Medicaid and SCHIP, where the dollars are so big," said Greg Vadner, director of Missouri's Division of Medical Services, at an Alliance for Health Reform briefing on October 1. In 2001, Missouri introduced legislation to cut Medicaid eligibility back to 225 percent FPL from 300 percent. The legislation failed, but with budgets on the chopping block, Vadner says, it may come up again in future budget negotiations.

If states respond to budget crunches by cutting Medicaid, however, it could worsen the effects of the economic slide. On average, for each \$1 that states cut from

their Medicaid general fund budgets, the total amount of spending on the program drops by \$2.33 because of the loss of federal Medicaid matching funds. In low-income states with higher federal matching rates, the consequences are more severe: \$1 in state cuts may translate into \$3 or \$4 in lost federal matching funds.

"Cutting Medicaid is, in the view of every state health official I've ever known, the most

HHS Poverty Guidelines for 2001*

Size of Family Unit	100 Percent FPL	200 Percent FPL
1	\$8,590	\$17,180
2	\$11,610	\$23,220
3	\$14,630	\$29,260
4	\$17,650	\$35,300
5	\$20,670	\$41,340
6	\$23,690	\$47,380
7	\$26,710	\$53,420
8	\$29,730	\$59,460
For each additional person, add	\$3,020	\$6,040

*Income thresholds are slightly higher in Alaska and Hawaii, where there is a higher standard of living.

Source: Federal Register, Vol. 66, No. 33, February 16, 2001, pp. 10695-7.

Governor Sundquist's Plan for a New TennCare

Tennessee's Medicaid 1115 expansion program, TennCare, which is by far the largest such program in the country, has been plagued by fiscal challenges virtually since its inception in 1994 and continued to experience serious budget problems in 2001.

In September 2001, Governor Don Sundquist (R) proposed trimming costs to the TennCare program by restructuring it into three benefit packages, dropping coverage for some beneficiaries, and closing enrollment to those determined "uninsurable" in the private market (i.e., they apply for coverage and are turned down).

TennCare Deputy Commissioner Mark Reynolds estimated that closing enrollment to uninsurable adults would save TennCare about \$7 million. The proposal also calls for greater cost sharing for children with family incomes between 100 percent and 200 percent FPL. According to the plan, about 180,000 beneficiaries would lose coverage. Among them, approximately 135,000 are adults earning more than 100 percent FPL who no longer meet the state's definition of "uninsurability"; 40,000 are Medicare beneficiaries who pay premiums to access TennCare benefits not covered by Medicare (such as prescription drug coverage); and about 4,000 are children whose families earn more than 200 percent FPL.

"TennCare in its present form costs more than we can afford," Gov. Sundquist said in remarks on September 28. "It has more enrollees than we can pay for, and it covers more benefits than we can support." Under the new structure, Sundquist says, TennCare will be leaner, more efficient, more focused, more streamlined, and will encourage personal accountability and fiscal responsibility.

Under the Governor's proposal, the new TennCare would consist of three products:

- **TennCare Medicaid**, which would offer a benefits package comparable to those offered in other states;
- **TennCare Standard**, which would offer a benefits package comparable to those offered by commercial

HMO plans, and would be open to uninsured adults living in poverty and uninsured children whose family incomes are below two times the federal poverty level and who lack access to employer-sponsored group health insurance; and

- **TennCare Assist**, which would assist low-income families that have access to private insurance and help families pay their share of family coverage in employer-sponsored health insurance plans.

Sundquist estimates that approximately 1.25 million Tennesseans will qualify for health care under the new TennCare program. Of those, about 950,000 will be eligible for TennCare Medicaid, and 300,000 for TennCare Standard. Sundquist also says that his proposal would reduce the annual state appropriation for the program by \$155 million and the federal appropriation by \$435.6 million, through premiums, premium taxes, and drug rebates.

Response to the proposal has been mixed. A legislative briefing paper released in October by Tennessee's Comptroller's office said that removing people from TennCare may save state tax dollars, but will probably not decrease overall public health care costs and will significantly reduce the state's federal matching dollars.

The report's author adds that those dropped from the program to save money would continue to incur health care expenses, and would likely obtain services at the most expensive source: emergency rooms. As a result, the public would continue to pay for these individuals' care through higher insurance premiums or increased health care prices. The plan has also met with significant opposition from Tennessee lawmakers, including the TennCare Oversight Committee.

State legislators approved in October a three-year extension of TennCare and are currently evaluating Gov. Sundquist's proposed changes to the program. If approved by the state legislature and the federal government, the restructured TennCare program will go into effect in July 2002. At press time, the proposal was pending review by legislative committees and scheduled for submission to the federal government on December 15, 2001.

counterproductive thing one could ever do in a time of difficult financing," said Sara Rosenbaum, professor of health law and policy at the George Washington University School of Public Health and Health Services, at the November 8 Alliance event. "Medicaid is one of the pillars that holds up the American health care system."

States Respond to Bleak Financial Picture

However, nearly all states must balance their budgets each year, and without major Medicaid cuts, they face raising

taxes, cutting spending, or both. In most states, governors have begun calling for across-the-board cuts. Governor John Kitzhaber (D) of Oregon has asked all state agencies to prepare options to reduce spending for the next fiscal year by 10 percent. In Washington, which was hit hard last year by layoffs in the high-tech and airplane manufacturing sectors, Governor Gary Locke (D) asked all state agencies to submit budget options to reduce costs by 15 percent in the next fiscal year.

South Carolina's Department of Health and Human Services is raising concerns among doctors and other providers as it considers reducing both prescription drug fees and nursing home reimbursement rates in order to cut \$60 million from its Medicaid budget.

Bill Prince, South Carolina's Health and Human Services Director, says that nursing homes and prescription drugs represent the largest line items in his state's budget. Thus, the Department plans to reduce Medicaid reimbursement rates for nursing homes and decrease pharmacist fees from \$4.05 to \$2.05 per prescription. The costs of the pharmaceutical program in South Carolina rose 18 percent in the first quarter of FY2001.

Some states, including Massachusetts, postponed their budget votes until late November to give them time to assess the effect of the aftermath of September 11 on state revenues. Others will deal with the issue when their 2002 legislative sessions begin (in January in many states). Oregon is planning a special legislative session to address the \$12 billion budget for 2001-03 that they passed last summer. Predictions indicate that state revenues could fall \$300 million short of projections, and that the budget will have to be rebalanced in July 2002.

There was some good news in Oregon, however. Despite calls for spending cuts by Republican legislators, Oregon's budget included an 18 percent biennial increase for the Oregon Health Plan (OHP). OHP includes the state's

Medicaid and SCHIP programs, a high-risk pool, the Family Health Insurance Assistance Program (an employer buy-in program), and a program that assists the self-employed and small businesses in affording private health insurance coverage.

SCHIP Enrollment Drives Medicaid Growth

For many states the current budget problems are at least partially rooted in successful efforts to expand SCHIP, which have led to higher-than-expected Medicaid take-up rates. State outreach to encourage SCHIP enrollment caused many families and individuals eligible for Medicaid to respond. The federal government pays a greater share of the costs for SCHIP enrollees than Medicaid enrollees (e.g., a state that gets a 50 percent federal match for Medicaid gets a 65 percent match for SCHIP), but the states are obligated to enroll Medicaid-eligible children in Medicaid, not SCHIP.

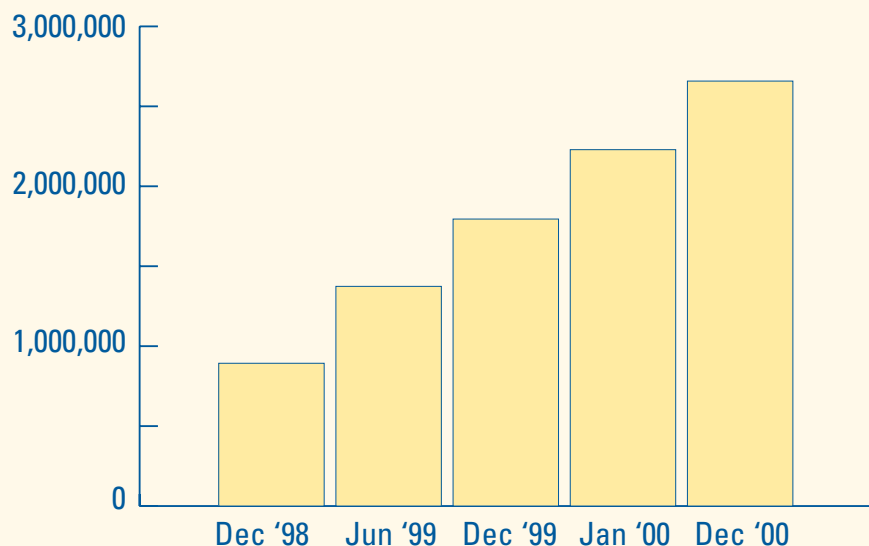
"The [popularity] of SCHIP has been drawing children not only into the SCHIP program, but also into the Medicaid program," said Pat Stromberg, executive director of the Pennsylvania SCHIP program, at the October 1 Alliance for Health Reform event. "We have about 34,000 more children enrolled in our public programs [both Medicaid and SCHIP] than we did at this time last year."

The budget implications of accelerated Medicaid enrollment can be significant. Twenty-seven states cited enrollment as one of the top two or three reasons behind expenditure growth in Medicaid. In Wisconsin, enrollment in BadgerCare, the state's Medicaid expansion program, was budgeted at 81,000 low-income adults and children for FY2001. Actual enrollment in the popular program exceeded 88,000 in October 2001, and BadgerCare faced an \$11.5 million shortfall last year. While the program has statutory authority to tighten eligibility requirements, program officials wanted to find the money elsewhere.

"We had been in talks with CMS [the Centers for Medicare and Medicaid Services] since the beginning about covering parents through the program," says Donald Schneider, chief of coordination of benefits for Wisconsin Medicaid. "But the enhanced SCHIP match was only available for kids." Wisconsin received a SCHIP 1115 waiver in January 2001 that allowed them to receive enhanced federal matching funds to cover parents, rather than the regular Medicaid match. The enhanced match helped them make up the shortfall.

SCHIP Enrollment in 50 States and the District of Columbia

Total Enrollment



Source: CHIP Program Enrollment: December 2000. The Kaiser Commission on Medicaid and the Uninsured. September 2001.

Adult Enrollment Overwhelms New Jersey's FamilyCare

Adult enrollment in New Jersey's combined Medicaid/SCHIP program—FamilyCare—vastly exceeded the state's expectations last year, leading officials to restrict eligibility for childless adults and redouble their efforts to bring more children into the program. Nearly a year after it expanded to include adults last fall, FamilyCare had already enrolled about 130,000 of them (36,000 of whom were non-parents) by early September; the program had only been anticipated to bring in 125,000 adults by 2003. Yet new enrollment for the program's primary target group—low-income children—lagged far behind at about 6,000, which was 18,000 less than expected.

FamilyCare began in 2000 as an aggressive demonstration expansion of KidCare—the state's original Medicaid/SCHIP program, established in 1998—which offered coverage to uninsured children up to 350 percent FPL. In July, the state enacted legislation to extend eligibility to uninsured parents up to 200 percent FPL and to adults without children up to 100 percent FPL. The expanded KidCare program came to be known as FamilyCare.

In January 2001, New Jersey qualified for an enhanced federal match for parents eligible for FamilyCare. The state paid to cover uninsured non-parents with incomes between 50 percent and 100 percent FPL using its own funds with no federal match. (Childless adults below 50 percent FPL were covered through Medicaid.) Under FamilyCare, SCHIP-eligible children and adults receive benefits equivalent to the most widely sold HMO plan in the state.

Prior to expanding, KidCare had enrolled about 67,000 of 187,000 eligible children. The state had hoped that extending the program to parents would improve children's enrollment. It's not clear why children's enrollment did not keep pace with that of adults; presumably many of the adults entering the program were parents of kids who were already enrolled.

In light of the overwhelming demand the new enrollees placed on the program, New Jersey reduced eligibility levels for childless adults from 100 percent to 30 percent FPL in September 2001 to help keep FamilyCare within

its 2002 spending limits. The state also lengthened the period that adults must wait before coverage takes effect. Previously, adults were eligible to receive care at a hospital or federally qualified health center after completing a program application but prior to enrolling in an HMO. Under the new rules, they must now enroll in an HMO before coverage begins (except for pregnant women, who still receive presumptive eligibility).

Meanwhile, FamilyCare has launched new outreach efforts that are focused on enrolling one of its original target groups: children between 200 percent and 350 percent FPL. State officials say the parents of these children may be unaware that they qualify for public insurance because of their higher income levels. Program officials will provide educational materials to schools aimed at these parents, as well as publicize at malls and state health centers.

New Jersey's experience underscores the great need to find ways to provide insurance to a previously uncovered group—poor adults. It also indicates the potential downside of providing a fairly comprehensive commercial benefits package to optional populations such as adults with no children. If enrollment surges, states may be faced with no other choice but to cut enrollment due to lack of funds. Many states are hoping they can use the new Health Insurance Flexibility and Accountability (HIFA) waiver guidance to create streamlined benefits packages, so that they can continue to expand to new populations without breaking the bank. (For more on HIFA, see p. 12.)

