State of the States

Bridging the Health Coverage Gap

STATE COVERAGE INITIATIVES

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Foreword

To say that 2002 was a challenging year for state policymakers and health care decision-makers would be an understatement. Indeed, according to some officials, the states were in the worst financial shape that they have been in for at least 20 years. The slide in state revenues that began in 2001 was accompanied by double-digit increases in health care inflation, and private-sector coverage suffered as well as state Medicaid budgets.

Last year, states struggled to contain costs without reversing the progress made over the past decade in expanding health care coverage, particularly to children. Unfortunately, many states had already exhausted the easy, one-time solutions—such as rainy day funds or tobacco settlement money—during the previous year. Moreover, in the wake of the recession, health care coverage was only one of many critical budget priorities for policymakers; others included education and vital public safety measures to protect Americans from tragedies like that which occurred on September 11, 2001.

If there is a silver lining to the states' coverage efforts in 2002, it is that the cost crisis forced them to find inventive and practical ways to address their uninsured using existing resources. By leveraging federal funds and using the enhanced waiver flexibility made possible through the Health Insurance Flexibility and Accountability initiative, states were able to ensure that relatively few people lost Medicaid coverage in 2002, although coverage changed for many beneficiaries. In addition, the states developed new strategies to lower pharmaceutical costs—a primary Medicaid budget driver—such as using evidence-based formularies or making improvements in purchasing. States also turned to disease management as a means of managing chronically ill populations while controlling costs.

Finally, the states continued to take advantage of public and private planning and demonstration activities in 2002. Eleven states and one U.S. territory were awarded grants through the Health Resources and Services Administration's State Planning Grant program to identify the number and characteristics of their uninsured and develop policy options for expanding or maintaining coverage. And three states received funds through the State Coverage Initiatives (SCI) program to design and implement new coverage models.

SCI has responded to the current reality by recognizing that preserving coverage has become as critical a goal for states as expanding health insurance is. We have broadened our technical assistance activities to include helping states develop cost-containment strategies and facilitating communication among states about which approaches are most effective. Moreover, the demonstration projects we awarded in 2002 are focused on creating public-private partnerships—which will help extend the financing of coverage models beyond the public sector. The Robert Wood Johnson Foundation recently reauthorized SCI for two years, and the program remains dedicated to helping the states through the ups and downs of state economies and politics.

Is the current crisis bad enough for federal, state, and private players to engage in a meaningful quest for new solutions? No one knows the answer to that, but experience tells us that necessity is a key driver of policy. Indeed, the last period of substantial health reform—the managed care era of the 1990s—was preceded by many of the same issues: rising costs, concerns about quality, increasing uninsured, and a broad sense of insecurity about whether states could preserve coverage. States have brought creativity and dedication to the table, but they will also need a national commitment and a return to a strong economy. With both of these, the states will be able to put the experience of the last decade into solutions for the next.

Vickie S. Gates
SCI Program Director

Executive Summary

Last year, the states were faced with an economic picture that could test the resolve of the most determined optimist. The national recession that began in 2001 went from bad to worse, and, at year's end, fiscal conditions were expected to further deteriorate before they improved. Overall, state budget shortfalls were estimated at 7.8 percent of revenues in Fiscal Year (FY) 2002, private insurance premiums rose nearly 13 percent, and Medicaid spending increased at a rate of 13.6 percent. By all measures, the states confronted a cost crisis unparalleled in scope to any since the one that ushered in the managed care era in the early 1990s.

Across the country, states fought hard to hold onto the coverage gains they made over the past decade and were eager to use all the tools available to them to reach that end. They quickly recognized the wisdom of partnering with the federal government, the private sector, and communities during this time of shared pain. At the same time, the change in the presidential administration brought with it an increased federal willingness to collaborate with the states and give them enhanced flexibility to make available dollars stretch farther.

A number of states used that flexibility—which was made possible chiefly through the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative—to restructure their public programs, build on employer-based coverage, and reach out to non-traditional populations such as childless adults. To date, seven states have received HIFA waivers, three have submitted applications and are awaiting approval from the Centers for Medicare and Medicaid Services, and 17 others are developing or considering proposals.

As Medicaid spending continued to skyrocket last year, the states pursued a range of innovative approaches to rein in program costs. In FY 2002, 11 states operated Medicaid disease management programs—which take an integrated approach to health care delivery in order to improve health outcomes for the chronically ill while controlling costs. Many states also looked to curb one of the major drivers of health care costs: prescription drug expenditures. Five states made use of the newly available Pharmacy Plus 1115 waivers, while several others adopted evidence-based strategies to ensure that Medicaid patients are provided with the most cost-effective drug therapies.

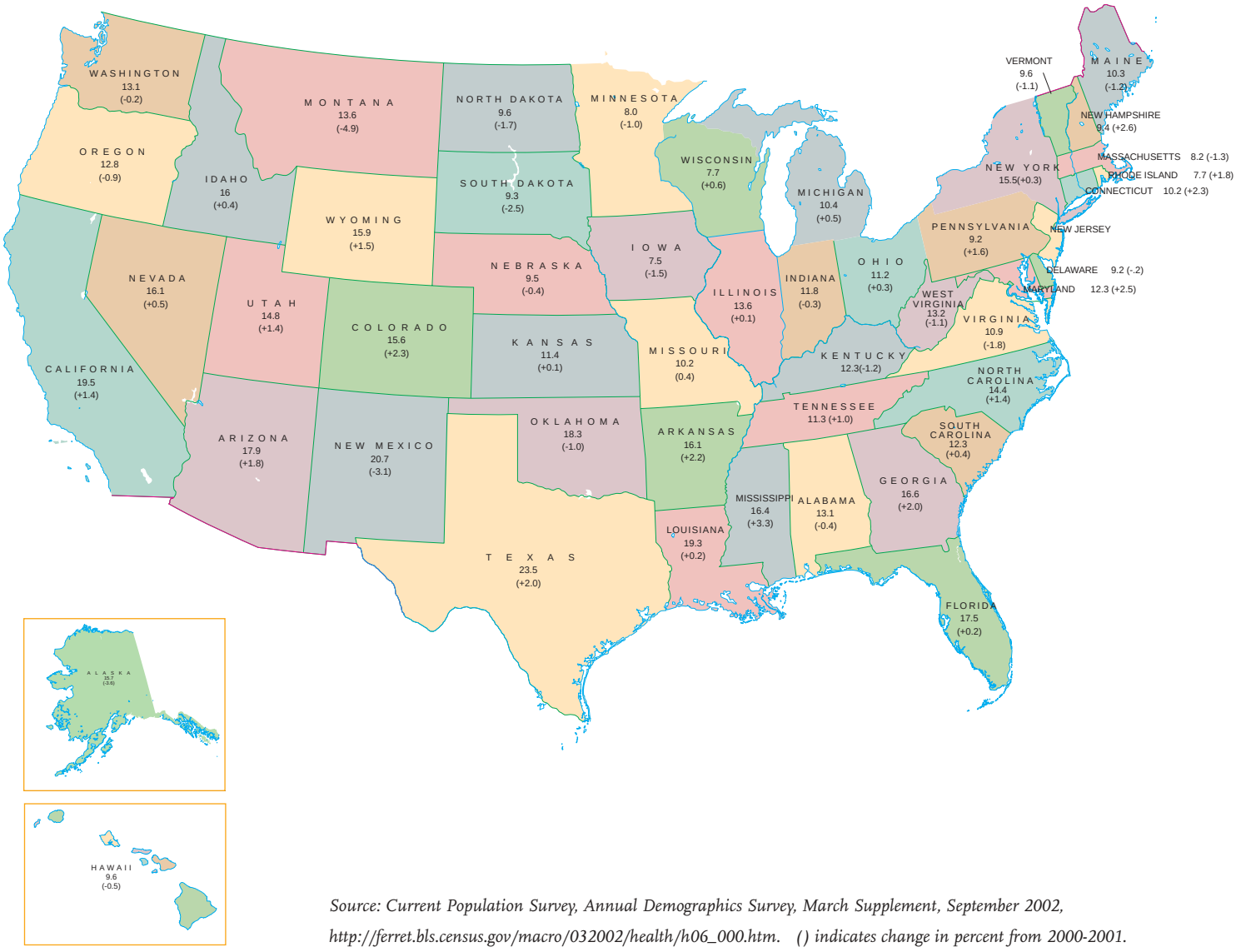
After experiencing continued drops in their small-group and individual insurance markets, the states also struggled in 2002 to maintain the reforms that they had implemented in the 1990s to make coverage more affordable to people at high medical risk. Several built partnerships with the private sector to reduce the cost of non-group coverage or developed plans to use new funds made available through the federal Trade Act of 2002—which was signed into law in August—to finance state high-risk pools.

Like the year before it, 2002 was characterized by intensive state planning and demonstration activities that will make it easier for states to preserve coverage and prepare for future expansions. In July, the federal government awarded $12.5 million to 11 states and one U.S. territory through the Health Resources and Services Administration's State Planning Grant (SPG) program. Under the 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.

In fall 2002, the State Coverage Initiatives program awarded its second round of demonstration grants—which totaled more than $3 million—to Hawaii, Virginia, and West Virginia. These awards are intended to support states as they design and implement innovative models for increasing or maintaining coverage for their citizens.

The states coped with extraordinarily difficult financial pressures last year and, in so doing, built new relationships and crafted innovative coverage strategies. Despite the bleak fiscal outlook, many state officials and policymakers managed to remain hopeful that they will be able to translate much of what they learned in 2002 into meaningful expansions once the economy improves or the right policy window opens. There is, after all, no survival value in pessimism.

Percentage of People without Health Insurance by State in 2001



Source: Current Population Survey, Annual Demographics Survey, March Supplement, September 2002, http://ferret.bls.census.gov/macro/032002/health/h06_000.htm. () indicates change in percent from 2000-2001.

State Budgets and Cost-Containment Efforts

With states facing approximately $40 billion in deficits for Fiscal Year (FY) 2002 and a projected $50 billion for FY 2003, the economic climate of the past year has been eerily reminiscent of the cost crisis that ushered in the managed care era in the early 1990s. At that time, health care inflation climbed as much as 15 to 20 percent per year. Now, employer health care costs are once again rising by double digits, and Medicaid spending alone is increasing at about three to four times the rate of inflation. According to recent figures, private health insurance premiums rose by 12.7 percent in 2002, up from 11 percent in 2001. Although state officials are trying to remain optimistic, they have fewer options for recovery now than they had in the 1990s.

"The 'low-hanging fruit' is gone," says Bill Murray, deputy director of policy in Virginia Governor Mark Warner's office. "We have exhausted the one-time solutions," such as using rainy day funds or reprioritizing budget items. In addition, unlike in the 1990s, in 2002 many states were not expecting such dramatic shortfalls after having experienced nearly a decade of economic prosperity.

"From a fiscal standpoint, this is the worst shape that states have been in for at least 20 years," says Kevin Carey of the Center on Budget and Policy Priorities. "Even though some economists say that the recession ended last December, the fourth quarter of FY 2002 was the worst so far."

The combined effect of decreasing state revenues and increasing health care costs has left many states feeling powerless. "If you look at the gap between revenue shortfalls and health care inflation, it's staggering," says John Santa, M.D., administrator of the Office for Oregon Health Policy and Research. "Our situation is primarily a revenue problem, but clearly health care costs are, at their current pace, unsustainable."

States have lost millions in capital gains and other taxes on which they rely to keep programs working and people insured. Oregon lost 80,000 jobs in FY 2002, most of them in the high-tech sector. This translated into $10 billion lost in personal income, of which the state could have gained $1 billion in tax revenues. California, which relies on personal income taxes for about half of its General Fund revenues, saw revenues from stock options and capital gains fall from about $17 billion in 2000-2001 to $6 billion in 2001-2002. Moreover, national estimates from the 2001 Current Population Survey reflect a slight decrease in the uninsured; the 2002 numbers are anticipated to indicate the full effect of the recession on coverage rates.

Unfortunately, the economy is not expected to rebound anytime soon—at least not for the next 12 to 18 months. The National Conference of State Legislatures anticipates that Medicaid spending will continue to outpace state revenue growth throughout 2003, and that private premiums will remain on the rise. Across the country, states are doing their best to keep their heads above water through what some have coined "the perfect storm." Some of their efforts to contain costs in 2002 included reducing benefits for some populations, cutting provider reimbursement rates, restricting program eligibility and outreach efforts, and raising taxes.

Medicaid Spending

Medicaid continues to be a primary cost driver for state budgets, comprising an average of 20 percent of overall state expenditures; only K-12 education is appropriated more funds. In the current economic situation, low-income populations are leaning on this program more than ever. In FY 2002, Medicaid spending grew by 13.6 percent, the fastest rate of increase since 1992. Several factors contributed to this growth, including enrollment increases, pharmaceutical cost increases, and per patient increases for inpatient and outpatient care.

States Forced to Make Eligibility Cuts

The dire nature of state budgets in 2002 caused states to use cost-containment strategies that they have previously avoided, including Medicaid eligibility restrictions. According to the Kaiser Commission on Medicaid and the Uninsured's Survey of State Medicaid Officials, 19 states have reduced, or plan to reduce, Medicaid eligibility in Fiscal Year 2003. Among them are the following.

Nebraska contained costs by eliminating a system of eligibility determination called "stacking." Under this system, the state determined eligibility by dividing total household income by the number of individuals in the household; the result was that people were often individually eligible for Medicaid when their family, as a unit, was not.

The state projects that, due to the stacking system, about 7 percent of the 132,500 children enrolled in Medicaid come from families with incomes that are actually above the state's eligibility level of 185 percent of the federal poverty level (FPL). The state discontinued the stacking method as of November 1, 2002; it also reduced the amount of income that the state disregards from 20 percent to $100, which is the federal minimum. Altogether, the state estimates that these changes will save $25.7 million.

Missouri also tightened its eligibility determination process. As of October 1, 2002, the state modified its spend-down provisions. Previously, Medicaid would pay for all expenses incurred on the day that an individual met his or her spend-down level (74 percent FPL). Now, however, people are responsible for meeting some of their health care expenses, in a cost-sharing arrangement similar to a deductible. In response to advocate concerns, Governor Bob Holden altered the policy to allow disabled, blind, and elderly individuals under 80 percent FPL to qualify for Medicaid. Missouri also reduced Medicaid eligibility for parents of children enrolled in the State Children's Health Insurance Program from 100 percent FPL to 77 percent FPL; Transitional Medicaid Assistance is required by law for about half of the people affected by the reduction.

Oklahoma plans to reduce eligibility for children aged 6 to 18 from 185 percent to 115 percent FPL, and for those aged 1 to 5 from 185 percent to 133 percent FPL. In addition, eligibility for the low-income elderly and disabled will be reduced from 100 percent to 80 percent FPL. These changes were slated to take effect November 1, 2002, but they have been delayed until March 1, 2003 due to a lawsuit filed by an advocacy group (which has since been dismissed). The state also stopped accepting certifications for its medically needy program as of October 1, 2002.

Massachusetts is terminating coverage of long-term unemployed adults under its MassHealth Basic program, effective April 1, 2003. This elimination is anticipated to affect 50,000 people.

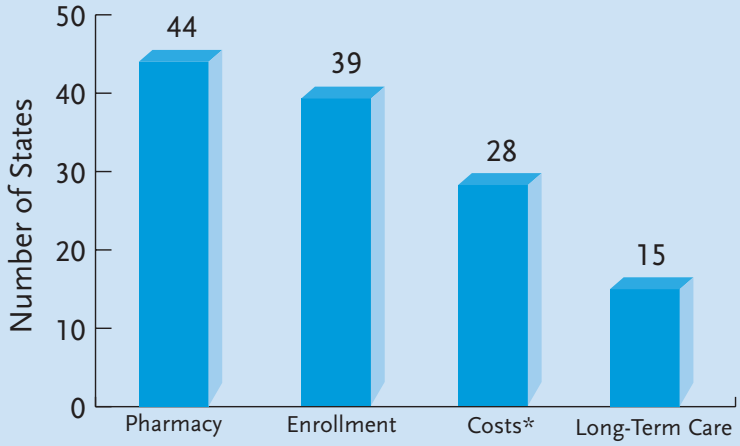
Medicaid enrollment, which increased an average of 8.6 percent in FY 2002, has risen recently for many reasons. First, the faltering economy has caused many people to lose jobs. As an individual's income declines, the likelihood that he or she is eligible for public assistance increases. In addition, successful outreach efforts for the State Children's Health Insurance Program (SCHIP) over the past several years have led to higher-than-expected Medicaid take-up rates. In other words, in their efforts to enroll children in SCHIP, the states uncovered many Medicaid-eligible children, whom they were obligated to enroll in the Medicaid program. Administrative simplifications to the enrollment process—which were made at a time when states could afford to increase enrollment—have also driven Medicaid growth.

In addition to the increased numbers of Medicaid beneficiaries, the cost of providing health care has increased. Hospitals costs (including inpatient and outpatient services) are driving spending not just in Medicaid, but in the health care sector overall. Nationally, spending on hospital inpatient and outpatient costs accounted for 51 percent of overall health care spending growth in 2001. At the same time, health care utilization is also increasing.

"People are getting more tests and treatments as managed care plans abandon tight restrictions on care, but higher hospital prices are playing a role as well," says Paul Ginsburg, president of the Center for Studying Health System Change.

Prescription drugs continue to contribute to Medicaid's high price tag as well; they account for about 10 percent of states' total Medicaid spending. The Centers for Medicare and Medicaid Services projects that costs for prescription drugs will grow at an average annual rate of 12.7 percent through 2011.

