

STATE ^{OF} THE STATES

January 2006

Finding Their Own Way



STATE
COVERAGE
INITIATIVES



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FOREWORD

The State Coverage Initiative's (SCI) annual *State of the States* report summarizes state activities to expand health coverage throughout the past year. It also takes into account the environment and context within which states are working.

This 2005 report is, unfortunately, not much different from that of last year. Times are still difficult for states and for coverage in general. No progress has been made to address the uninsured in a comprehensive way at the national level, and the numbers keep on rising. But, the silver lining is that state leaders continue to be creative in finding new opportunities to expand coverage.

While some state budgets are beginning to rebound, health care costs are a growing portion of state budgets and many state policymakers feel they are unsustainable. States leaders recognize that their ability to fully address the problem of the uninsured is dependent on a federal partnership. There does not appear to be consensus on a comprehensive national solution to address the uninsured.

As our cover image conveys, states keep finding their own way. We are continually impressed by the creativity and persistence of state policymakers to keep access to health care on the agenda and expand health insurance coverage. *State of the States: Finding Their Own Way* summarizes strategies states are implementing or considering and their early experiences. Many state policy-

makers are working toward a clear goal of increasing insurance coverage. However, they are going about it in many different ways — some focusing on public expansions and others looking at market-based strategies. While some states are working to strengthen the safety net, others are simply waiting for the policy window to open.

SCI remains committed to supporting states in their coverage expansion efforts. As we begin 2006, we are happy to share our new and improved coverage matrix on our Web site — statecoverage.net. With more state-specific coverage information than ever before, this is just one of the many tools we are developing to assist policymakers as they seek to expand coverage. We also continue to provide hands-on assistance to help states create approaches to expand coverage by tailoring our approach based on the context of each state's unique fiscal and political environment.

We are honored to work with states across the country that are willing to act to address the important issue of health insurance coverage. We look forward to helping states find their way in 2006.



Director, State Coverage Initiatives

EXECUTIVE SUMMARY

For the fourth year in a row the number of uninsured has continued to grow, reaching an all-time high of 45.8 million people in 2004. Had public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) not enrolled more individuals, the number would have been higher. The percent of individuals covered by their employers has declined to 68.1 percent, the lowest level since 2000.

A discussion of coverage in 2005 would not be complete without addressing the issue of health care costs. High utilization of services and advances in technologies are driving increases. Health insurance costs are still on the rise, outpacing both employer wages and inflation. Payers are beginning to focus on targeting the underlying drivers that will decrease costs over the long term. Talk of consumer-driven health care as a remedy to control costs continued, but so far, consumer-directed products only represent a small portion of insured individuals.

From a budget perspective, 2005 was a year of ups and downs for states. Financial conditions appear to be improving for many states, demonstrating a gradual recovery following four years of intense fiscal stress. This is signaled by smaller budget shortfalls and stronger revenue growth than in recent years. However, many states still face serious challenges, ranging from a backlog of expenditures and spending increases for many programs to the uncertain economic impact of Hurricanes Katrina and Rita.

And then there is Medicaid. States have been aggressive in containing costs in the Medicaid program as it continues to be a growing portion of their budgets. They have focused on strategies that encourage more cost-effective use of services, but have also had to rely on more traditional methods that reduce eligibility, cut benefits, or reduce payments to providers. While some states cut benefits or eligibility, a few states, including Washington and Texas, were able to restore eligibility and benefit reductions from prior years.

States developed a new twist on mandating coverage, with Maryland passing legislation to require employers to pay their "fair share" and Massachusetts considering an individual mandate. Some states built on the purchasing power of large groups for lower cost, higher quality coverage. Several examined the Healthy New York program as a model for public reinsurance to make premiums more affordable. Pennsylvania developed a partnership with their Blue Cross plans to fund coverage through the state's adultBasic program.

Maine, Oklahoma, New Mexico, and West Virginia implemented new coverage initiatives in 2005 and worked through start-up challenges. Spurred by continued budget challenges and the threat of federal changes to the Medicaid program, many states have also developed Medicaid reform proposals. States have also looked to community-based coverage strategies as a major part of their efforts to address the ever-present dilemma of the uninsured.



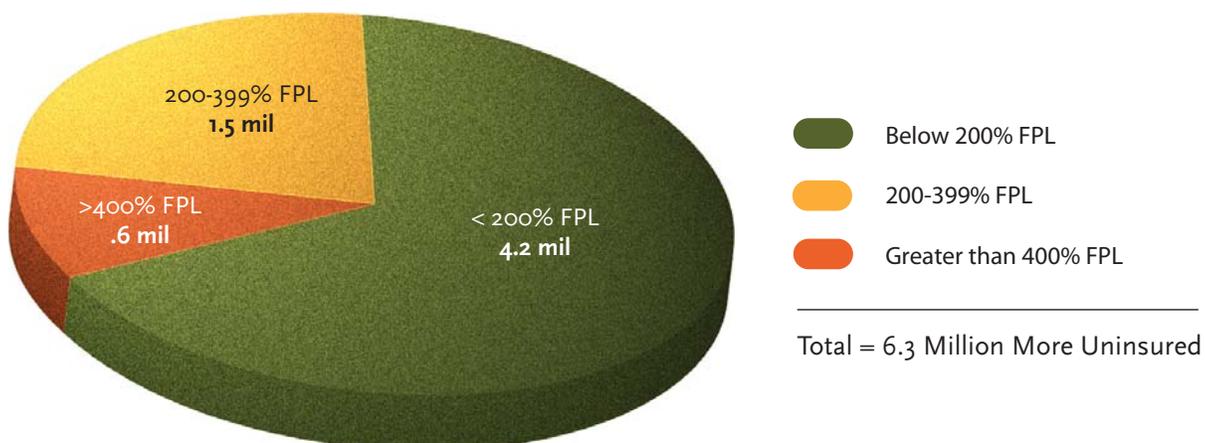
UNINSURANCE IN AMERICA

No one report card exists on how the United States is faring on health insurance coverage. However, one thing is certain: the number of uninsured is rising. The reasons for the increase in the uninsured are complex, including the state of the economy, the labor market, the cost of health care, and the availability of insurance in the private market and through public programs. The number of uninsured in the United States continued to rise in 2004 to 45.8 million people, or 15.7 percent of the population, according to data from the Current Population Survey (CPS) released in 2005. The most recent data also shows that employer-sponsored insurance continues to decline, while coverage through public programs increases (See Figure 2 on p. 8). This means that had public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) not enrolled more people in recent years, the growth in the uninsured would have been even greater.

A recent analysis by the Urban Institute analyzed changes in insurance coverage between 2000 and 2004 and showed that lack of insurance coverage is beginning to affect middle- and higher income Americans (Figure 1). They found that the number of uninsured non-elderly adults grew by more than 6 million during this time period. The increase was attributed only to adults.¹ One-third of the growth in uninsurance occurred among those above 200 percent of the federal poverty level (FPL). Public programs such as Medicaid and SCHIP are covering children who lost access to employer-sponsored insurance, but these programs generally do not cover adults.²

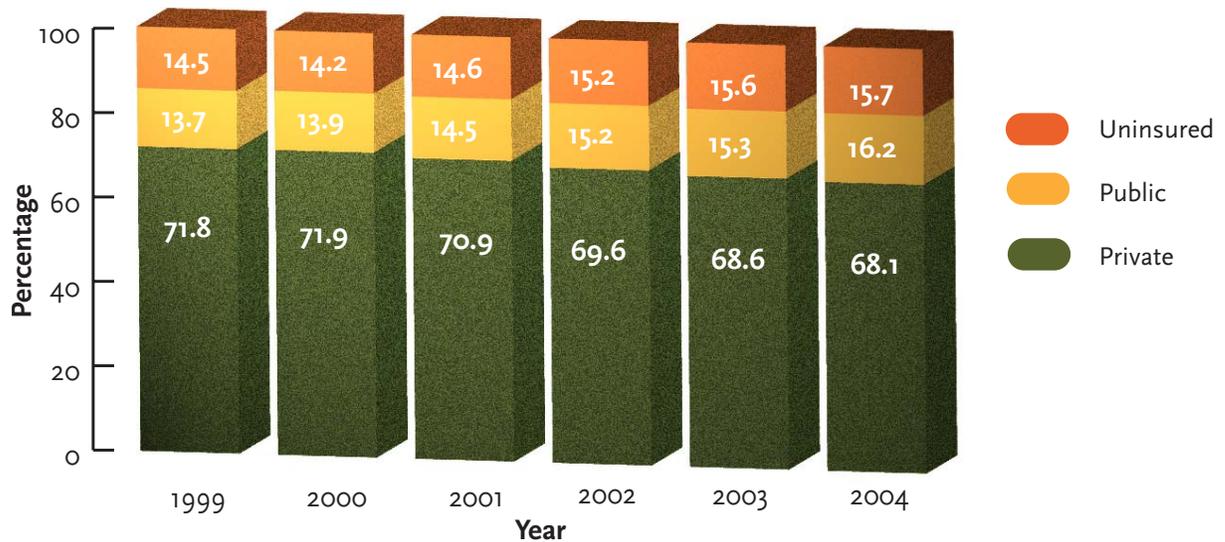
This decrease in employer-sponsored coverage is found across the states. Even states with traditionally high levels of employer-sponsored insurance have experienced declines. There continues to be a three-fold variation in the percentage of uninsured across the states, according to CPS data (See Figure 3 on p. 9).

Figure 1: Growth in Non-Elderly Uninsured Adults, by Federal Poverty Level, 2000–2004



Source: Holahan, J. and A. Cook. "Changes in Economic Conditions and Health Insurance Coverage, 2000–2004," Health Affairs, November 1, 2005.

Figure 2: Sources of Health Insurance Coverage, Non-Elderly



Source: CPS March 2003 Supplements 1997 — 1992, 2003 and 2004 Data from *Income, Poverty, and Health Insurance Coverage in the United States*. CPS, August 2004 and August 2005.