Indeed, over the next year, New Jersey officials are planning to evaluate how they might use HIFA to construct benefits packages that make further expansions possible. They are also hoping to take advantage of the flexibility that HIFA provides states in developing employer buy-in programs. New Jersey implemented a new premium support program through FamilyCare in July 2001. By late November, the program had enrolled about 100 individuals from 35 families. FamilyCare applicants are eligible for the program if they have access to employer-based coverage, and have employers that meet the program's benefits, cost-sharing, and cost-effectiveness requirements.

Taking a family-based approach, BadgerCare covers both eligible children and their parents with the same services as Medicaid on the premise that health insurance is essential for working families with children and that covering the entire family improves children's enrollment and ultimately the quality of health care they receive.

"We are moving forward with the program as is and do not foresee any cuts at this time," despite lingering budget problems, says Schneider. "BadgerCare was designed as a

family coverage plan, and we feel it's important to maintain our commitment to covering these groups."

States Also Face "SCHIP Dip"

In the near future a budgeting quirk in Title XXI of the Social Security Act, known as the SCHIP dip, could compound the states' budgetary challenges resulting from growing enrollment. In order to balance the federal budget, Congress wrote a substantial reduction in SCHIP fund-

ing into the 1997 legislation that created the program for FY2002-04. Funding had been set at \$4.1 billion a year for FY1998-2001 and will return to that level in FY2005, but will decline to \$3.1 billion for FY2002-04.

The availability of unspent funds from previous years may mean that states do not feel the impact of the dip immediately, but observers predict that over time states may not be able to absorb its effect. The Office of Management and Budget has estimated that the dip in funding could mean that, by 2005, the number of

children receiving coverage will begin to decline, with as many as 400,000 children losing their coverage from FY2005-06.

“This program isn’t even out of kindergarten yet,” says says Pat Stromberg, executive director of the Pennsylvania SCHIP program. “There is a lot of expectation and a lot of growth yet to go.” Indeed, according to an HHS estimate, total SCHIP enrollment for FY2000 was approximately 3.3 million—a 70 percent increase over FY1999. And enrollment is likely to increase further, as programs become more established and continue their outreach efforts.

“In the projections that we’ve done, we believe that we have sufficient funding at the moment,” says Stromberg. “But a year or two from now, if our enrollment continues, we may have a funding issue as well.”

Missouri is spending all of its SCHIP money, and Greg Vadner, director of Missouri’s Division of Medical Services, anticipates that the state will have to kick in additional general revenue. “We would argue that there’s not enough SCHIP money,” he says.

States Use Tobacco Money for Expansions

In 2001, states continued to use substantial portions of their share of the 1998 national tobacco settlement on health-related initiatives.

In June, the Pennsylvania legislature passed enabling legislation with regard to the use of the state’s tobacco settlement funds. The state announced that 30 percent of the funds will be used to provide health care coverage for adults. “We’re seeing that it will potentially be the parents of SCHIP-eligible children [who will benefit from this new money],” says Stromberg.

The legislation also allocates 8 percent of the funding toward expanding eligibility for PACENET, the state’s prescription drug assistance program for seniors, and earmarks 10 percent for reimbursements to hospitals that care for uninsured patients.

In November 2000, Arizona voters approved Proposition 204 (known as Healthy Arizona), which requires the state to spend money from the national tobacco settlement to expand eligibility for the Arizona Health Care Cost Containment System (AHCCCS—the state’s Medicaid program). Approximately 45,000 Arizonans have enrolled in the program since eligibility was expanded in April 2001—17,000 of whom are parents of children already enrolled in AHCCCS or Kids Care, the state’s SCHIP program. The state expects enrollment to reach between 137,000 and 185,000 new eligibles by 2005.

Some states have also used tobacco money to address budget issues. Although the monies were secured largely to develop smoking cessation and other prevention programs, “the tobacco dollars can be used in any way the states see fit,” says Lee Dixon, director of the Health Policy Tracking Service at the National Conference of State Legislatures. And states may need such resources as they face reduced allotments in their SCHIP programs in the coming year.

Prescription Drug Costs Continue as Budget Driver

Another significant reason for the escalating health care costs is the rising cost of prescription drugs, due both to an increase in the number of prescriptions per Medicaid enrollee and to inflation in the average cost of each prescription. Responding to a survey in spring 2001, 48 state Medicaid directors listed pharmacy costs as one of the top three factors driving Medicaid budget shortfalls, with 36 listing it as number one.¹ The cost of providing prescription drug coverage for Medicaid beneficiaries accounted for 20 percent of the growth in the Arkansas Medicaid program over the last year. In Oregon, prescription drugs accounted for 60 percent of the state’s biennial increase for the OHP.

In the last four years, Medicaid drug spending in Massachusetts has increased by more than 60 percent, and now comprises about \$738 million of the \$5 billion program. These costs have led the state to become the latest to require Medicaid beneficiaries to use generic drugs when available. Beginning November 28, 2001, approximately 860,000 beneficiaries in the state’s traditional Medicaid program must use generic medications except when doctors deem it medically necessary to use other drugs and obtain prior approval from the state to do so. (See box on page 10 for more details.)

According to Matt Salo, director of health legislation at NGA, current financial drivers of Medicaid budgets such as long-term care and prescription drugs were never intended to be major components of the Medicaid program as it was originally conceived in 1965. Still, states

continue to look for ways to provide this benefit to their citizens because of the federal government's failure to act on these concerns.

In 2001, states were keenly focused on managing chronic diseases and pharmaceutical benefits, both in state employee benefits plans and in Medicaid. "There is a real tension for purchasers in balancing the desire to provide beneficiaries with state-of-the-art care against the reality of limited dollars for health care purchasing," says Joan Henneberry, director of the Health Policy Studies Division at NGA. "States as purchasers are trying to be more efficient and effective on all fronts."

Henneberry explains that states are doing this by:

- Paying lower prices for pharmaceuticals through multi-state purchasing agreements and pooling purchasing within their governments (e.g., state employees, retirees);
- Managing utilization through formularies and multi-tiered co-payment mechanisms;
- Improving fraud, abuse, and waste measures that focus on consumers, prescribers, and pharmacies; and
- Implementing disease management programs and working with pharmacy benefit managers to serve beneficiaries with chronic illnesses.

In January 2002, the Washington Department of Social and Health Services (DSHS) began using a therapeutic consultation service (TCS) to curb increases in the cost of health care for its low-income residents. The service requires pharmacists to review the safety and costs of drugs prescribed to Medicaid patients. The service gives the state both more control over prescription drug costs, which currently exceed \$800 million per biennium, and better oversight of drug therapies. (See box at right.)

"A conservative estimate is that the TCS will save the Medicaid program here upwards of \$20 million over the next year and a half," said Dennis Braddock, secretary of Washington's DSHS, in an October 18 press release. "TCS also will help us help doctors and their offices by providing them with a fast check on a patient's full prescription history as well as up-to-date, expert advice from consulting pharmacists." Other state efforts have included innovative formularies and regional purchasing pools. (See box on p. 10.)

Washington's Therapeutic Consultation Service Program

In January 2002, Washington became the second state in the nation to offer a therapeutic consultation service (TCS) to Medicaid doctors, helping them better target prescription medicines, as well as ease some of the high costs the state now faces.

How TCS works:

1. The pharmacist at the counter receives a Medicaid prescription and sends that information to TCS, which has expert pharmacists on duty to handle queries.
2. Requests for non-preferred drugs or the fifth request for a brand-name drug in a calendar month will trigger expert pharmacists to review the new prescription against the patient's entire prescription history.
3. The pharmacist at the counter is notified to alert the prescriber so that he or she can consult with TCS.
4. During the consultation, TCS will be able to offer additional information, including the possibility of alternative or generic medications that may be suitable. TCS pharmacists will also be able to say whether the prescribed drug is likely to conflict with another drug prescribed for the patient earlier.
5. The prescriber will have the option of changing the prescription, although physicians will still have final authority to make this call.

Source: "DSHS Form Kicks Off New Pharmacy Service to Make Medicaid's Prescription Drugs Safer, Less Expensive," Washington Department of Social and Health Services press release, October 18, 2001.

¹ Source: Smith, Vernon, and Eileen Ellis. *Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002*, for the Kaiser Commission on Medicaid and the Uninsured.

State Efforts to Lower Drug Costs in 2001

A Story of Federal Inaction, State Innovation, and Industry Litigation

Escalating drug expenditures topped state agendas last year, with more than 40 states considering legislation to lower pharmaceutical costs in their 2001 sessions. The surge in state activity was largely driven by the staggering toll that prescription drugs have taken on Medicaid budgets, as well as a desire to help low-income and elderly people buy medications in light of federal inaction on the issue. The states have pursued a range of creative policies, including disease-management approaches, generic-drug use requirements, and multi-state buying pools. Although the pharmaceutical industry has blocked state efforts to varying degrees, last year the states again demonstrated their willingness to find—and fight to maintain—new solutions to an entrenched problem.

Medicaid Formularies

In July, Florida phased in an innovative Medicaid formulary that gives drug companies the option to offer cost-saving programs instead of paying an enhanced rebate to have their products listed on it. To participate, manufacturers can either increase the cash rebate they already provide the state under federal law or provide disease management or health education programs that will produce savings estimates of at least \$16 million. (If the drugmakers' programs do not meet this goal, the companies must pay the difference in cash.)

Both Pfizer and Bristol Meyers have already opted to provide such programs. Pfizer instituted a disease-management program for chronically ill patients last summer, and Bristol Meyers is currently hiring for a similar program for minority populations with depression, HIV, and certain cancers. The Bristol Meyers program is projected to save the state \$16.3 million—and the Pfizer one \$30 million—over the next two years.

The Pharmaceutical Research and Manufacturers of America (PhRMA) tried to block the Florida formulary in court in August, claiming that the plan violates Medicaid law. Federal legislation stipulates that drugs can only be excluded from a formulary if they confer no significant clinical advantage over other medications, and Florida's plan lists "preferred" drugs chosen primarily on the basis of cost. However, the state's formulary does not technically bar any drug from being prescribed; doctors can choose non-formulary products as long as they receive prior approval through a phone bank of pharmacists. For this reason, the court ruled against PhRMA's bid for an injunction.

Last summer, Oregon passed legislation to create a formulary for the fee-for-service portion of its Oregon Health Plan. The state anticipates the program will save it up to \$7 million over the next two years. The state's Health Resources Commission will select the formulary's reference drugs, which are the medications they consider to be the most clinically effective and cost-effective ones in their class. Medicaid will reimburse physicians for up to the price of the reference drug in a given class regardless of which agent they prescribe. (Doctors can be fully reimbursed for substitutions when medically necessary, however.) Oregon is still awaiting federal approval of the plan, which calls for patient cost sharing in the amount of the cost difference between reference and non-reference drugs when patients choose the more expensive non-reference drugs.

Michigan passed a law in 2001 that directed the state's Department of Community Health to develop a program to lower Medicaid costs. Late last year, the Department proposed creating a formulary that will include two cost-effective drugs from each of 40 therapeutic classes. The state appointed a medical panel to create the list, which was finalized December 7; the program is scheduled to take effect January 14, 2002. Pharmaceutical companies will be allowed to have their drugs added to the list if they lower their prices to match those of the selected drugs. On November 30, PhRMA filed a lawsuit to block the program in Michigan court, on the grounds that it limits patients' quality of care by restricting their ability to obtain medications.

Multi-state Purchasing Pools

In May, New Hampshire, Vermont, and Maine banded together to form a drug-buying pool that will hopefully save each of them 10 to 15 percent on pharmaceutical costs per year. The tri-state group engaged a prescription benefits manager (PBM) to consolidate purchasing for more than 1 million area residents, including Medicaid enrollees, residents without access to drug coverage, and some Medicare beneficiaries. The PBM and the states are now determining which specific cost-savings strategies to pursue. In late fall, officials from the three New England states were discussing expanding their pool to include Connecticut, Rhode Island, Massachusetts, Pennsylvania, and New York.

In October, seven other states—Louisiana, Maryland, Mississippi, Missouri, New Mexico, South Carolina, and West Virginia—announced a plan to create a multi-state pool based on the New England model. Tom Susman, director of the West Virginia Public Employees Insurance Agency, has been selected to lead the effort. His agency issued an RFP requesting PBMs to submit proposals in December 2001.

Drug-Discount Programs

Late in 2000, Vermont received approval to use the state's Medicaid program to offer drug discounts to seniors and other adults who do not meet Medicaid income-eligibility requirements. After engaging in multiple court battles with PhRMA, the state was forced to shut down the program in June, however, because a federal appeals court ruled that it was improperly approved by HHS.

For much of last year, PhRMA also succeeded in blocking a similar program in Maine, although Maine won a major victory in May when a federal appeals court lifted an injunction against the program. Under Maine Rx, which was enacted into Maine law in 2000, the state leverages pharmaceutical discounts from drug companies by consolidating purchasing for nearly 325,000 uninsured residents. Drug companies must make their prices "reasonably comparable" to those charged to the lowest-paying customers

or face state-imposed fines. The law creating the program also authorizes the state to establish price caps if Maine officials find that companies have not met fair pricing standards by early 2003.