Top Factors Increasing Medicaid Spending



* Cost of health care services.
Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

In a survey of Medicaid officials in 50 states and the District of Columbia, Vernon Smith of Health Management Associates and colleagues found that 44 states listed pharmacy as one of the top three factors contributing to Medicaid spending growth. Prescription drugs for Massachusetts's 900,000 beneficiaries cost $890 million in 2001.

Increased pharmaceutical utilization and more expensive medicines are two reasons for the cost explosion. Drug companies devote enormous sums to marketing new drugs, and, thanks in large part to direct-to-consumer advertising efforts, today's health care consumers feel empowered to demand that their health care providers prescribe these drugs (despite the availability of less costly and often equally effective alternatives).

The good news, at least in Oregon, is that there has been moderation of costs. Some popular brand-name drugs have gone generic, and no new "blockbuster" medications have been approved in the last year. Oregon has also used evidence-based criteria to create a preferred drug list for its Medicaid program. (For more information, see p. 26.)

Because of its significant concentration of state funds, Medicaid is clearly wearing a bull's eye. "It is virtually impossible for states to slow the growth of overall state expenditures without including Medicaid in the group of programs to be cut," says Smith. Most lawmakers resist cutting the program, especially in an economic downturn, because the need for Medicaid is often strongest when the economy falters.

However, officials warn that, absent a rebounding economy, cuts loom large for 2004. Governor Warner of Virginia has indicated that another $1 billion in cuts will be necessary when the General Assembly meets in January to discuss the 2004 budget, possibly including public education and Medicaid funding. Even two years ago, such action seemed unthinkable.

"The fact that state policymakers have felt compelled to embark on substantial Medicaid cuts is a clear indicator of the severity of the current situation," says Smith.

Meanwhile, the states have looked to the federal government to help them absorb some of the damage caused by substantial Medicaid shortfalls. In July 2002, the Senate passed bipartisan legislation that would provide fiscal relief to the states by raising the federal matching assistance percentage (FMAP)—Medicaid's federal matching rate—for 18 months; unfortunately, however, the House failed to pass the provision this past fall.

The legislation would have increased all states' FMAP rates by 1.35 percentage points and allowed any state whose FMAP is lower than what it was in the prior fiscal year to retain the higher rate. Altogether, the law would have provided states with $6 million in additional federal matching funds.

Reining in SCHIP Outreach

Despite the success of SCHIP, which turned five years old in October, in insuring approximately 3.5 million children, a few states have had to make tough choices about outreach activities in order to contain costs.

The states' budgetary challenges resulting from growing enrollment will likely be compounded by a budgeting quirk in Title XXI of the Social Security Act known as the "SCHIP dip," which went into effect in 2002. The Balanced Budget Act of 1997 included a 10-year budget authorization in which spending dipped for FY 2002 through FY 2004 by 26 percent, or more

than $1 billion per year. (see Figure on p. 8.) The intent was to ensure a balanced budget by 2002 under the economic assumptions that were in use in 1997. The timing could not be worse for states. Coupled with reduced state resources, the SCHIP dip could by some estimates affect an estimated 900,000 children between 2003 and 2006.

Senators Jay Rockefeller (D–W.Va.), Lincoln Chafee (R–R.I.), Edward Kennedy (D–Mass.), and Orrin Hatch (R–Utah) introduced in August legislation that would essentially correct the SCHIP dip by providing additional funding for FY 2003 and FY 2004. Unfortunately, on November 20, in its last day of legislative activity of 2002, the Senate failed to pass the bipartisan compromise legislation. The Children's Health Improvement and Protection Act of 2002 would have restored state allotments to their 2001 level and increased federal monies to the SCHIP program. The law also would have established a caseload stabilization pool to make available expiring funds to states that have spent high percentages of their annual SCHIP allotments.

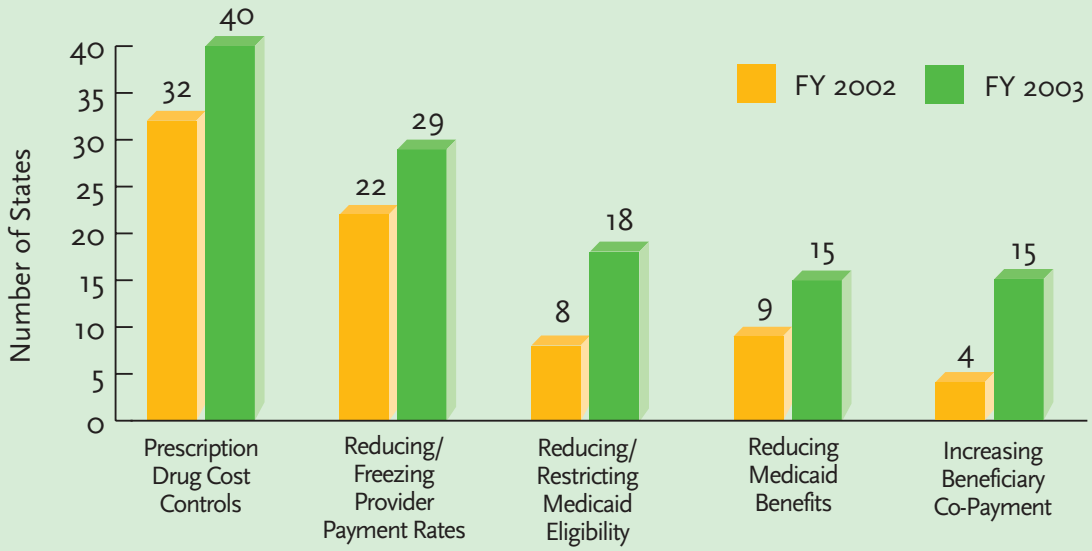
States Struggle to Close the Gap

Last year, declining revenues meant that most states had to put public program expansions on hold; this year, the decline has meant cutting eligibility, services, provider payments, and more. According to Vernon Smith, state revenue forecasters are very conservative as a general rule. "But the numbers keep coming in even lower than these conservative estimates," he says. Because most states are required by law to balance their budget each year, budget-cutting has become an almost year-round activity.

States tried to do the "painless" things first, including restrictions on out-of-state travel, moratoriums on equipment purchasing, and administrative reductions. However, these actions alone have proven insufficient to bring the states back into the black.

"We have been through a trimming process," says John Young, associate director for Health Care Quality, Financing, and Purchasing in the Rhode Island Department of Human Services. "All agencies looked at where they could save money and were asked to cut 2 percent in benefits, 5 percent in personnel, and 10 percent in contracts."

States' FY 2002 and FY 2003 Cost-Containment Strategies to Control Spending Growth



Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June 2002.

In Washington state, the estimated cost of covering programs that the state currently provides exceeds forecasted revenue by $2.1 billion (about 5 percent of the General Fund expenditure cost) for the 2003-2005 biennium. The Health Services Account, which is used to finance Washington's Basic Health plan and Medicaid children's coverage, will have a $500 million shortfall, representing approximately 25 percent of the Account's planned expenditures. Governor Gary Locke presented a new budget in December, and the legislature will convene in January to find new ways to maintain services.

Governor Warner of Virginia cut $858 million of the state's projected $1.5 billion shortfall through 1,837 state government layoffs, closing Department of Motor Vehicles offices one day a week, forcing colleges to raise tuition or lay off staff members, and reducing many community services. Funding for each of the state's 91 agencies was cut an average of 11 percent, with some slashed by as much as 15 percent (the maximum allowed by law). Virginia's biennium general fund budget is $25 billion.

Another way states are securing short-term funds is through securitizing tobacco settlement funds. Through this mechanism, the state sells the revenue stream of its tobacco settlement payments in return for a single, up-front payment. As of October 15, 2002, 15 states had securitized their tobacco settlement revenue, and many more are considering it in the near future.

Eligibility and Enrollment

According to Vernon Smith, the toughest thing for states to do is cut eligibility for public programs. Some states, such as Rhode Island, have managed to avoid this action, but others, like Oklahoma, have had to take extreme measures. The state was forced to slash eligibility from 185 percent of the federal poverty level (FPL) to only 133 percent FPL for children aged 1 to 5. For those aged 6 to 18, eligibility was cut from 185 percent FPL to 115 percent FPL. The eligibility reductions are scheduled to go into effect March 1, 2003, and will affect approximately 62,000 people annually. (See box on p. 5 for more information about state eligibility cuts.)

In 2002, the Washington legislature cut the state-funded medical assistance program for non-citizens receiving Medicaid—a move that affected about 28,000 immigrants. These individuals were given the opportunity to buy into the Basic Health plan, but with reduced benefits and substantial premiums and co-payments.

Federal Funding for SCHIP

Source: Section 2104(a) of the Social Security Act. Reprinted with permission from FamiliesUSA.

According to research done on behalf of the Kaiser Commission, 18 states were reducing or restricting eligibility for FY 2003, compared with only seven states taking such action in FY 2002. Iowa, New Jersey, Montana, North Carolina, and Utah capped enrollment in their SCHIP program in 2002. Overall, Medicaid eligibility was reduced or restricted in 25 states in FY 2002 or FY 2003, including Missouri (32,600 people are losing Medicaid insurance), Nebraska, (25,000 people), and Massachusetts (50,000 people were cut from the program, effective April 1, 2003).

Other states are taking a "back-door" approach by making it more difficult for eligibles to enroll in Medicaid. California Governor Gray Davis eliminated the proposed $5.9 million in funding in the 2002-2003 state budget that would allow school districts and counties to begin implementing "express lane" eligibility this year through the School Lunch program. However, the budget allows for implementation in July 2003 through the School Lunch and Food Stamps program. Governor Davis has the option to move this date back in his 2003-2004 budget, which will be released in January.

Other tactics include cutting funding for administrative staff, reinstating monthly reporting of eligibility, and eliminating media outreach. Ironically, virtually all of the methods used just a few years ago to bring people into the Medicaid program are now being used to keep them out.

Like all states, Rhode Island is struggling to keep its public programs intact. John Young acknowledges that, while there are few options to balance the budget, the state has benefited in the past from a legislature committed to the Medicaid program. "But the options to the incoming legislature are fewer," he says. The good news is that "restricting eligibility is, at least for the moment, off the table in Rhode Island."

Cutting Benefits

A July 2002 study from the Kaiser Commission on Medicaid and the Uninsured revealed that 14 states scaled back Medicaid benefits for FY 2003. In most cases, the first to go was dental benefits for adults. Also on the chopping block were reduced home health services, vision benefits, and some women's health services.

New York's Disaster Relief Medicaid Program

In the wake of the September 11, 2001, terrorist attacks on the World Trade Center, New York state implemented a temporary Disaster Relief Medicaid (DRM) program that enabled New York City residents to receive four months of Medicaid coverage. Administrators were forced to quickly design and implement the program, which used a shorter and simpler application process than the state's usual Medicaid program, because the attacks interfered with the state's computerized enrollment system.

Between September 24, 2002, and January 31, 2002, approximately 342,000 New Yorkers enrolled. To be eligible for DRM, applicants had to complete a streamlined, one-page application form and attest that their income fell within the guidelines for Family Health Plus, the state's Medicaid expansion to adults. Processing of the applications was also expedited: Officials approved individuals' requests either the same day that they applied or the next day.

Faced with an overwhelming demand, the state enlisted the help of community-based organizations and health plans to assist with the enrollment process. Policymakers have commended the state for its prompt response to a crisis and noted that the program could serve as a model for how to expedite enrollment into public programs.

For FY 2003, the Massachusetts Department of Mental Health endured a $13.8 million budget cut, which led to the elimination of free services for individuals with mental illness. Only those who are severely mentally ill will retain access to community health centers in Boston; the rest will be shifted to private mental health care providers—a process that could take months.

According to John Santa, Oregon will end up with a balanced budget provided that two things happen: 1) taxpayers approve an income tax increase in January; and 2) the economy doesn't take a turn for the worse. If voters do not pass the tax initiative on January 28, Santa says the state can expect the following programs and services to be cut:

- Medical Assistance Programs (by $22.3 million);
- Senior and Disabled Services (by $22.1 million);
- Developmental Disabilities Services (by $12.1 million);
- Mental Health Services (by $11.6 million); and
- Services to Children and Families (by $8 million).

If the measure fails, lawmakers could approve a different mix of cuts or come up with money to restore

programs, allowing state agencies to avoid some of the reductions. Enhanced cost sharing (increased deductibles and co-payments) is more politically acceptable than cutting programs as a means of tightening controls on health care and health insurance coverage. Co-payments for health care services other than prescription drugs were instituted or increased in 16 states in FY 2002 and/or FY 2003.

The toughest thing for states to do is cut eligibility for public programs.

John Young submitted in October a recommendation to the governor to cut the Rhode Island Medicaid budget in FY 2004 by offering several resources that could help pay for the program, including cutting provider reimbursement, implementing cost sharing, and restructuring (not cutting) services, such as prescription drug case management.

Cutting Reimbursements

For states looking to save money, reducing reimbursements is an attractive place to start. In FY 2002, 22 states implemented provider rate cuts or freezes. However, in some cases, cutting rates can make a bad situation worse. Providers may decide that they cannot afford to participate in the Medicaid program any longer due to low reimbursement. This will in turn result in reduced access to care for beneficiaries.

In Arkansas, many providers, especially those in rural areas, have been forced to reduce or eliminate the scope of their services and cease operation altogether. Realizing the potential danger of this action, incoming governors in several states (e.g., New Mexico, Pennsylvania, South Carolina, and Vermont) said they wanted to increase Medicaid reimbursement to participating doctors to ensure good access to care for enrollees.

The Massachusetts Legislature in July decided to reduce reimbursement for Medicaid prescriptions by 11 percent for a savings of about $60 million. CVS, Brooks Pharmacy, and Walgreen, the state's three largest pharmacy chains, threatened to withdraw from the state's Medicaid program (which serves about 900,000 beneficiaries), close stores, and reduce hours, arguing that the cut was not economically rational and would result in fewer medical services for the state's neediest citizens. In October, state officials scaled back the plan to set the reimbursement rate at wholesale acquisition cost plus 6 percent. In addition, pharmacies' dispensing fee was increased from $3 to $3.50 per brand-name drug and $5 per generic, effective November 1.

Responding to a legislative mandate to save $21.1 million on pharmacy costs in 2002, the Washington Legislature reduced payment for pharmaceuticals for Medicaid clients from 89 percent to 86 percent of the average wholesale price for brand-name drugs, and from 89 percent to 50 percent for generics. According to state officials, there has been some initial fallout with the loss of pharmacies serving Medicaid clients, but the state has set up a mail-order pharmacy program to try to offset the loss of retail access.

In Oregon, hospital lobbyists in November were successful in replacing a hospital reimbursement cut with the elimination of mental health, chemical dependence, and dental benefits for beneficiaries in the Oregon Health Plan. According to John Santa, this action was taken with no explicit discussion or hearing on the matter. "Stressful times result in political maneuvers," he says.

Raising Taxes

Perhaps the most universally unpopular way to boost revenue is through raising taxes. Tax increases were voted down in several states last November, and many gubernatorial candidates campaigned on the promise of no new taxes. Rhode Island's Governor Don Carcieri (R) vowed not to raise taxes in his first year in office, and Illinois' Rod Blagojevich (D) ruled out increases in the personal income or sales tax in his state.

"My guess is that it's going to be necessary to demonstrate a strong effort in controlling expenditures before our policymakers consider general tax increases," says Neil Bergsman, director of the Office of Budget Analysis in Maryland.

"Demonstrating commitment to maintaining current levels of state services, Governor Huckabee in November called for a 5/8^{ths} percent state sales tax increase," says Kevin Ryan, project director for the Arkansas Center for Health Improvement. "The tax increase is projected to raise $230 million to $250 million per year and is intended to support current levels of programs in the area of Medicaid, education, prisons, and public safety." In addition, about 10 percent of this revenue increase will be dedicated to large-scale industrial recruitment by funding promotion of what are referred to as "super-project" sites in order to attract additional jobs to the state.

However, Tricia Leddy, administrator for the Center for Child and Family Health at the Rhode Island Department of Human Services, is confident that sufficient cost efficiencies can be found to meet budget targets. To maintain funding for RIte Care, the Child and Family Services portion of the state's Medicaid program, the agency has adopted a two-pronged approach. First, Leddy says, the state leverages other funding sources, such as:

- Accessing federal funds through a SCHIP 1115 waiver (obtained in January 2001), which allows the state to cover parents of Medicaid and SCHIP children with 67 percent of federal funds, rather than with the lower Medicaid federal contribution.
- Using RIte Share, the state's premium assistance program, to keep individuals in available employer-sponsored insurance and thus reduce the amount of money spent on public coverage. Approximately 2,500 people enrolled in RIte Share in 2002.
- Implementing cost sharing for individuals deemed able to pay. Monthly premium collections began in January 2002 and are based on a sliding scale.
- Using new state legislation requiring commercial insurers to routinely "match" their member files to Medicaid enrollment files. By doing this, the state will have more current and accurate information about Medicaid enrollees who also have commercial coverage.

"This legislation was important given the number of Medicaid enrollees who have 'double coverage,'" says Leddy. "By knowing on a regular and prompt basis when any of our enrollees is also enrolled in commercial insurance, and then ensuring that the Medicaid program is the insurer of last resort, we are better able to leverage commercial insurer dollars to offset significant state funds."

For states looking to save money, reducing reimbursements is an attractive place to start.

The second approach Rhode Island is taking to achieve cost savings is by enrolling disabled populations into Medicaid managed care health plans. The state is transitioning foster children and Supplement Security Income (SSI)-enrolled children from the Medicaid fee-for-service system to a coordinated continuum of care provided by health plans. Last year's enrollment of foster children into health plans resulted in significant state savings due to a one-third decrease in hospital days. Rhode Island is planning to achieve additional savings by enrolling all SSI children into health plans this year.