In addition, more than half of the growth in the number of uninsured from 2000 to 2004 was in the South. This region experienced the greatest increase in population, including a large growth of its low-income population, and a significant decrease in employer coverage rates.³

The cost of health insurance coverage is a likely driver of some of the decline in insurance coverage, with the average cost of a family health insurance policy growing to nearly \$11,000—a rate nearly three times faster than wages. In 2005, three out of five employers (60 percent) offered coverage, down significantly from 69 percent in 2000, with most losses in small companies. Among employers with 200 or more workers, 98 percent offer health coverage, whereas only 59 percent of companies with 3 – 199 workers offer coverage.⁴

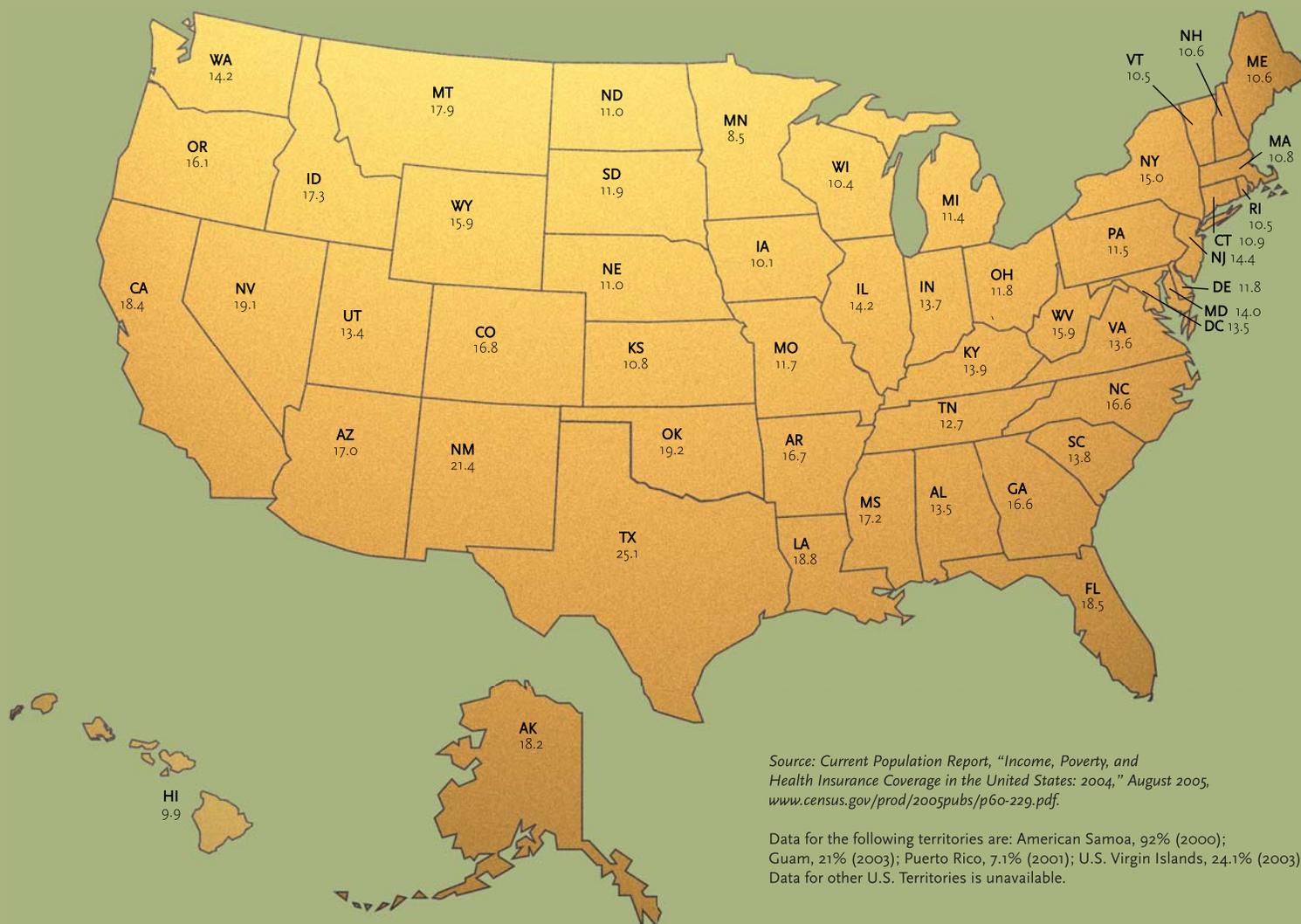
Over the past few years, the increase in uninsurance has been primarily among young adults, whites, and native-born Americans, demonstrating that uninsurance is not exclusively affecting racial and ethnic minorities or non-citizens, as some previously thought.⁵

The situation looks even worse when taking into account a 2005 study by The Commonwealth Fund, which

found that nearly 16 million Americans are underinsured, meaning their insurance did not adequately protect them from catastrophic health care expenses.⁶ Underinsured adults are almost as likely to go without necessary medical care or to take on medical debt as those who are uninsured. In April 2005, President Bush signed the Bankruptcy Abuse Prevention and Consumer Protection Act, otherwise referred to as the Bankruptcy Reform Act. Although the Act was not developed to directly address the medical bankruptcy issue, there has been concern regarding whether the new regulations will exacerbate the growing number of individuals reporting medical debt.

All these statistics matter because they attest to the health of our nation. There is a well-documented connection between insurance coverage and access to care and health: The uninsured are more likely to go without needed care and have poorer health outcomes than those with insurance.⁷ There is a cost to the nation as a whole for failing to address the number of uninsured—at least \$35 billion in uncompensated care is absorbed by providers and ultimately results in higher costs for those with insurance.⁸

Figure 3: Percentage of People without Health Insurance by State, 2002–2004 Avg.



The Institute of Medicine (IOM) estimated the cost of uninsurance from a different perspective, that of health capital: "Our health is like other investments. It gives us a stream of future returns in the form of enjoyment of life, productivity, and developmental potential. Individuals in better health obtain higher returns. Those who die prematurely lose all returns. The dividends from higher levels of health capital include higher expected lifetime earnings, the value we individually place on being alive

and healthy, and improved educational and developmental outcomes in children."⁹

The IOM concluded that the health capital foregone each year due to uninsurance is estimated between \$65 and \$130 billion.¹⁰ The numbers can be analyzed in many ways, but the bottom line so far is that, as a country, we are failing to make the grade.



PARKER

INCREASING HEALTH CARE COSTS: CAUSES AND SOLUTIONS

It comes as no surprise that one reason many Americans lack insurance coverage and the number of uninsured is growing is the rising cost of health care. Over the past five years, health insurance costs have risen 54 percent, outpacing both employer wages and inflation.¹¹ At the same time, the percentage of employers offering coverage has steadily declined. In 2005, 60 percent of employers offered health insurance—the lowest rate in the past decade.¹²

In response, most payers are refining and developing new strategies to address underlying drivers of health costs. State policy leaders are engaged in market-wide cost-containment initiatives while also focusing on managing skyrocketing costs in their public programs.

INCREASING HEALTH CARE COSTS AND HEALTH INSURANCE PREMIUMS

Numerous economic indicators illustrate the significant increase in health care spending in the United States (See Figure 4 on p. 12). The increasing expenditures on health care in general are manifest in increasing health insurance premiums. The most recent information on the annual growth in private health insurance premiums as reported by employers shows an increase of 9.2 percent between 2004 and 2005.¹³ Health insurance premiums rose at two-and-a-half times the rate of inflation.¹⁴ While still substantial, this increase is less than those experienced over the last four years, which saw increases between approximately 11 percent and 14 percent each year. An average annual premium for employee-only coverage was \$4,024 in 2005 with family coverage averaging \$10,880 (See Figure 5 on p. 12).¹⁵ In 2003, it took almost 14 percent of median family income for a family of four to purchase family health insurance, up from 9.6 percent in 1999.¹⁶

COST DRIVERS

There are myriad factors contributing to dramatic increases in health care costs. A significant amount of research has been and continues to be done to understand cost drivers and their true impact on the overall health care system. New research in 2005 concluded that a primary driver of private health care spending is the rise in treated disease prevalence. That is, rather than the main driver of higher spending being an increase in the cost per treated case (unit cost), it is an increase in the number of cases treated (overall utilization). “Changes in treated disease prevalence are caused by a rise in the population prevalence of disease, changes in clinical thresholds (and awareness) for treating and diagnosing disease, and new technologies that allow physicians to treat additional patients with a particular medical condition,” states an article written by Kenneth Thorpe and colleagues.¹⁷ A 2004 article in the *Journal of the American Medical Association* corroborated these findings, stating that “chronic disease is now the principal cause of disability and use of health services and consumes 78 percent of health expenditures.”¹⁸

From a more global perspective, another factor contributing to escalating costs is the underlying health care financing structure. Since consumers are somewhat isolated from the full cost of insurance, some suggest they are tacitly encouraged to use more health care services than if they were required to pay more for services or if they knew the true cost of each service. While there is an increasing focus on “consumer-directed health care” as a possible solution to control costs, there also have been efforts by health plans and employers to constrain health care spending through the use of tiered networks, and a number of utilization management techniques for prescription drugs such as tiered co-pays, preferred drug lists, and mail-order purchasing. (For more on consumer-directed care, see p. 15.)

Figure 4: National Health Expenditures

	1960	1985	2003
(in billions of current dollars)			
Aggregate spending	27	427	1,679
Per capita	143	1,765	5,670
(in billions of constant 2003 dollars)*			
Aggregate spending	166	730	1,679
Per capita	891	3,019	5,670
Share of GDP	5.1%	10.1%	15.3%

Source: National Health Expenditures, Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census. * Adjusted for changes in the Consumer Price Index for all-Urban Consumers, "all items"

Other leading causes of increasing health care costs include workforce shortages that drive up labor costs, reduced cost-containment practices as managed care continues to retreat, increases in technological advances, the development of expensive new drugs with direct-to-consumer marketing being associated with strong sales, and an aging population. Many of these elements are interrelated and thus can exacerbate each other.

Some states have expressed concern regarding the effect of medical malpractice cases on health care costs. While it is driving practice costs for certain specialists, the impact on costs to the overall health care system is low.¹⁹

POSSIBLE REMEDIES FOR COST CONTAINMENT

Focusing on the bottom line, a greater number of employers recently have been shifting a higher percentage of premiums to the employee and offering less generous coverage. While these strategies primarily focus on

decreasing premiums in the short term, there are other efforts to target the underlying drivers that, employers hope, will affect costs over the long term.

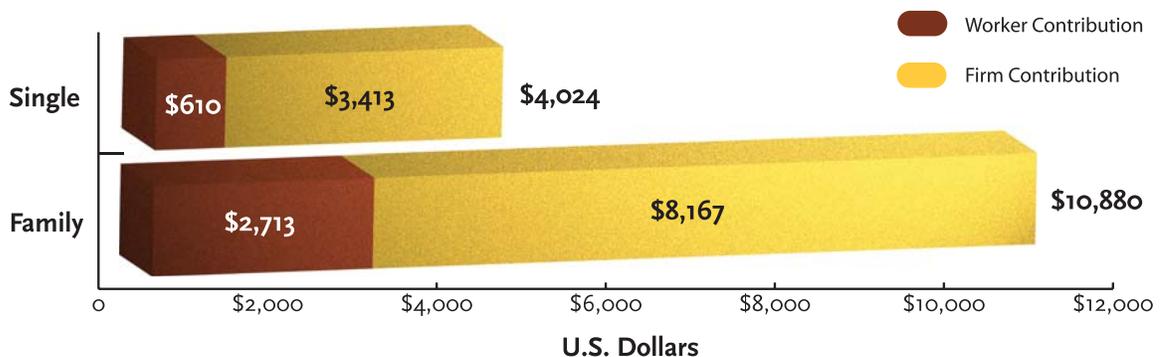
Consumer-Directed Health Care

Consumer-directed health care is based on the idea that individuals who have more of their own money at stake will use services more appropriately and seeks to eliminate or reduce over-utilization. It also aims to provide enhanced information about the cost and quality of services and providers. Ideally, the consumer's purchasing power will then drive the market to become more cost-effective.

Pay-for-Performance Models

States have also been playing a role in the development of quality information that can be used for public reporting to guide consumers to better plans and providers as well as to support pay-for-performance activities. Numerous states have created public reports on the

Figure 5: Average Annual Premiums for Covered Workers, All Plans, 2005



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2005.

quality of care provided by health plans, hospitals, and nursing homes. Minnesota has created a comprehensive Web site that provides cost and quality information as well as other consumer information on buying health insurance and managing chronic health conditions. Several states including California, Iowa, Massachusetts, Rhode Island, Utah, and Wisconsin have been working to develop pay-for-performance mechanisms within their Medicaid programs.

MEDICAID ENROLLMENT AND ELIGIBILITY

States have been aggressive in containing costs in the Medicaid program because it accounts for a growing portion of their budgets. In addition to addressing the growth in health care costs that all payers are experiencing, public programs must also deal with increases in enrollment. States continue to focus on cost-containment strategies that encourage more cost-effective use of services, but have also had to rely on more traditional strategies that reduce eligibility, cut benefits, or reduce payments to providers.