In August, PhRMA requested that the U.S. Supreme Court consider overturning the May ruling that upheld the Maine program—a move that has once again delayed its implementation.

In July, Indiana reduced the amount that pharmacies were reimbursed by Medicaid from \$4 to \$3 per prescription. A group of pharmacists challenged the policy in court, however, arguing that the lost revenue for pharmacies would translate into reduced hours and personnel. In October, they won an indefinite injunction against the discount plan.

The Maryland legislature launched an initiative in July to help low-income seniors pay for prescriptions. The state has submitted a waiver request to the Centers for Medicare and Medicaid Services (CMS) to require drugmakers to sell to Medicare beneficiaries at discounted Medicaid rates. At the end of the year, the state had received some encouragement from CMS, but was still awaiting final word.

Other State Efforts

In July, Georgia became the first state to institute a sliding scale for Medicaid co-payments based on income. The state had previously charged a flat rate of \$0.50 for preferred prescriptions; the new scale ranges from \$0.50 to \$3. Georgia officials anticipate savings of up to \$18 million annually.

In late October, Massachusetts launched a Medicaid generic-drug-use policy that may be the strictest to be implemented by any state to date. Other states have set monthly Medicaid reimbursement limits for brand-name drugs, but Massachusetts requires doctors to prescribe generics almost exclusively under Medicaid. The only exception is when doctors determine that other drugs are medically necessary—in which case they must still obtain prior approval to use them from the state. Massachusetts hopes this approach will save the state Medicaid program \$10 million in the first year.

NEW ADMINISTRATION, NEW FOCUS

HHS Gives States More Flexibility to Expand Coverage

As states work through their issues internally, the federal government plays a role that changes over time depending on who controls the White House and Congress. Perhaps the clearest indication of the kind of help states can expect to receive under the Bush administration with Secretary Tommy Thompson heading the Department of Health and Human Services (HHS) is the Health Insurance Flexibility and Accountability (HIFA) 1115 Demonstration Proposal.²

At the August 4 opening session of the National Governors' Association's annual meeting, Thompson announced that HIFA was being created "to reduce the obstacles faced by states to use the available federal

matching funds to expand coverage, and to allow them to use current funding in more innovative ways." Focused on expanding coverage to individuals below 200 percent FPL and partnering with the private sector, HIFA allows states to tailor benefits packages for optional and expansion populations under Medicaid or SCHIP, but does not change the benefits that states must offer to mandatory groups.³ As with other 1115 demonstration waivers, HIFA projects will be approved for an initial five-year period.

"Our goal is to give governors the flexibility they need to expand insurance coverage to more Americans through innovative approaches, including the kind of health insurance options available in the private sector," said Thompson in an HHS press release issued August 4. "Through this initiative, we are creating a new, simpler process for states to propose and implement creative ideas to help uninsured residents."

Breast and Cervical Cancer Patients: A New Categorically Eligible Medicaid Population

In March 2001, Maryland, New Hampshire, and West Virginia became the first states to receive federal approval to cover a new categorically eligible population under Medicaid—breast and cervical cancer patients. Since then, 29 other states have taken advantage of the optional eligibility created by the Breast and Cervical Cancer Act, which Bill Clinton signed into law in October 2000. States receive federal matching funds to cover these patients at the enhanced SCHIP level.

For more than a decade, the Centers for Disease Control and Prevention has offered free breast and cervical cancer screening through the National Breast and Cervical Cancer Early Detection Program, but until now the cost of treatment has not been covered. The new provision offers coverage for uninsured patients with incomes up to 250 percent FPL who undergo free screening and discover the need for treatment. Medicaid covers the costs of any surgery, radiation, chemotherapy, follow-up care, and medication. The legislation also extends four hours of unpaid leave for screenings to workers with less than two weeks of paid sick leave per year.

According to advocates, the law is a sound policy that took four years to find its way to the floor for Congressional passage. "We saw a need and for several years fought an uphill battle to enact [this law] because it

was good public policy and would help women immediately," says Fran Visco, president of the National Breast Cancer Coalition. All states are expected to opt into the program, perhaps within the next legislative year.

Yet many have mixed feelings about adding a new eligibility category at a time when Medicaid budgets are so strapped. "It is very popular legislation, and most states have been successful at enacting it," says Stephanie Wasserman, senior policy specialist for the National Conference of State Legislatures. "At the same time there has been much concern about fiscal issues overall."

Indeed, cost concerns have led some states to implement restrictions to the program. In Alaska, for example, the Senate added a provision that calls for the program to expire after two years. "We put some fiscal constraints in there so that it could not just continue to drive up the cost of medical care," explains Sen. Pete Kelly (R), co-chairman of the Senate Finance Committee.

Other states have developed creative financing solutions. In Washington, the legislation establishing the program calls for part of the state match to be paid by the Susan G. Komen Breast Cancer Foundation. A few states, including Colorado, have used tobacco settlement money to fund their portion of the costs.

"In the end, the justification for many states has been that the portion of the Medicaid budget required is not that significant," says Wasserman. "This piece would not have that great an impact, compared to other Medicaid and budgetary concerns, and ultimately that helped sway most states in favor of enacting this legislation."

But some stakeholders have pointed out that the difference between mandatory, or “core,” populations and optional populations is not necessarily the same as that between lower and higher income groups. According to one participant in a Children’s Defense Fund conference call in September, “Some individuals that fall under optional populations can be quite poor and unable to afford the potential cost-sharing increases that the initiative allows the state to impose.”

Others point out that, although increasing cost sharing or streamlining benefits may not be ideal, it allows states to give more people some coverage, rather than having to drop certain beneficiaries from public programs entirely due to lack of funding. States will likely have to make difficult choices “to sustain the progress that’s been made, and to consider what we can do in light of recent events and the souring economy to ensure that progress continues to move forward,” said Cindy Mann, senior fellow at the Kaiser Family Foundation, at an October 1 Alliance for Health Reform briefing.

In general, state officials and advocates have greeted the HIFA initiative with measured optimism, claiming that they cannot assess the initiative’s full value until HHS provides more details about how it will work. They are particularly interested in understanding the financing options allowed under the guidelines.

As with other 1115 demonstration projects, HIFA initiatives must be budget neutral. Essentially, states can design expansions for whichever populations they choose using their federal SCHIP allotment (which they must match). To ensure that expansions do not cost more than they would in the absence of the demonstration, states can redirect Medicaid disproportionate share hospital payments, reduce benefits for certain populations, or increase cost sharing on premiums paid by or on behalf of enrollees.

Under the program, HHS has pledged to:

- Encourage state innovation to improve how Medicaid and SCHIP funds are used to cover low-income individuals;
- Give states the programmatic flexibility required to support approaches that increase private coverage options;
- Simplify the waiver application process by providing clear guidance and data templates; and
- Increase accountability in the state/federal partnership by ensuring that Medicaid and SCHIP funds effective-

ly increase coverage, particularly by providing more private insurance options.

HIFA’s components closely follow the Medicaid policy recommendations that NGA made earlier this year. The NGA recommendations centered on three key goals: 1) restructuring Medicaid’s prohibitive “all-or-nothing” benefits approach; 2) allowing appropriate cost-sharing arrangements; and 3) establishing more prompt and limited CMS review of waiver applications and proposed amendments.

Many feel that HIFA’s largest flaw is that it provides no additional federal money to help states pursue expansions. “In a time of serious state fiscal situations, without the enhanced match, few states will be able to come up with the money to propose significant expansions,” says Matt Salo, director of Health Legislation at NGA. But he acknowledges that HIFA’s flexibility “will be important in helping transform the Medicaid program into one that meets the needs of 21st century health care.”

HIFA is supported through unused SCHIP allotments and Medicaid funds. The Office of the Actuary at CMS projects that the states will begin FY2002 with an extra \$11 billion in prior years’ unspent SCHIP allotments, in addition to the \$3.1 billion specifically allocated for FY2002. Only Rhode Island is expected to exceed its total available SCHIP funding for FY2002, having expanded SCHIP to cover children up to 250 percent FPL and parents up to 185 percent FPL.

The states are projected to spend \$3.6 billion (25 percent) of the \$11 billion in leftover funds. Many states can use the remaining \$10.5 billion for further program expansions through HIFA and other waiver opportunities.

Building on Employer-Based Coverage

HIFA also allows states greater flexibility in developing employer buy-in programs. In recent years, eligibility for public programs has expanded through Medicaid and SCHIP waivers, as has the likelihood that working people who are unable to afford their employer-sponsored insurance premiums will be eligible for public insurance. As a result, states are looking to partner with the private sector to provide coverage to more families with higher incomes. HIFA encourages states to coordinate private insurance options with Medicaid and SCHIP, and provides flexibility in calculating cost-effectiveness and in determining benefits and cost sharing.

² An application template for the HIFA waiver is available on the HHS Web site at <http://www.hcfa.gov/medicaid/hifatemp.pdf>.

³ **Mandatory populations** are groups that a state is required to cover in its Medicaid state plan (e.g., children under age six, pregnant women up to 133 percent FPL). **Optional populations** are groups that can be covered under a Medicaid or SCHIP state plan (i.e., they do not require an 1115 waiver to receive coverage). **Expansion populations** are individuals who can only be covered under Medicaid or SCHIP under an 1115 waiver (e.g., childless, non-disabled adults under Medicaid).

Partnering with the private sector through an employer buy-in is a win-win coverage technique for states. They can share the cost of insuring an individual with the employer, and use the employer-based system to expand coverage—which is politically popular. Employees like the idea of having private coverage rather than being insured by a public program, and many small employers want to do the right thing by offering a health care benefit to their workers. Buy-ins may also improve the continuity of coverage and help to keep families in a single insurance plan.

Nonetheless, state buy-in programs typically have low rates of participation because few low-income workers are offered employer coverage, and employer premium contributions may be too low to qualify. Buy-ins can also be administratively burdensome. Employer plans often fail to meet the program's cost-effectiveness test.⁴ And a mobile, low-wage worker may leave a job, moving to another employer before the buy-in can be established. Finally, firms that offer coverage may be reluctant to participate in buy-ins because they often have few workers who are Medicaid eligible.

Still, some buy-in programs are succeeding. Rhode Island's employer buy-in program, Rlte Share, was created in February 2001 to address the fiscal crisis that the state's Medicaid/SCHIP demonstration program (Rlte Care) experienced in the late 1990s. In 1998, the state expanded Rlte Care to include parents of eligible children with incomes up to 185 percent FPL. Reflecting officials' concern that public coverage would substitute for, or "crowd out," private coverage, RI Health Reform 2000 requires all individuals and families eligible for Rlte Care and with access to employer-sponsored coverage to enroll in Rlte Share. Rlte Share pays employers and providers, respectively, for 1) the employees' share of the premium; and 2) the employees' co-pays and expenditures for Rlte Share services not covered by the employers' plans.

"Rhode Island seems to be ahead of the curve in tackling the complex technical issues associated with establishing an employer buy-in," says Joel Cantor, director of the Center for State Health Policy at Rutgers University and national advisory committee member of the *State Coverage Initiatives* program.

Rlte Share has several design features that make it less administratively burdensome than other buy-ins. Cost-effectiveness of employer plans is assessed at the program level and based on an average family rate rather than calculated for each individual family. The state has also worked closely with insurers to streamline the benefit certification process. In addition, the state will use an SCI demonstration grant to evaluate and refine RlteShare in 2002. (See p. 30 for details.)

"We took things as far as we could by expanding fully funded public coverage," says Tricia Leddy, administrator

of the Center for Child and Family Health in the Rhode Island Department of Human Services. "The way to go now is to create employer-assistance programs that close the insurance gap between publicly funded and employer-sponsored coverage. The HIFA guidelines are on the right track in terms of encouraging and enabling states to go further in expansions by allowing families to stay in employer-based coverage."

Building on employer-based coverage is also a key focus for Oregon, which intends to work with the federal government to obtain matching funds for its buy-in, the Family Health Insurance Assistance Program (FHIAP), which was added to the Oregon Health Plan in 1997. Because the program is financed solely by the state, the state has the freedom to determine the benefits provided, the cost sharing required, and the waiting periods and employer participation rules that apply. Without federal financial support, however, FHIAP faces tight funding constraints: enrollment is capped at 5,000 beneficiaries while another 19,000 remain on a waiting list.

"We are working both internally and externally to figure out what HIFA can mean for Oregon, specifically how it differs from other waivers," says John Santa, M.D., administrator of the Office of Oregon Health Plan Policy and Research. "At this point, it looks like HIFA is worth pursuing."

Other Oregon officials are concerned about the apparent prohibition of state-only programs being brought under the HIFA umbrella. "It is important that people eligible for FHIAP under the new expansion receive the federal match," says Bob DiPrete, director of the Oregon Health Council. (For more on FHIAP and new initiatives Oregon will implement under an SCI grant, see p. 30.)

For Wisconsin, public-private partnerships are only a small component of the BadgerCare program because low-wage employees generally lack access to family coverage through their employer. About 100 people from 43 families are participating in BadgerCare's Health Insurance Premium Payment program, and another 130 families are eligible and pending enrollment. The state established the buy-in option in 1999 to maximize limited public funds, encourage and support low-income adults by minimizing the stigma of public programs, and keep families together under a single health insurance plan.