States Weigh Costs, Benefits of Disease Management

Disease management (DM) is an integrated approach to health care delivery for the chronically ill that seeks to improve health outcomes while controlling costs. By encouraging participants to take ownership of their health through exercise, improved diet, smoking cessation, and proper medication, states hope this innovative way to rein in health care expenditures will grow as a viable option. According to a Kaiser Commission on Medicaid and the Uninsured report "Medicaid Spending Growth: Results from a 2002 Survey," in FY 2002, 11 states had disease management programs as a component of their Medicaid programs, and, in FY 2003, 21 states will be operating DM programs.

For states that have DM programs, their resources are targeted to diseases affecting a large segment of the population, those that are expensive to treat, or those that tend to see high rates of largely preventable emergency room use. Commonly targeted conditions include diabetes, coronary artery disease, chronic heart failure, and depression. States have the option of whether to run their programs in-house, or to contract with private disease management organizations (DMOs).

Of the current state-run DM programs, most have not been operational long enough to warrant a quantitative analysis of their financial benefits, although some qualitative assessments have been done. Initially, for most states, savings have not been as large as expected in the short term, but improvements in the quality of care have been seen. Alternatively, states with in-house disease management programs found some success at improving the quality of care while reducing expenditures.

In the states with privately run programs, officials have seen some level of success when the DMO is at financial risk for the success of the program. To ensure some level of savings, states working with DM consultants to run their programs have begun writing minimum savings guarantees into their contracts, ranging from 4 to 6 percent over current spending.

Measuring Program Effectiveness

The most effective measurement of the success of DM programs is comparing actual program expenditures against what would have been spent if the program were not in place, also known as baseline spending. Unfortunately, other factors often affect the baseline, including changes in treatment patterns or differences in utilization, making straightforward assessments nearly impossible. There are other accepted performance indicators states use to evaluate their DM programs including:

- Overall Cost Savings;
- Component Cost Savings;
- Return on Investment;
- Prevention Activities;
- Clinical Measures; and
- Adherence to Clinical Guidelines.

Florida has one of the largest and most established DM programs in the country. The state runs programs in diabetes, asthma, HIV/AIDS, hemophilia, congestive heart failure, end-stage renal disease, depression, and hypertension. The programs began in the late 1990s, and have yielded enough data to begin tracking their success. To date, independent evaluations have been completed for asthma, diabetes, hemophilia, and HIV/AIDS.

In Florida's asthma program, the evaluation found that prescription drug costs increased an average of $125 per person, but inpatient and outpatient medical costs decreased by $200 per person, yielding a net savings to the program, although enrollment was very low. The hemophilia and HIV/AIDS programs saw savings of nearly 40 percent compared to the previous year's baseline spending.

At a minimum, states are seeing that they can achieve improved quality of care for DM program participants, and find some level of financial savings in the bargain. Despite concerns about the best way to measure their financial benefits, Medicaid DM programs will continue to expand as states struggle with maintaining coverage levels in a limited fiscal environment.

State Approaches to Preserving Coverage

Faced with enormous deficits, states have been eager to use all the tools available to them to contain costs and preserve coverage in 2002. They have become increasingly aware that, in order to get through this difficult time, they must share resources and develop strong partnerships—with one another, the federal government, the private sector, and communities. The 2001 change in the presidential administration brought with it an increased federal willingness to give states flexibility to make available state dollars stretch farther. A number of states have taken advantage of that flexibility to restructure their public programs, build on employer-based coverage, and reach out to non-traditional populations such as childless adults. They have also continued to find solutions to work with the private sector to develop premium-assistance programs and other public-private partnerships.

Perhaps states' most important means of reaching out to their uninsured populations in 2002 was through the Health Insurance Flexibility and Accountability (HIFA) 1115 waiver initiative, which was unveiled in 2001 under the Bush administration. Through HIFA, the federal government has given states greater waiver flexibility to finance expansions—primarily by enabling them to access their unused title XXI State Children's Health Insurance Program (SCHIP) allotments, design benefit packages, and increase cost-sharing requirements for optional and expansion populations, and establish enrollment limits for their public programs. HIFA has also enhanced states' capacity to build on employer-based coverage.

To date, seven states have already received HIFA waivers from the Centers for Medicare and Medicaid Services (CMS), three have submitted applications and are awaiting approval, and 17 others are developing or considering proposals, according to a 2002 survey from the Kaiser Commission on Medicaid and the Uninsured. (See table on p. 14 for details on states with approved HIFA waivers.) Several other states, including Tennessee and Utah, have designed coverage programs through regular 1115 waivers that incorporate HIFA-inspired approaches to restructuring Medicaid benefits.

Although states recognize the benefits of reaching out to new populations such as low-income childless adults, they also realize that they are not working in a static environment. States are making, or considering making, future cuts to their Medicaid programs if the economic situation continues to deteriorate. Consequently, current budget woes may inhibit states from moving forward on ambitious expansions. In California, for example, officials have decided to hold off on the implementation of their approved HIFA waiver due to the state's current funding problems. The waiver, which was approved early in 2002, would have extended coverage to 30,000 uninsured parents of Medicaid and SCHIP children.

Restructuring Public Programs

In 2002, many states focused on restructuring their public programs to make them more cost-effective. Although state policymakers have been interested in pursuing this approach for some time, many felt that, until recently, the federal government did not allow them enough flexibility to tailor Medicaid benefits packages. Tennessee and Oregon made some of the most significant reforms to their programs last year. Both states received waivers to establish tiered benefits packages targeted to specific Medicaid populations.

In May, Tennessee received approval for a five-year demonstration project to create a three-tiered benefit structure for TennCare—the state's Medicaid 1115 expansion program. TennCare, which has reached out to hundreds of thousands of vulnerable people in the state, has been plagued with fiscal challenges virtually since its inception in 1994, and its problems have only worsened in the wake of the current economic downturn. The state hopes that this new structure will help reduce escalating costs and maintain enrollment at manageable levels.

In addition to establishing multiple benefits packages, Tennessee's waiver calls for greater cost sharing for children with family incomes between 100 and 200 percent of the federal poverty level (FPL) and restricts enrollment to people who are above the federal poverty level and considered "uninsurable" in the private market (the waiver also imposes a new definition of "unin-

HIFA Waivers Approved to Date

Name	Implementation Date	Eligible Population	Funding Sources
Arizona HIFA Amendment	*Phase 1:* 11/1/01 *Phase 2:* 10/1/02 0-100	*Phase 1:* Childless adults 0-100 percent FPL, net of income disregards *Phase 2:* Parents of SCHIP and Medicaid children, 100-200 percent FPL	Title XXI/SCHIP
California Parental Coverage Expansion	7/1/02	Parents, relative caretakers, and legal guardians with net incomes 200 percent FPL not eligible for Medi-Cal	Title XXI/SCHIP
Colorado Adult Prenatal in Child Health Plus	10/02	Pregnant women 134-185 percent FPL	Title XXI/SCHIP
Illinois KidsCare Parent Coverage	10/02 or 1/03	Parents of KidCare eligibles to </= 185 percent FPL	Title XXI/SCHIP
Maine Care for Childless Adults	10/1/02	Childless adults </= 100 percent FPL	DSH
New Mexico State Coverage Initiative	*Phase 1:* 2/03 *(Phase 2 requires further approval)*	*Phase 1:* Childless adults and parents of Medicaid and SCHIP children to 200 percent FPL	Title XXI/SCHIP
The Oregon Health Plan 2 (OHP2)	2/03	*OHP Plus:* previous Medicaid eligibles and pregnant women and children up to 185 percent FPL *OHP Standard:* Parents of SCHIP and Medicaid eligible children and childless adults to 185 percent FPL *FHIAP:* Families and individuals to 185 percent FPL	Title XXI/SCHIP

Pending HIFA Waivers

Delaware Healthy Adult Program	N/A	Transitional Medicaid from 65-185 percent FPL	Title XXI/SCHIP
Michigan MIFamily*	N/A	Blind and disabled to 350 percent FPL; Medicaid and SCHIP parents to 100 percent FPL; childless adults to 100 percent FPL; and pregnant women from 186-200 percent FPL	Savings from a re-defined program for caretaker relatives; adding optional coverage groups with re-defined benefits; expanding state programs; unused SCHIP funds; and local money.
New Jersey Standardized Parent Service Package	N/A	Medicaid and SCHIP parents to 200 percent FPL	Savings from standardization of the parent service package to Plan "D" of NJ FamilyCare.
Washington Medicaid and SCHIP Reform Waiver	N/A	Parents of Medicaid and Basic Health children to 200 percent FPL; childless adults to 200 percent FPL	

* made inactive by Governor, pending budget and gubernatorial election.

surable;" for more information, see p. 32). Although Tennessee's strategy is very much in the spirit of the HIFA initiative, the state submitted a traditional 1115 waiver to CMS. The proposal included significant changes to the state's previous 1115 demonstration, including a revision to the way in which the state calculates budget neutrality. The 1994 waiver used aggregate spending caps, while the revised waiver will include budget-neutrality terms based on per member per month calculations. The state hopes to implement the restructured TennCare program in 2003, as soon as the state legislature finds sufficient funds to support it.

The new TennCare will consist of three products.

- **TennCare Medicaid** will be provided to the mandatory Medicaid population. Barring some modest changes to the benefit package, beneficiaries covered under TennCare Medicaid will continue to receive the same comprehensive package that was available under the previous demonstration.

- **TennCare Standard** will cover medically eligible and uninsured individuals under 200 percent FPL and non-Medicaid dual eligibles. The standard package will be comparable to the state employees' HMO package, except for mental health benefits, which will be maintained from the previous demonstration. Under the standard package, Tennessee is also instituting a three-tiered pharmacy benefit; beneficiaries under 100 percent FPL will pay $1, $3, or $5 co-payments depending on the drug, while those above 100 percent FPL will have higher co-payments ($5, $15, $25).

  Enrollees with incomes above 100 percent FPL will pay premiums and co-payments for the TennCare Standard package that are similar to those imposed in the previous demonstration. Depending on income, premiums will range from $20 to $150 for individuals, and $40 to $375 for families. Beneficiaries will be charged a $10 co-payment for most visits; however, dental and psychiatric outpatient services will require a $15 co-payment.

- **TennCare Assist** is targeted to families at or below 200 percent FPL that have access to private insurance. TennCare Assist would provide subsidies to help these individuals pay premiums for employer-sponsored insurance.

Oregon received federal approval in October 2002 to restructure the Oregon Health Plan (OHP) in order to extend coverage to an additional 60,000 Oregonians. The state submitted a HIFA waiver to access the unallocated portion of its SCHIP funds and develop tiered benefits packages. It also requested a modification of its current 1115 waiver to secure a federal match for the Family Health Insurance Assistance Program (FHIAP), Oregon's state-funded program that subsidizes employer-sponsored insurance.

The state's new demonstration program, which is called Oregon Health Plan 2 (OHP2), will comprise three benefit packages.

- **OHP Plus** will cover all mandatory populations and some optional populations, such as pregnant women and children in families with incomes up to 185 percent FPL. All eligible children will be in OHP unless their parents choose to cover them in FHIAP through subsidized private group or individual coverage. OHP Plus is a comprehensive package equivalent to that offered through the original OHP. (For more information on OHP and Oregon's prioritized list of treatments and conditions, see box on p. 16.)

- **OHP Standard** will cover adults eligible based on income (currently it will extend up to 100 percent FPL, but the state proposes to gradually increase eligibility to 185 percent FPL). This population includes parents of children enrolled in Medicaid and SCHIP and childless adults with incomes up to 185 percent FPL. This streamlined benefits package is budgeted at approximately 78 percent of the actuarial value of OHP Plus. State officials spent several months doing actuarial work in order to design a benefits package similar to a commercial plan that would save the state money and fit the needs of the OHP Standard population.

States Balance Flexibility and Fairness

Within the past couple of years, the federal government has given states more flexibility than ever to modify the health insurance benefits packages and cost-sharing structures of their coverage demonstration projects. This flexibility was made possible chiefly through the Health Insurance Flexibility and Accountability (HIFA) 1115 demonstration initiative, which was unveiled in 2001 under the Bush administration. Increasingly, states are using regular 1115 waivers to design flexible coverage strategies that involve restructuring Medicaid benefits packages as well.

HIFA gives states enhanced waiver flexibility to streamline benefits packages, create public-private partnerships, and increase cost-sharing for optional and expansion populations covered under Medicaid and the State Children's Health Insurance Program (SCHIP). The thinking is that, by allowing states more latitude to create innovative health insurance models, the federal government will encourage them to cover more of their uninsured using existing financial resources. "Through this inititative, we are creating a new, simpler process for states to propose and implement creative ideas to help uninsured residents," says Health and Human Services (HHS) Secretary Tommy Thompson when he introduced the HIFA initiative at an August 4, 2001, meeting of the National Governors Association.

But with that flexibility comes responsibility. Because HIFA does not include an infusion of new federal money, states must make difficult trade-offs in order to reach out to new groups. Unfortunately, there are no clear guidelines—or precedents—as to how much coverage is enough or at what point on the income scale it is appropriate for states to begin streamlining benefits or imposing cost-sharing increases. Moreover, the decision to expand coverage under HIFA often forces states to confront what is essentially a philosophical question: Is reduced coverage for more people preferable to extensive coverage targeted to a smaller group? "Even in the best of circumstances, this discussion is a mix of evidence, opinion, politics, and emotion," says John Santa, M.D., of the Office for Oregon Health Plan Policy and Research (OHPPR).

Oregon was one of the first states to experiment with restructuring their Medicaid benefits packages in order to expand coverage. In 1994, the state implemented a benefits strategy called the Oregon Health Plan (OHP) to expand access to affordable health care to all Oregonians. To fund the OHP, the state created a priority list of treatments and conditions for the Medicaid portion of the plan. During harsh economic times, the state covers only the highest priority treatments for residents below the poverty level; when the financial climate is strong, beneficiaries are given more comprehensive coverage. "For more than 15 years, there has been a focus on benefits in our state," says Santa. "Our citizens understand the difficult choices we must make to work toward universal coverage."

Now, Oregon is once again at the forefront of state health care reform. Using the flexibility made available through HIFA, Oregon is creating a new, streamlined health benefits package within the OHP Medicaid program to cover people who do not fall into mandatory Medicaid categories (See text on p. 15 for more details). Several other states, including Tennessee, Utah, and Washington, are following suit with their own plans to modify benefits designs within their Medicaid programs. The former two states are implementing their expansions under regular 1115 waivers, while the latter is pursuing a HIFA initiative.

Many state officials agree that such flexible approaches represent their best hope of giving as many people as they can some coverage rather than having to drop certain beneficiaries entirely in order to meet budgetary challenges. But advocates point out that the difference between mandatory, or "core," populations and expansion groups is not necessarily the same as that between lower and higher income groups. Some individuals that fall under expansion populations—such as childless adults—can be quite poor and unable to afford the potential cost-sharing increases that HIFA allows states to impose. Moreover, some critics feel that the pared-down benefits HIFA permits represent an erosion in coverage for vulnerable populations.

"Increased state flexibility could merely redistribute the financial burdens and access barriers that already exist in our health care system," says Gail Shearer, director of health policy analysis at the Consumers Union, a nonprofit consumer advocacy group. "States are under enormous pressure to cut benefits such as prescription drugs or mental health or to limit coverage to a small

subset of the vulnerable population," she says. "But there is no 'right' answer as to whether one person is more worthy of coverage than another."

Yet many states feel that it has become increasingly necessary for them to determine appropriate benefits packages for various populations, despite the difficulties involved with doing so. As public programs continue to move higher up the income scale to cover greater numbers of uninsured, they say, it only makes sense that states also move toward benefits packages that are more comparable to those offered in the private market.

"We absolutely agree that you need a comprehensive package for categorical groups," says Rod Betit, executive director of the Utah Department of Public Health. However, for expansion populations, particularly those at the higher-end of the income scale, it makes sense to design packages that more closely resemble the commercial packages that these individuals may eventually acquire in the marketplace.

HIFA has also come under fire because it allows states to use SCHIP funds to finance expansions to adult populations. In August 2002, the General Accounting Office (GAO) issued a report concluding that HHS's approval of several recent waivers that enabled states to use SCHIP funds for adults is inconsistent with the program's statutory objective of expanding coverage to children, and is thus "not authorized." Such spending could eventually prevent the redistribution of that money to other states that have exhausted their allocations for covering children, the report says. Arizona's HIFA waiver prompted particularly strong criticism because it enables the state to use SCHIP funding to cover adults without children (as well as parents of Medicaid- and SCHIP-children).

GAO expressed further concern that HHS has not consistently ensured that several waivers it has approved were budget-neutral—a requirement of all section 1115 waivers. In the case of two waivers, those for Utah and Illinois, GAO contends that the projections of what the states would have spent without the waiver includes certain costs that were either inappropriate or impermissible for assessing budget neutrality. (For more information on Utah's waiver, see p. 19; for more on Illinois, see p. 22.)

Following the release of the GAO report, the Senate Finance Committee proposed legislation to prevent HHS from granting 1115 waivers allowing child health funding to be used to cover childless adults, but it did not pass in the 107th session of Congress.

Still, the GAO report is significant in that it illustrates a widening gulf between how some members of Congress and the administration view public programs. In its comments on the GAO report, HHS disagreed with the GAO's assertion that waivers that use SCHIP funding to cover adults are inconsistent with the intent of the SCHIP statute, stating that such waivers "must be viewed as a comprehensive approach in providing health insurance coverage to those who were previously uninsured, some of whom may indeed be former Medicaid recipients."

Without any new federal money, states must make difficult trade-offs in order to reach out to new groups.