A study assessing state Medicaid program changes found that eight states made eligibility changes in FY 2005, a sharp reduction from 2004. For the most part, these states reduced or eliminated optional benefits (e.g., adult dental services or pharmacy benefits). Some cuts were quite significant, with the largest occurring in Tennessee. A few states, including Washington and Texas, were able to restore eligibility and benefit changes from prior years.²⁰ (For more on Medicaid program changes, see p. 28.)

PRESCRIPTION DRUG COVERAGE

States also continue to focus on changing the design of pharmacy benefits to encourage more cost-effective utilization. Activities include requiring more drugs to have prior authorization, implementing or expanding preferred drug lists, and using more supplemental rebate mechanisms. Many states have also sought membership in multi-state purchasing pools to access larger supplemental rebates.

DISEASE MANAGEMENT

In general, states and other payers are focusing cost-containment efforts on high-cost populations—such

Wellness Programs Encourage Employees to Take Care of Themselves

Another emerging cost-containment strategy gaining momentum from states and local communities is wellness programs. These programs are primarily based at the employer level with some states adopting insurance legislation to allow insurers to discount premiums if the employer integrates the wellness program into the health insurance benefit.

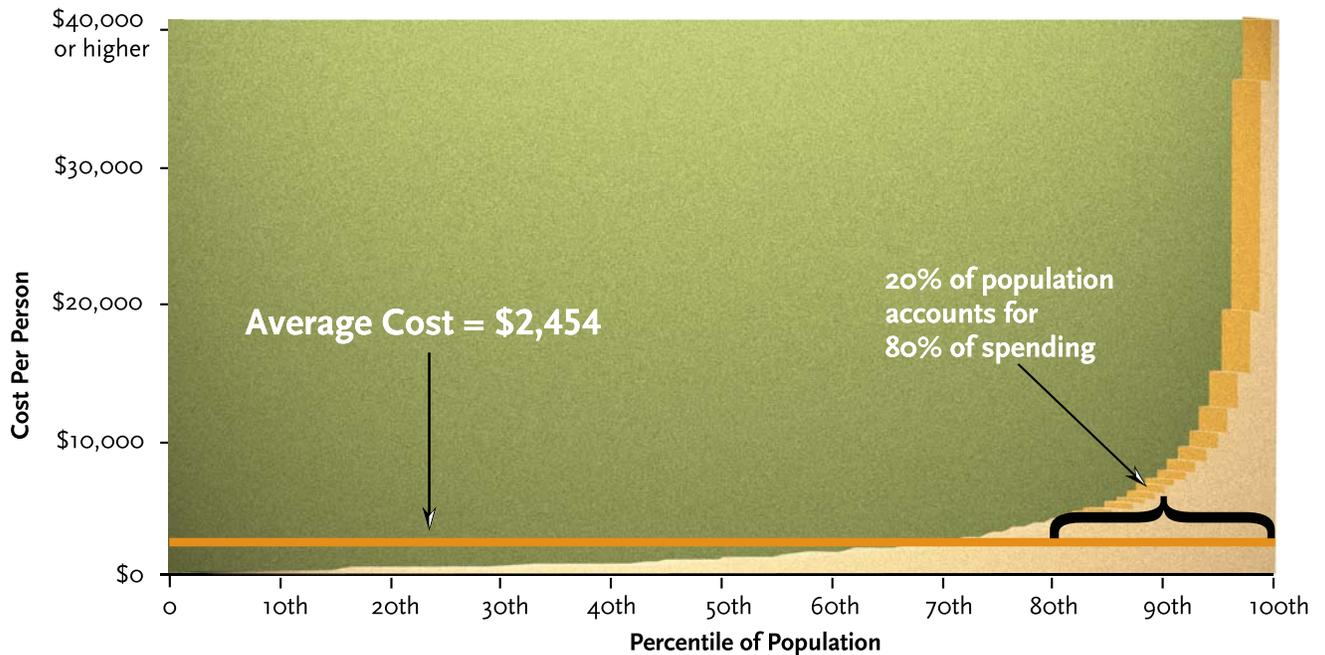
Some states and local entities are experimenting with new programs for their public employees. In King County, Wash., employees and partners are encouraged to participate in health improvement programs through benefit design incentives with the goals of improving the health status of county employees and reducing the rate of increase in health care costs through positive personal behavior changes. Employees can receive reduced out-of-pocket expenses if they complete a wellness assessment and participate in health improvement programs. This program focuses on reducing health care costs in general, translating into lower premiums due to a better risk experience for the group.

as those with chronic conditions—recognizing that if their utilization is left unchecked, health care spending will not decrease. Employers have been at the forefront demanding better information on the cost and quality of services as well as pushing health plans to incorporate disease management (DM) into their care model.

As such, state efforts to implement DM programs have expanded.²¹ At least 25 states have implemented DM programs for their Medicaid populations.²² These programs focus on the chronically ill and use an integrated approach to improve health outcomes and reduce health care costs.

Although many operational challenges remain and the results of early experiences from states with DM programs show some promise, it is still too early to make definitive conclusions on the impact of these programs.²³ States still hope that DM programs can help them to use scarce Medicaid dollars more effectively and enable them to maintain—or even expand—coverage.

Figure 6: Annual Claims Distribution, Non-Elderly Adults, 2001



Source: Employee Benefits Research Institute 2005 estimates from the 2001 MEPS

EXPANDING HEALTH INFORMATION TECHNOLOGY

System-wide changes that have the potential to reduce costs by providing more efficient and higher quality care include expanding the use of health information technology, supporting evidence-based medicine for clinical decision-making, and encouraging care to be delivered in the most appropriate setting. Oregon's Drug Effectiveness Review Project (DERP), in collaboration with at least 13 other states—primarily Medicaid programs—performs evidence-based reviews of the clinical effectiveness of drugs in the same therapeutic class. The program was developed to create a preferred drug list (PDL) for Oregon's Medicaid program that selects drugs based on their review.

REGULATORY AUTHORITY

States also have the power to control costs more directly through their regulatory authority. A majority of states still use the Certificate-of-Need (CON) process to ensure that new health care services and facilities are developed only as needed to ensure a rational growth in capacity. Most states regulate the prices paid to providers in their public programs through the use of a payment formula. Maine's Dirigo Health program contains a comprehensive set of voluntary and mandatory cost-containment

initiatives, such as a moratorium on CON, expansion of CON beyond hospitals to cover physicians' office visits, and placing the CON program on a budget to fund only a predetermined amount of new capital projects each year through the creation of the Capital Investment Fund. The Dirigo Health Agency found \$9.8 million in savings from these initiatives in the first year of the program; however, the Maine Insurance Superintendent was not able to support that level of savings in a final analysis, demonstrating how difficult it can be to quantify savings from these kinds of initiatives in measurable and objective ways. (For more information on Maine, see p. 26.)

Eliminating administrative and clinical waste, implementing new information technology systems and evidence-based medicine protocols, as well as the financial incentives to use them, are crucial in creating high benefit-lower cost approaches to delivering high quality health care. In order to ensure the most effective use of dollars spent by both public and private purchasers, it is important to continue exploring new payment incentives that pay for quality and efficiency. Ultimately, however, the implementation of all other cost-containment strategies will have little effect if appropriate care management strategies are not implemented to manage the most costly chronically ill patients.

Consumer-Directed Care: An Avenue for Change?

Since the establishment of Health Savings Accounts (HSAs) in late 2003, consumer-directed care has been the focus of new benefit design efforts. HSAs and their predecessors, Health Reimbursement Arrangements (HRAs), are the cornerstone of consumer-directed health plans (CDHPs). Although consumer-directed care can take many forms, the common characteristics are a high-deductible health plan (HDHP) combined with an account (personal or employer-owned) that can be drawn down to cover eligible health care services before the deductible has been met.²⁴

There are several types of consumer-directed accounts, but the two most common are HRAs and HSAs. HRAs are owned and funded solely by employers. HSAs, in contrast, are owned by the individual and offer special tax treatment for account contributions, but can be funded by the employer and the employee. The goal of these consumer-directed products is to encourage consumers to be more cost-conscious and prudent purchasers of health care services.

TAKE-UP RATES FOR CDHP

The Kaiser Family Foundation/HRET 2005 Employer Health Benefits annual survey found growing enrollment and interest in consumer-directed health plans, but only a small percentage of insured individuals actually get coverage through a consumer-directed product. Approximately 2 percent (1.6 million) of all covered workers are enrolled in HRA/HDHP products and another 1.2 percent (810,000) covered workers have chosen HSA/HDHP arrangements.²⁵ A previous study found that about one-third of those purchasing HSAs through the individual market were previously uninsured and approximately a quarter of those in the small group market were previously uninsured.²⁶

Of all firms that offer health benefits, approximately 20 percent in 2005 offered a high-deductible health plan to workers. Employers are also expressing increasing interest in these coverage models, with 22 percent reporting they are somewhat likely to offer a HRA/HDHP and 4 percent are very likely. The numbers are similar for an HSA/HDHP (25 percent somewhat likely and 2 percent very likely).²⁷

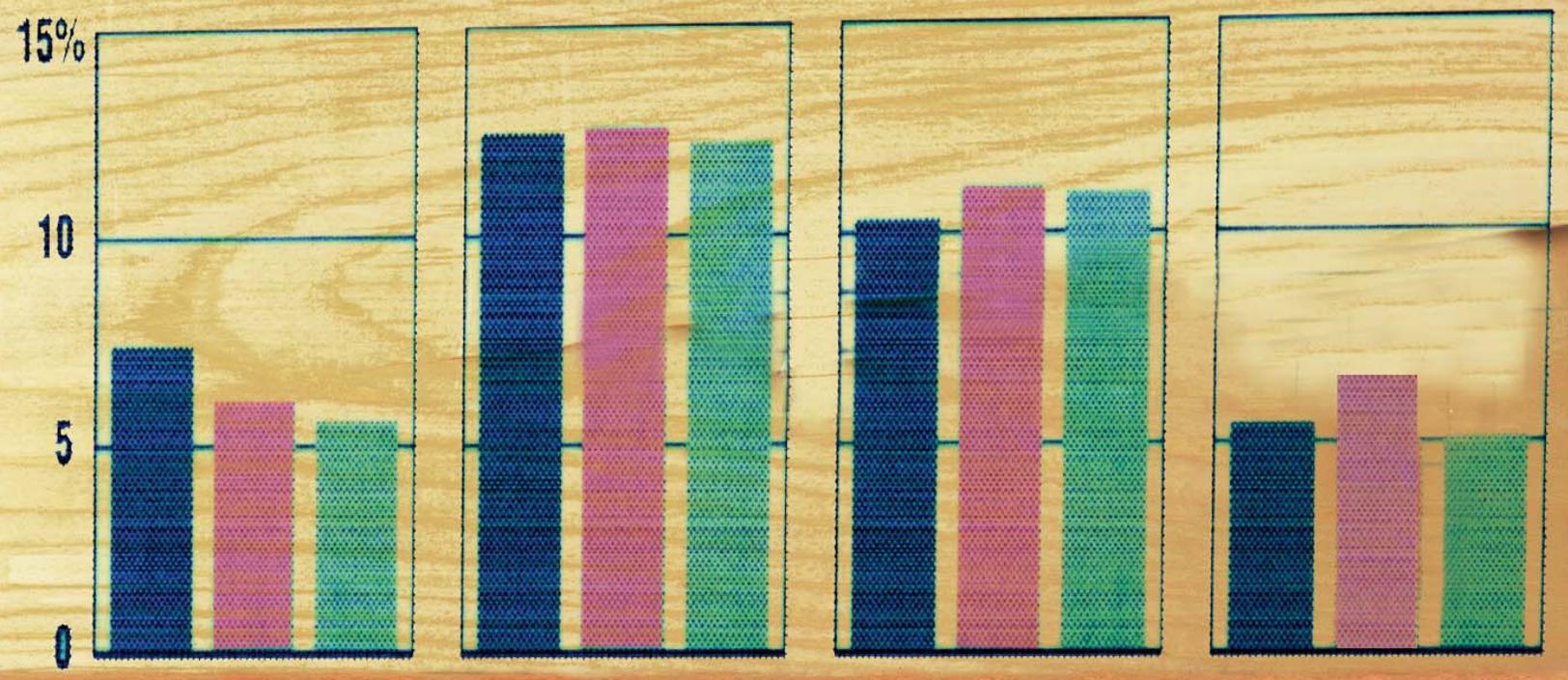
State policymakers have an interest in consumer-directed care as a possible new benefit design that could be affordable enough to encourage the previously uninsured to

buy coverage. For these products to be perceived as having value, they not only have to offer a lower premium but must also provide meaningful benefits. Whether or not the addition of a personal account to an HDHP can change the uninsured's perception of value remains to be seen.