"We have not had time to evaluate HIFA in any depth to determine what, if any, benefit it will be to our program," says Donald Schneider, chief of coordination of benefits for Wisconsin Medicaid. "Currently we are focusing on funding and other issues for our programs as they exist."

State officials in Massachusetts say they will not pursue a HIFA demonstration at this time because they have already expanded through a combination of their Medicaid 1115 waiver and SCHIP. "Many of the groups

targeted by HIFA are already covered in Massachusetts,” says Beth Waldman, director of program implementation at the Massachusetts Division of Medical Assistance.

The Massachusetts premium-assistance program has two components: 1) an employee subsidy called Premium Assistance; and 2) an employer subsidy called the Insurance Partnership. Through these programs, Massachusetts hopes to:

- Increase the number of employees receiving health insurance through their employer;
- Discourage crowd-out of private coverage by state and federally funded health insurance programs; and
- Increase the number of small employers who offer health insurance coverage that meets the state standard.

Approximately 4,000 employers participate in the Massachusetts premium-assistance programs, which cover about 12,000 individuals. According to Charles Cook, director of benefit coordination and recovery operations for the Massachusetts Division of Medical Assistance, survey data last summer confirmed that the percentage of Massachusetts employers who offer health insurance, which had been declining steadily over the last decade, had not only stabilized, but shown a slight increase.

“The ability of a state to pursue a policy of subsidizing employer-sponsored insurance is directly tied to the viability of a marketplace,” says Cook.

Introducing the HIFA option has gone a long way toward establishing a better relationship between CMS and the states. Moving forward, state officials hope the federal government will continue to recognize their need for flexibility.

Thompson Administrative Actions with State-Level Impact

CMS Clears Backlog of State Waivers, Plan Amendments

The flexibility that state officials desire includes timely responses from HHS to state requests for waivers and plan amendments. Since the beginning of the Bush administration, HHS has approved more than 1,000 state plan amendments and waivers under Medicaid and SCHIP. In October 2001, Secretary Thompson announced that the department had cleared a backlog of nearly 400 proposed amendments to state Medicaid programs, some of which had been pending for several years. Of these, 346 were approved, and about 50 were

CMS: A New Name, A New Direction

Last summer, Secretary Thompson announced that the Health Care Financing Administration (HCFA) was looking for a new name, “to give the agency a new direction and a new spirit.” After a five-day renaming contest among HCFA employees that yielded approximately 800 entries, HCFA became the Centers for Medicare and Medicaid Services (CMS) on July 1, 2001. Emphasizing that the organization is trying to create a new culture of responsiveness, Thompson said that the most important word in the name is the last one: services.

CMS was organized around three centers to clearly reflect the agency’s major lines of business: traditional fee-for-service Medicare; Medicare+Choice; and state-administered programs, such as Medicaid and SCHIP.

The Center for Medicare Management will focus on management of the traditional fee-for-service Medicare program. This includes development of payment policy and management of the Medicare fee-for-service contractors.

The Center for Beneficiary Choices will focus on providing beneficiaries with information on Medicare, Medicare Select, Medicare+Choice and Medigap options. It also includes management of the Medicare+Choice plans, consumer research and demonstrations, and grievance and appeals functions.

The Center for Medicaid and State Operations will focus on programs administered by states. These include Medicaid, SCHIP, insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act.

In announcing the new name, Thompson said, “We provide essential services to millions of health care consumers and the health care providers that serve them...and we are going to provide these services at a level of excellence that Americans deserve. This is just a beginning.”

withdrawn by the states or rejected by HHS. The department estimates that these approvals have expanded eligibility to more than 1.4 million people and enhanced benefits for about 3.5 million.

Eliminating the backlog had been one of the department’s goals for this year “because we knew that it would result in better health care for more people,” says

⁴ Federal legislation requires states to demonstrate that it would cost less for them to enroll a family in an employer buy-in than to cover them through regular SCHIP or Medicaid. (States are also required to ensure that participants are offered the equivalent of the full Medicaid benefits package—which means states must provide employees with additional “wrap-around” benefits to cover what employer-based plans do not.)

New Patient Protections for Medicaid Managed Care Beneficiaries

In August 2001, the Department of Health and Human Services proposed regulations to build on protections for Medicaid beneficiaries that were created under the Balanced Budget Act of 1997.

Under the new rules, beneficiaries will be given additional rights in the following areas:

Emergency room care

Health plans must pay for a Medicaid beneficiary's emergency room care whenever and wherever the need arises.

Second opinions

All beneficiaries will be allowed to get a second opinion from a qualified health professional.

Women's health services

Women will be allowed to directly access a women's health specialist in the network for the care necessary to provide routine and preventive health care services as already available in Medicaid fee-for-service.

Patient-provider communication

Managed care plans will be prohibited from establishing restrictions that interfere with patient-provider communications, such as gag rules.

Network adequacy

Managed care plans will be required to assure that they have the capacity to serve the expected enrollment in their service area.

Marketing activities

States will be required to approve marketing materials used by the managed care plans to enroll Medicaid beneficiaries. Plans are prohibited from using door-to-door, telephone, and other forms of cold-call marketing.

Grievance systems

All managed care plans must have a system in place to accommodate enrollee grievances and appeals. Grievances must be resolved within state-established timeframes that may not be longer than 90 days and must be resolved by managed care organizations within 45 days. However, expedited timeframes exist for resolving appeals when the life or health of the enrollee is in jeopardy.

Thompson. "We will continue to encourage governors to innovate to help even more people in need. Working with the states is a successful strategy that we will continue to build upon."

Medicaid Managed Care Regulations Delayed

In early 2001, HHS placed temporary holds on various Medicaid managed care regulations instituted by the Clinton administration. According to Secretary Thompson, the previously issued rules went far beyond what Congress intended with the Balanced Budget Act, and its excessive mandates actually threatened beneficiaries' access to care under Medicaid. New rules proposed by HHS in August will guarantee Medicaid beneficiaries access to emergency room care, a second opinion when needed, a timely right to appeal adverse coverage decisions, and other essential patient protections. (See box at left.)

Thompson asserts that the new rules allow states more flexibility in deciding how best to protect the approximately 19 million Medicaid beneficiaries enrolled in managed care plans. At the same time, the regulations will give states flexibility to provide these protections in a workable manner. He says the new provisions are "more concise and understandable and will reduce the regulatory burden on the states and health plans."

Some lawmakers have expressed concern, however, that the Clinton rules contained "key measures to protect millions of Americans from managed care abuses." These measures went into effect on January 19, 2001—one day before President Bush took office. The final rules will be issued in early 2002.

HHS Issues New SCHIP Regulations

Also in early 2001, Secretary Thompson announced that he would delay previously issued SCHIP rules for at least 60 days to hear and respond to governors' concerns that the new rules would increase administrative costs for states and health plans. HHS eventually released its interim final rule on June 25, 2001, with changes to a small but significant portion of the January 25 regulations. The re-issued rule then went into effect on August 24, 2001.

In July 2001, a broad collection of national, state, and local health care advocacy groups, children's organizations, religious groups, and health care providers submitted a letter to Thompson stating that most of the changes could weaken important child health protections. The letter was signed by more than 100 organizations, including Families USA, the American Academy of Pediatrics, and the Children's Defense Fund. It is currently being considered by the federal government and could result in further adjustments.

Upper Payment Limits: Administration Closes Medicaid “Loophole”

In late November 2001, CMS proposed a regulation that would decrease the upper payment limit—a formula governing state reimbursements to public hospitals—from 150 percent to 100 percent. Coined by many as a “loophole” in federal law, upper payment limits allow states to pay city- or county-owned care facilities more than the actual cost of health services, receive additional matching funds from CMS, and then require the facilities to return the extra state funds. This process permits states to capture more federal Medicaid matching dollars.

Because some states use returned funds for initiatives other than health care, however, upper payment limits have been sharply criticized. Indeed, CMS Administrator Tom Scully calls them “the single biggest public policy outrage” in his lifetime.

But others have criticized the proposed regulation, arguing that the flexibility on upper payment limits was written into federal regulations to protect vulnerable hospitals and shore up the safety net for low-income families. According to the National Governors’ Association (NGA), the pro-

posed rule would reduce federal funding to states and hospitals by a total of \$9 billion over five years. In addition, NGA says that while proposing these cuts, the administration has not offered any new funding to help redirect money to the states that use the rule the most. NGA had hoped that the cut would be accompanied by an increase in the federal share of Medicaid spending.

California relies heavily on the payment for its public health safety net, and stands to lose approximately \$300 million annually under the new regulation, according to state officials. “Our already-strained safety net health care infrastructure simply cannot survive a loss of this magnitude and still maintain the level of critical services the public expects and deserves,” says Denise K. Martin, president and CEO of the California Association of Public Hospitals and Health Systems.

But Scully says that California and other states with long-established programs will not be affected for several years. Fourteen states that were recently approved to use the loophole at the 150 percent rate, however, must reduce to the 100 percent rate in early 2002. These include Colorado, Florida, Georgia, Idaho, Indiana, Kentucky, Michigan, Minnesota, Montana, Nebraska, New York, South Carolina, Texas, and Washington.

“Essentially, there is disagreement about the extent to which states should be regulated,” says Rachel Klein, health policy analyst for Families USA.

The NGA said the June regulations “narrowed available state options and imposed new requirements while not seeking to preserve a healthy diversity in public policy.” NGA called for the final regulations to “preserve flexibility, foster innovation, and strengthen the state-federal partnership to reach our common goal of ensuring our nation’s children have access to quality care.”

Among the issues of greatest concern are:

- **Cost sharing.** The final rule revises the 2.5 percent maximum cost-sharing requirement for families below 150 percent FPL to a 5 percent maximum. The NGA asserted that the administration had moved beyond its authority in mandating co-payments not to exceed 2.5 percent. In addition, NGA argued that SCHIP-eligible families have the ability to make reasonable contributions toward their children’s health care, and allowing them to do so empowers them to “become even more responsible families.” In contrast, the coverage advocacy groups stated in their letter to the federal government that they viewed the 2.5 percent cap as “recognizing that some families with incomes below 150

percent of poverty with several children, or with one child with special health care needs, will not be sufficiently protected by the provision that their premiums and cost-sharing obligations be ‘nominal.’”

- **Secretary-approved coverage.** The new rule expands the older definition of “secretary-approved coverage” to permit any Medicaid section 1115 benefits package for children previously approved by the secretary. From the NGA perspective, the provision “broadens the states’ flexibility in designing a benefits package,” but according to the coverage advocates, it “defines an overly broad array of benefits packages as automatically qualified.” Coverage advocates are concerned that packages approved for one population may prove inadequate for another population, and that each proposed package should undergo its own review process to assure appropriate coverage.
- **Social security numbers.** The new rule allows states to require a social security number for children, but not for adult family members who are not applying for coverage. The health advocacy groups see this as a “troubling interpretation of the Privacy Act that could create barriers to the enrollment of eligible children in immigrant families.” According to the NGA, the states have not seen the requirement of children’s social

security numbers deter applicants for Medicaid, and state officials see the change in policy as a way to “allow states to better coordinate SCHIP applications with Medicaid and other human services.”

- **Grievance and appeals process.** The policy changed to allow states either to establish a review process and minimum standards established in January or to demonstrate that participating providers comply with state-specific grievance policies currently in place for health insurance issuers. The governors “believe these changes will minimize increased burdens on the states and promote equity among health insurers in the public and private sectors,” while the advocacy groups express concern over loss of a minimum standard. They believe the “original standards offered adequate state flexibility and that the importance of providing adequate consumer protections to all SCHIP enrollees outweighs the concerns expressed about administrative burdens.”

HHS now faces a challenge of finding appropriate balances between protecting children’s access to coverage and avoiding overburdening the states. An HHS response was anticipated sometime this fall, but no date was set at press time.

To access the SCHIP regulations, see <http://www.hcfa.gov/init/hcfa2006.pdf>. To access comments, see http://www.familiesusa.org/mediaalerts/chip_comments.htm, and <http://www.nga.org>.

State reaction to Thompson taking over HHS has been generally positive so far. While states still desire additional federal financial support, progress has been made in what some would call the most important challenge for CMS: its image problem with the states.

“This administration appears to be responsive to the flexibility needs of states,” says John Santa of Oregon. “When we have spoken to the folks at CMS, they have uniformly been willing to listen.”

INSURANCE MARKET REFORMS IN 2001

Four States Struggle to Make Their Markets Work

In a year when spiraling health care costs forced many policymakers to focus on maintaining rather than expanding coverage, the states were also playing defense in the area of insurance market reform.

The early 1990s saw several states, including New Hampshire, Washington, Kentucky, and New York, make comprehensive small group and individual market reforms designed to make coverage more affordable for people at high medical risk. Now, those states are repealing or struggling to maintain their reforms as carriers have left the market.

“A number of factors have contributed to carriers leaving,” says Deborah Chollet, senior fellow at Mathematica Policy Research, Inc., “and it is not obvious that regulation has been the most important factor or even a significant factor.” Chollet says the growth in group markets over the past several years may have influenced the current trends.

“Many working families who had been buying individual coverage apparently were offered group coverage in tight labor markets,” contributing to shrinking business among individual carriers. These carriers have responded to an increasingly competitive environment by demanding less state regulation and greater use of high-risk pools.