Many state officials agree with that conclusion, pointing out that states have always been laboratories for health care reform and, by allowing them greater flexibility, the federal government is enabling them to continue in that important role. Moreover, they say, flexibility may be the only way that states can maintain the gains they have made over the past decade and continue to make incremental expansions during bleak economic times.

"The GAO report was about as far from reality as can be," says Matt Salo, director of health legislation at the National Governors Association. "Budget neutrality needs to be liberalized, not restricted, and waiver processes need to be streamlined, not drawn out," he says. "Budget neutrality has always been an inconsistent process and one that has been redefined by every state that has come in to negotiate."

Oregon's waiver stipulates that the state legislature can reduce its value to 56 percent (i.e., the federally mandated level) if fiscally necessary. To reach the 56 percent level, the state would have to remove four services from the package that are technically optional: prescription drugs, mental health and chemical dependency coverage, dental benefits, and coverage for durable medical equipment. In November 2002, the Emergency Board of the Oregon Legislature removed coverage for all of these benefits except prescription drugs for the current biennium. The state made this move in order to balance its budget and avoid provider reimbursement decreases.

- **The Family Health Insurance Assistance Program** covers families and individuals with incomes up to 185 percent FPL by providing premium assistance on a sliding-scale basis for employer-sponsored insurance. FHIAP is a premium-assistance program that was created in 1997 and, until now, has been operated with state-only funds. The state was given approval in its 1115 waiver to receive a federal match, so FHIAP was consequently folded into the OHP2 structure. Typically, benefit packages offered through employers are less rich than other OHP2 packages.

HIFA has enhanced states' capacity to build on employer-based coverage.

Oregon has always been progressive in the area of health care reform, so it's not surprising that the state's modified 1115 waiver contained several provisions that have never been approved by CMS before. For example, the waiver allows low-income working adults who are eligible for OHP Plus to make an informed choice about which type of coverage they would like to receive. They can opt for employer-sponsored insurance with premium assistance through FHIAP or maintain OHP Plus benefits, which are more comprehensive. The new provision does not oblige the state to provide additional wrap-around coverage for those selecting private coverage. However, CMS has required the state to inform beneficiaries that they are eligible for OHP Plus and that they or their children can choose to stop participating in private coverage and transfer back to the Medicaid/SCHIP program at any time.

This provision will no doubt help the state contain costs, but Oregon officials stress that it is also advantageous for beneficiaries to be able to choose the coverage that best suits their needs. Although private insurance is associated with fewer benefits and greater cost sharing than public coverage, it also carries less of a stigma, broader provider networks, and potentially better access. Moreover, by opting for coverage through FHIAP, families can be insured through a single policy, even when parents and children are eligible for different programs. "The key issue is that we wanted the flexibility to ensure that a family can be insured in the same policy, with the same card, and have access to the same network of physicians," says John Santa, M.D., of the Office for Oregon Health Plan Policy and Research. "People have different priorities and interests and we think it is reasonable to honor those differences."

Another new component of Oregon's 1115 waiver is that it allows providers to refuse to treat patients who do not comply with the cost-sharing requirements for adults with OHP Standard coverage. No other state has ever implemented such a policy in their Medicaid program because federal law requires states to provide treatment regardless of beneficiaries' ability to pay.

In August 2002, the state of Washington submitted a HIFA waiver, which, if approved, will also call for significant changes to benefits and cost-sharing structures within the Medicaid program. (Washington initially proposed the plan over a year ago, but CMS felt the original waiver did not include sufficient detail and thus asked state officials to resubmit it.) The waiver is an ambitious proposal that seeks to cover 20,000 parents, single adults, and couples with Title XXI funds. The state has also requested permission from CMS to implement an enrollment freeze if necessary.

Washington used its Basic Health (BH) plan—a state-only coverage plan requiring significant co-payments and premiums for people whose incomes are too high to qualify for Medicaid—as a template for services provided to adults in the expansion population. Washington felt comfortable establishing the BH plan as a floor because it is comparable to packages offered in the commercial market. State officials compared utilization rates in the Medicaid

and BH populations to identify which services to preserve for the expansion group. "It has never been easy to decide which services are essential," says Roger Gantz, Washington's Medicaid director.

The state will use co-payments as a way to create incentives for beneficiaries to use the appropriate services. Beneficiaries will have to pay approximately $5 for brand-name drugs when a generic is available, and $10 for non-emergent use of the hospital emergency room.

Focus on Parents and Childless Adults

Over the past year, states also placed an increased emphasis on covering parents of SCHIP-eligible children and childless adults. In fact, virtually all the HIFA states have included proposals to reach out to adult populations. (See table on p. 14 for details on the states' HIFA expansion populations.) Some advocates and others have criticized these efforts, stating that such expansions dilute the original intent of SCHIP, which is to provide health care to low-income children. (See box on p. 16 for more on the trade-offs of flexibility.) But many state officials point to research suggesting that, by extending coverage to parents, states are more likely to bring in children who are eligible for SCHIP but not enrolled.

As for childless adults, states have become increasingly aware that neglecting this population may, in fact, be a long-term driver of health care costs. When adults lack insurance, they are more likely to incur health care expenses at the most expensive source: emergency rooms. Ultimately, the public pays for these individuals' care through higher insurance premiums or increased health care prices.

Last spring, Utah made a significant leap into new territory when it received federal approval to provide primary and preventive care services to 25,000 parents, single adults, and couples with incomes under 150 percent FPL. The state is financing the expansion by folding the Utah Medical Assistance Program (UMAP) into the network, reducing benefits for some of its 17,600 beneficiaries in its current Medicaid population, and increasing cost sharing. Although Utah's plan shares HIFA's philosophical emphasis on flexibility, it was approved as a traditional 1115 waiver.

One important way in which Utah's waiver differs from HIFA is that it allows the state to streamline benefits for some mandatory Medicaid beneficiaries rather than only optional and expansion groups. Utah's proposal calls for a reduction among both optional and mandatory populations, including section 1931 adults and those in transitional Medicaid (section 1925). Both groups will experience reductions in hearing, vision, and some dental services, as well as a cap in the number of physical therapy, chiropractic, and psychiatric visits. In addition, the groups will lose coverage for non-emergency transportation and have a cap on the amount of mental health services to be used per year.

Utah's decision to cut into the benefits of its mandatory groups has drawn criticism from the General Accounting Office and others, who claim that the expansion represents an erosion in coverage for vulnerable individuals. But Rod Betit, executive director of the Utah Department of

Last year, states placed an increased emphasis on covering parents and childless adults.

Public Health and a key player in developing Utah's proposal, believes the waiver will increase the state's investment in health care. It should contribute to the national understanding of whether and how the availability of primary and preventive services improves health status and reduces uncompensated care, he says. "We feel that we made reasonable choices with the limited amount of state money that we had."

Utah's program—which is called the Primary Care Network (PCN)—offers what Betit refers to as "front-end" services. Newly eligible beneficiaries will have access to services similar to those provided at community and rural health centers, including physician office visits, immunizations, emergency care, lab, x-ray, medical equipment and supplies, basic dental care, hearing and vision screening, and prescription drugs. The expansion population will have to pay a $50 annual enrollment fee in addition to co-payments, which will be similar to those charged in the state's SCHIP program.

Although the expansion population's benefit package does not cover inpatient hospitalization, the program incorporates features outside the waiver that may address this limitation. According to Betit, beneficiaries can take advantage of resources donated from the community. These "invisible" components include hospital and specialty care, health education services, and referrals to pharmacy assistance programs.

The state also passed new legislation in March 2002 that allows insurers to offer the primary care product. As a result, employers can offer the product to their employees and work with insurers to add on to the program to make it more comprehensive.

As of mid-November 2002, PCN had 7,088 approved enrollees, and more than 21,000 individuals had submitted applications to the Department of Health. However, about a quarter of approved enrollees had failed to pay the enrollment fee, according to state officials. The state attributes this to the high percentage of applications coming from people who were formerly enrolled in UMAP—a state-only program that was abolished with the creation of the PCN. Because more than half of those who applied for the PCN fell into the same low-income eligibility levels targeted through the UMAP, such individuals may be finding the enrollment fee to be a barrier.

Arizona has also initiated an expansion to adult populations. In fall 2001, the state became the first in the nation to receive a HIFA waiver. It is using the waiver to access its unspent federal SCHIP funds to finance expansions to two target groups: 27,000 childless adults with adjusted incomes up to 100 percent FPL and 21,000 parents of Medicaid and SCHIP-eligible children with adjusted incomes up to 200 percent FPL. The state has already implemented the expansion to childless adults; as of November 2002, 91,822 people had enrolled. The expansion to parents was fully implemented this January.

The benefits package for the expansion populations is equivalent to that provided under the state's SCHIP program. Childless adults will have the same cost-sharing requirements as other Medicaid recipients, and parents of Medicaid and SCHIP children will pay the same co-payments required in SCHIP.

Maine also initiated an expansion to childless adults via HIFA. In mid-September, the state received approval to extend coverage to approximately 11,500 low-income childless adults at or below 100 percent FPL via a HIFA waiver. The state intends to further broaden coverage to childless adults up to 125 percent FPL a year after the initial expansion has been fully implemented. "We believe that, as result of this expansion, we will be able to provide direct services to people who otherwise would not have access to such care," says Eugene Gessow, director of the Bureau of Medical Services. "The expansion will also indirectly reduce the burden on the safety net in Maine."

Maine's waiver differs from other HIFA states in that it will be financed through unused Medicaid Disproportionate Share Hospital (DSH) payments rather than unused Title XXI funds. Maine opted to use DSH funds because, like several other states, it did not have any SCHIP funds left. In addition, the state could not rely on managed care savings as a funding mechanism because the Medicaid program does not have any capitated managed care contracts.

Public/Private Partnerships

In recent years, the states have been gravitating toward developing employer buy-in programs and other public-private partnerships as a means of extending coverage to working people who are unable to afford their portion of employers' insurance plans. Unfortunately, however, most states have found it difficult to implement employer buy-ins (which typically use Medicaid or SCHIP funds to subsidize employer-sponsored insurance) because, to do so, the states must meet a number of federal requirements that can cause substantial administrative burdens.

Now, the HIFA initiative has opened new doors for states to pursue public-private partnerships that may be easier to implement and operate. Although HIFA addresses many of the structural challenges

Forty-Eight States Cover Breast and Cervical Cancer Treatment

Despite tight budgets in 2002, states continued to expand Medicaid coverage to women with breast and cervical cancer—a population that became categorically eligible for the program through The Breast and Cervical Cancer Treatment Act. This law, which was enacted in October 2000, allows states to cover women who have incomes up to 250 percent of the federal poverty level (FPL) and have undergone free screening through the Breast and Cervical Cancer Early Detection Program and discovered the need for treatment.

To date, the Department of Health and Human Services has approved the expansion of these benefits in 48 states.[1] In order to implement this expansion, all states must be approved for a state plan amendment; most states also require authorizing legislation. Once approved, the state will receive federal matching funds for these patients at the enhanced State Children's Health Insurance Program (SCHIP) level—which typically covers between 65 and 83 percent of the total program costs. 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.

To finance the expansion, some states are using existing funding allocated to state health or Medicaid departments; others have had to appropriate new funds. In light of current cost concerns, many states have developed creative financing solutions. In Washington state, the legislation establishing the program calls for part of the 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.

On January 15, 2002, President Bush signed the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001. This law clarifies that American Indian women with breast or cervical cancer who are eligible for health services provided under a medical program of the Indian Health Service or a tribal organization are included in the optional Medicaid eligibility category.

[1] *Oklahoma and Massachusetts are the two states that have not been approved. The District of Columbia currently has a pending amendment.*

of developing employer buy-ins, states must still face the reality that only a small share of the typical employer's workforce are income eligible. Likewise, very few people in public programs have access to employer-sponsored insurance—most are either unemployed or work for employers that do not offer coverage.

New Mexico's premium-assistance program has been described as a "next generation employer buy-in." Under a HIFA demonstration project that was approved in August 2002, the state will implement an innovative program that will combine federal, state, and employer dollars to provide health insurance to adults with incomes up to 200 percent FPL. The state intends to launch the program in June 2003.

New Mexico's coverage model has several design features that make it less administratively burdensome than a typical employer buy-in, including a state-created benefits package that will greatly simplify the process of coordinating with employers. Unlike typical employer buy-ins—in which the state needs to verify each employer's benefits plan before it can provide premium assistance—in New Mexico's program, the components of the benefits package will already be known because the state has designed it in advance to meet federal requirements for all participating employers.

The state-designed benefits package, which is called the State Coverage Initiative (SCI), is less comprehensive than Medicaid; it puts limits on hospital inpatient days, mental health services, and an overall limit of $100,000/year for services used. The program will be financed through federal and state funds, employer contributions, and employee premiums.

Insurance brokers will offer the SCI product along with other private packages. From both employers' and employees' perspectives, the coverage will seem like private insurance, although it is actually a partially publicly funded product whose eligibility is income-based, like SCHIP and Medicaid.

Premiums will vary depending on employees' income and will range from $20 to $35 per month. The lowest income employees (below 100 percent FPL) will not be required to pay monthly premiums. Unemployed individuals are also eligible to receive the state package as long as they cover both the employer and employee share of the premium. The state will

implement several crowd-out features, including a six-month waiting period and a 75 percent take-up requirement for businesses. Also, because the benefits package is valued slightly below what is offered in the commercial market, people may be discouraged from switching to the SCI product.

The state is focusing on marketing the product to the many small businesses in New Mexico with a majority of low-income workers, as well as those that have never offered coverage. "Many small businesses want to provide health care to their employees, but haven't been able to afford it," says Garrey Carruthers, former governor and CEO of one of New Mexico's managed care organizations. "SCI gives them an affordable option that is not a government handout."

The states are gravitating toward developing employer buy-in programs and other public/private partnerships.

Small business owners that participated in focus groups indicated that they are very interested in the SCI product. For one reason, it is significantly cheaper than current commercial products. Also, signing up for the product is simple because employers do not have to select from different benefit plans for their employees. The SCI product is optional for businesses with a low percentage of low-income workers, but the state anticipates that at least some will be interested. The secondary target market for the product will be employers whose employees are not taking up their commercial product.

The state hopes that this program will substantially reduce costs. By incorporating employer and employee contributions and offering a more basic benefits package, New Mexico will only have to pay $20 per month for each enrollee in the SCI program; typically, a non-disabled adult costs $85 per month through regular Medicaid.

Illinois also received a HIFA waiver in September that enabled it to incorporate its existing premium-assistance program into SCHIP. The state's buy-in was created in 1998, but, until now, it has been financed through state-only funds. "Before HIFA, it was too complex to meet SCHIP's cost-sharing and benchmark provisions," says Jane Longo, Chief of the Bureau of KidCare—the state's SCHIP program. "With HIFA, we can now have a very simple premium assistance program that doesn't require a great administrative burden for the state."

The state received federal approval to offer rebates for employer-sponsored insurance to all optional adult and child populations between 133 and 185 percent FPL. However, to date, the state has opted to offer the program only to children with incomes between 133 and 185 percent FPL. As of November 2002, approximately 20 percent of enrolled children in this income range were enrolled in the premium-assistance program.

At some point, the state plans to extend the program to other populations. "We believe it is important to encourage systems of employer-based coverage," says Longo, "and it is worthwhile for us as it allows employers to bear some of the expenses."

Children who meet the income eligibility levels are eligible for premium assistance if they are covered by private insurance that includes physician and inpatient services. Parents must pay a portion of the child's premium, but the state will reimburse the family up to $75 per month for the portion of private insurance premiums they must pay to cover eligible children. The program does not impose any cost-sharing or benchmark requirements.

In September, Massachusetts announced a plan to expand coverage among uninsured workers on the island of Martha's Vineyard from 200 percent to 400 percent FPL. The plan will be funded by the state as well as employer and employee contributions. Due to start in spring 2003, the program will use a graduated, income-based, premium-assistance payment scale to provide subsidies to about 1,600 low-income workers. The coverage will be provided through the state's "Insurance Partnership," a component of Massachusetts's Medicaid program that provides employer subsidies and employee premium assistance.

Nearly 20 percent of those who live on Martha's Vineyard are uninsured—in part due to the preponderance of small, seasonal businesses on the island.

(By contrast, 8 percent of Massachusetts residents lack health insurance.) The island also has the lowest proportion of employers offering health insurance in the state.

The state is hoping that this effort will serve as a test project that will shed light on the larger question of whether to expand coverage to more working uninsured people throughout the whole of Massachusetts. "The bottom line is that most of the uninsured in Massachusetts are employed and under 400 percent FPL," says Charlie Cook, director of the Insurance Partnership at the Massachusetts Division of Medical Assistance (DMA). "This program will allow us to project the budgetary implications of taking an employer-sponsored insurance initiative statewide from 200 to 400 FPL on a graduated basis." For this reason, the DMA is cautiously optimistic that it will receive authority from the legislature to move forward on this program, even though the state is looking to make across-the-board Medicaid cuts in light of budget pressures.

Reaching Out to Communities

In 2002, states reached out to communities to develop partnerships that could help maintain and expand coverage. Many community-level programs are designed to provide coverage to individuals who aren't eligible for a public program. Some state health care agencies have stepped up to support these initiatives with both financial and non-financial assistance. As a result, state-community partnerships are forming that could help fill some of the remaining coverage gaps throughout the country.

Michigan, for example, submitted a HIFA waiver request this past spring that would allow it to fold a county-level pilot program into its SCHIP program—called the MIChild program—to reach out to uninsured adults under 100 percent FPL. The waiver would expand coverage to more than 200,000 uninsured low-income adults, including 80,000 parents of children enrolled in the MIChild program between 51 and 100 percent FPL. Unfortunately, however, the state has had to halt its plan due to overwhelming budget pressures. After negotiations with CMS had begun, Governor John Engler requested in early September that work on the waiver be delayed.