Several states have passed legislation that conforms their insurance laws to allow high-deductible health products that meet federal guidelines. Other states have gone further to encourage the purchase of HSAs by making contributions to these accounts tax-deductible under state income tax law. Seven states that tax income maintain taxation on HSA contributions and 34 states have given HSA contributions special tax treatment. Some state leaders have looked to incorporate CDHP principles and increase enrollee responsibility and risk into existing programs such as public coverage and high-risk pools. Currently, 11 states have added an HSA/HDHP option to their high-risk pool, and several states have submitted Medicaid waiver concept papers that include consumer-directed benefit designs.²⁸ (For more information on Medicaid and consumer direction, please see p. 29.)

State leaders are often divided on CDHPs. On one hand, these products may reduce the uninsured and provide choice to consumers. However, if CDHP products are offered alongside more traditional preferred provider organization (PPO) products, and younger and healthier workers select the CDHP option, CDHPs may disrupt markets by segmenting existing risk pools. According to Mary Elizabeth Senkewicz, senior health policy and legislative advisor for the National Association of Insurance Commissioners, "Adverse selection is always a concern of state regulators and, if these products lead to risk segmentation, those effects will need to be mitigated." She also noted concern about whether consumers will understand the complex relationship between services purchased using health savings accounts and whether those services will count toward the individual's deductible.

Increasing health care costs have driven much of the interest in consumer-directed health care, but evidence is still mixed on whether the models can reduce the overall growth of health care costs, especially for the high-cost users of health care and those with chronic disease.



STATE BUDGETS: THE RECOVERY BEGINS

State policymakers' ability to implement strategies that address the uninsured largely depends on the availability of funding and the states' fiscal situation. Given the fiscal crisis that has been looming over most states for the past few years, there have not been enough resources to allow for many coverage expansions. Financial conditions appear to be improving for many states, however, demonstrating a gradual recovery following four years of intense fiscal stress for many states. This is signaled by smaller budget shortfalls and stronger revenue growth than in recent years. Although states confronted fiscal year (FY) 2006 with a combined deficit between \$32 and \$36 billion,²⁹ proposed state budgets anticipated revenues that are 5.2 percent higher than for the previous fiscal year.³⁰

States vary, however, in their recovery from the economic downturn that began in 2001. They face serious challenges, ranging from a backlog of expenditures and spending increases for many programs to the uncertain economic impact of Hurricanes Katrina and Rita. States are struggling with double-digit growth in Medicaid expenditures, demands for increased K-12 education spending, and federal actions to reduce the deficit. They are also feeling the absence of a federal fiscal relief package, after benefiting from one in FY 2004.

Looking ahead, many states face not only an aging workforce and a budgetary time bomb in the guise of unfunded pension liabilities, but also an aging Medicaid population that will demand more expensive services like long-term care and prescription drugs.

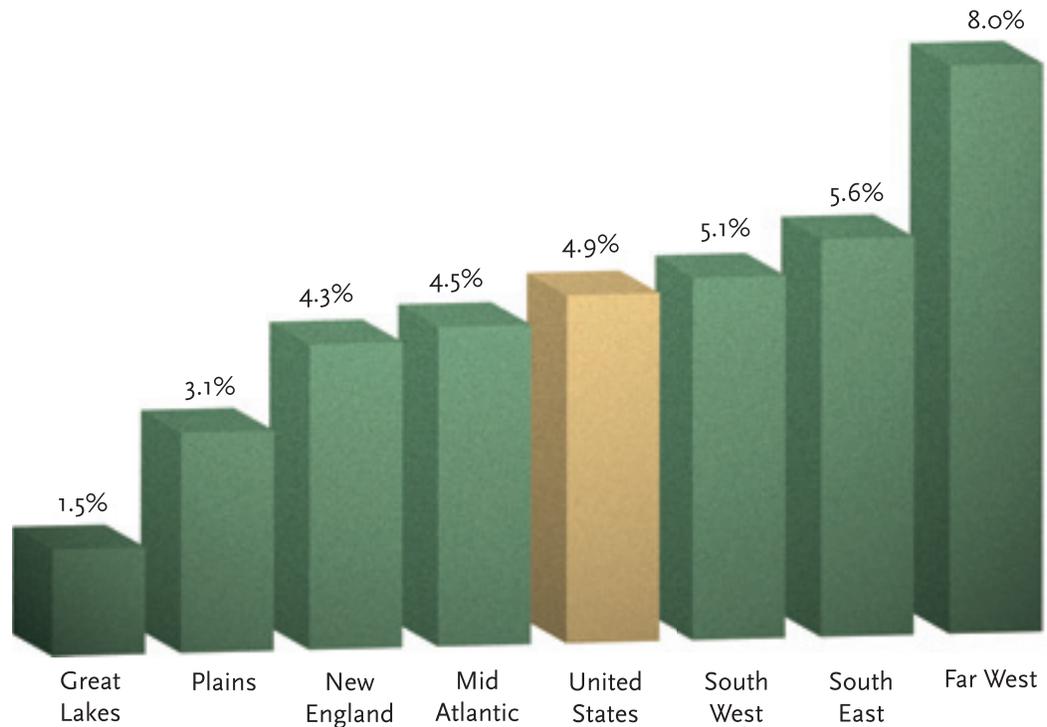
REVENUES STRENGTHEN BUT STATES FACE BACKLOG OF EXPENDITURES

As states prepared their FY 2006 budgets, many had to impose program cuts or tax increases in order to balance their budgets. While revenue bases are growing again, many states still confront sizeable deficits. In early 2005, states projecting the largest deficits for FY 2006 were California, New Jersey, New York, Ohio, and Texas. Mississippi, New Jersey, and Texas faced especially large shortfalls, when viewed as a share of their overall 2005 state budget. Still, these deficits are significantly smaller than the budget shortfalls experienced by states in FY 2003 and 2004, which reached \$75 to \$80 billion during each of those years.³¹

Growth in revenues appears to be one of the bright spots in the fiscal outlook for states (see Figure 7 on p. 18). In fact, revenues improved significantly for most states in FY 2005; this trend is expected to continue in FY 2006. In FY 2005, revenues exceeded original budget projections for 42 states and three other states met their revenue targets; only five states found that their revenues fell below budget projections.³² Buoyed by strong personal income tax revenue growth, state tax revenue grew 13.3 percent in the third quarter of 2005 compared to the same quarter in 2004. This represents the strongest nominal revenue growth since at least 1991.³³ In a further sign of easing fiscal pressures, the gap between Medicaid spending growth and state tax revenue growth dropped to 2.6 percent, its lowest level since 1999.³⁴

Although revenues appear to be rebounding, they have not yet returned to levels reported prior to the fiscal crisis of 2001. State tax revenues remain about 8 percent below their 2000 high after adjusting for inflation and population

Figure 7: Regional Variation in State Revenue Growth, 2004–2005



Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004, and October 2005.

growth.³⁵ Nevertheless, an improving tax revenue outlook will help states as they struggle with pent-up spending pressures from Medicaid and other programs, along with federal actions to reduce the deficit.

While budget shortfalls are smaller than those of the last few years, they will be challenging nonetheless for states and localities to absorb as they slowly emerge from the fiscal crisis of the last several years. Many states have exhausted rainy-day funds and other one-time measures used in past years to balance their budgets. And many have already made difficult cuts in state programs. Though less severe than in years past, the most recent budget deficit figures suggest that states still have a way to go in their fiscal recovery.

When faced with additional spending cuts, states have few places left to turn. In fact, states have already cut real per capita general fund spending by about 6.4 percent from its 2001 high.³⁶ States have not had to make cuts of this magnitude in the last 20 years. “States face competing fiscal pressures from Medicaid,

elementary and secondary education, infrastructure needs, and pension payments,” explains Nick Samuels, an associate at the National Association of State Budget Officers.

Many states are reluctant or are finding it difficult to reduce spending for education, Medicaid, transportation, and corrections. In particular, states are under pressure to increase elementary and secondary education spending per pupil to meet rising standards of learning. “As a result, states are balancing their budgets by reducing expenditures in the ‘all other’ category, which accounts for just under one-third of total state expenditures. This category includes programs that in many cases are already underfunded or strained, such as state police, pension funds, care for the mentally ill and disabled, and environmental and housing programs,” says Samuels (see Figure 8 on p. 19).

State and local budgets face another risk as their workers age and promised pension payouts mount. The Government Performance Project, a source of

independent information on state management performance funded by the Pew Charitable Trusts, found that, in more than half the states, one in five employees will retire within the next five years. Yet state governments are short as much as \$163.4 billion in pensions promised through their public employee retirement systems.³⁷ Compounding the problem, some states reduced payments to their pension funds in order to balance their budgets following the fiscal crisis of 2001.

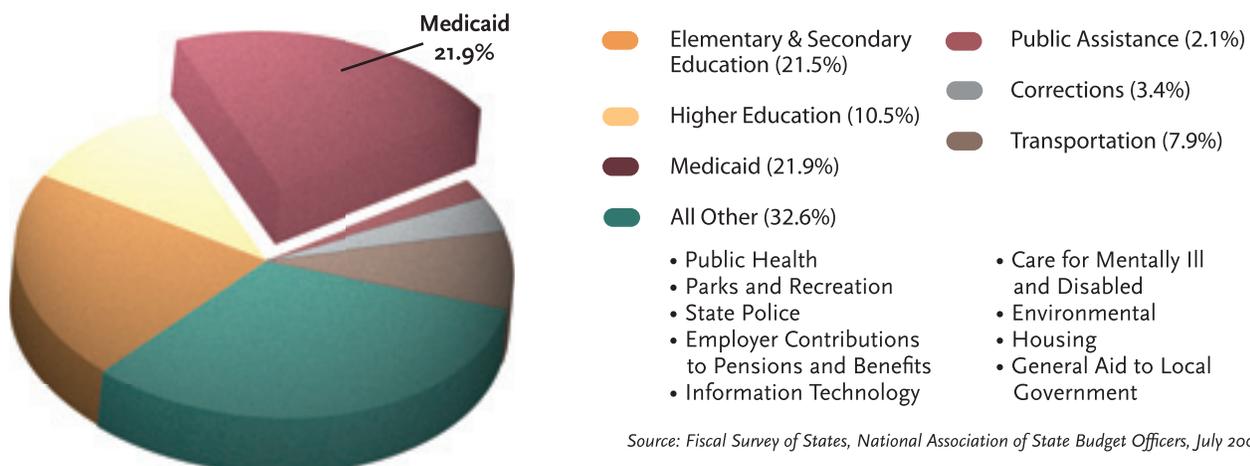
Hurricanes Katrina and Rita forced the Gulf Coast states to confront new and unexpected fiscal challenges. With many of its residents evacuated across the country, Louisiana faces an especially precarious economic situation because it relies heavily on personal income tax for its revenue base. The cost of rebuilding New Orleans and the state's entire Gulf Coast will be staggering, and whether many of the state's displaced residents will return remains to be seen. The loss of at least some oil refining capacity compounds Louisiana's financial difficulties since the state relied, in part, on extraction taxes imposed on refineries. Alabama and Mississippi were also hit hard by the hurricanes and face many of the same challenges.