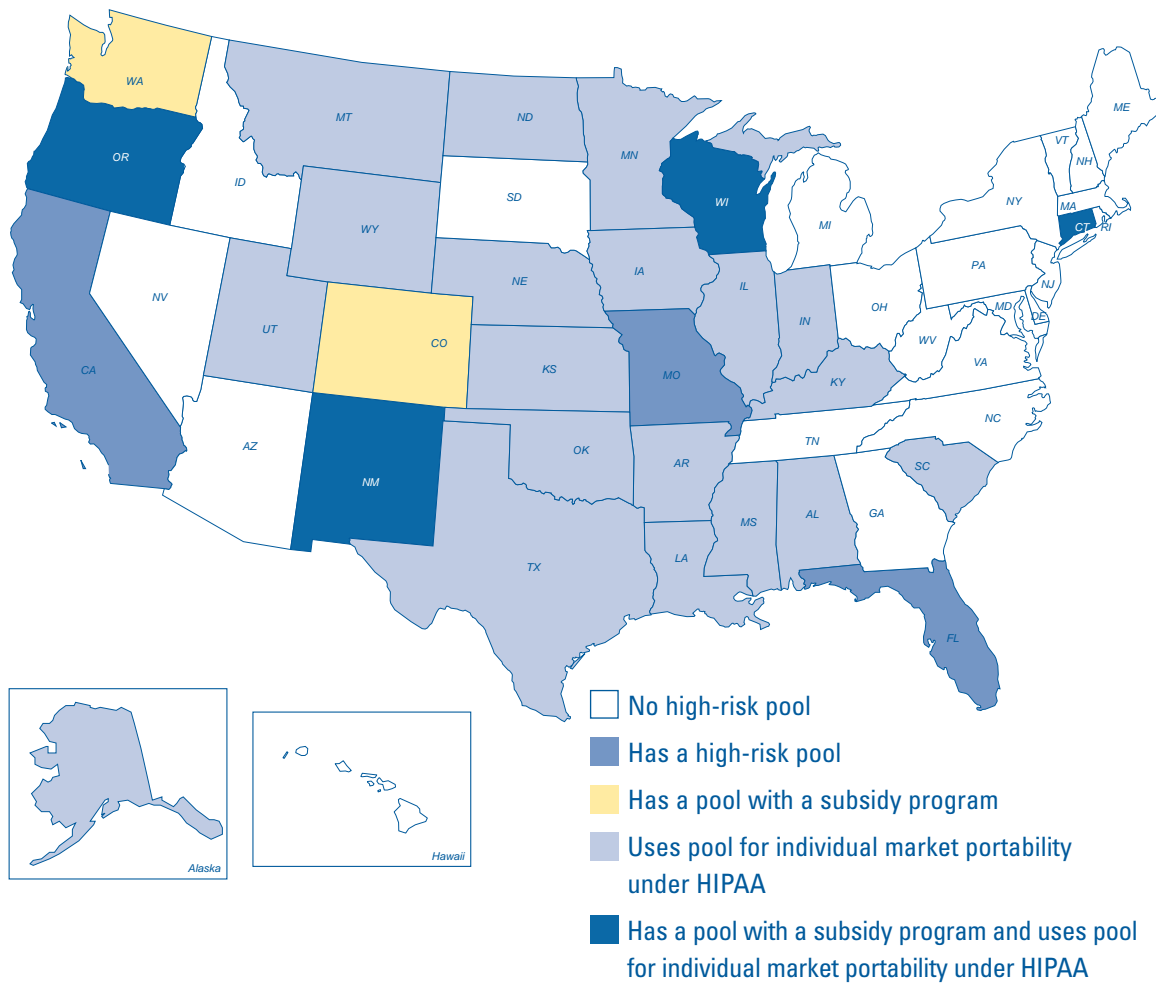
New Hampshire Repeals Reforms, Creates Risk Pool

Last summer, New Hampshire passed legislation to roll back its individual market regulations and create a high-risk pool. The new law, which repeals guaranteed issue and increases rating flexibility, will go into effect in July 2002—as New Hampshire’s new risk pool becomes operational. State legislators and insurance department officials hope that the reforms will revive an individual insurance market that has been dwindling since the late 1990s. “We’re trying to prevent a train wreck,” says David Sky in the state’s insurance department.

The new rating rules allow insurers to mark up premiums by 50 percent on people who have health problems and by 400 percent on older individuals. The legislation also introduced a health-status underwriting factor that allows carriers to charge smokers 50 percent more than nonsmokers. The law allows insurers to extend waiting periods for coverage of pre-existing conditions from 9 to 18 months in the individual market, and it sets a waiting period of 12 months for coverage of pre-existing conditions in the state’s high-risk pool. A second law passed last summer reduced the open enrollment period for groups of one in the small group market.

State officials are in the process of generating requests for proposals to hire the administrative and actuarial support they will need to create their new high-risk pool, which

States with High-Risk Pools in 2001



In many states, high-risk pools are the sole health insurance option for people without employer-based coverage who have been denied individual coverage because of a medical condition. The pools were first established in Connecticut and Minnesota 25 years ago. They have grown significantly within the past couple of years, with enrollment increasing nearly 12 percent between 1999 and 2000 in the states that offer them.

The pools have expanded largely because people are leaving the individual insurance markets due to rising premiums and coverage rejections. The Health Insurance Portability and Accountability Act (HIPAA), which eliminated the pools' waiting periods in some states for people who have continuous coverage in the group market, have also driven their growth.

Insurance benefits offered through risk pools vary from state to state, but they tend to be comparable to those in basic private market plans. Most states cap premiums at 125 to 200 percent of the average premium for a comparable plan.

will be the 30th such pool in the country. (For more on high-risk pools, see box above.) The legislation establishing the pool stipulates that it can never close and that premiums cannot exceed 200 percent of the average rate in the individual market. It also requires the pool's benefits to be actuarially equivalent to those offered by private insurers. The pool will be funded through an assessment on individual, group, and stop-loss insurer premiums.

“We tried to avoid the problems we saw in other states’ risk pools by creating one that offers affordable premiums to persons of ordinary means and will not close due to insufficient funds,” says Alex Feldvebel, New Hampshire’s deputy insurance commissioner. Feldvebel believes that the small size of the state and its individual insurance market—which comprises just 1 percent of New Hampshire’s population aged 0 to 64—will also work in its favor, because the pool’s financing is unlikely to be overwhelmed due to high demand.

New Hampshire passed its legislation hoping to attract carriers back into its market. The state experienced a slow exodus of individual insurers, coinciding with the 1994 passage of comprehensive health reforms in the individual and small group insurance markets, as well as with significant growth in group coverage. In both markets, New Hampshire required guaranteed issue, guaranteed renewability, and modified community rating.

Following the rollback of New Hampshire's individual market reforms, however, one additional carrier left the New Hampshire market; two individual insurers remain, both offering only high-deductible plans.

In the small group market, New Hampshire's reforms generally achieved their goals of increasing access, eliminating job-lock, and ensuring affordable premiums among high-risk individuals, Feldvebel says.

Individual Carriers Resume Writing in Washington State

After passing a law to roll back its individual market reforms, Washington saw its three largest commercial insurers—which had stopped writing new policies in the state in the late 1990s—resume accepting individual applications last year. The state had passed the legislation in March 2000, but the rollback did not take effect until January 2001.

Washington's law increased from three to nine months the waiting period for coverage of pre-existing conditions in the individual or small group markets and in the state's high-risk pool. It also allows insurers in the individual market to deny coverage to the costliest 8 percent of those who apply for it, based on their results on a health questionnaire used for underwriting.⁵ (Those who are denied coverage can turn to Washington's high-risk pool, called the Washington State Health Insurance Pool.) Finally, the legislation mandates that all comprehensive individual plans offer maternity and prescription drug benefits, but carriers are no longer required to obtain the state's approval for rate increases in the individual market.

The legislation, which Governor Gary Locke (D) said "allowed the insurance system to work like an insurance system," was designed as a compromise with individual carriers in the state. Group Health, Premera Blue Cross, and Regence Blue Shield had refused to sell new policies in response to the denial of large rate increases that followed the repeal of the state's extensive 1994 reforms, including guaranteed issue and adjusted community rating. The carriers said they would write new business if the state agreed to roll back the reforms. In many counties, the Washington State Health Insurance Pool (WSHIP) was its only source of individual coverage for more than a year. Now that the insurers are accepting new business, private individual coverage is once again available to new applicants in all counties of the state.

Legislators had hoped that the roll back would attract new insurers to Washington's individual market, but that has not happened. "Our efforts to bring carriers into the state have not been very successful," says Bill Hagens, health policy advisor for Insurance Commissioner Mike Kreidler. "But if you looked at individual coverage across the country in the past, the reality is that the Blue Cross plans were the primary source of coverage. Small indemnity plans were not a big part of the picture."

Since the underwriting screen was implemented, insurers have rejected an estimated 6 percent of the costliest individuals, Hagens says. However, premiums have not gone down in the individual market; in fact, they have increased by an average of about 20 percent. Moreover, enrollment in WSHIP did not grow significantly last year, suggesting that many of those rejected by private insurers cannot afford coverage in the pool.

Kentucky Opens High-Risk Pool, Legislates Underwriting

Using tobacco settlement funds, Kentucky opened a high-risk pool called Kentucky Access in January 2001. Having passed legislation allowing medical underwriting as of January 1, Kentucky Access was created to allow high-risk individuals to purchase insurance when denied coverage through private insurers or offered coverage only at extremely high premiums. The \$33-million-a-year initiative is also intended to help restore competition to Kentucky's badly ailing individual market. "We are not totally where we want to end up, but we have seen some progress," says Insurance Department Commissioner Janie Miller.

Kentucky experienced a significant exodus of its smaller insurers following its comprehensive reforms in the early 1990s, which included guaranteed issue of all products. Just two individual carriers remained in the state, and one of them (the state's Blue Cross Blue Shield plan) was writing over 95 percent of all individual business. Kentucky Access will supplement, and may eventually replace, Kentucky's Guaranteed Acceptance Program, which reimburses participating insurers for some losses resulting from covering high-risk individuals. Since January, four companies have entered Kentucky's individual market, and rate increases have started to level off, Miller says.

Low enrollment in the pool was a concern in the early part of last year, but by fall the number people entering it—an average of about 90 per month through September—was "right on target," Miller says. According to Fred Nelson, director of Kentucky Access, the insurance department had expected to enroll between 3,000 and 5,000 people in the pool over the next four years, or about 60 to 100 individuals per month.

In addition to premium revenue, the pool is financed with tobacco settlement funds, an assessment on premiums written by stop-loss carriers, and an assessment on premiums written by health insurance carriers offering fully insured plans. Last summer Governor Paul Patton (D) cut the pool's funding by \$10 million and used the funds to help alleviate the state's \$326-million budget shortfall. State legislators worried that the move would jeopardize the pool's future, but Miller says the one-time cut will not affect its operations for FY2001 or FY2002, and "it's still too early to say if it will impact the program later down the road." For now, the insurance department has no plans to scale down the program or its marketing efforts.

Officials in Kentucky tried to draw on the experiences of other states with high-risk pools to design one that avoided their problems. "Consumers commonly complain that high-risk pools offer inadequate benefits, impose lifetime maximums, and don't give people an opportunity to see the doctors they want when they want to see them,"

says Miller. Kentucky Access puts no lifetime limit on benefits for many of its plans, and the legislation that created it stipulated that the pool's benefits must mirror what is available in the private market.

Healthy New York Makes Its Debut

Beginning in January 2001, all health maintenance organizations in New York State offered a state-subsidized health insurance benefits package for eligible businesses with 50 or fewer employers, working individuals, and sole proprietors. The plan, known as Healthy New York, was instituted as part of New York's Health Care Reform Act (HCRA) of 2000 to extend coverage to more working uninsured. "There's been a lot of interest in Healthy New York, especially among individuals," says Insurance Department Superintendent Gregory V. Serio, "but we're still sweating through the details."

To keep coverage in New York's individual and small group markets affordable, Healthy New York offers subsidies in the form of stop-loss coverage that reimburses insurers for 90 percent of high-cost claims between \$30,000 and \$100,000. The plan is also intended to keep costs down through high co-payments (\$500 per hospital stay) and a pared-down benefits package, which includes no mental health coverage and a limited prescription drug benefit.

New York's insurance department could not provide up-to-date enrollment information on Healthy New York because the offices of Empire Blue Cross—one of the state's major insurers—were destroyed in the September 11 attacks on the World Trade Center. Superintendent Serio did indicate, however, that sole proprietors comprised about one-half of the plan's enrollees, while individuals and small businesses were each responsible for about a quarter.

"The last I heard, only about 900 people were enrolled," says Mark Scherzer, legislative counsel for the advocacy group New Yorkers for Accessible Health Coverage. "I would be surprised if more than 2,000 people had enrolled through the end of the summer." According to Scherzer, the Insurance Department had initially hoped to enroll tens of thousands of people in publicly subsidized insurance made available through HCRA, a big chunk of which was to come from Healthy New York.