Michigan's county-level pilot program offered coverage to single, childless adults who do not qualify for Medicaid. As of November 2002, 17 counties were operating the project, which was funded through state and county resources through the end of 2002. It is unclear whether the counties will receive additional state resources to continue to provide services in 2003.

If Michigan's economic situation stabilizes in the near future, the state hopes to revisit its HIFA waiver. Indeed, state officials are continuing their work on the plan should the governor ask CMS for a reinstatement of the waiver.

Although the timing of the expansion wasn't right in 2002, the state remains committed to working with communities. "We believe that if we give counties the right infrastructure in terms of financial and administrative resources, they will successfully implement programs to reach out to indigent populations," says Carol Isaacs, deputy director of Health Legislation and Policy Development in the Michigan Department of Community Health. The state's intent with their waiver was not only to provide entry into the delivery system for a population that has been thus far dependent on the safety net, but to promote better use of services.

Florida is also collaborating with counties to reach more uninsured people through its Health Flex program, which is currently under development. For this state-only funded initiative, counties will work with area providers—including HMOs, provider groups, county plans, and community hospitals—to offer coverage to uninsured people up to 200 percent FPL. Small employers, employees, and local communities will all contribute to the cost of the premium. The state will collaborate with participating providers to develop pricing and benefits design for Health Flex coverage. The state foresees that there may be a large degree of variation between the packages offered in the 21 participating counties—ranging from basic to comprehensive coverage—depending on the population demographics, funding sources, and type of providers participating in each community.

Pregnant Women

States are very much aware of potential health and financial consequences that pregnant women face when they do not receive adequate pre- and post-natal care, as well as the negative impact it has on newborns. Moreover, research indicates that it is critical to engage mothers in the delivery system in order to ensure continued coverage for their children. Fortunately, HIFA has made it easier for states to reach out to pregnant women.

Colorado will expand coverage to 13,000 uninsured pregnant women at or below 185 percent FPL through its HIFA waiver, which was approved in September 2002. Like other HIFA states, Colorado will spend unused SCHIP funds to provide a benefit package similar to that available in the insurance market.

Michigan and Utah also included pregnant women in their expansion groups. In its now-halted expansion plan, Michigan hoped to broaden its coverage of pregnant women under full Medicaid from 186 to 200 percent FPL. Utah's expansion will provide Medicaid coverage to 150 high-risk pregnant women whose incomes exceed the state's eligibility limit.

State Efforts to Lower Drug Costs

Pharmaceuticals continued to account for a large portion of health care costs in 2002, with spending on prescription drugs outpacing that associated with any other component of health care. According to the Urban Institute, Medicaid payments for outpatient pharmaceuticals rose over 16 percent annually between 1990 and 2000, from $4.8 to $21 billion, and that trend is likely to continue well into the next decade. States pursued a range of innovative pharmaceutical cost-containment efforts last year, including making use of the newly available Pharmacy Plus waivers and developing formularies based on evidence-based research.

New Flexibility Through Pharmacy Plus

In January 2002, the Bush administration introduced the Pharmacy Plus 1115 waiver program to help states reduce the strain on their Medicaid budgets caused by the absence of a Medicare prescription drug benefit. Pharmacy Plus allows states to extend pharmacy coverage to certain low-income elderly and disabled individuals who do not qualify for Medicaid. It also gives states flexibility to design pharmacy benefits packages for demonstration populations that may differ from those provided in the Medicaid state plan. As of November 1, five states have been granted Pharmacy Plus waivers: Illinois, South Carolina, Florida, Wisconsin, and Maryland,[1] and at least seven others have applications pending, according to CMS.

Under a Pharmacy Plus demonstration program, a state may extend prescription and over-the-counter drug coverage to Medicare beneficiaries or people with disabilities who are not eligible for full Medicaid benefits and have incomes below 200 percent of the federal poverty level (FPL). Like other 1115 waivers, Pharmacy Plus projects must be budget neutral to the federal government and must extend over a period of five years.

The waiver demonstrations are also required to ensure that individuals have access to primary care services. This access might include referring patients to federally qualified health centers, providing a primary care benefit package, or coordinating care through a contracted pharmacy benefits manager. To satisfy this requirement, Illinois, South Carolina, and Wisconsin provide drug utilization review; Florida connects participating individuals to primary care providers.

The financing for Pharmacy Plus waivers differs from that of 1115 waivers in that the state is responsible for ensuring budget neutrality—that is, that the costs of the demonstration do not exceed what would have been spent if the expansion had not been done—for not only the expansion population targeted through the waiver, but for all elderly individuals covered under Medicaid. In other words, the waiver sets a global Medicaid spending cap on all services for all Medicaid beneficiaries aged 65 or older throughout the waiver period, including the newly eligible. Once the state exceeds the cap, the federal government will no longer provide a match and thus all services must be paid with state-only funds.

This financing is based on the theory that providing a drug benefit will lead to a healthier elderly population that is less likely to "spend down" into Medicaid, or spend their income on managing their medical conditions to the point where they become Medicaid eligible. But some states have expressed concern that this new approach toward budget neutrality will leave their Medicaid budgets at significant risk. Aside from states' obvious concern that they are now financially liable for a greater proportion of beneficiaries than they would be otherwise, they are worried because pharmaceutical costs are skyrocketing and coverage of the elderly currently constitutes about 70 percent of total Medicaid spending. "The budget neutrality requirement of Pharmacy Plus waivers is not just about prescription drugs," said one participant at a briefing on the waivers held by the National Health Policy Forum. "It's also about what happens to Medicaid budgets overall when states serve a growing elderly population."

1 *Technically, Maryland's program is a modification to its existing 1115 program and not a Pharmacy Plus waiver. Because their program so closely resembles a Pharmacy Plus demonstration, Maryland is included in this discussion.*

State Pharmacy Plus Demonstrations

Program	Previous Rx Program?	Eligibility	Cost Sharing	Benefits
Illinois "Circuit Breaker"	Yes	200 percent FPL Adults over 65	$5 enrollment (<100 percent FPL) $25 enrollment fee (>100 percent FPL) $3 co-payment (> 100 percent FPL) State covers up to $1,750/year (after cap, state covers 80 percent, individual 20 percent)	Medicaid Rx
Florida Silver Saver	Yes	120 percent FPL Medicare only	$2 to $15 co-payment $160/month maximum	Medicaid Rx
Wisconsin Senior Care	No	200 percent FPL Non-Medicaid eligible, except Qualified Medicare Beneficiaries (QMBs)	$20 enrollment fee $5 to $15 co-payment $500 annual maximum (only 160-200 percent FPL)	Medicaid Rx
South Carolina SilverXCard	Yes	200 percent FPL Adults over 65	$500 deductible ($10-$21 copay after deductible is met)	Medicaid Rx; some OTC drugs with doctor's order
Maryland Pharmacy Discount Program	Yes	116 percent FPL Non-Medicaid QMBs (Discount program for Medicare beneficiaries to 175 percent FPL)	$5 co-payment (Enrollees in discount program pay 65 percent; state pays 35 percent)	Medicaid Rx

The Pharmacy Plus program allows states to fold their previous state-only funded prescription drug programs into the new waiver. If a state chooses to do that, however, it must build on the program rather than simply shift all of its costs to Medicaid. For example, South Carolina covered individuals up to 175 percent FPL using solely state funds through its SeniorCare program before seeking a Pharmacy Plus waiver. The state's demonstration includes those previously covered, as well as those up to 200 percent FPL. Florida's previously state-only funded Prescription Assistance Program for Seniors has been entirely replaced by the Pharmacy Plus demonstration. The monthly benefit for the program, however, was raised from $80 to $160 per month with the receipt of the waiver.

Under the Pharmacy Plus programs in Illinois, South Carolina, and Wisconsin, seniors are eligible up to the 200 percent FPL ceiling (the former two programs apply to all seniors over age 65, while the latter pertains only to non-Medicaid-eligible older adults, except for Qualified Medicare Beneficiaries [QMBs]). Florida's Silver Saver program capped its eligibility at 120 percent FPL for Medicare-only beneficiaries. Maryland's Pharmacy Discount Program is eligible to QMBs up to 100 percent FPL and no more than $4,000 in assets for an individual, and to those eligible for its current Pharmacy Assistance Program eligibility (116 percent FPL for individuals, with $3,750 in assets, and 97 percent FPL for couples, with $4,500 in assets).[2]

2 *Maryland's program also includes a discount (65 percent coinsurance) for Medicare eligibles at or below 175 percent FPL.*

All of the programs cover drugs that are part of the Medicaid state plan. South Carolina's SilverXCard program also reimburses beneficiaries for over-the-counter medications with a doctor's written order. The structure and levels of patient cost-sharing also vary by state (See table on p. 25 for more details).

Pharmacy Plus reduced the strain on state Medicaid budgets caused by the absence of a prescription drug benefit.

The Pharmacy Plus waiver template gives states flexibility to decide whether to extend eligibility to individuals with private insurance. South Carolina elected to exclude individuals with private insurance from its program. The Illinois program, however, reimburses those with private insurance with a monthly rebate check for premiums, deductibles, and co-payments related to prescription drug coverage. Florida's program rebates private insurers, and both Florida's and Wisconsin's programs provide wraparound pharmaceutical coverage to ensure that beneficiaries with private coverage have pharmacy benefits comparable to those offered through the state Medicaid program.

Preferred Drug Lists

Over the past year, several states have adopted evidence-based strategies to ensure that Medicaid patients are provided with the most cost-effective drug therapies. In developing their preferred drug lists (PDLs), states typically use a team of researchers or practitioners to evaluate the medical evidence on various medications for common conditions. They use reported clinical findings to determine which drugs are most clinically effective. Drugs that are low cost and are proven to be effective are included on the PDL, while drugs not included on the PDL become subject to prior authorization, which typically reduces their use substantially.

Oregon's Practitioner-Managed Prescription Drug Plan

In 2001, Oregon began creating an evidence-based formulary for the fee-for-service portion of its Medicaid program. The formulary was established as part of a bill (SB819b) passed in 2001 by the state legislature. The Oregon Health Resource Commission is responsible for assessing the effectiveness of about 25 classes of prescription drugs over the next two years.

Under the plan, the Commission selects the formulary's reference drugs based on which are the most clinically effective ones in their class. Medicaid will cover up to the price of the reference medication in a given class regardless of which agent a physician prescribes. The plan calls for patient cost sharing in the amount of the cost difference between the reference and nonreference agents when patients choose the more expensive nonreference drugs.

Throughout 2002, the Oregon Commission continued to make progress on the plan. This past summer, they implemented recommendations on four classes of drugs: proton-pump inhibitors, long-acting opioids, statins, and non-steroidal anti-inflammatories. In many cases, the Commission was unable to find evidence that one drug was more effective than any of the others in its class, so they based their assessment on the drugs that were least expensive. They then placed those drugs, as well as all others within 105 percent of their cost, on their reference list.

The list is intended only as a guide for physicians; doctors can still prescribe other drugs without prior authorization by writing "DNS" or "Do Not Substitute" on the prescription. "Formulary is a swear word in Oregon, and prior authorization is not far behind," says John Santa, M.D., of the Office for Oregon Health Plan Policy and Research, speaking about the state's latitude in allowing doctors to make drug substitutions if needed. "Therefore, we are testing the nation's most liberal exception policy." Santa presented information on Oregon's Medicaid prescription drug plan at the State Coverage Initiatives July 2002 national meeting for state officials.

The Commission recently completed assessing three additional classes of drugs—angiotensin-converting enzyme inhibitors, triptans for migraine, and estrogens—and released recommendations on those agents in December 2002. They will begin work soon on a final group of drug classes, including muscle relaxants, oral hypoglycemics, calcium channel blockers, beta-blockers, and medications for urinary incontinence.

At the end of September, the pharmaceutical companies Purdue Pharma and Purdue Frederick filed a lawsuit in Oregon state court objecting to the fact that two opioids produced by Purdue Pharma—Oxycontin and MsContin—were left off of Oregon's formulary. The lawsuit also contended that the administrative rule allowing the state to include drugs that cost 105 percent of the price of the reference drug violates the legislative intent to ensure that patients receive the most effective drug. The Oregon Court of Appeals will hear the case at a later date.

Michigan's Pharmaceutical Best Practices Initiative

Michigan made progress with a similar evidence-based program in 2002. The state appointed a Pharmaceutical and Therapeutic review board to determine reference drugs for 40 classes of medications. The reference medications, as well as all other drugs priced below them, are placed on a PDL. Pharmaceutical companies are allowed to have their drugs added to the list if they lower their prices to match those of selected drugs. If doctors want to prescribe a drug not included on the list, they must receive prior authorization to do so. In February 2002, the program was phased-in.

According to Carol Isaacs, Deputy Director of Health Legislation and Policy Development in the Michigan Department of Community Health, the program has saved the state close to $800,000 per week for Medicaid fee-for-service recipients since its implementation. In addition, the cost of an average claim has been reduced by $3.60.

The state has been confronted with legal challenges to its program throughout the past year. Currently, both state and federal suits are pending. In one lawsuit, the Pharmaceutical Research and Manufacturers of America contends that Michigan does not have the legal authority to coerce drug manufacturers to pay rebates beyond those authorized by the federal Medicaid Act.

However, in a September 18 letter from CMS to state Medicaid directors, Dennis Smith, Director of the Center for Medicaid and State Operations, assured Michigan and other states with similar programs that federal Medicaid law does, in fact, allow them to use prior authorization to encourage drug manufacturers to participate in state Medicaid programs. Moreover, on December 16, a Michigan Court of Appeals unanimously ruled that the state's preferred prescription drug program is legal.

Other State Efforts

Jury Still Out on the Cost Savings of the Florida Formulary

In July 2001, Florida's Medicaid program phased in an innovative 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 get their drugs on the list, 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. Both Pfizer and Bristol Meyers Squibb have opted to provide such programs for chronically ill patients; the Bristol Meyers Squibb program is projected to save the state $16.3 million—and the Pfizer one $30 million—over the next two years.

Last year, spending on prescription drugs outpaced that associated with all other components of health care.

In October 2002, the Pfizer Health Solutions released interim data on the Pfizer program indicating that, to date, it has resulted in a significant improvement in a variety of clinical measures. For example, prior to the program, 21 percent of Medicaid beneficiaries with diabetes did not monitor their blood sugar levels, compared with only 5 percent among those who were assessed after disease management was implemented. Although these findings are promising, it is still unclear whether they will translate into sufficient cost savings.

Washington Offers Mail-Order Pharmacy

In September 2002, the state of Washington began offering a mail-order pharmacy benefit to its Medicaid participants. The state's Department of Social and Health Services (DSHS) created the program because it was concerned that some pharmacies may refuse to serve Medicaid patients due to state budget cuts to pharmacy reimbursement rates. As of August 1, the state reduced payments from 89 percent to 86 percent for brand-name drugs and from 89 percent to 50 percent for generics. Many pharmacies in rural counties have already stopped filling prescriptions for Medicaid beneficiaries in response to the cuts. The mail-order service is available statewide. The DSHS is also providing transportation to some participating pharmacies.

Insurance Market Reforms

Just as the states strived to preserve coverage through public programs in 2002, they also struggled to maintain the reforms that they had implemented within the past decade to make coverage more affordable to people at high medical risk. Within the last several years, many carriers have exited state insurance markets in response to low market shares and, possibly, state regulations and the cost of mandated benefits.

It's not clear that state market reforms made in the early 1990s are the most important factor, or even a significant factor, contributing to carriers leaving. Nevertheless, insurers have responded to current trends by demanding less state regulation and greater use of high-risk pools. In 2002, some states also built partnerships with the private sector to make individual and small-group coverage more affordable. Others developed plans to use new federal funds encouraging market-driven strategies through the Trade Act of 2002 (see box on p. 30).

Healthy New York Gains Momentum

January 2003 marked the two-year anniversary of Healthy New York—New York state's health insurance program for workers in small firms and low-income groups who lack access to affordable coverage. Although the program got off to a slow start in year one, it picked up the pace this past spring and has maintained a 13 to 14 percent increase in enrollment per month since then. As of late November, enrollment in the program was more than 20,000.

"As with any government program, it has taken time for the public to become familiar with Healthy New York and to get comfortable with it," says New York Insurance Department Superintendent Gregory V. Serio. "But if imitation is the sincerest form of flattery, we must be doing pretty well," he says. "Private carriers have been rolling out more and more competitive packages since Healthy New York has been implemented."

Healthy New York was created as part of New York's Health Care Reform Act (HCRA) of 2000 to extend coverage to more working uninsured. Under the program, all HMOs in New York state must offer a state-subsidized health insurance benefits package for eligible businesses with 50 or fewer employers, working individuals, and sole proprietors. Although some carriers had feared initially that the program would become an individual pool, so far the state has seen a balanced mix of enrollees. "Sole proprietors and small employers make up about half of enrollees, and individuals comprise the remainder," Serio says.

Healthy New York is intended to keep costs down through high hospital co-payments ($500 per stay) and a pared-down benefits package, which includes no mental health coverage and a limited prescription drug benefit. The program also 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.

According to Katherine Swartz, professor of health policy and economics at the Harvard School of Public Health, the stop-loss initiative is the most important aspect of the program. "By having the government act as reinsurer," she says, "the state takes responsibility for very high cost individuals"—the group that insurers feel most nervous about taking on. "No other state has done this in quite the same way." (Swartz wrote a report on Healthy New York for the Commonwealth Fund in November 2001; it is available at www.cmwf.org/programs/newyork/swartz_healthyny_bn_484.asp.)