MEDICAID SPENDING CONTINUES TO STRAIN STATE BUDGETS

While Medicaid spending growth slowed over the last three years, averaging 7.5 percent in FY 2005, Medicaid expenditures continue to outpace state revenues.³⁸ From FY 1999 until FY 2004, K-12 education spending accounted for the largest share of state spending. Today, Medicaid accounts for the largest and fastest growing category of state expenditures. For many states, Medicaid expenditures exceed amounts budgeted for the program. Twenty-six states experienced Medicaid shortfalls in FY 2005, an increase from FY 2004 when 22 states experienced program deficits.³⁹

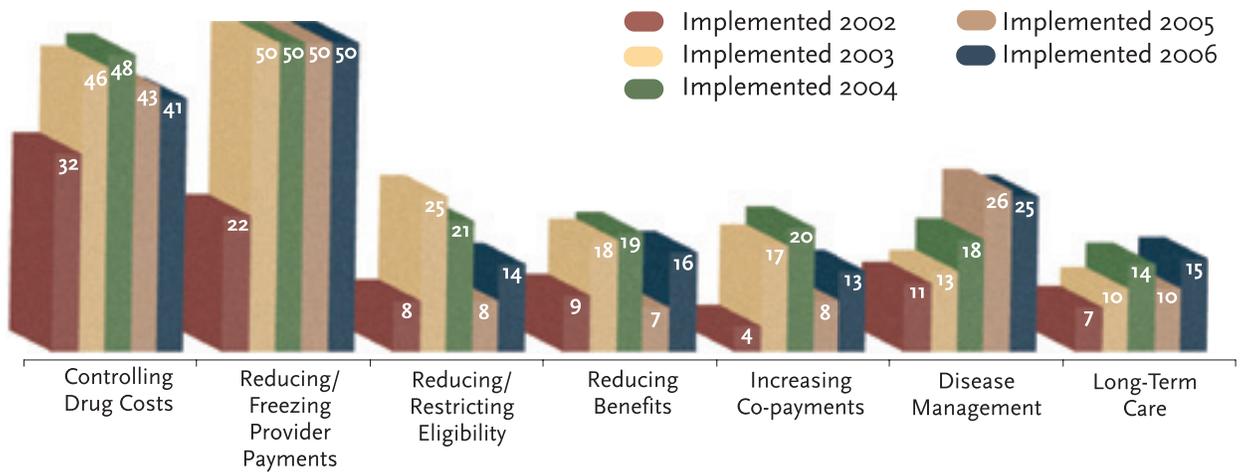
Congress' annual budget resolution in April 2005 called for \$10 billion in Medicaid cuts over five years; this resolution established spending priorities and gave congressional committees guidance as they headed into the budget reconciliation process. Cuts of this magnitude would enlarge state deficit gaps and force states and localities to make additional program cuts and tax increases.

Figure 8: Total State Expenditures, Estimated FY 2004



Source: *Fiscal Survey of States, National Association of State Budget Officers, July 2005*

Figure 9: States Undertaking New Medicaid Cost-Containment Strategies, FY 2002 – FY 2006



Note: Past survey results indicate not all adopted actions are implemented.

Source: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September and December 2003, October 2004, and October 2005.

“Relief efforts following Hurricanes Katrina and Rita have highlighted the important safety net role played by Medicaid and have called into question some of the strategies proposed to achieve the \$10 billion in savings proposed by the Administration and Congress,” says Vernon Smith, principal at Health Management Associates.

Medicaid programs find themselves vulnerable to many of the same factors that are driving up health care spending in the private sector. Demand for costly long-term care services, prescription drugs, and new technology, coupled with heavy inpatient and outpatient utilization, have helped drive up expenditures in state Medicaid programs. As the population ages, states will face growing demand for expensive services such as the new Medicare prescription drug benefit and long-term care.

While an improving economic outlook has slowed Medicaid enrollment growth rates over the last few years, enrollment remains a powerful driver in increasing Medicaid expenditures. Due to the economic downturn that began in 2001, many more Americans are now covered by Medicaid than just a few years ago. Across the country, overall Medicaid enrollment increased 4.2 percent in FY 2004, and an estimated 4.1 percent for FY 2005.⁴⁰ Enrollment among families grew 10.1 percent on average per year between 2000 and 2003. While enrollment among aged and disabled grew more slowly at 2.9 percent on average

per year during this same period, this group accounts for most of the spending increases under Medicaid.⁴¹ In fact, the elderly and disabled cost about seven times more per recipient than children and adults.⁴²

Iowa offers one example of a state that has experienced strong enrollment growth. “The eligibility rules have not changed in our state but more people seem to need Medicaid,” says Iowa Medicaid Director Eugene Gessow. “More people have problems getting access to health care. Our Medicaid enrollment has jumped 12 percent in just the last two years.”

LONG-TERM OUTLOOK

In a recent survey, state Medicaid officials expressed more optimism about the future of the Medicaid program than they had in previous years. At the same time, these officials remain concerned about the long-term fiscal outlook for the program.⁴³

“As the fiscal situation improves, states will once again be able to look to Medicaid as a strategy to address issues of the uninsured,” says Smith. He points out that half of states either have an 1115 waiver or are considering an 1115 waiver; use of this waiver is the most common strategy for expanding coverage to the uninsured. “The challenges are daunting and none of these approaches are easy, but states have a long track record of being creative,” Smith adds.

Ohio and Oklahoma: Two Contrasting Experiences with Economic Recovery

The beginnings of economic recovery experienced by many states in FY 2005 have completely bypassed others. With a hard-hit manufacturing economy and an unemployment rate stuck at 6 percent, Ohio must now contend with deep budget cuts across the board. The Medicaid program alone will need to reduce expenditures by \$2.4 billion over the next two years. Changes in the state's once generous reimbursement to nursing homes will produce nearly half of these savings, but the remainder must come from benefit and eligibility cuts that will result in a loss of coverage for 25,000 adults. Implementation of the Medicare prescription drug benefit has posed added hardship, amounting to \$57 million in budgeted expenditures that could have been used to restore benefit or eligibility cuts.

"We are concerned about our ability to continue using Medicaid to expand coverage for the uninsured," says former Ohio Medicaid Director Barbara Edwards.⁴⁴ The state is particularly worried about growth in its aged and non-aged disabled populations. Expenditures for these populations are further straining the state's Medicaid budget. While Ohio's dually eligible population is relatively small (6.6 percent), it accounts for a large portion (22 percent) of Medicaid spending. "Growing expenditures for our dually eligible population will further constrain Ohio's flexibility to use the state's Medicaid program to meet the needs of the uninsured," says Edwards.

Oklahoma is fortunate enough to have strengthening revenues, and is already pursuing strategies for expanding their Medicaid programs to address the needs of the uninsured. The state's revenues have been buoyed by soaring oil and natural gas prices; as a result, the state's Medicaid program is better off than many. For now, the state has been able to avoid cutting services to Medicaid recipients while trying to ensure the program runs as efficiently as possible. The state is also implementing several 1115 waivers to expand coverage to the working uninsured.

"In this country, Medicaid is a primary driver for affecting change to health care to the general public," says Charles Brodt of the Oklahoma Health Care Authority. "We're in the waiver business and hope to improve health care delivery to non-traditional Medicaid populations."

STATE STRATEGIES TO EXPAND COVERAGE

In 2005, new state policy initiatives to expand coverage continued to respond to the ongoing factors contributing to uninsurance: low offer rates by small businesses, and the increasingly unaffordable cost of coverage. State work in 2005 ranged from developing new initiatives to working through challenges of newly implemented programs. Spurred by continued budget challenges and the threat of federal changes to the Medicaid program, many states have also developed Medicaid reform proposals.

NEW INITIATIVES

Illinois and Massachusetts led the way with the approval of new initiatives, but a number of governors and legislators have made health insurance coverage a priority.

Illinois

On November 15, 2005, Illinois Governor Rod Blagojevich (D) signed the Covering All Kids Health Insurance Act. “We’ve worked hard for three years to make health care available for more working and low-income families,” Blagojevich said. “But thousands of kids from working class and middle-class families have fallen through the cracks because their families earn too much to qualify for government programs, but still can’t afford coverage. That’s not what the American Dream is all about. This week we took the opportunity to make sure that every child in Illinois has access to affordable, good health insurance.”

Since 2002, Illinois has annually expanded coverage under its FamilyCare program. Currently, Illinois covers children in families up to 200 percent of the federal poverty level (FPL) and parents with family incomes up to 133 percent FPL. Beginning in July 2006, the All Kids initiative will make insurance coverage available to all uninsured chil-

dren with premiums charged on a sliding scale by income. A family of four earning \$40,000 to \$59,999 will pay \$40 a month per child, families earning \$60,000 to \$79,999 will pay \$70 per child, and families earning \$80,000 to \$99,999 will pay \$100 per child. Children in families with higher incomes and without insurance will also be eligible, but the premiums will be higher.⁴⁵

The program is estimated to cost \$45 million in the first year and will be funded through savings generated by implementing a new primary care case management program in the FamilyCare and All Kids health care programs. The Act requires the state to apply for waivers to receive federal funding under Medicaid or the State Children’s Health Insurance Program (SCHIP), but it directs the state to implement All Kids regardless of whether a federal waiver is approved.⁴⁶

Massachusetts

In Massachusetts, several health care reform proposals have been introduced and the legislature has passed two different versions. Given the activity in Massachusetts, it seems likely that an expansion in insurance coverage will be enacted. Governor Mitt Romney (R) opened the debate with a proposal featuring an individual mandate, an insurance exchange, and state subsidies for low-income uninsured. The insurance exchange allows the payment of premiums from individuals to be paid pre-tax and allows for more affordable, portable products to be sold to individuals and small employers. The Romney proposal requires no new taxes, but will use money from the existing uncompensated care pool, general state revenues, and current federal funding streams. Additional dollars flow into the system from health insurance premiums paid either on a sliding scale basis for those at or below 300 percent FPL or straight premium payments for those above 300 percent FPL.

The Massachusetts House and Senate finished their formal sessions with each passing a different health care bill. The two chambers have begun their work to reconcile the differences between the bills. At the time of writing this article, the House and Senate have named three members to the conference committee and they have begun their work.

The House version combines a “pay or play” proposal with an individual mandate to achieve universal coverage. The bill would impose a 5 percent payroll tax on employers, with 11 – 99 employees and a 7 percent payroll tax on those employing 100 or more employees. Businesses that currently offer coverage would receive a credit for the amount they currently spend on health insurance and/or health care for their employees. All Massachusetts residents would be required to purchase health insurance if they could afford it. The legislation states that those individuals that cannot find affordable products will not be penalized. However, the proposal states that, starting in 2007, residents in the state will have to confirm health insurance coverage by reporting on state income tax forms. The Department of Revenue will enforce this provision and penalize those that can afford to pay a premium. To fill the gap between Medicaid and employer-sponsored coverage, the House would create a subsidized health insurance product. In addition, the House version proposes a Medicaid expansion for all adults up to 100 percent FPL, for children from 200 to 300 percent FPL, and for parents from 150 to 200 percent FPL.