Scherzer says that financial and administrative obstacles were likely reasons for low enrollment among small businesses. Healthy New York requires employers to pay half of the plan's premium share (employees pay the other half) and to fill out detailed forms to prove they meet eligibility requirements. The limited benefits package may

also reduce the plan's attractiveness. "Small business owners don't want to offer group coverage with lesser benefits," Scherzer says.

To be eligible for Healthy New York, small businesses must:

- Have 30 percent of employees earning no more than \$30,000 or be a sole proprietor with a household income of less than \$35,000 per year;
- Not currently offer insurance and not have offered insurance in the past 12 months; and
- Offer the plan to all full-time employees earning \$30,000 or less and pay at least 50 percent of the premium.

Working individuals and employees are eligible if they have incomes up to 250 percent FPL and if their employers do not offer health insurance or have not offered it for the past 12 months.

Serio says that the insurance department has not yet processed reimbursement payments for Healthy New York's small group and individual stop-loss initiatives. It has, however, processed them for two other stop-loss funds created under HCRA, which were intended to stabilize premiums for standardized, comprehensive direct-pay contracts (which individual carriers—and all HMOs—are required to issue). The direct-pay stop-loss funds applied to claims between \$20,000 and \$100,000. For those initiatives, the claims submitted by insurers slightly exceeded the amount of funding that was available, so the state had to apportion its payments to carriers.

More employers and individuals may become interested in Healthy New York if the state increases its promotional efforts, Scherzer says. According to Serio, the insurance department is continuing to think through how best to inform people about the program, particularly with regard to its crowd-out provisions.

"We'd like to recast the program so people can see potential eligibility rather than just the prohibitions," Serio says. Although Healthy New York has a 12-month waiting period (for both individuals and employers) designed to prevent crowd-out, there are several exceptions that people may not know about. At the individual level, for example, the waiting period does not apply if prior coverage was terminated due to loss of employment or change to a new employer without health insurance, among other things.

"Insurance is never easy," Serio says, "but we're pleased at the interest in Healthy New York so far."

STATE PLANNING AND DEMONSTRATION EFFORTS



Despite the harsh economic reality that states faced last year, 2001 was in one sense a good year for coverage initiatives: It was a time characterized by intensive state planning and demonstration activities. More than half the states were awarded public or private grant funds aimed at planning or implementing new coverage models. The federal government awarded 20 states one-year planning grants that totaled more than \$23 million through the Health Resources and Services Administration's (HRSA) State Planning Grant (SPG) program. In addition, The Robert Wood Johnson Foundation's *State Coverage Initiatives* (SCI) program awarded four states nearly \$5.4 million in large demonstration grants and five states up to \$150,000 each in policy planning grants. Two states—Arkansas and Oregon—took advantage of both HRSA and SCI demonstration grants, using the former to develop feasible coverage options and the latter to narrow down and implement them.

The HRSA State Planning Grants: States Shift Focus from Expanding to Maintaining Coverage

When HRSA—a division of the U.S. Department of Health and Human Services (HHS)—announced that it would provide one-year grants to help states develop plans for covering all their uninsured, the states' response was greater than HRSA anticipated. Thirty-five states and U.S. territories applied for the initial round of HRSA grants, which were awarded to 11 state agencies in September 2000.

Under the HRSA SPG program, state grantees collect data to identify the number and characteristics of their uninsured and use that information to develop policy options for providing citizens with affordable health insurance benefits similar in scope to the Federal Employees Health Benefits Plan, Medicaid, coverage offered to state employees, and other quality benchmarks.

The first group of grant recipients, which received a total of \$13.6 million in federal funds, were generally states that had low rates of uninsurance. The hope was that the grantees could use the infusion of federal money—and the opportunity to conduct targeted state-level research that it afforded—to develop policies for cov-

ering the remaining pockets of uninsured in their state. With a strong economic climate before them and a decade of incremental expansions behind them, the states were optimistic that the grants might finally put universal coverage within their grasp.

By the time HRSA announced that it would provide grants to an additional nine state agencies in March 2001, the financial outlook in states was not quite as rosy. The national economy had begun to slow, and many states reported Medicaid budget shortfalls for the first time in years, in part due to successful SCHIP expansions. HRSA's second-round state grantees, which received \$10.2 million, tended to be states with higher rates of uninsurance.

The 20 HRSA grantees submitted their first grant reports and recommendations to HHS Secretary Tommy Thompson in October 2001. However, the states are now struggling to adapt their plans to a world that has been dramatically altered. The economic fallout from the war on terrorism has driven states across the country to make deeper cuts to budgets that had already been stripped to the bone in the pre-existing economic slow down. "Since HRSA awarded our grant in 2000, the world has changed a lot," says Amy Lischko, co-principal investigator of Massachusetts's HRSA grant and assistant commissioner for the Massachusetts Division of Health Care Finance and Policy. "We are probably not going to see new expansions requiring additional public dollars for some time."

Indeed, the focus of the HRSA grants has largely shifted from identifying options to broaden health insurance coverage to finding ways to maintain current coverage levels. Nevertheless, the planning grants have proven to be no less valuable to states now than they had been anticipated to be when the first awards were made in September 2000. Perhaps more than anything, they have given the states the knowledge and political momentum they need to sustain the notable progress they made throughout the 1990s toward improving health care coverage.

Emerging Options

Once the HRSA grants are completed, the project teams will present their final recommendations to their state legislatures, which will consider a course of action in their 2002 sessions (in most cases). In light of the states' worsening economic situations, they will likely propose

resourceful approaches that can be implemented in the context of severely limited state budgets, but at the same time do not expand coverage to the degree intended by the original grants.

The grantees may shift away from pure public program expansions, for example, such as extending SCHIP to parents, and concentrate on strategies that build on employer-sponsored coverage. States across the country have become increasingly interested in public-private solutions to the uninsured over the past decade, because the likelihood that working individuals will be eligible for public programs has increased as federal eligibility for public insurance has expanded. Indeed, at a July 2001 meeting convened by the SCI program, 32 state officials came together to discuss strategies for expanding coverage through the employer-based system, including tax credits,

premium-assistance programs, direct and indirect employer subsidies, and purchasing pools.

As small group insurance markets become increasingly competitive, the grantees may also look at incremental approaches that make coverage more affordable to employers—such as reinsurance mechanisms and eliminating the offering of mandated benefits.

Some of the HRSA states will probably also make use of the new HIFA waiver guidelines when developing their plans. The guidelines may help states to stretch available dollars farther by allowing them to streamline Medicaid and SCHIP benefits packages for optional populations, such as childless adults and higher-income families. The states could then use the savings they generate to cover more people and maximize federal funding.

HRSA State Planning Grantees

<i>FY2000 Grantees</i>	<i>Award</i>	<i>FY2001 Grantees</i>	<i>Award</i>
Arkansas Center for Health Improvement	\$ 1,393,322	Arizona Health Care Cost Containment System	\$ 1,162,879
Delaware Health Care Commission	\$ 800,900	California Health and Human Services Agency	\$ 1,197,000
Illinois Department of Insurance	\$ 1,200,000	State of Colorado	\$ 1,300,000
Iowa Department of Health	\$ 1,303,731	Connecticut Office of Health Care Access	\$ 668,110
Kansas Insurance Department	\$ 1,298,205	Idaho Department of Commerce	\$ 1,119,421
Massachusetts Division of Medical Assistance and the Division of Health Care Finance and Policy	\$ 1,069,195	South Dakota Department of Health	\$ 1,056,812
Minnesota Department of Health, Health Economics Program	\$ 1,630,931	Texas Department of Insurance	\$ 1,350,735
New Hampshire Department of Health and Human Services, Office of Planning and Research	\$ 1,033,315	Utah Department of Health	\$ 1,102,000
Office for Oregon Health Plan Policy and Research	\$ 1,253,264	Washington Office of Financial Management	\$ 1,320,400
Vermont Agency of Human Services, Office of Vermont Health Access	\$ 1,288,892		
Wisconsin Department of Health and Family Services, Division of Health Care Financing	\$ 1,349,846		

Filling the Data Gap

The grantees' methods of studying the uninsured vary, but each state has balanced qualitative and quantitative approaches, including household and employer surveys, focus groups, and interviews with key constituents, such as local legislators and insurance industry leaders. The states have been working with universities and private consulting firms to develop their methods and collect data. They have also received considerable technical assistance from The Robert Wood Johnson Foundation's *State Health Access Data Assistance Center* (SHADAC) and SCI programs. (For more on SHADAC, see box below.)

Traditionally, states have relied primarily on federally funded national surveys to measure the number and characteristics of their uninsured, including the Current Population Survey (CPS), the Behavioral Risk Factor Surveillance Survey, and the Medical Expenditure Panel Survey. But that has begun to change, as states have

become increasingly frustrated with the limitations of national instruments. States are trying to improve on small state-specific sample sizes, a lack of timeliness, and inconsistent results because of methodological differences between federal and private surveys.

Many of the HRSA states, including Colorado, Massachusetts, and South Dakota, have collected data using their own household and employer surveys, which they either created or refined under the SPG program. By conducting surveys that capture larger sample sizes and cover more sub-state locations, states can make more precise coverage estimates and assess their uninsured at the county and regional levels, according to Kathleen Call, co-principal investigator of the SHADAC program. They can also gain political leverage by drawing on state-specific data to support their case for making a policy change.

SHADAC Helps States Understand Uninsured

When the *State Health Access Data Assistance Center* (SHADAC) program began in September 2000, Principal Investigator Lynn Blewett wasn't sure that states would seek out their services. "In the beginning, we were concerned that we'd have to go knocking on states' doors," she says. The goal of SHADAC—a 3-year, \$4 million initiative of The Robert Wood Johnson Foundation—is to help states gather policy-relevant information on their uninsured and underinsured populations. The program is also working to develop a comparable state-by-state picture of the uninsured by coordinating state survey efforts.

As it turns out, SHADAC's timing was impeccable. The same month it started, HRSA announced that 11 states had been selected to receive funds through its State Planning Grant program. Instead of having to search out states, "we were inundated with requests for assistance," says Blewett, an assistant professor in the Division of Health Services Research and Policy at the University of Minnesota School of Public Health (where SHADAC is located). "We feel that the program is right on target and is really filling a need."

Indeed, SHADAC has played a key role in helping the HRSA grantees, as well as other states interested in conducting state-level research, design survey instruments, select vendors, develop sampling strategies, and prepare requests for proposals and survey questionnaires. SHADAC has also assisted states that didn't conduct surveys by helping them make the best use of existing information from private and national surveys, and policy research organizations.

Moreover, SHADAC has encouraged the states to learn from one another by bringing them together for meetings and workshops, and facilitating shared approaches to data collection. In August 2001, SHADAC hosted a workshop for researchers and policy analysts from 10 states—six of which were HRSA grantees—to discuss, for the first time, the possibility of developing uniform methods for measuring the nation's uninsured on a state-by-state basis.

Several states have already developed survey instruments that have been replicated elsewhere. For example, the Florida survey has been revised and administered in Indiana and Kansas. Minnesota's instrument has been used in Colorado and is currently being considered by several other states, including West Virginia and Pennsylvania.

SHADAC's goals complement those of the *State Coverage Initiatives* (SCI) program, which helps states develop and implement policies for expanding coverage that build on the data they have collected on their uninsured. SCI provides financial and technical assistance to states through its demonstration and planning grants (see box and story on p. 27), on-site consultations with state governments, regional workshops, publications, and a Web site (www.statecoverage.net).

The SHADAC Web site (www.shadac.org) provides states with links to private and national surveys, state data resources, issue briefs on data collection issues, and technical assistance and survey information. Together, the staffs of SHADAC and SCI hope to provide states with comprehensive support that covers all aspects of the expansion process.

In Colorado, the HRSA project team recently designed and conducted a statewide phone survey of 10,000 households that will break down uninsurance rates by region, according to Sue Williamson, Colorado's HRSA project administrator and director of EPSDT (the child health component of Medicaid) in the state's Department of Public Health. "This is the first time that we are able to measure coverage variations across the state," Williamson says. She reports that the team finished collecting data from their survey—which they adapted from Minnesota's six-year-old instrument—in the summer of 2001.

Other HRSA grantees, including Arizona, Idaho, and Iowa, have elected not to conduct extensive state-level surveys, but rather to find the most effective way to bring existing data to bear on their state's policy development discussions.

For example, project leaders in Arkansas and Illinois have worked with SHADAC staff to extract state-relevant components of the CPS, says SHADAC program director Kelli Johnson. (For more on the CPS, which was recently expanded and revised to better address states' needs, see box at right.)

One of Arizona's methods of information gathering was to compile policy analyses on what other states have done to improve coverage, including their strategies for identifying key sub-populations of the uninsured, according to Linda Redman, Arizona's HRSA project director and an independent health care consultant. The project team hopes that combining what they are learning about Arizona's insurance landscape with the lessons from other states' experiences will guide them toward the most effective expansion approaches, Redman says.

Iowa's SPG team focused its survey efforts on measuring the opinions of businesses and the public toward both the uninsured and various alternatives for expanding coverage. "We weren't interested in creating a tremendously exacting picture of who the uninsured are," says Anne Kinzel, Iowa's SPG director and project director in the state's Department of Public Health. "Instead, we wanted to check the realities about the uninsured against people's perceptions [by asking people whether they knew that 80 percent of uninsured Iowans were employed, for example], and to ascertain the business community's tolerance for change." Iowa's team hired a private contractor and public opinion polling firm to conduct voter and employer surveys and focus groups.