Superintendent Serio agrees, stating, "we've taken some of the pressure off of the provider and the community." Through the stop-loss initiative, "we've had a big impact in terms of educating the health insurance marketplace to distribute risk upstream [i.e., at the state level] rather than downstream [at the provider and patient level]." Several other states appear to be following New York's lead: Idaho, Oregon, South Dakota, and Vermont are currently exploring similar reinsurance mechanisms as part of State Planning Grants through the Health Resources and Services Administration (HRSA; for more on HRSA, see p. 35).

Since Healthy New York was implemented, health plans have experienced drops in premiums by as much as 5 percent, according to Serio. "This indicates that adverse selection has not been occurring," says Raymond Sweeney, Executive Vice President of the Healthcare Association of New York State. In other words, medical claims costs through the program have come in below what carriers had expected, suggesting that its target population—the working uninsured—are healthier and less cost-sensitive than the state had originally predicted.

As a result of these promising findings, the state is currently reviewing bringing the stop-loss corridor down even more, says Serio, possibly setting the low end at $5,000 or $10,000. The insurance department plans to make a decision on this by January 2003.

Swartz says the program has also succeeded in keeping its premiums down relative to the private market in New York. "Healthy New York offers premiums that are about 30 to 50 percent lower than those typically available in the self-pay market," she says, "and about 15 to 25 percent less than those available in the small-group market."

However, Swartz points out that—even with lower premiums—the program is expensive for some target beneficiaries, accounting for more than 5 percent of before-tax income for most individuals and many low-income employees in small firms. Further analyses are needed to learn which income groups are purchasing coverage through the program, and whether the state is reaching all of those it intended to reach. "You have to unravel where the 20,000 enrollees came from," says Sweeney. "Are people concentrated at the higher end of the income scale because the package is still not affordable to those at the lower end?"

According to Swartz, one of the reasons that the program struggled with under-enrollment in its first year was a lack of marketing and publicity. Compared with some of the other coverage initiatives implemented under HCRA, including the Family Health Plus and Child Health Plus expansions, Healthy New York was not as heavily promoted on public billboards and advertisements, even though it was targeted at some of the same low-income groups.

A second major challenge the state faced in enrolling small employers is that it is often difficult to find these firms before they go out of business. Healthy New York's crowd-out requirements for businesses that offer insurance preclude enrollment for one year, Swartz explains, and many firms fail within their second year. "When critics say that Healthy New York is not succeeding because of under-enrollment, they often are not thinking through the enormous difficulties that are associated with publicizing this program and finding eligible firms," she says.

According to Serio, the crowd-out requirements that were legislated into Healthy New York have been the greatest impediment to enrollment so far. In the coming year, the insurance department will address this issue by modifying or eliminating some of those provisions, including changing the waiting period for eligible individuals and businesses from 12 to 6 months. Serio says the state has also taken steps to improve publicity for the program, including launching an aggressive radio campaign in 2002, working with local Chambers of Commerce to promote the program, and making regular updates to the Healthy New York Web site (www.healthynewyork.org).

Finally, over the next year, the state plans to authorize a second benefits package that will provide flexibility for enrollees to choose their own benefits. The new package will be offered at a lower premium because it will not include prescription drug coverage.

The Trade Act of 2002: Tax Credits, High-Risk Pools, and Coverage Grants

Although there was a dearth of federal action on the uninsured last year, the Trade Act of 2002 could provide some relief to states that have been affected by trade, and may serve as a model for market-driven coverage strategies in the future. Signed on August 6, 2002, the legislation gives the president increased latitude to negotiate trade deals with other countries and provides a host of benefits, such as cash assistance and job training, to workers harmed by free trade. The expanded system of Trade Adjustment Assistance (TAA) provides tax credits to purchase health insurance, two new grant streams for state high-risk pools, and additional federal resources to help states preserve coverage. Preliminary estimates indicate that several hundred thousand workers displaced by foreign competition and certain retirees could be eligible for assistance.

"Many in Washington view these TAA credits as a test of health insurance tax credits for the uninsured in general," explains Stan Dorn, senior policy analyst at the Economic and Social Research Institute. "Displaced workers who lost their jobs and health insurance because of free trade need this legislation to succeed, but the stakes go far beyond this relatively small group of uninsured."

Tax Credits

The tax credits are similar to the Earned Income Tax Credit (EITC) in that they are fully refundable. In other words, households with no tax liability receive the credits in full. The main beneficiaries are workers certified by the Department of Labor as losing employment because of foreign competition and retirees aged 55 to 64 who receive pension payments from the Pension Benefit Guarantee Corporation. Qualifying taxpayers can claim these credits to reimburse health insurance costs incurred in December 2002 or later.

However, beginning in August 2003, eligible individuals can give insurers advance payment of their health insurance credit instead of waiting until they file a tax return to claim it. The 65 percent tax credit may be used for individual or family coverage to purchase "qualified" health insurance, including: COBRA coverage, coverage under a spouse's employment-based plan if it pays less than 50 percent of the premium, and policies in the individual market if the worker received individual coverage during the 30 days prior to job loss. Also, in states that elect to offer coverage to TAA recipients, individuals may use the credits to buy into state-based insurance, such as coverage made available through state contracts with group or individual health plans (including qualified high-risk plans).

"This new program's success or failure may hinge, in large part, on states' willingness to give displaced workers a place to take their tax credits," says Dorn. "Fortunately, TAA legislation offers the new resources and flexibility that will be needed for most states to take on new responsibilities in the current, horrendous fiscal climate."

High-Risk Pools

The Trade Act of 2002 appropriates funds for state high-risk pools—including both seed and matching grants. Legislation allocated $20 million for start-up grants for states without qualifying high-risk pools. States could receive up to $1 million by the end of Fiscal Year (FY) 2004 if they did not have a pool set up by August 6, 2002. The funds may be used to help any beneficiaries (not just those affected by trade), but for TAA eligibles, the pool must not impose pre-existing condition limits and must provide premiums rates and covered benefits consistent with the National Association of Insurance Commissioners' model health plan. The Center for Medicare and Medicaid Services, which will administer the grants, estimates that 27 states are eligible for the seed grants, 20 of which do not currently operate a high-risk pool.

"This is the first time that the federal government has recognized the need to assist the funding of guaranteed access pools," says Bruce Abbe, vice president of public affairs for Communicating for Agriculture, a rural advocacy group. "We're encouraged that the issue of covering high-risk individuals is receiving broader awareness in Washington." Abbe says that, moving forward, his group will continue to examine the biggest ongoing problem with these pools—lack of adequate funding.

The second stream of high-risk pool funds—$80 million over FY 2003 and 2004—may pay for up to 50 percent of the losses of operational pools. Given the expense of covering high-risk individuals (premiums typically cover 50 percent of pool costs), these subsidies may allow states to serve more high-risk individuals or to provide greater benefits.

"With total 2001 losses of over $400 million for operating pools, these funds will help but there are still considerable funding issues," says Abbe. To be eligible, pools must offer two or more coverage options and must have premiums set at no more than 150 percent of the premium for comparable standard risk rates.

Interim Grants and System-Building Funds

Finally, the Trade Act adds two new funding streams to the existing National Emergency Grant program run out of the Department of Labor (DOL). The first pool, $200 million over three years, provides for interim health insurance coverage and other assistance for TAA recipients. The funds are intended as an interim stop-gap while advance payment of tax credits is operationalized. This money may be used to pay for TAA health insurance premiums or other assistance and support for displaced workers. Grant funds may supplement, but not supplant, existing state and local coverage resources and may not be used as state match to draw down federal resources. As of December 2002, the DOL has yet to provide further guidance on how these funds can be used.

A second pool of funds provides $310 million over six years for eligible individuals enrolled in health coverage. The grants may also fund start-up and other administrative costs on behalf of TAA recipients, such as eligibility verification and notification, outreach, processing, and data management. The DOL has invited state workforce agencies to apply for modest start-up grants.

The State Coverage Initiatives program will publish an issue brief on these new opportunities for states in early 2003. Please check www.statecoverage.net/ for more information.

Both state officials and outside observers are encouraged by Healthy New York's recent surge in growth and success in keeping health insurance premiums down, although they acknowledge that the program is a work in progress. "The program has exceeded our expectations and continues to exceed them," says Serio. "We're always keeping an eye toward the future, though."

Enrollment Dwindles in New Jersey's Non-Group Market

A decade after New Jersey implemented some of the most aggressive insurance market reforms in the country, enrollment in the state's non-group market continues to decrease at a steady and severe pace. The decline has been about 3 percent per quarter since 1996, when enrollment peaked at roughly 186,000 covered individuals. According to the state's most recent 2002 figures, only about 85,000 remain in the non-group market today.

In the early 1990s, few carriers in New Jersey offered individual coverage to people who lacked employer-sponsored health benefits. To address this situation, the New Jersey legislature implemented policy changes called the Individual Health Coverage Program (IHCP). The IHCP was intended to guarantee issue of health coverage under standard health benefit plans for individuals regardless of age or health status.

Some features of the program include guaranteed issue and renewal, restricted waiting periods for pre-existing conditions, mandated pure community rating, and a requirement for carriers to achieve a medical loss ratio of at least 75 percent. In other words, insurers must set a premium low enough that at least 75 cents of each dollar collected is spent on health care claims. The IHCP also includes a "pay or play" mandate, which requires carriers to either participate in the individual market or pay an assessment based on their premium volume in the group market.

After initially stabilizing New Jersey's faltering market, the IHCP has experienced steadily rising premiums in addition to declining enrollment. Whether these changes were caused by the IHCP regulations is an area of intense interest for both state policymakers and researchers. "That's the $64,000 question," says Joel Cantor, Sc.D., principal investigator of a grant project examining the IHCP and member of the State Coverage Initiatives National Advisory Committee. Because New Jersey's reforms are so comprehensive, he says, they provide a good test of the whole concept of inclusive regulations.

"Early on, many saw the IHCP as a regulatory success story," Cantor says. "But today people fear that the market is experiencing an adverse selection death spiral, in which open enrollment and community rating attract high-risk individuals, leading to higher premiums and the exit of lower-risk groups."

According to Cantor, New Jersey's decline in non-group enrollment may have been exacerbated by the strong economy that has dominated the last decade. Until recently, he explains, the labor market has been tight in the state. A good economy usually leads more people to get jobs and more employers to offer benefits. Thus, as a greater number of individuals move into the group market, fewer and perhaps higher risk people are left in the individual market. Despite the recent worsening of the economy, non-group enrollment in New Jersey has not shown any signs of leveling off—at least as of about six months ago, Cantor says.

Cantor's research will examine the extent to which economic factors and market regulations have contributed to rising premiums and declining enrollment. He expects to have preliminary results by spring 2003.

The state is also hoping to shed more light on the potential effects of its reforms through New Jersey's HRSA state planning grant, which was awarded in spring 2002. As part of its grant project, state officials will convene an expert panel in April 2003 to synthesize the emerging body of research on state insurance market regulations and draw implications for policy.

At this point, all the reforms of the original IHCP package have remained in place. It's not clear whether New Jersey will make any changes to the IHCP in the future, but, if it does, the state will likely avoid making severe rollbacks. "The IHCP has served, and continues to serve, those with chronic conditions relatively well," says Ward Sanders, executive director of the IHCP board in the New Jersey Department of Banking and Insurance.

"The challenge for policymakers is to encourage younger, healthier persons to enter New Jersey's individual market without chipping away at the gains we've made for those with health conditions." Sanders envisions that modifications to issuance and rating rules may be part of future policy discussions about how to revive the state's market.

Once more is known about the cause of New Jersey's dwindling non-group market, the state's experience may have implications for other states that have made broad individual market regulations, such as Maryland, New York, and Vermont.

Colorado Experiences Decline in Small-Group Market

Signifying a trend seen in many states across the country, Colorado's insurance department announced last year that the state's small-group market experienced a significant drop that many fear indicates an adverse selection death spiral. In 2001, enrollment dropped by 81,845. The remaining number of individuals covered in the small-group market is the lowest since the department started monitoring trends. Colorado is one of a handful of states that offers limited guaranteed issue to self-employed business groups of one. For more information, visit www.dora.state.co.us/insurance/pb/sga043002.pdf.

TennCare Adopts New Policy on Uninsurables

In May 2002, Tennessee received federal approval for an 1115 waiver that will allow it to limit enrollment in TennCare—the state's 1115 expansion program—among uninsurable individuals and implement a new definition of "uninsurability." (For information on other aspects of this waiver, including the state's plan to restructure benefits packages, see story on p. 13.)

Previously, uninsurable individuals who were eligible for TennCare could enter the program at any point. Under the new waiver, uninsurable individuals above the federal poverty level (FPL) will be permitted to enroll only once per year; those below the FPL remain free to enroll whenever they wish.

The waiver will also enable the state to use more stringent criteria in assessing uninsurability. As of this summer, insurance department officials began using their own medical underwriter to review medical records and determine whether applicants who claim to be uninsurable are truly incapable of obtaining private coverage. In the past, the state considered a turndown letter from one insurance company as adequate proof of uninsurability.

By reclassifying uninsurability, the state hopes to decrease the number of people entering TennCare who have access to private insurance. "In the past, some people actually shopped around for turndown letters from insurance companies so that they could enter TennCare," says TennCare spokeswoman Lola Potter. "People were gaming the system."

Nevertheless, some advocates and others have expressed concern because, combined with other waiver changes, the new definition of uninsurability may result in as many as 180,000 individuals losing coverage. Moreover, in a legislative briefing released in October 2001, Tennessee's Comptroller's Office said that those dropped from the program to save money may actually drive health care costs by obtaining services at the most expensive source: emergency rooms.

As Potter points out, however, the waiver stipulates that the state will pay $110 million to the hospitals that have the most reimbursement losses from TennCare. This will mitigate the extent to which these institutions will have to shift costs to private payers.

In July 2002, TennCare entered an 18-month stabilization period, during which the state has agreed to assume all risk for the program's beneficiaries. "One thing we've learned is that, where there is movement of lives, there is unpredictability in risk," Potter says. "A lot of people will be undergoing benefit changes as a result of our waiver, and we want to help managed care organizations adjust to that." After the stabilization period, managed care organizations will once again assume risk for enrollees.

Maryland Creates High-Risk Pool

Maryland passed legislation in its 2002 session to create the 31st high-risk pool in the country—the Maryland Health Insurance Plan. The pool is scheduled to become operational on July 1, 2003.

The pool will replace the state's "Substantial, Available, and Affordable Coverage" (SAAC) program. Under SAAC, individual carriers offer open enrollment twice yearly to individuals who have been turned down for private coverage, and in return the state offers the insurers a discount on their entire book of business. Maryland is the first state in recent years to transition from such a program—which is commonly referred to as an insurer-of-last-resort plan—to a high-risk pool.

According to Brenda Wilson, chief of managed care at the Maryland Insurance Commission, SAAC lost favor in recent years after one of the large HMOs in the state—FreeState Health Plan—withdrew from the individual market and cancelled its individual medically underwritten business. The two plans participating in SAAC, Optimum Choice and Aetna Health Plan, threatened to pull out of that program because they were concerned they would have to cover many of the cancelled enrollees.

At around the same time, the state reduced the discount it offered to SAAC carriers from 4 percent to 2 percent—a reduction from about $53 million to $26 million. "Because only a few thousand people were enrolled in the SAAC program," says Wilson, "it was a situation where the state was giving substantial funds to carriers and not getting much back." Ultimately, the state opted for a high-risk pool because SAAC carriers would not commit to remaining in the program.

Maryland is planning to offer the same comprehensive benefits package for the pool that was available through SAAC. The pool will be financed through an assessment on hospitals—a mechanism that makes sense for Maryland because it is an all-payer state. The state will also apply for a federal grant to help establish the pool through the Trade Act of 2002.

Premiums will be set between 110 and 150 percent of the standard rate. "We hope to offer lower deductibles," says Wilson, "but that's still to be determined." State officials have yet to decide on many other operational details for the pool, such as application and premium information and whether the state will impose a waiting period for pre-existing conditions.

States have responded to current trends by demanding less regulation and greater use of high-risk pools.

The pool will be available to Maryland residents who have been turned down for private coverage, have a chronic condition, or can only get coverage at rates higher than those available through the pool. Wilson says the pool offers several potential advantages over SAAC. "It will have more subsidization than SAAC, and that may make it more attractive premium-wise," she says. "Plus it's community-rated, which should make it appealing to an older and sicker population."

New Hampshire Implements Rollbacks, Opens Pool

In July 2002, New Hampshire implemented legislation to increase rating flexibility and repeal guaranteed issue in the state's individual insurance market. The state also opened a new high-risk pool, which was created as part of the same law.

The revised 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 non-smokers, and permits insurers to extend the waiting period for coverage of pre-existing conditions from 9 to 18 months.

New Hampshire's risk pool, called the New Hampshire Health Plan, offers benefits that are actuarially equivalent to those offered in the individual market. The law establishing the pool stipulates that it can never close and that premiums cannot exceed 200 percent of the average rate in the individual market. The pool is funded through an assessment on individual, group, and stop-loss insurer premiums.

The state created the pool and modified its rating rules in an effort to attract individual carriers back into the market after having experienced an insurer exodus coinciding with the passage of comprehensive market reforms in the early 1990s. New Hampshire has not evaluated whether the much higher allowable rates and waiting periods in the individual market have worsened the problem of uninsurance, especially for individuals with health problems.

According to Fred Potter, the Executive Director of the New Hampshire Health Plan, "It's too early to say conclusively how the regulations have impacted the individual market, but we believe that they are having their intended effect." Potter says that, since July, several individual carriers have re-entered the market, and rates have improved.