The Senate version aims to insure one-half of the state’s uninsured in the next two years, and does not include either a payroll tax or an individual mandate. The legislation would expand Medicaid eligibility for children from 200 to 300 percent FPL, parents from 150 to 200 percent FPL and documented immigrants. In addition, the Senate bill looks to increase enrollment in the Insurance Partnership Program, a premium assistance program that provides subsidies to small employers and their workers. Changes to this program include expanding eligibility from 200 to 300 percent FPL, increasing the allowable firm size from 50 to 75, and increasing the subsidies to employers.

EMPLOYER MANDATES

Legislators in 12 states introduced “pay or play” bills in 2005, requiring employers to pay for or provide health insurance to their workers. Hawaii is still the only state with an employer mandate in effect and their law preceded the federal Employee Retirement Income Security Act (ERISA) requirements, which many see as an obstacle to implementation of these types of bills. In 2003, California came close to an employer mandate with the passage of S.B. 2—the Health Insurance Act of 2003. The legislation would have required businesses with more than 50 employees to pay a fixed fee for workers and those that offered insurance would receive a credit against the fee.⁴⁷ However, the mandate was rejected by California voters in 2004.

The Maryland Legislature took a new approach to an employer mandate with the passage of the Fair Share Health Care Fund in 2005. The legislation was vetoed by Governor Robert Ehrlich (R), but the legislature will consider a veto over-ride in January 2006. The proposal would have required private sector firms that employ 10,000 or more to spend at least 8 percent of their payroll on health care. A lower threshold applied to non-profits. As a practical matter, only one company—Wal-Mart—did not meet the requirement.

Other states addressed the growing problem of fewer employers covering their workers by publishing information on the employers with a large percentage of workers or their dependents who are uninsured or covered by public programs. The Connecticut Office of Legislative Research published a January 2005 analysis of Husky A and B (Connecticut’s SCHIP program) enrollment and employer data, finding that 25 employers account for 13 percent of the working recipients enrolled in the program.

PURCHASING POWER

States continued to look to strategies that use their purchasing power or the consolidated power of small groups to purchase health care. Kansas Governor Kathleen Sebelius (D) signed legislation creating a new state agency called the Kansas Health Care Authority. By July 2006 the new Authority will take over management of several Kan-

sas health programs, including Medicaid, SCHIP, state pharmacy programs, the state employee's health benefit program, workers' compensation, MediKan (a program for the uninsured), and the Kansas Business Health Partnership (a not-for-profit entity created to develop and market a low-cost health plan to small businesses). The Kansas Business Health Policy Committee, which oversees the Partnership, will develop a health insurance product for small businesses (less than 50 employees) and whose employees are low-wage (less than 200 percent FPL), including funding for a pilot subsidy.

Minnesota's Smart-Buy Alliance, established in November 2004, combines six state agencies and several private sector and labor groups to agree on a uniform set of principles with the goal of reducing health care costs and improving quality outcomes by promoting evidence-based medicine, rewarding "best in class" providers, and reducing inappropriate or unnecessary care. The Smart-Buy Alliance purchases health care for approximately two-thirds of Minnesotans.

Montana passed the Small Business Health Care Affordability Act, allowing small businesses in Montana to join a purchasing pool to obtain health insurance. The program provides tax credits to small businesses that are currently offering health insurance and will provide premium assistance for small employers that begin to offer insurance through the State Health Insurance Purchasing Pool or a qualified association plan.

HEALTHY NEW YORK: A MODEL PROGRAM FOR OTHER STATES

Several states looked to Healthy New York (Healthy NY) as a model for improving access to insurance for small businesses, the self-employed, and low-wage workers. Healthy NY is a state-subsidized reinsurance mechanism that reimburses health plans for 90 percent of claims paid between \$5,000 and \$75,000 on behalf of a member in a calendar year. All health maintenance organizations (HMOs) are required to offer a Healthy NY product. Established in 2001, enrollment in Healthy NY has recently taken off, with more than 100,000 active enrollees as of October 2005, and averaged more than 7,000 new enrollees per month in 2005. Approximately 57 percent of enrollees are working individuals, 18 percent are sole proprietors, and 25 percent are enrolled through small employer groups.

Several states with Health Resources and Services Administration (HRSA) state planning grants have actively considered a version of the Healthy NY program for their states, and both Delaware and the District of Columbia had legislative initiatives proposed that would have created similar programs in their states.

FUNDING INITIATIVES

States continue to face the challenge of finding funding for coverage initiatives. States have tried to leverage employer funding and Medicaid financing as much as possible and others have looked to dedicated funding sources such as tobacco taxes.

Pennsylvania found new sources of funding through a partnership between their Blue Cross plans and the state's adultBasic program, which provides insurance coverage to uninsured adults with incomes below 200 percent FPL. In 2004, adultBasic's waiting list had grown to more than 100,000 due to limited state funding.

In February 2005, Pennsylvania Governor Edward G. Rendell (D) announced an agreement with the state's four Blue Cross/Blue Shield plans for an ongoing annual commitment of funds for Annual Community Health Reinvestment (ACHR). Overall, this represents a commitment of nearly \$1 billion over the life of the agreement. In its first year, more than \$85 million of the nearly \$150 million in committed ACHR funds was used to enroll uninsured individuals on the waiting list for the adultBasic program. The remainder was committed to other health care-related services in the community. The Blues plans agreed that a certain percentage of their premiums, based on a formula, will go toward providing health care for low-income Pennsylvanians. For the next six years, 60 percent of those funds will be dedicated to providing health insurance through state-approved programs for both low-income and uninsured persons through programs like adult Basic. (For more on not-for-profit insurers, see p. 40.)

LIMITED BENEFITS

States continued to look to previously tried strategies to expand coverage. Georgia and Kentucky passed legislation in 2005 to attempt to make coverage more affordable by allowing carriers to develop new products without many of the state mandated benefits. Prior state experi-

ence suggests that removing mandates from the benefit package alone does not generate the cost savings necessary to encourage employers to begin to offer coverage or for uninsured individuals to afford coverage; however, the continued rise in health care costs may begin to make these products more attractive.⁴⁸ Texas is one state that has positive enrollment experience in limited-benefit plans, with more than 17,000 enrolled in the new Consumer Choice plans; however, the plans' affordability may be a result of higher cost sharing allowed by these new plans.

IMPLEMENTING COVERAGE PROGRAMS

Maine

Enrollment in Maine's DirigoChoice program began in January 2005. A new insurance product created to improve health insurance coverage in the state, DirigoChoice is one component of a broad health reform strategy that also includes new cost-containment strategies and state-wide quality improvement programs.

DirigoChoice is a new health insurance option available to small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance that offers discounts on monthly payments and reductions in deductible and out-of-pocket costs on a sliding scale to enrollees with incomes below 300 percent FPL. The plan is offered through a partnership between the state and Anthem Blue Cross Blue Shield of Maine. Since the start of the program, DirigoChoice had served over 8,600 members. This includes more than 750 small businesses. Almost half of DirigoChoice members are in the small group market, while 30 percent are sole proprietors, and 22 percent are individuals.

Funding for DirigoChoice comprises employer contributions, individual contributions, and state general and federal Medicaid matching funds (pursuant to a CMS-approved managed care contract) for those individuals who are eligible. After the initial year of the program, funding for premium discounts will be generated through a legislatively required Savings Offset Payment.

Determining the amount of the Savings Offset Payment has proven to be one of the challenges of the program. As required by the law, the Dirigo Health Agency filed

estimates with the Insurance Superintendent that the reforms had resulted in savings of \$110.6 million. After a review of the Agency's estimates and consideration of different estimates from stakeholders, the Maine Insurance Superintendent announced that the program had accrued \$43.7 million in savings in its first year (\$33.7 million from voluntary measures implemented by hospitals, \$2.7 million from averted bad debt and charity care, and \$7.3 million from the provider fee initiative).

Noting the importance of a transparency in the review of savings, Trish Riley, director of the Governor's Office of Health Policy and Finance, said, "Health care finance is complicated, and reasonable people can disagree—and did disagree—about exactly how much has been saved. In any such review, differences are discovered and expected by this extensive public review and determination of the Superintendent allows us to move forward with real savings."

After this independent review by the Insurance Superintendent, the Dirigo Health Board voted to assess the total value of the certified savings of \$43.7 million. The assessment will allow the program to serve nearly 23,500 people and lift the waiting list for individuals and sole proprietors in 2006. Even with the externally reviewed savings, payers are still challenging the determination of savings. In late November, the Maine Association of Health Plans filed suit in the state court asking for an injunction against the assessment.⁴⁹

Oklahoma

On September 30, 2005, the Oklahoma Health Care Authority (OHCA) received federal approval for the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). O-EPIC is a Health Insurance Flexibility and Accountability (HIFA) demonstration initiative waiver that proposes to cover an additional 50,000 residents in the state with incomes at or below 185 percent FPL. O-EPIC began enrollment at the beginning of November; in the first three days, the enrollment office received 103 employer applications, signaling interest in the program.

The O-EPIC program initially will be available for workers and spouses with household incomes at or below 185

Figure 10: New State Coverage Programs Implemented in 2005

State	Program (start date)	Enrollment Updates (November 2005)	Program Web site
Maine	DirigoChoice (January 2005)	8,676 members	www.dirigohealth.maine.gov/dhlpo2.html
New Mexico	State Coverage Insurance (July 2005)	2,300 members	www.nmsci.state.nm.us/nmscihome.aspx
Oklahoma	Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) (November 2005)	228 applications received	www.oepic.ok.gov
West Virginia	West Virginia Small Business Plan (January 2005)	650 members	www.wvsbp.org

percent FPL who work in firms with 25 or fewer workers, including those that currently offer coverage. Unemployed individuals seeking work will also be eligible. Participating employers will be required to pay 25 percent of the cost of total premiums. Employees will be responsible for up to 15 percent, and the state and federal governments will pay whatever is not covered by the employer/employee contributions. The program will also include a “safety-net” option for eligible workers and spouses whose employers are unable or unwilling to participate. These individuals will be permitted to directly buy an insurance product offered by the state. The state is devoting approximately \$50 million per year to the initiative, which will be generated through a new tobacco tax that took effect on January 1, 2005.

New Mexico

In July 2005, New Mexico implemented the State Coverage Insurance (NMSCI) program, a public/private partnership resulting in the creation of a new employer-sponsored insurance program. The state contracts with managed care organizations to provide the product. This program was developed in part with grant funding from The Robert Wood Johnson Foundation’s State Coverage Initiatives program.

New Mexico initially received approval for their HIFA waiver in 2002. Working through implementation challenges—information system issues, changes in benefit package, and most important, funding—the program began enrolling beneficiaries in July 2005. As of Novem-

ber 2005, the program covered 2,300 people and had 800 pending applications—exceeding enrollment expectations. The program expects to cover 10,000 individuals in the first year of the program.

New Mexico’s program is available to low-income, uninsured, working adults with family income below 200 percent FPL. An individual may enroll through their employer or as a self-employed individual. The premium is paid through contributions from the employer and employee in combination with state and federal funds. The self-employed must pay the employer as well as the employee portion of the premium. The benefit package is a comprehensive health care benefit with a total benefit maximum. The NMSCI plan features cost-sharing designed to ensure that low-income participants would have access to care.

NMSCI is part of a much larger strategy that New Mexico is focused on to address the uninsured. In March 2005, Governor Bill Richardson (D) signed four pieces of legislation, which, alongside the NMSCI program, will promote and increase access to coverage. The legislative initiatives include expanding the existing Health Insurance Alliance, an entity that brings together a group of independent health insurers to offer reduced cost health plans to companies with 50 or fewer eligible employees. The Small Employer Insurance Program (SEIP) will provide options for small employers (50 or fewer employees) to voluntarily buy into a pool. Gov. Richardson also approved legislation allowing 19 – 25 year olds to continue

on their parents' coverage and requiring insurers to offer insurance to part-time employees. The state hopes that an additional 21,000 New Mexicans will be insured through these programs.