According to Kinzel, the findings indicate that more than 80 percent of representatives from Iowa businesses believe that all working Iowans should have access to health insurance. "It turns out that businesses have a tolerance for increasing coverage that is far greater than anyone expected," she says.

What Do CPS Revisions Mean for States?

In the Medicare, Medicaid, and SCHIP Balanced Budget Act of 1999, Congress allotted \$10 million to the U.S. Census Bureau's FY2000 budget to expand and refine the Current Population Survey (CPS). In addition to a monthly household survey, which primarily covers labor force data, the CPS includes an annual component—the March CPS Supplement—that reports income, work experience, Medicaid, Medicare, and employer-provided health insurance.

As part of its effort to improve the CPS, the Census Bureau recently expanded the number of households sampled in the supplement from 64,990 in 2000 to 98,990 in 2001. According to Lynn Blewett, Principal Investigator of the SHADAC program, the expansion "will definitely increase the precision of states' insurance estimates by decreasing the error associated with them, but it will not have a huge impact on the estimates themselves."

"I think a bigger issue will be the new release of data that reflect the verification question," Blewett says, referring to the recent addition of a question that asks respondents directly whether they were uninsured. In the past, the CPS asked people to look back over the past year and say "yes" or "no" to whether they had specific types of insurance. If all the answers were "no's", the person was assumed to be uninsured.

The verification question, which was added in March 2000, is intended to correct for overreporting of uninsurance, which likely occurred because respondents either did not recognize their source of coverage on the survey or reported their current rather than past insurance status.

According to Blewett, the recent drops in the CPS's 1999 and 2000 estimates of the uninsured do not represent an actual decline, but rather the difference in how the uninsured are being counted. Visit www.shadac.org for tables comparing CPS state-specific insurance rates with and without the question. The site also contains issue briefs on the impact of CPS revisions on state insurance estimates, and other relevant topics.

Learning about Employers

Most of the HRSA grantees have sought to gather detailed information about the employers in their state, reflecting their increasing interest in finding public-private solutions to the uninsured. Through their projects, many states have learned that employer surveys are harder to conduct than they had anticipated, however. This is largely because surveyors often find it difficult to reach the person who knows about a given business's employee benefits and insurance take-up rate.

"Our contractor was surprised at how hard it was to get responses from businesses," says Jeremiah Cole, co-principal investigator for Massachusetts's grant and director of the Office of Strategic Initiatives within the state's Division of Medical Assistance. "We kept contacting answering machines instead of human beings." Due to the difficulty the state had in reaching employers, the Massachusetts project team mailed the survey to employers who could not be reached by phone, and ultimately reduced the number of businesses they expected to study in their quantitative employer survey, according to Cole. He says the employers that were the most difficult to reach were very small businesses and large, multi-state companies.

While identifying ways to build on employer-based coverage was a key objective of Massachusetts's HRSA grant, the decision to focus on private-sector approaches emerged as a natural outgrowth of the planning process for other states, such as Arkansas.

"Through our grant, we learned that virtually all employers—ranging from small businesses with 10 or fewer employees to Fortune 500 companies—felt responsible for helping their employees to get health insurance," says Joseph Thompson, M.D., project leader for Arkansas's HRSA grant and professor of pediatrics at the University of Arkansas for Medical Sciences.

Building Political Consensus

The HRSA project directors uniformly report that bringing varied stakeholders together to learn from one another has been one of the most productive aspects of their projects. The states created their own governance structures to direct their grants; in many cases, the regular meetings of these advisory groups or steering committees provided the first opportunity that relevant interest groups had ever had to sit down at the same table.

Many states found that including employers in the planning process helped them to build political will for their expansions. "One of the reasons we were successful in creating a dialogue is that we have people talking about this who normally wouldn't be—the business community," says Pamela Hunt, Idaho's planning grant director. "It's no longer just doctors and low-income advocates; it's the

CEOs of major companies," says Hunt. "The political community listens to the business community." Idaho is the only grantee whose lead agency is the state's Department of Commerce.

Arkansas convened a health policy roundtable of employers, insurers, and providers that used a computerized polling technology called an audience response system (ARS) to build agreement on their policy options, says Thompson of Arkansas. After the group listened to presentations or engaged in debates on policy options, they input their preferences and opinions into the ARS, which achieved group consensus by evaluating aggregate responses. "This approach helped us neutralize political rhetoric during the decision-making process," says Thompson.

Some states organized large forums to build consensus, such as regional seminars, policy summits, and town meetings. "The more communication you have, the more likely you are to find a solution," says Madelynne Brown, manager of Illinois's HRSA project and assistant director of the Illinois Department of Insurance.

Last year, Illinois's SPG team convened three policy summits that brought together more than 100 interest groups, including doctors, public health officials, small and large employers, insurance companies, and consumer advocates.

Illinois's grant leaders presented their research findings (from quantitative household surveys and focus groups) to all participants, who then broke into small groups of eight led by facilitators. The groups worked to reach agreement on the most appropriate expansion proposals, discussed their thoughts with the larger group, and then voted on recommendations.

Looking Forward

In light of the budgetary challenges now facing states, the HRSA grantees will need to be resourceful and innovative to maintain the steady progress they have made over the last decade. Perhaps the biggest question facing them now is: How far can their creativity take them? The states may emerge from the HRSA planning process with a sense that "tinkering around the edges"—by developing approaches that slowly build on the current health care system—is the best that they can hope for in the absence of more fundamental reforms and new funding sources. The enhanced waiver flexibility that the federal government has given states is no doubt helpful, but it may not be enough to compensate for the lack of state and federal dollars available to address the uninsured. "So far, this has been a hard issue to resolve without money," says Linda Redman of Arizona.

Nevertheless, the state planning grants have been tremendous learning opportunities that have helped the states to replace political rhetoric with real information,

SCI Policy Planning Grants

The SCI program awards small, fast-track grants for up to \$150,000 to support states in planning coverage expansions. These grants are reviewed on a rolling basis as received; grant periods vary but cannot exceed two years. To date, SCI has awarded planning grants to:

Hawaii, which will analyze data sets and prioritize coverage options, hold a policy summit for stakeholders to communicate progress and get buy-in, and hold community dialogues, focus groups, and key informant interviews;

Kansas, which will strengthen the operational, strategic, and evaluative procedures of its Business Health Partnership, a purchasing pool that combines public subsidies with employee and employer contributions, in order to bring it to a self-supporting operational level;

Maine, which will create a council of employers and consumers to set health care goals for the next 5 to 10 years, develop performance measures to assess their progress, and present an annual report to the governor, legislature, and citizens;

New Mexico, which will develop a consortium of stakeholders to outline employer-based expansion options, hold regional hearings to obtain grassroots input, and design an implementation plan; and

West Virginia, which will conduct survey analysis, target public programs for expansion through buy-ins and administrative simplification, and analyze private market options.

New Mexico's grant started on April 15, 2001, and Maine's started on June 1, 2001. Both West Virginia and Hawaii began their grants on October 1, 2001. Kansas's grant started November 1, 2001.

and that have given public and private decision-makers a forum to focus more intently on the uninsured. In that way, they have laid the groundwork needed to make the uninsured an important policy priority in the 21st century.

To view the 20 HRSA states' interim final reports to the Secretary of Health and Human Services, go to: <http://statecoverage.net/hrsareports.htm>.

Turning Planning into Policy: SCI Awards Four States Nearly \$5.4 Million to Expand Coverage

In October 2001, the SCI program awarded the first of its large demonstration grants—\$1 million to \$1.5 million to support the design and implementation of significant coverage expansion programs—to Arkansas, New Mexico, Oregon, and Rhode Island. SCI's goal is to help state governments to develop and implement expansion policies by providing them with both financial and technical assistance.

Unlike the broad-based planning grants awarded under HRSA, SCI's demonstration grants are targeted to states that are ready to achieve a sizable coverage objective, such as expanding eligibility to all children in the state, achieving near universal access to coverage, or demonstrating an innovative coverage model or partnership. The program selected states that demonstrated a strong commitment—from both their executive and legislative branches—to supporting the proposed expansions.

"One of the strengths of SCI is that it supports any state ready to take a significant step forward in expanding coverage—whether the state is a long way down that path or just getting started on it," says Alan Weil, chair of SCI's national advisory committee and co-director of the Urban Institute.

Each demonstration project will last a maximum of three years, and will be divided into design and implementation phases. The states will match 25 percent of their award through direct or in-kind support. Applications for SCI's second and final round of demonstration grants, which will be awarded to another four states, are due on July 1, 2002. For more information, see <http://www.statecoverage.net>. To follow are descriptions of each of the first-round demonstration grant projects.

Arkansas: A Multi-Faceted Approach

SCI awarded the Arkansas Center for Health Improvement (ACHI), sponsored by the Arkansas Department of Health and the University of Arkansas for Medical Sciences (UAMS), a demonstration grant of \$1.5 million. Arkansas will use the funds to implement a multitude of public and private initiatives—including Medicaid expansions and employer- and community-based partnerships—designed to attack the problem of the uninsured from different angles.

Arkansas is characterized by a disproportionate number of small businesses and individuals without health insurance and a population whose poor health status relates to its lack of coverage. Historically, the state has lacked the

Review of Selected 2001 Articles and Reports

“Building a Consensus for Expanding Health Coverage”

Charles Kahn and Ronald F. Pollack, Health Affairs, January/February 2001

To be effective, health coverage expansions must have broad-based support, transcending ideological and partisan boundaries, according to authors Charles Kahn, president of the Health Insurance Association of America, and Ronald F. Pollack, Executive Director of Families USA. In this article, the authors seek to find common ground toward a proposal to expand health coverage. In developing their proposal, they agreed to follow guidelines to maintain current coverage levels, build on existing structures, maximize public funds, and focus on those with the greatest need. To access this report, go to: <http://membership.hiaa.org/pdfs/Kahn.pdf>.

Coverage Matters: Insurance and Health Care

Institute of Medicine, September 2001

The first of six reports to be released by the Institute of Medicine, this report provides an overview of health insurance in America. It looks specifically at how coverage is gained and lost, why so many people have none, and who lacks insurance. It also outlines the IOM's Committee on the Consequences of Uninsurance's analytic plan for the series of reports. This report is available online in full text at: <http://national-academies.org/webextra/uninsured> or by calling the National Academy Press at (800) 624-6242.

Covering America: Real Remedies for the Uninsured

Economic and Social Research Institute, June 2001

This report is the compilation of 10 submissions by expert health analysts and researchers attempting to answer the question: “How should the nation's health care financing and delivery system be reformed to ensure coverage for nearly all Americans?” The resulting proposals represent a spectrum of approaches and philosophical perspectives. The report compares the various approaches included in the report, as well as background information on the status of uninsurance. To access this report, go to: www.esresearch.org.

How the Slowing U.S. Economy Threatens Employer-Based Health Insurance

Jeanne W. Lambreaux, George Washington University for the Commonwealth Fund, November 2001

With the slowing of the U.S. economy, the focus of federal health policy has shifted from expanding to maintaining health insurance coverage. Within the past year, rising unemployment and health care costs have threatened to erode employer-based coverage, and the recent terrorist attacks have worsened the strain on state and national economies. This report summarizes other recent reports and provides new analysis of job-based health insurance, unemployment, and the economic consequences of the lack of health coverage. Copies of this report are available from the Commonwealth Fund by calling the publications line at 1-888-777-2744 and ordering publication number 511. The report can also be found on the Fund's Web site at: <http://www.cmwf.org>.

funding, infrastructure, and policy and technical expertise to design and implement long-term expansion strategies, but that has begun to change. In November 2000, Arkansans demonstrated their commitment to the uninsured by passing a ballot initiative that allocated a large portion of the state's tobacco settlement proceeds to public coverage expansions. Legislators subsequently passed enabling legislation for Medicaid expansions that totalled over \$30 million in state and federal funds.

Arkansas' multi-faceted demonstration project will allow the state to test which expansion strategies hold the most long-term promise, while at the same time reaching out to both very low-income individuals and the working uninsured. “Historically, as a nation, we've relied on either the private or the public sector to address the uninsured. But

the answer will probably be with approaches that bridge the two worlds,” says Joseph Thompson, M.D., professor of pediatrics at UAMS and ACHI and project leader of the SCI grant.

Under Arkansas's earlier HRSA grant, a state working group convened a policy planning roundtable of 21 individuals, including employers, insurers, providers, and consumers. “Through our roundtable, every issue has been fully explored. There are no surprises in our plan,” says Thompson. The state will use its SCI grant funds to implement the roundtable's recommendations.

Demonstration initiatives focused on increasing public coverage include: expanding Medicaid to 19- to 64-year-olds to 100 percent FPL and pregnant women up to 200 percent FPL. These public initiatives alone, which will be

Medicaid “Mandatory” and “Optional” Eligibility and Benefits

Kaiser Commission on Medicaid and the Uninsured, July 2001

This policy brief describes the current structure of the Medicaid program and provides coverage and spending information on mandatory and optional populations based on an analysis conducted for the Commission by the Urban Institute. It is intended to provide a context for understanding recent efforts to restructure Medicaid through legislative changes or waivers to the federal statute. This report can be accessed electronically at: <http://www.kff.org/content/2001/2256/2256.pdf>.