Enrollment in the pool is modest so far—only about 50 members—but this is largely an idiosyncrasy of the calendar, according to Potter. "Most major coverage packages start with the calendar year, so it wouldn't make sense for most people to enroll in a new plan in July [when the pool opened] after they're likely to have burned through their existing deductible." To date, most of the pool's enrollees are individuals who were rejected for coverage in the private market.

Potter says he expects to see more robust enrollment in the pool this January, and that the state will continue to monitor how it and the new rating rules affect the insurance market. "We're encouraged so far," he says. "Now we seem to have a real market with real competition."

Congress Appropriates Over $1 Million to Assist Low-Income Montanans

In 2002, Montana became the seventh state to offer a premium subsidy program for low-income enrollees in its high-risk pool—the Montana Comprehensive Health Association (MCHA). Montana Senate Bill 315 enabled MCHA to implement sliding-scale premiums for low-income individuals, provided that the pool obtained external funding to do so. The Association acquired the funds through a $1.25 million federal appropriation, which was granted by Congress in January 2002 as part of the No Child Left Behind Act (HR 1). The funds were awarded for a one-year demonstration project, after which the state will need to find other funding sources.

Launched in September 2002, the subsidy program is available to individuals at or below 150 percent FPL. "We've already had over 100 enrollees," says Claudia Clifford, senior policy advisor to the Montana insurance commissioner. "Interestingly, many are people who are already enrolled in the pool—which is indicative of the number of low-income individuals who are willing to pay relatively high premiums to protect themselves medically and financially."

The subsidy was originally designed to cover 50 percent of health insurance premiums during the waiting period for pre-existing conditions and 40 percent after the period is satisfied. But to attract more uninsured and uninsurable individuals, MCHA will increase the subsidy to 65 percent and 55 percent, respectively, starting on January 1, 2003. For the subsidized program, the waiting period was shortened from 12 to 4 months. There will be a deductible carryover for individuals who satisfy the pre-existing waiting period during the initial four-month start-up period.

Clifford says there are several possible ways that the state might procure continued funding after the federal appropriation ends. "We're looking at federal TAA [Trade Adjustment Assistance] funds appropriated for high-risk pools, a 75 percent refundable tax credit, or possibly direct state appropriations."

State Planning and Demonstration Efforts

HRSA Grants Provide State-Level Insight into the Uninsured

Over the past three years, more than half the states in the country have received one-year planning grants through the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services (HHS). In total, the federal government awarded $35 million to 11 states in September 2000, nine states in March 2001, and 11 states and one U.S. territory in July 2002 (see map on p. 39). Under HRSA's State Planning Grant (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.

The changing experiences of the HRSA grantees from the time the first awards were made until now reflect how states have altered their approach to the uninsured in the wake of an economic reversal. States that were awarded the first round of grants undertook their projects during one of the nation's longest periods of sustained economic growth, while current grantees are struggling to develop plans in the midst of a dismal economy characterized by falling revenues and budget-breaking expenditures.

Correspondingly, the immediate focus of the HRSA grants shifted from identifying options to broaden health insurance coverage in 2000 to finding ways to maintain current coverage levels through incremental or low-cost/no-cost options in 2001 and 2002. Expanding coverage has become a long-term goal.

Through the SPG program, each state was awarded about $1 million, which they used to conduct qualitative and quantitative state-level research of their uninsured, including household and employer surveys, focus groups, and interviews with key constituents, such as local legislators and insurance industry leaders. At the conclusion of the grant projects, the states had to submit a report to the Secretary of HHS summarizing their work and findings. Under contract with HRSA, AcademyHealth produced in December 2001 a consolidated interim report to the Secretary, which summarizes the experiences of the round I and II grantees. A final report is scheduled to be released in spring 2003. The third group of grantees is anticipated to complete their grants by June 30, 2003.

Methods and Findings from the First 20 Grantees

HRSA's round I and II SPG states vary tremendously in their geographic, financial, and political landscapes. For example, there is a $15,000 difference between the states with the highest and lowest median incomes (Connecticut and Arkansas, respectively), and the percentage of uninsured ranges from 8 percent (Minnesota) to 23.3 percent (Texas), according to 2000 Current Population Survey (CPS) data.

The planning grants were led by various agencies within each state, including departments of health and human services, health policy offices, departments of insurance, and governors' offices. The states created 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 stakeholders had ever had to sit down at the same table.

Most of the SPG grantees conducted state-level surveys to assess their uninsured, insured, and employer coverage rates. Although states already have access to coverage data through national instruments such as the CPS, many preferred creating their own surveys in order to understand better issues specific to their state. By using their own surveys, states can draw information about relevant racial and geographic subpopulations, for example, or the breakdown of uninsured in rural versus urban areas. Seventeen of the first 20 grantees funded household surveys, and 12 conducted employer surveys or expanded the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) to assess state-level issues.

The states also engaged in qualitative research to learn about the values, attitudes, and behavior of employers, those who lack coverage, and those with public and private coverage. Altogether, 15 of the first 20 states conducted focus groups with low-income uninsured

and target populations, employers, or other stakeholders (e.g., unions, providers, business representatives, chambers of commerce, insurers, brokers). Several states organized large forums, such as regional seminars, policy summits, and town meetings, in order to gather stakeholder input into the problem and to build political consensus around potential expansion options.

The states' research revealed a number of valuable findings that helped them put a face on today's uninsured and dispel myths about them. Specifically, they learned that:

- Significant numbers of those currently without coverage have incomes above 250 percent of the federal poverty level (FPL). Twenty-nine percent of those in Texas, for example, and 22 percent of those in Washington fell within this income range.
- More than 70 percent of the uninsured are employed at least part-time.
- Many uninsured either don't know they are eligible for public programs or have faced other barriers to enrollment.
- Among the working uninsured, many were not eligible for their employers' insurance or could not afford the cost-sharing or premium requirements.
- The most common reason for lack of coverage among those aged 18 to 25 was that these individuals did not believe they needed health insurance.

Once their SPG grants were completed, the project teams presented their final policy recommendations to HHS Secretary Tommy Thompson. In light of the states' worsening economies, many of the 20 initial grantees proposed resourceful approaches that could be implemented in the context of severely limited budgets. One popular strategy was to plan low-cost or no-cost options such as simplifying application requirements to reach out to those eligible but not enrolled in public programs or launching educational efforts to consumers and small employers to clarify insurance options, costs, and benefits available in their state. Another incremental approach that states found appealing was to target specific subpopulations for expansions, including childless adults, parents of State Children's Health Insurance Program (SCHIP)-eligible or enrolled children, minorities, the working uninsured, or the temporarily unemployed.

A number of grantees have also looked at incremental approaches that make coverage more affordable in the small group and individual insurance markets—such as pooling, reinsurance mechanisms, and eliminating the offering of mandated benefits.

Across the board, the state grantees gravitated away from pure public program expansions toward strategies that build on employer-sponsored coverage. In developing their policy options, most states homed in on individuals at or below 200 percent FPL—a group that includes many low-wage workers—and proposed reaching them through public-private partnerships; these included plans to create premium-assistance programs, provide direct or indirect employer subsidies, establish purchasing pools, and offer working individuals tax credits for the purchase of employer coverage.

The states' plans also indicate their willingness to partner with the federal government and use the new flexibility offered them through the Health Insurance Flexibility and Accountability (HIFA) initiative. From the states' perspective, HIFA has been an important tool enabling states to control costs while expanding coverage—by developing non-entitlement strategies, for example, or creating commercial-like benefits populations for expansion groups. (For more on HIFA, see p. 13.)

As part of their grant projects, the states were asked to make recommendations to HHS as to how the federal government can help states better address the uninsured. Among the recommendations that topped the states' lists were requests for a Medicare prescription drug benefit, which would allow states to redirect the money they are currently spending on pharmaceutical assistance toward expansion efforts; full deductibility for health insurance; and additional flexibility to create public-private partnerships. The states

HRSA Grants Spur State Innovation

Although most of the first 20 State Planning Grant (SPG) states focused on developing incremental approaches designed to maintain current coverage levels, a few states used their funds to examine more comprehensive coverage strategies.

Iowa, a round I grantee, explored a creative coverage approach that would provide a kind of safety net for the insured. The state's idea was to create a Health Security Trust, into which every insured Iowan would pay a small amount each month. The money would be used to expand public programs to people in the event that they lost coverage. In other words, paying into the trust would guarantee residents health insurance, which would be provided on a sliding fee scale based on current income level.

Because such a high number of Iowans are insured (about 90 percent), one of the project team's guiding principles was to develop options that work for the insured as well as the uninsured. In surveys and focus groups, many respondents were concerned that they might lose their coverage if the economy worsened, or that they would quickly go through their lifetime coverage limits because of a catastrophic illness, for example.

According to Anne Kinzel, Iowa's SPG project director, the plan has been tabled in light of the economic downturn. Moreover, despite early enthusiasm for the trust, some stakeholders have raised questions about how to determine eligibility and link the trust to existing public programs. Like most states, Iowa is now focused on maintaining the coverage that's already in place. The state is revisiting its focus group and survey research as well as other policy options to find approaches that more closely align with today's budgetary realities.

Still, Kinzel says the project helped Iowa learn about the attitudes of its citizens. "If nothing else, we have a better understanding of the beliefs of Iowans about the uninsured," she says. "Given that the vast majority of our citizens are insured, it's been very important to assess how far they are willing to extend themselves for others."

Using its round II Health Resources and Services Administration (HRSA) funds, California's SPG team created the Health Care Options Project. The state's approach was unique in that it generated policy options by issuing a request for proposal (RFP) for creating universal coverage in the state.

"In this debate there have been so many people on all different sides, so we thought the best way to proceed in a neutral manner was to do an RFP," says Genie Chough, California Health and Human Services assistant secretary.

The project, managed by the California Health and Human Services Agency, offered bidders $20,000 to support development of up to 10 proposals; the state ultimately funded nine of these. California contracted with Lewin and Associates to do an analysis of the nine options, comparing benefits, funding mechanisms, impact on health outcomes, quality of care, and other aspects.

Two of those nine papers are now being used as the foundation for bills that are before the California legislature, including:

- A proposal to expand coverage through Medi-Cal, the state's Medicaid program, to those with incomes below 133 percent of the federal poverty level (FPL), and Healthy Families, California's State Children's Health Insurance Program, to those between 133 and 250 percent FPL; and

- A single payer proposal to cover all Californians that would be financed by combining existing public programs.

"The administration is not in a position to pick these up at this point," says Chough. "We wanted to move forward because the window will open and close all the time." Chough believes several of the other proposals may also be the basis for future legislation. "As long as we are ready to go, that's half the battle," she says.

More information on the project is available at www.healthcareoptions.ca.gov.

Multi-State Database Gives Grantees Instant Access to Data

Using funds from its round I Health Resources and Services Administration (HRSA) grant in 2000, Arkansas developed a multi-state database integrating federal and state-level coverage data that is used and supported by 20 states from all three rounds of the planning grant program. To date, Connecticut, Idaho, Illinois, Oregon, South Dakota, Texas, Vermont, and Arkansas have added state-level information to the database from their State Planning Grant (SPG)-funded household and employer surveys. Federal and local-level information was obtained and distilled from the Behavioral Risk Factor Surveillance System, Current Population Survey, and County Business Patterns.

"We needed to unlock the black box of data for policymakers, and that meant being able to answer questions in real time wherever the policy discussion was occurring," says Joseph Thompson, M.D., associate director of the Arkansas Center for Health Improvement. Using three software programs, Thompson and the SPG team built a platform that enables users to crunch data quickly and provide immediate answers to research questions on the uninsured. "Before this tool, if we got questions, we would have to ask our analysts to run data and return with an answer a few days later," says Thompson. "By then, the discussion had already moved forward."

Indeed, the database has turned political discussions in Arkansas from sometimes uninformed debates to thoughtful exchanges based on data rather than opinion. "In one instance we were looking at options for covering parents of Medicaid-eligible children, and we wanted to know how many of them were working full-time," Thompson says. "Instead of taking a week to get the answer, we had it in about 30 seconds."

After creation of this database, HRSA funded Arkansas to expand the project so that other states could participate in its development. Currently, national datasets reflecting information reported by all 50 states are available for use by the 20 states participating in the integrated database. Of these 20, 12 use the tool to facilitate analyses of results from their state-specific surveys.

The database is accessible via an Internet site that is password protected for security. Participating states have the option of using a secure, state-specific dataset or drawing on information from the entire public database. Arkansas provides training and user support through conferences and Web-based and on-site training sessions, and Center for Health Improvement personnel attend meetings in other states to operate the database if requested. For more information, contact Shirley Tyson, program manager at the Arkansas Center for Health Improvement, by phone at (501) 660-7563 or by e-mail at tysonshirley@uams.edu.

also suggested that the federal government sponsor further research on health care affordability and cost sharing; improve the CPS and MEPS to increase the validity of data in individual states; enact federal tax changes to encourage individuals and small businesses to buy health insurance; and provide additional flexibility on eligibility and enrollment caps. (For more information about states' interim and final reports, please visit www.statecoverage.net/hrsa.htm.)

Round III States Launch Projects

In July 2002, HRSA awarded its third set of state planning grants, which totaled just under $12.5 million, to 11 states and one U.S. territory—the Virgin Islands. Unlike the first two groups of grantees—who were caught in the changing environment of the recession and September 11, 2001—the round III states began their work well after the reality of the economic downturn had set in. In terms of their data collection, the states are looking at which of the uninsured are most at risk of losing coverage and assessing the impact of those losses on existing programs.

For the most part, the round III states have followed in the footsteps of their predecessors in terms of their governance structures and the methods they have used to conduct qualitative and quantitative research. However, several of the latest grantees are conducting research projects that include innovative modeling techniques.

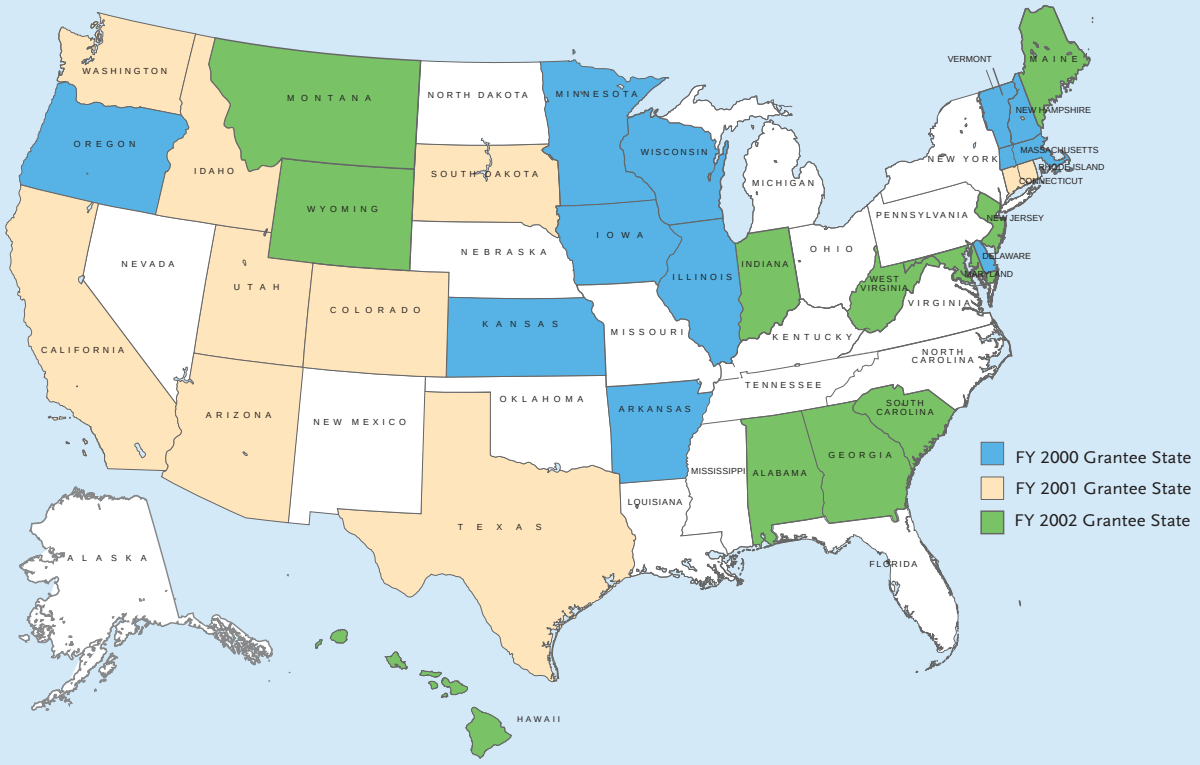
In Maryland, for example, the planning grant team is conducting a two-part econometric modeling effort. Econometric modeling allows states to assess the financial and coverage implications of various expansion models. The first model will cost out a series of Medicaid expansions for low-income parents and single adults. The second series of models, which is less defined at this point, will focus on proposals to expand coverage in the small group insur-

ance market. Maryland's insurance market is heavily regulated, and the state hopes to use focus groups, along with the modeling results, to assess whether loosening those regulations could lead to greater participation.

Hawaii also plans to use econometric modeling as part of its efforts. First, the SPG team will gather information on the state's uninsured that can be broken down by ethnicity—a factor that may be particularly important in Hawaii given that the state has a high proportion of minorities. For example, the team will assess how well employment status and income levels correlate to ethnicity. After the team has identified characteristics of its uninsured, they will evaluate the costs of covering those people through public programs, an employer-based plan, or a combination of the two.

New Jersey is also engaging in an innovative research strategy that will allow it to estimate the number of uninsured and working people who are unable to afford private coverage. The SPG team will draw on state, national, and private data on employer-based and public program premiums and couple that data with family income data to identify the number and characteristics of families with and without access to affordable coverage. These findings will be shared with policymakers and project advisors to inform policy discussions in the state.