West Virginia

In mid-March of 2004, West Virginia, also a SCI grantee, passed key legislation (S.B. 143) intended to help uninsured small businesses provide coverage for their employees. The new law created a private/public partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies that choose to offer the plan. The design of the Small Business Plan includes both primary care and major medical coverage at a cost that is 20–25 percent lower than the market rates. The state hopes that it will expand the number of covered working persons and their families at no cost or risk to the state.

The West Virginia Small Business Plan builds on the purchasing power of large groups by allowing small businesses access to the buying power of the PEIA. It allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly. PEIA is the largest self-insured plan in the state, providing insurance to public employees in state agencies, state universities and colleges, as well as county boards of education.

Program enrollment began in January 2005 and as of November 2005, more than 650 individuals were enrolled, representing 134 businesses. Current state efforts are focused on marketing the plan to small businesses. More recent policy initiatives in West Virginia have focused on improving access to affordable insurance in the individual market. The state established the WVAccess high-risk pool in 2005 and policymakers are currently developing an initiative similar to the Small Business Plan for uninsured individuals.

MEDICAID REFORMS

In FY 2004, Medicaid spending surpassed education as the largest item in state general funds budgets. With projected growth of 8.8 percent in 2005, Medicaid is likely to outpace state revenue growth. Additionally, in many states Medicaid is now covering a growing number of the working uninsured. States continued their cost-containment efforts (see Figure 9 on p. 20), but also increasingly looked to more comprehensive reforms to address the growing Medicaid cost crisis. At least 16 states initiated major Medicaid reform plans in 2005. Some of the common elements in many reform packages are the redesign of the Medicaid benefits, cost-sharing changes, efforts to encourage patient responsibility, and coordination of safety-net funding into coverage programs.

Tennessee

One of the biggest changes to a state Medicaid program in 2005 was in Tennessee. After months of negotiations, Tennessee was granted a waiver amendment on March 24, 2005, to end coverage of adults in the expanded eligibility categories—that is, uninsured and uninsurable adults. TennCare continues to cover approximately 119,000 non-Medicaid-eligible children. After a long legal battle, the state finally began disenrolling members in June. Approximately 320,000 individuals are being disenrolled. Beginning with the 1994 creation of TennCare, the program has gained national attention as a far-reaching effort to expand coverage and it will certainly continue to be in the national spotlight as different groups assess the impact of the program changes.

Florida

Florida is moving ahead with plans to redesign their Medicaid program. In mid-October, the state received federal approval to require Medicaid participants in two counties (Broward and Duval) to choose between a variety of managed care plans and benefit packages. Managed care plans will receive risk-adjusted payments and will be able to develop different, but actuarially equivalent, benefits. A “Choice Counselor” will advise beneficiaries in choosing

a plan. In each plan, there will be a comprehensive care component in which the insurer assumes the risk, and a catastrophic care component, in which risk is shared by the insurer and the state. The state will establish an overall maximum benefit for all recipients except children under age 21 and pregnant women. Beneficiaries may “opt out” of a Medicaid-approved plan and use their allocation to purchase insurance through their employer. Beneficiaries will also be given an Enhanced Benefits Account, in which the state will deposit funds to reward healthy behaviors, such as weight management, smoking cessation, and diabetes management. These funds could be used for health-care related expenses.

Initially, the Florida program will be mandatory for Temporary Assistance for Needy Families (TANF) and Aged and Disabled eligibility groups. Current income and asset limits for enrollment will apply. The program will be phased in by county, beginning with Broward (Ft. Lauderdale) and Duval (Jacksonville). The state will establish a low-income pool to provide direct payments to safety-net providers to subsidize care to the uninsured. Growth in state Medicaid expenditures will be tied to growth in state revenues rather than historic growth in Medicaid, thereby both constraining the growth of the Medicaid budget and making it more predictable.⁵⁰ The demonstration still requires the formal approval of the Florida Legislature before it may be implemented.

CONSUMER DIRECTION IN MEDICAID

There is a growing trend in some states to try to expand beneficiary choice and encourage patient responsibility in the Medicaid program by looking to consumer-directed benefit designs. Like Florida’s Enhanced Benefit Account, West Virginia, South Carolina, and Kentucky all have proposals that include some type of personal account. In general, these accounts are designed to encourage Medicaid enrollees to use preventive services and make healthy lifestyle decisions. Kentucky’s KyHealth Choices, submitted to CMS in November 2005, calls for creation of “Get Healthy Accounts.”⁵¹ Get Healthy Accounts will allow individual members who have specific targeted diseases

to earn funds by participating in certain healthy practices as identified by the Commonwealth. Such activities may include annual exams or disease management protocols. The individuals may then access the accounts to purchase additional health care services, assist with cost-sharing requirements, or purchase gym memberships, smoking cessation programs, or other traditionally non-covered services under Kentucky Medicaid.

MEDICAID FUNDING

Iowa and Massachusetts received approval to modify their safety net funding. In exchange for giving up \$66 million in Inter-Governmental Transfers, Iowa received a waiver to provide a limited set of Medicaid benefits to adults ages 19 – 64 up to 200 percent FPL, using a limited-benefit package and a limited provider network. Under the Massachusetts’ MassHealth waiver extension, a Safety Net Care Pool will be established using a combination of demonstration savings, in addition to the Commonwealth’s Medicaid Disproportionate Share Hospital (DSH) allotment, to pay for subsidies toward health insurance for low-income residents not eligible for Medicaid.

Louisiana is still awaiting approval for their HIFA waiver, submitted to CMS in July 2005, which pools DSH allotments to expand insurance coverage and provide greater access to primary health care services for uninsured individuals under 200 percent FPL.

The Vermont Agency of Human Services accepted a capped federal contribution to their Medicaid program under their waiver, “The Global Commitment to Health,” approved in September 2005. In exchange for accepting the capped federal payment, with a 9 percent inflationary trend adjustment, Vermont will have increased program flexibility, the authority to alter pieces of the benefit package, the ability to increase participant cost sharing, and flexibility to implement new cost-control strategies. Vermont will manage its Medicaid program within a five-year, \$4.7 billion budget and the state will be financially at risk to keep expenditures below this target. The Vermont Office of Health Care Access will convert into a statewide public managed care organization and has the authority to use any additional funds to reduce the uninsured rate.

Communities Address Coverage Gap

The growing interest in local initiatives to improve access to health care is fueled by the erosion of employer-sponsored benefits, and the lack of a comprehensive strategy to address the uninsured. In 2005, several states looked to community coverage strategies as a major part of their efforts to ameliorate the ever-present dilemma of the uninsured.

The health care “pressure cooker” has reinvigorated local efforts and brought together coalitions of city and county officials, hospital and physician leaders, philanthropists, and community activists to help their uninsured and low-income neighbors. Vondie Woodbury, director of the Muskegon Community Health Project, is a firm believer in this strategy. Her organization developed the Access Project in Muskegon, Mich., which is considered one of the pioneer community programs (see p. 31). “We have achieved 100 percent access. Anybody who needs to go to the doctor, we can get them there,” says Woodbury. “You don’t have to wait for Congress to act. You can engage the community and go about the business of what you think health care ought to be for your friends and neighbors.”

Communities have long played a role in developing health care initiatives at the local level and these efforts are an important part of the safety net. Steeply rising health care costs and the diminishing ability to spread the charity care burden, however, are forcing safety net providers to stretch limited dollars farther than ever. Woodbury and other colleagues have been working with members of Congress to introduce legislation to allow states to more easily adopt three-share models like Muskegon’s.

Realizing the potential for change at the local level, several national foundations and the federal Health Resources and Services Administration (HRSA) have provided grants and technical assistance to support local access to care projects. The Robert Wood Johnson Foundation’s Communities In Charge Program, the W.K. Kellogg Foundation’s Community Voices Program, and HRSA’s Healthy Community Access Program (HCAP) were designed to help promote and spread innovations at the local level. Even the HRSA State Planning Grant (SPG) program, which is designed to support statewide coverage efforts, has found that, for many states, progress on expanding coverage may rest with community initiatives.

Models for local initiatives vary considerably depending on geography, the nature of the local community, the resources at hand, and the entrepreneurial leaders who start and sustain them. Each targets a specific slice of the uninsured

population, offers a particular set of benefits, and pieces together available funding from public and private sources. Each has also identified its priority, such as improving access to insurance coverage, or increasing access to care and strengthening the health care safety net.

Some of the common models seen in local coverage programs include:

Individual insurance coverage programs. For those not enrolled in employer-sponsored or other group insurance plans, and not otherwise eligible for public programs like Medicaid and SCHIP, individual coverage programs seek to provide basic benefits to individuals or families who cannot afford insurance on their own. The Health Flex program in Florida allows limited-benefit plans to be sold by insurers, health maintenance organizations, provider-sponsored organizations, and public or private community-based organizations. Several of the providers in the Health Flex plans are safety net providers who are organizing access to their services in a coverage model.

Multi-share employer-based insurance programs. Building on private group coverage, “three-share” programs seek to split the premium cost between the employer, employee, and subsidy partner(s), which can be a local government, state government, or private foundation. Muskegon County, Mich., has served as the model for many other community three-share initiatives.

“Managed care” safety net programs. Providing an explicit medical home and actively tracking and managing the care of indigent patients is a way to help improve patient care and stretch limited uncompensated care dollars as far as possible. The approach is usually generated by public or private safety net hospitals that want to help control and improve the utilization of charity care. Community Health Works program in Macon, Ga., provides case management for uninsured individuals with high-risk medical conditions.

Donated or discounted care programs. Provider volunteerism is the cornerstone of these programs that organize a significant volume of free or reduced-cost care. In several counties in Maine, the CarePartners program uses a donated care model and provides access to comprehensive health care services, care management, and low-cost or free pharmaceuticals.

Sustaining funding is a significant hurdle for all of these models, despite the fact that communities have tapped a variety of funding sources. These range from property tax revenues, local foundations, or donated services from providers, to partnering with the state Medicaid program to identify Medicaid matching funds through disproportionate share hospital (DSH) funds, Inter-Governmental Transfers (IGTs), or Certified Public Expenditures (CPEs).⁵²

STATE INVOLVEMENT IN COMMUNITY PROGRAMS

Georgia and Illinois were among nine other states to be awarded the first round of HRSA SPG Pilot Project funding. These two states used their statewide grant to support and develop coverage programs at the local level. Illinois worked on expanding three-share programs in three counties while Georgia brought together four diverse communities to help them build capacity to move forward on a plan, guide them through understanding the options available, as well as help them ascertain what questions must be asked at the forefront of the process. They are not the only states thinking about local initiatives, however. Oregon, which has been a leader in statewide strategies to address the uninsured, is looking to community coverage initiatives as part of their 2006 HRSA Pilot Project Planning grant.

“In recent years it has become apparent that there is a need to consider both state- and community-level approaches to improving access. We want to learn how best to support communities as they play an integral part in addressing the gaps in coverage,” says Jeaneane Smith, deputy administrator in the Office of Oregon Health Policy and Research. “We are hopeful that these communities’ experience in reforming their delivery systems and maximizing finances will provide for broader community-level expansion across the state.”

Louisiana, though facing the aftermath of the devastating Hurricanes Katrina and Rita, is not retreating from its plan to allow communities to develop and finance Medicaid expansions at the local level. In August 2005 (prior to Hurricane Katrina), Louisiana submitted a Health Insurance Flexibility and Accountability (HIFA) waiver. While it is unclear how this waiver will play out as it has not received approval from the Centers for Medicare and Medicaid Services (CMS), community programs have taken on new importance as the state rebuilds the health care system.