Insuring the Uninsurable: An Overview of State High-risk Health Insurance Pools

Lori Achman and Deborah Chollet of Mathematica Policy Research, Inc., for the Commonwealth Fund, August 2001

Obtaining coverage in the individual insurance market is not a viable option for many people who have extensive health care needs but lack employer-sponsored health insurance. More than half of the states operate high-risk insurance pools to help insure those who have been denied private health coverage in the individual market.

This report presents a profile and analysis of state high-risk pools currently in operation. The authors find that, although these pools help provide coverage to some high-risk individuals, they generally have had a limited impact in making insurance available and affordable, tend to impose pre-existing condition exclusions, have long waiting lists, and are often closed to new applicants altogether. To access this report, go to: http://www.cmwf.org/programs/insurance/achman_uninsurable_472.pdf.

Workers without Health Insurance: Who Are They and How Can Policy Reach Them?

Bowen Garrett, Len M. Nichols, and Emily K. Greenbaum of the Urban Institute for Community Voices, August 2001

Why do some workers have employer-sponsored health insurance while others do not? What policy initiatives are best suited to the specific conditions of most uninsured workers? This report surveys the literature on the working uninsured and uses 1999 Current Population Survey data to paint a more detailed portrait of the working uninsured that can inform policy discussions. It can be found at: <http://www.wkkf.org/documents/health/communityvoices/cv479.pdf>.

State Health Access Data Assistance Center Issue Briefs

“The Current Population Survey and State Health Insurance Coverage Estimates”

“Impact of Changes to the Current Population Survey on State Health Insurance Coverage Estimations”

“State Health Insurance Coverage Estimates: Why State Estimates Differ from CPS”

Recent legislation required the Census Bureau to increase the sample size it uses for the Current Population Survey (CPS) to more accurately estimate the number of uninsured. These issue briefs explain the reasons for this and other recent changes to the CPS and discuss why CPS estimates differ from state-generated measures of the uninsured. All three issue briefs can be found at: <http://www.shadac.org/publications/pubs.htm>.

largely financed through tobacco settlement proceeds, will decrease the number of uninsured Arkansans by 3,000 pregnant women and 30,000 other adults per year.

The state also plans to implement three recently legislated private-sector initiatives. These include creating community-based health insurance purchasing pools to support small employers; developing risk pools to stabilize existing private-sector health insurance coverage for small businesses; and allowing carriers to offer plans without state-mandated benefits. In addition, the state hopes to create a Medicaid employer buy-in program to support the large number of working uninsured in Arkansas. Arkansas began its demonstration work, which it expects to continue for three years, last fall.

New Mexico: Pooling Purchasing to Provide Private Coverage

SCI awarded New Mexico's Human Services Department, in partnership with the New Mexico Hospitals and Health Systems Association, \$1.5 million to implement an innovative coverage model that combines a premium-assistance program with a purchasing pool for adults with incomes up to 200 percent FPL. Under New Mexico's model, the state—rather than employers—would purchase commercial insurance on behalf of employees, who would pay cost sharing on a sliding scale. Employers would also contribute to the premium, which the state would send to the insurer in one lump sum, much like with regular group insurance.

New Mexico plans to submit an 1115 waiver request to CMS to permit the commercial benefits and cost-sharing requirements outlined for the program. According to Angela Monson, SCI national advisory committee member and Chair of the Senate Finance Committee in Oklahoma, one of the most appealing aspects of the project is its plan to use employer and employee contributions in combination with federal Medicaid funding.

Another advantage to New Mexico's approach is that it allows the state to pool purchasing for enrollees, so that it can leverage federal dollars to provide both public and private funding. "By using the Medicaid program as a mechanism to provide private coverage, this will be, in the truest sense, a public-private partnership," says Monson. Moreover, the program will reduce some of the administrative obstacles normally associated with employer buy-ins. Because the state will contract with insurers directly, it will have first-hand access to information about benefits and premium contributions, which is needed to track enrollment and perform cost-effectiveness analyses.

The project will build on the work of an SCI policy planning grant that runs through December 2001. (For more on SCI's planning grants, see box on p. 27.) That grant brought together over 36 stakeholders to analyze options for expanding coverage to adults with incomes up to 235 percent FPL.

The demonstration project team anticipates that the state appropriations needed to implement the program will be passed in early 2002. The state plans to submit a HIFA waiver to CMS by March 2002, and CMS has indicated that they should be able to approve the waiver within 60 days. New Mexico plans to implement its program beginning in January 2003.

Oregon: Using Federal Flexibility to Move toward Universal Coverage

Under the direction of John Santa, M.D., of the Office for Oregon Health Plan Policy and Research, Oregon will use its \$1.5 million in demonstration grant funds to expand and restructure its innovative Oregon Health Plan (OHP). Although a stable feature of Oregon's political economy, the OHP is under financial strain because of rising drug costs, increased program expenditures, and delivery system challenges. Still, state officials plan to continue to expand coverage; the Oregon legislature recently enacted a law that will increase OHP eligibility from 170 to 185 percent FPL for children, and from 100 to 185 FPL for adults.

The OHP, which has been in operation since 1994, was created to extend access to affordable health care to all state residents with incomes below the federal poverty level. To define the covered benefits, the state created a

prioritized list of services (condition/treatment pairs). OHP benefits are set through legislative allocation of resources.

Using its grant funds, Oregon hopes to be one of the first states to use the new HIFA waiver guidance from CMS to create two separate benefits packages for OHP; this will help the state afford further expansions. "Our citizens understand the difficult choices we must make to work towards universal coverage," says Santa.

Under the new benefit plan, categorical Medicaid eligibles (children, the blind and disabled, the elderly, pregnant women, and TANF families) would continue to receive the OHP's prioritized list of services. However, other individuals below 100 percent FPL (who are eligible for OHP only because of Oregon's current 1115 waiver) and the adult expansion population—mainly single adults and childless couples—would receive a package that resembles commercial insurance, with an actuarial value of 78 to 80 percent of the current prioritized list.

Building onto employer-based coverage is another key focus of Oregon's demonstration project. The state intends to work with the federal government to obtain matching funds for its Family Health Insurance Assistance Program (FHIAP), an employer buy-in that was added to the OHP in 1997. With a waiting list of 19,000 people, FHIAP is clearly in high demand. However, because the program is financed solely by the state, enrollment is currently limited to 5,000.

A third project initiative will be to gain federal approval to insure families under a single policy, even when parents and children are eligible for different programs. SCHIP's current Medicaid screen-and-enroll requirements often do not make this possible. Oregon expects to submit two waiver requests to CMS to support its policy initiatives (one HIFA, one an extension of the state's current 1115 waiver) in February 2002.

Rhode Island: A Cutting-Edge Employer Buy-In

Rhode Island's demonstration grant was awarded to the Rhode Island Department of Human Services (DHS) in the amount of \$860,000. Under the direction of Tricia Leddy, administrator of the Center for Child and Family Health at the DHS, the project will focus primarily on evaluating and refining RItE Share, the state's newly established employer buy-in. The overall goal of the project is to cut the state's uninsurance rate in half, from 6.9 percent to 3.5 percent.

RItE Share was created in February of this year to alleviate funding problems that the state's Medicaid/SCHIP demonstration program—RItE Care—experienced in the late 1990s due to instability in the private market. In 1998, the state expanded RItE Care to include parents of eligible children with incomes up to 185 percent FPL.

What's New on the SCI Web Site (www.statecoverage.net)

STATE COVERAGE MATRIX

SCI has compiled information on coverage strategies employed by all 50 states and the District of Columbia. The regularly updated matrix lists coverage expansions made through three categories: the Medicaid program, the State Children's Health Insurance Program, and state-only programs (programs without federal funding). Using this tool readers can:

1. Look at the national picture of the strategies states are using to expand coverage;
2. Link to state web pages and other pertinent sites to learn more about specific state strategies or major state programs; and
3. Compare state approaches within a particular expansion mechanism, such as 1115 waivers.

Look for new classifications to be added to the matrix soon, such as a Health Insurance Flexibility and Accountability (HIFA) Initiative Demonstration waiver column.

The matrix can be found at: <http://statecoverage.net/matrix.htm>

PUBLICATIONS

Publications produced by the SCI team in 2001 are also posted on the Web site. Highlights from the year include:

- Issue Briefs on Full-Cost Buy-ins, Medicaid Disease Management and Wisconsin's BadgerCare program;
- Newsletter articles on high-risk pools, prescription drug cost-containment efforts, and state responses to Medicaid budget shortfalls; and
- Technical reports on crowd-out and employer buy-ins.

Go to: <http://statecoverage.net/publications.htm>, for a full list of SCI publications and links to their text.

STATE REPORTS

SCI continually compiles state coverage-related reports and provides links to them through a Web database organized by state; it is also searchable by keyword and category of report. The reports are from a variety of sources, including Blue Ribbon commissions, task forces, coalitions, and state policy offices and departments. Almost 90 reports from more than 25 states are currently posted and relate individual states' experiences with topics such as premium support, family coverage, and access. The database now includes presentations from SCI's July Workshop in Denver entitled "Building on Employer-Based Coverage: A Workshop for State Officials," as well as copies of states' CMS-approved 1115 waiver proposals. To access these and the other state reports, go to: <http://www.statecoverage.net/statereports>. Please contact the SCI team at SCI@ahsrhp.org if you know of or have reports that should be posted.

GRANTS

The newly redesigned grants page of the Web site now includes the current SCI demonstration grant recipients' proposals. The site also contains all of the documents required to apply for SCI planning or demonstration grants. For more details, please go to: <http://statecoverage.net/grants.htm>.

COMING SOON

In the coming months, SCI will post HRSA's consolidated report to the U.S. Secretary of Health and Human Services on the results of the State Planning Grant program, which was contracted to the Academy. Meanwhile, the site contains each of the 20 state grantees' individual interim reports to HHS. They can be found at: <http://statecoverage.net/hrsareports.htm>.

(previously only children up to 250 FPL were covered), and officials became concerned that public coverage was partially substituting for private. "We took things as far as we could in the full coverage mode," says Leddy.

Under Health Reform 2000, the legislation that included the formation of Rite Share, all individuals and families eligible for Rite Care and with access to employer-sponsored coverage must enroll in the premium-assistance program. Rite Share pays the employees' premium share and reimburses providers directly for wrap-around benefits not included in employers' plans. (For more about Rite Share, see p. 14.)

The grant activities, which will begin in January 2002, include: identifying and implementing strategies to increase employer participation and retention in Rite Share; comparing the quality of care of Rite Care and Rite Share; quantifying the savings from Rite Share (so they may be used to fund further expansions); examining coverage options for the disabled, and modifying subsidy payment mechanisms so employees are paid directly instead of employers.

To access the grant applications for the four demonstration states, visit SCI's grants page at: <http://www.statecoverage.net/grants.htm>.

FINAL THOUGHTS

Since the 1997 passage of the SCHIP legislation, health policymakers have seen a remarkably robust economy contribute to steady progress in public policy efforts to help reduce the number of uninsured. Gains made through state innovation and the federal funding provided under SCHIP have been heartening and rewarding, but success has not come without consequence. As documented here, in some cases, effective SCHIP outreach has led not only to the programs themselves outgrowing expectations and budgets, but also to the addition of many eligibles to state Medicaid rolls. That growth, combined with the effects of escalating health care costs and a weakening national economy, had begun to burden state budgets even before the recession became a reality. As a result, the states turned their energies from seeking further expansions to sustaining the gains they had already achieved.

As devastating as the events of the last half of the year were, it's worth remembering that some good can come out of even the worst experiences. The slowed rate of progress and the sobering of the nation's mood may lead the states to turn inward to craft new coverage strategies with the creativity that is so often associated with restricted resources.

A moderation of pace may particularly benefit efforts to expand coverage through employer-based insurance. The experience of such leaders as Rhode Island and Oregon has demonstrated that, although building on private coverage remains a desirable goal, there are many technical obstacles that must be overcome to do so effectively. Time to examine the lessons learned thus far could help state leaders to work through those challenges and identify approaches that take maximum advantage of the resources brought to bear by the federal government, employers, and individuals. States across the country can also use the experiences of the HRSA states—which focused on examining a host of coverage options—to reflect on the alternatives that are most appropriate now and in the future. Rather than concentrating on spending and implementing, the states may become more focused on relationship-building, which does not require substantial resources but might yield mutual understanding that could lead to policies that work better for all involved once more resources are available.

The more sober environment may also mean the public is prepared to make more difficult policy choices than it was in more economically vital times. For example, streamlining benefits packages for some individuals in order to expand or maintain coverage may seem more reasonable to a population that has become inclined to sacrifice for the greater good.

The so-called “tinkering around the edges” that some say defines current expansion efforts need not be seen as a stalling of progress. Used well, it could serve as a much-needed chance for breath catching. Ideally, in the upcoming year, states will examine what they have accomplished with an eye both to holding on to their gains and to articulating what their experience to this point has taught them. When they get the opportunity to move forward, they will do so with a much clearer sense of the soundest way to go.



ACADEMY
FOR HEALTH SERVICES RESEARCH
AND HEALTH POLICY