HSRA Grantee States



SCI Awards Three States Grants to Expand Coverage

In fall 2002, the State Coverage Initiatives (SCI) program awarded its second round of demonstration grants—which totaled more than $3 million—to Hawaii, Virginia, and West Virginia. The states will use the grants to design and implement innovative models for increasing or maintaining coverage for their citizens. The three states were chosen among eight applicants.

SCI chose states that were in a position to make substantial progress toward a sizable coverage objective, such as expanding eligibility to all children in the state or demonstrating a creative coverage model or partnership. 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 awards through direct or in-kind support.

The plans of the three awardees—each of which focuses on building on employer-sponsored insurance—reflect a growing awareness among states that partnering with the private sector may be their best means of bridging existing gaps in coverage. This approach takes some of the pressure off of already weakened public programs and helps maximize scarce state dollars. Virginia and West Virginia are working on increasing coverage options for low-income workers by reaching out to small businesses, while Hawaii will make an option for part-time employees a major piece of its strategy.

Two of the demonstration states—Hawaii and West Virginia—also received funds last year through HRSA's State Planning Grant program, and will use what they learn through that program to inform development of their demonstration projects.

West Virginia's Employer Buy-In

The SCI program awarded the West Virginia Public Employee Insurance Administration (PEIA) a $1.36 million grant to design a coverage expansion to small businesses with 50 or fewer employees. PEIA operates an insurance pool for employees of local governments that covers about 8,000 lives. State officials hope to double enrollment over the first two years of the project by enrolling employees at eligible small businesses.

Because the PEIA insurance coverage program reaches people in every county in the state—it covers nearly 200,000 state employees and retirees, and allows some nonprofit agencies to participate in the local pool—it is well positioned to reach employers in rural and urban areas. West Virginia has one of the highest uninsurance rates in the country, with 20 percent of adult residents lacking coverage.

Tom Susman, PEIA director, says that the program will offer coverage at lower rates than carriers currently offering insurance in the state's small-group market. The policies will be rated on age, not health status, making them more affordable for a small business owner. To limit turnover and adverse selection, employers must sign a three-year contract, and 75 percent of employees must enroll in the program or other coverage.

"There is a need, and we believe there is also the ability to meet that need, but we had to develop a mechanism to provide the product," says Susman. Eligible small businesses will also be able to participate in West Virginia's multi-state purchasing coalition, which is operated through PEIA. The coalition leverages employers' combined purchasing power to buy prescription drugs at a discount.

The idea of allowing small businesses to join PEIA was made possible by state legislation passed in 1990 to permit the expansion of the public insurance program to other populations. While PEIA is the lead agency on the grant, the Health Umbrella Group, a coalition of leaders from state agencies that provide, fund, and regulate health care in the state of West Virginia, has worked together from the start of Governor Bob Wise's administration in 2001 and continue to have input in the process.

Grant activities include holding community meetings across the state to give current and potential PEIA members a chance to air their concerns; establishing a public advisory council of stakeholders; convening focus groups to help design the benefit package; and conducting a formal project evaluation. Roll-out of the plan will start in rural areas, where there is more need for coverage options and little competition from other insurers.

Because state employees, the largest group enrolled in PEIA, may worry that new participants will cause a premium increase if their health status is poorer than that of current members, officials plan to ensure that all participants are comfortable with the expansion and its safeguards against adverse selection.

"One of the real challenges of this undertaking is to be able to articulate that this is a win-win situation," says Sally Richardson, executive director of the West Virginia University Institute for Health Policy Research and a major contributor to the project. "A significant part of this grant is not only selling the product, but selling the benefits as well."

One of the most important components of West Virginia's grant will be its marketing efforts to bring all affected parties on board with the PEIA expansion. "We are going to have to rely on the insurance agent community, and the local Chambers of Commerce to make this available," says Susman. If West Virginia's financial picture improves, the state may offer a subsidy for eligible low-income employees to increase enrollment.

Hawaii's Plan to Cover Part-time Workers

Hawaii plans to use the more than $1 million that it was awarded through the SCI program primarily to build a public-private partnership that will insure people who are not covered by the state's employer mandate. The Hawaii Uninsured Project (HUP), a group of political, health, business, and community leaders who were convened to address Hawaii's growing number of uninsured, will conduct the demonstration. Hawaii is the only state in the union with an employer mandate to provide coverage for all full-time employees who work 20 or more hours per week.

Nevertheless, Hawaii's uninsured population has grown by 5 to 10 percent in the last few years, mainly due to a state recession that began in the last decade. As the state's economic crisis worsened in the mid-1990s, employers began reducing employees' hours to below 20 per week so that they could avoid having to offer insurance. As a result, many residents have had to work several part-time jobs, few of which provide coverage, in order to make a living.

State officials hope that, by building a partnership between the state and employers, they can create a worker access pool that will insure these people through one coverage source. Sole proprietors and state, local, and part-time workers are exempt from the 1974 mandate, the Prepaid Health Care Act (PHCA). Hawaii's PHCA is currently the only exemption to the federal Employee Retirement Income Security Act.

For years, Hawaii has had one of the highest insured rates in the country, and the state has been committed to achieving universal coverage. As the number of uninsured has increased, policymakers in the last few legislative sessions have started to look at reforming the PHCA.

"Because of the Prepaid Health Care Act, people in Hawaii are pretty much born with coverage, and health insurance is considered a basic right here," says Pi'ilani Pang, project manager of HUP. "Coverage and its costs are now a political lightning rod in the state."

To address the problem, Hawaii has developed a multi-faceted approach under its demonstration grant that includes creating a pool to offer affordable insurance for uninsured workers; covering all eligible but uninsured people in the state's public programs; and expanding coverage to all children in the state's SCHIP program. To reach the large number of working uninsured, the state will work with key stakeholders to look at various options, ranging from a voluntary to a mandatory pool, and the types of incentives needed for employers and employees to participate.

In addition to the work being done with SCI funds, HUP will also seek to expand the safety net, obtain federal reimbursement for the care of Compact of Free Association Citizens, and explore options to improve the PHCA. Through all these strategies, the state hopes to meet the health insurance needs of the 120,000 uninsured residents of the state.

To guide development of its model, the state plans to use several information sources, including a health coverage public opinion survey to obtain public and employer input. State officials will also

learn from focus groups and key informant interviews with small and large employers, a conference of stakeholders, and econometric modeling.

"This is going to require a little give and take, but people are excited at the prospect of increasing coverage," Pang says. Participants hope the solutions they create in Hawaii, especially strategies to cover the part-time working uninsured, can be replicated by other states.

William M. Kaneko, president of the Hawaii Institute for Public Affairs (HIPA), says Hawaii is unique because its grant work has a broad-based, public-private steering committee and significant private-sector leadership through the Institute. "HIPA's value is being a neutral party for this effort." For those reasons, Kaneko believes it has been easier to bring labor and business to the table as a part of this process.

Loretta Fuddy, deputy director of health in the Hawaii State Department of Health, the SCI grantee agency, says she believes Hawaii can still reach its goal of universal coverage. "It's still possible," she says, "we just need to find the best strategy."

Virginia Plans SCHIP Expansion and Public-Private Model

The SCI program awarded the Office of the Secretary of Health and Human Services in Virginia a $1.1 million demonstration grant to assist the state in increasing coverage for pregnant mothers and developing a public-private partnership to increase coverage options for small businesses. More than 1 million of Virginia's residents are currently uninsured.

Virginia's grant team includes health care officials from all levels in the state, including Secretary of Health and Human Services Jane Woods and Governor Mark Warner's Deputy Director of Policy William Murray.

In the first of two phases to their project, Virginia hopes to provide coverage to pregnant mothers with incomes between 133 percent and 200 percent FPL through the state's SCHIP program. (Pregnant women below 133 percent FPL are covered through Medicaid.) Nearly 4,300 uninsured mothers are estimated to have delivered babies in Virginia in 2001. The state hopes to enroll close to 4,000 eligible pregnant mothers by 2005.

State officials will also look at the feasibility of insuring mothers for up to 24 months postpartum, in the hope that continued engagement in the health care system will encourage mothers to seek appropriate care for their children. The state plans to apply medical management techniques to improve outcomes and lower pregnancy-related health care costs.

State officials are optimistic that, by increasing coverage for pregnant mothers, they will help reduce preventable birth defects, infant mortality, and use of neonatal intensive care units, and be able to reach newborn children and toddlers without insurance. During this first phase of the grant, the team will also look at options for creating a women's health benefit package. Officials in Virginia believe that this type of expansion makes the best health policy and fiscal sense and can be implemented in the context of a difficult fiscal climate.

In the second phase of the demonstration, the state will design a model to help small businesses cover their employees. One of the few states to offer an employer buy-in under SCHIP, Virginia has experienced minimal participation in its program. The state will examine the reasons behind the low level of participation and look closely at another coverage model—the Local Choice program—as a possible mechanism for developing a public-private partnership with small businesses. Local Choice is a government insurance pool that covers employees of school boards, county agencies, and other quasi-governmental agencies. It covers approximately 29,000 lives and 214 groups and offers expertise in benefit planning, including technical support and wellness programs.

The grant team intends to examine trends in the small employer insurance market, and identify successful models in operation nationally, including West Virginia's PEIA program. According to Jane Woods, secretary of Health and Human Services, in 2002 Gov. Mark Warner and the general assembly added funds to encourage moving forward on both phases of the state's demonstration project. "We must have a partnership with the legislature from the beginning, and we have had success working hand in hand with them," says Woods. Through the SCI grant, the project team will have access to policy development capabilities that should help them flesh out the options under consideration.

What's New at Statecoverage.net

The State Coverage Initiatives (SCI) team is continually updating its Web site to better meet the needs of state health policy officials. Visit the site to view some of the features added or expanded in 2002.

New Publications

Health Insurance Flexibility and Accountability Initiative: Opportunities and Issues for States, by Gretchen Engquist and Peter Burns.
This issue brief evaluates:

- How Health Insurance Flexibility and Accountability (HIFA) waivers differ from traditional Medicaid 1115 waivers;
- What HIFA allows states to do, including the opportunities it affords them to alter benefits packages and cost-sharing rules;
- The mechanics of HIFA, including the complexities associated with meeting its budget neutrality requirements; and
- States' experience with HIFA waivers thus far.

The brief is available online at www.statecoverage.net/pdf/issuebrief802.pdf.

State Health Care Spending: A Systems Perspective, by Caton Fenz
This brief explores how state policymakers can evaluate the costs and benefits of policy changes from a broad, systems-based perspective—that is, taking into account not just the direct effects of proposed programs or cutbacks, but also the indirect effects they have on other parts of the health care system. The brief presents several examples of states that have taken such an approach and highlights systems solutions that states can try in light of their current budget crises. To access this brief online, visit: www.statecoverage.net/pdf/issuebrief502.pdf.

Disease Management: Findings from Leading State Programs, by Ben Wheatley
This brief describes the experience of eight states that were among the first to establish disease management (DM) programs for chronically ill Medicaid enrollees. Early results indicate that, while DM has helped to reduce preventable health complications and unnecessary service utilization, net savings from the programs have not always met states' high expectations. Nevertheless, these programs continue to evolve and expand as states search for ways to control costs while also improving care quality. This brief can be accessed online at: www.statecoverage.net/pdf/issuebrief1202.pdf.

Expanded Meeting Reports

This section of the Web site archives meeting slides, transcripts from Question and Answer sessions, and presenter biographies. SCI hosted two meetings in 2002: Health Insurance Coverage in an Era of Flexibility and Innovation and Containing Costs to Preserve Coverage. For information from these and previous years' meetings, go to: www.statecoverage.net/meetings.htm.

New State Reports Searchable Database

This new database is a full-text search engine of reports produced by and about state programs that was launched in January 2002. It now contains more than 500 reports and is searchable by state and/or keyword. The SCI team relies on state officials to inform them of new reports. The team can be contacted by e-mail at sci@academyhealth.org.

About Coverage

The "About Coverage" section of the site has been revamped, updated, and re-stylized. SCI hopes this section will give policymakers a macro view of coverage issues, with the ability to drill down through links. Additions include new data on the consequences of uninsurance and information on rising health care costs. Visit www.statecoverage.net/coverage.htm.

HRSA SPG Reports

The SCI Web site now includes a section devoted entirely to the Health Resources and Services Administration's State Planning Grant program. Visit www.statecoverage.net/hrsa.htm for individual grantee reports, links to state Web sites, and syntheses prepared by SCI staff. Information on the third round of SPG states will be posted in 2003.

Coming in 2003

Stan Dorn of the Economic and Social Research Institute will author an issue brief analyzing the impact on states of the Federal Trade Act of 2002.

Isabel Friedenzohn, SCI associate, will write a brief about how states are rethinking the design of their Medicaid programs, particularly with regard to benefit design and cost sharing.

In his brief, Caton Fenz, legislative coordinator in the Harris County, Texas, Budget Office, will discuss how states may leverage local government dollars to finance coverage expansions.

Mila Kofman of Georgetown University will provide practical information to state policymakers in her issue brief about establishing purchasing pools for small businesses.

Reports of Interest in 2002

Care without Coverage: Too Little Too Late, May 2002
Health Insurance Is a Family Matter, September 2002
Institute of Medicine
The Institute of Medicine's Committee on the Consequences of Uninsurance continued its series examining the medical, financial, and emotional consequences of uninsurance on individuals, families, communities, and society, in two new reports.

Care without Coverage: Too Little Too Late summarizes the evidence comparing the health of insured and uninsured adults. The main findings are that working-age Americans without health insurance are more likely to: receive too little medical care and receive it too late; be sicker and die sooner; and receive poor care when they are hospitalized.

Health Insurance Is a Family Matter points out that all members of a family may experience negative physical and emotional effects if any family member lacks coverage.
Both reports, as well as more information on the six-part series, can be accessed online at: www.iom.edu/IOM/IOMHome.nsf/Pages/Consequences+of+Uninsurance, or by calling the National Academy Press at (800) 624-6242.

Medicaid Spending Growth, Results from a 2002 Survey
Kaiser Family Foundation, September 2002
This report outlines the findings of a survey of state Medicaid officials that was conducted by Vern Smith and colleagues at Health Management Associates.
It focuses on the recent expenditure increases and tax revenue decreases that states have faced and examines the factors that have driven them. The report also details the cost-containment strategies that states are taking to address their budget shortfalls. The full report can be accessed at www.kff.org/content/2002/4064/4064.pdf.

Five Things Everyone Should Know about SCHIP
Lisa Dubay, Ian Hill, and Genevieve Kenny
Urban Institute, Assessing the New Federalism Project, October 2002
Five years since the enactment of the State Children's Health Insurance Program (SCHIP), qualitative evaluations have indicated that the program has succeeded in extending coverage to many low-income families. However, there is still room for improvement: More than a quarter of children below 100 percent of the federal poverty level remain uninsured. This brief outlines five key points about SCHIP; it touches on both the program's successes and areas where further action is needed. This brief can be accessed online at www.urban.org/UploadedPDF/310570_A55.pdf.

Health Insurance Purchasing Cooperatives
Elliot Wicks of the Economic and Social Research Institute for the Commonwealth Fund, October 2002
Health insurance purchasing cooperatives are one way that small employers can overcome the disadvantages associated with their size and offer health insurance to their employees. This brief evaluates small employers' experiences with insurance purchasing cooperatives and draws lessons about their potential as a coverage expansion mechanism for the future. To view this report online, visit: www.cmwf.org/programs/insurance/wicks_purchasingcooperatives_ib_567.pdf
or call the Commonwealth Fund at (888) 777-2744.

Washington State Planning Grant on Access to Health Insurance Research Deliverables – 2002
The state of Washington received a Health Resources and Services Administration State Planning Grant for the 2001 fiscal year. During that time, the project team generated many reports on issues related to health care access. Topics covered in these issue briefs include:

- Income adequacy and affordability of health insurance;
- Financial incentives to purchase and/or offer health insurance;
- Administrative simplification;
- Market and regulatory reforms to improve access;
- Purchasing pool options;
- Subsidies for charity care and safety net services; and
- Benefits packages.

Final Thoughts

Throughout the past year, states made valiant efforts to develop resourceful approaches for preserving and expanding coverage during tight times. Even if the states cannot implement their plans right away due to budgetary restraints, they are poised to use what they have learned when the right window of opportunity opens. The federal government's increased commitment to flexibility has also motivated the states to find creative solutions. "The fact that states remain interested in expansions, both to traditional and non-traditional populations, tells us that we are moving in the right direction," says Theresa Sachs, Technical Director for the Division of Integrated Systems at CMS.

Perhaps the biggest question facing the states now is: How far can they take flexibility and innovation in the wake of such tremendous budgetary pressures? With the economy not expected to rebound anytime soon, the states may have to make even tougher choices in 2003 than they did last year. Looking forward, states are calling for an increased federal match for their public programs and a Medicare drug benefit to shift the burden of covering drugs for low-income seniors to the federal program that is responsible for the care of that population.

Meanwhile, in the private sector, some innovative large employers are experimenting with wellness initiatives and consumer-directed health plans as a means of managing their health insurance costs. At the federal level, the Bush administration is in favor of using federal tax credits, opening more health centers, and creating a Medicare drug benefit.

No one knows which, if any, of these strategies might make a difference in maintaining or expanding coverage next year, or if a major paradigm shift toward a new type of cost-containment or coverage mechanism may be in the offing. But it is clear that the year 2002 generated one type of wealth: a richness of ideas.

State Index

Boldface indicates a substantial discussion of a state strategy or program.

STATE COVERAGE INITIATIVES

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