Access Health: Muskegon County, MI ⁵³

- ◆ Access Health is known as a “three-share plan”: Employers, employees, and the community each pay about one-third of the cost of the program.
- ◆ The community share is subsidized by federal DSH funds.

Eligible employers:

- ◆ Employers are eligible if they have not offered health insurance for at least 12 months.
- ◆ Open to employers with a median wage of workers below \$11.50/hour.
- ◆ Employees must work at least 15.5 hours per week over a 13-week period before they are eligible.
- ◆ Employees and dependents must be uninsured and not eligible for public programs.

Benefits package:

- ◆ Inpatient and outpatient services
- ◆ Primary and preventive care services
- ◆ Emergency room care
- ◆ Prescription drugs
- ◆ Health care services are provided only within Muskegon County

Experience to date:

- ◆ Access Health began in 1999 and by the end of 2004 served more than 420 employers and 1,150 employees and dependents.
- ◆ The program has been able to keep costs low. In 2003, the employee’s share was \$46 per month and the community share was \$62.

LESSONS LEARNED

Community efforts to improve health care are not new; in fact, they offer a rich history for policymakers to draw on for the development of new community coverage efforts. While the prior experiences of diverse local initiatives have shown that they can be an important part of the safety net for the uninsured, few have demonstrated long-term ability to expand coverage on their own. This is true, in large part, because of the difficulty in reaching and signing up individuals or employers who have often gone without insurance, or sustaining long-term and sufficient funding streams to lower the cost of health care enough to encourage take-up.

Perhaps one of the most important lessons so far is that the investment in developing relationships among critical stakeholders, particularly state and local officials, is essential to implement complex health programs. Local initiatives present important opportunities for states to consider as they determine their state strategies for covering the uninsured.

State Coverage Matrix

There is a reason why states have been referred to as laboratories for innovation: States have continued to experiment and try new models to expand coverage. Many states have focused on strategies that build on the existing employer-sponsored insurance market to cover lower income groups, build existing public coverage programs to cover higher income groups or new populations, or link the public and the private sectors.

State	Medicaid and SCHIP Waivers	Reinsurance	High-Risk Pools	Limited-Benefit Plans	Group Purchasing Arrangements	Other
Alabama			✓			✓
Alaska			✓			✓
Arizona	✓	✓				✓
Arkansas	✓		✓	✓	✓	
California	✓		✓		✓	✓
Colorado	✓		✓	✓		
Connecticut		✓	✓			✓
Delaware	✓					✓
District of Columbia	✓					✓
Florida	✓		✓	✓		
Georgia				✓		
Hawaii	✓					✓
Idaho	✓	✓	✓			
Illinois	✓		✓			✓
Indiana			✓			
Iowa	✓		✓			
Kansas			✓		✓	✓
Kentucky			✓	✓		
Louisiana			✓			
Maine	✓					✓
Maryland	✓		✓	✓		✓
Massachusetts	✓	✓				✓
Michigan	✓					✓
Minnesota	✓		✓	✓		✓
Mississippi	✓		✓			

The State Coverage Initiative's Web site provides a wealth of information through the coverage matrix. This research tool organizes available information on specific strategies states have used to expand or sustain insurance coverage. The matrix provides real-time information on state approaches to expanding coverage, descriptions of strategies, research sources, specific information on state's coverage environments, and available information on all known strategies employed by each state.

Access the coverage matrix at www.statecoverage.net/matrix.

State	Medicaid and SCHIP Waivers	Reinsurance	High-Risk Pools	Limited-Benefit Plans	Group Purchasing Arrangements	Other
Missouri	✓		✓			
Montana	✓			✓	✓	
Nebraska			✓			
Nevada						
New Hampshire		✓	✓			
New Jersey	✓			✓		✓
New Mexico	✓	✓	✓		✓	
New York	✓	✓			✓	
North Carolina						
North Dakota			✓	✓		
Ohio						
Oklahoma	✓		✓			
Oregon	✓		✓			✓
Pennsylvania						✓
Rhode Island	✓					
South Carolina			✓			
South Dakota			✓			
Tennessee	✓					
Texas			✓	✓	✓	
Utah	✓		✓	✓		
Vermont	✓					
Virginia						✓
Washington			✓	✓		✓
West Virginia			✓		✓	✓
Wisconsin	✓		✓		✓	✓
Wyoming			✓			



FEDERAL CHANGES FOR PUBLIC PROGRAMS

Last year, coverage-related actions at the federal level focused on creating health savings accounts and preparing for the implementation of the Medicare drug benefit. This year, all eyes were on the federal budget.

BUDGET RECONCILIATION

With less than two weeks left in 2005, Congress was close to an agreement on a conference report for the long overdue budget reconciliation package. The conference agreement saves \$40 billion over 5 years, cutting approximately \$6.4 billion from the Medicare program and \$4.8 billion from the Medicaid program over five years. The long-term savings to Medicaid are projected to be \$26.5 billion over 10 years. The savings are anticipated as a result of numerous changes to both programs that will certainly have implications on state coverage efforts.

Lawmakers in both chambers were working intensely up to the winter congressional recess. However, the work on the federal budget had begun much earlier. In April, Congress passed a Joint Budget Resolution calling for \$10 billion in Medicaid savings over 10 years. Congress also called for the establishment of a Medicaid Commission to make recommendations on how to find savings from the program over five years by September 2005, as well as make longer-term recommendations for changes in the program by December 31, 2006. Several of the initial recommendations by the Commission were included in the conference agreement, and the Commission is still meeting to develop long-term recommendations for changes to Medicaid.

In November, the House and Senate each passed their respective versions of the federal reconciliation budget package. The House of Representatives (H.R. 4241) cut

approximately \$50 billion from the federal budget over five years, including approximately \$11 billion from the Medicaid program. The Senate (S. 1932) cut \$35 billion over five years, including approximately \$4.3 billion from the Medicaid program.

The contested issues in the budget ranged widely from whether oil exploration and drilling should be allowed in the Arctic National Wildlife Refuge (ANWR) to whether a Medicare stabilization fund would be preserved to encourage preferred provider organizations to offer drug coverage in underserved regions. For states, the central issue was how much in savings would be expected from the Medicaid program and what kind of flexibility they would be given to make program changes. With Medicaid the largest item—and growing—in most state budgets, the National Governors Association supported many changes that would result in savings for both the federal and state government. However, the NGA did oppose the cuts that would shift costs to state governments (see box on p. 37).

Summary of Major Medicaid and SCHIP Budget Issues

The final conference agreement targets several pieces of the Medicaid program for cuts.⁵⁴ The following are the major sources of savings (all figures scored over five years):

- ◆ Cost-Sharing and Benefit Package Design:
\$3 billion savings

The debate over cost-sharing and benefit package cuts sparked a heated debate in Congress and continues to divide the chambers. The conference committee gave states flexibility to impose additional cost-sharing on non-preferred prescription drugs and inappropriate emergency room use. In addition, some optional populations (> 100 percent FPL) could receive alternative benefit packages and be charged increased cost-sharing or premiums.

◆ Prescription Drugs: \$3.8 billion savings

The bill increases transparency of prescription drug pricing by establishing a new, upper payment limit for multiple source drugs, mandating that states collect rebates on physician prescribed drugs, and including authorized generic drugs in calculating the average manufacturer's price (AMP).

◆ Asset Transfers: \$2.5 billion savings

The bill reduces Medicaid spending by increasing penalties on individuals who improperly transfer assets to qualify for Medicaid long-term care, increasing the look-back period, changing the countable income formula, and making those who own more than \$500,000 (or up to \$750,000 at state option) in housing equity ineligible for Medicaid long-term care services.

◆ Katrina Relief

The federal government will reimburse the states, at 100 percent matching rate, for costs associated with Medicaid and SCHIP Katrina evacuees. The enhanced matching rate will sunset in May 2006. To further assist states affected by Hurricane Katrina, the Secretary of Health and Human Services was provided \$2 billion to pay for the non-federal share of expenditures, and the states were provided with grant money for high-risk pools.

◆ State Children's Health Insurance Program (SCHIP)

The conference agreement provided \$283 million in SCHIP funds to states that overspend their allotment in FY 2006. The final conference committee report does not allow CMS to approve additional waivers to states to cover childless adults with unspent SCHIP funds. For all states, redistributed SCHIP funds will be limited to providing coverage to children.

◆ Medicaid Transformation Grants

Up to \$150 million in both FY 2007 and 2008 is available for grants to states to improve the effectiveness and efficiency in providing medical assistance. There is no requirement that the state provide matching funds for these grants.

SCHIP REAUTHORIZATION

With the authorization of the SCHIP program to occur in 2007, states have raised concerns regarding how the program should be structured and identified ways to improve and reform the program. Although cited as a possible model for Medicaid reform, SCHIP's capped financing system has been the subject of debate. Concerns have been raised over inequities and misallocations resulting from funding based on a pre-set formula rather than funding that responds to program needs. Still SCHIP is a popular program in Washington and in state capitals, covering over 4 million children.⁵⁵

In many states there has been a mismatch between the state's funding needs and the level of available federal funds. Some states have ended up with more SCHIP funds than they spent while other states lacked the necessary funds to keep pace with the program costs and enrollment growth. In 2004, 36 states spent more than their federal SCHIP allotment.⁵⁶

In 2004, the National Academy for State Health Policy convened an advisory group of 10 state SCHIP directors to identify and discuss their major concerns related to reauthorization. A report was produced outlining the major areas that the directors recommended should be addressed during reauthorization in order to further advance the SCHIP program's goal of reducing the number of uninsured children in low-income families.⁵⁷ For example, many would like the federal statute to be revised to give states with separate SCHIP programs more flexibility. In particular, these states would like to be able to provide additional coverage in certain circumstances, have enrollment flexibility, and the ability to enroll certain excluded populations.

ANNUAL FEDERAL SPENDING BILLS

At the time this report went to print, Congress had yet to approve the final conference agreement on the annual health care spending bill (Labor-Health and Human Services Appropriations). However, the fate of grant programs that states rely on for coverage-related planning activities was largely known.

Governors Address Medicaid Reform

The National Governors Association (NGA) established a Medicaid working group in 2004 to report on both short-term and long-term recommendations for the restructuring of Medicaid. NGA Chairman Virginia Gov. Mark Warner (D) and Vice-Chair Arkansas Gov. Mike Huckabee (R) testified before the Senate Finance Committee in June 2005 to present the workgroup's specific recommendations for short-term Medicaid reforms.

The long-term vision is to preserve the current structure for the most vulnerable groups such as the dual eligibles, the disabled, and the very poor. For low-income, but relatively healthy individuals, Medicaid should be transformed into an insurance product that looks more like SCHIP.

The recommendations by the NGA working group included:

- ◆ Reforming Medicaid long-term care policy with regard to how assets are counted.
- ◆ Creating greater transparency for prescription drug pricing, and greater ability for states to negotiate the best price with the pharmaceutical industry.
- ◆ Allowing greater flexibility for benefit packages and cost-sharing.
 - A state could establish co-payments, premiums, or deductibles and make those cost-sharing provisions enforceable. No more than 5 percent of family income could be spent on cost-sharing. For higher income
- ◆ families (> 150 percent FPL), a 7.5 percent cost sharing cap could be applied.
- Allow states to develop alternative benefit packages based on the SCHIP model. This proposal would move beyond the traditional distinction between “mandatory” and “optional” populations and would include flexibility to set benefit limits and cost-sharing amounts, allow employer buy-in programs, eliminate retroactive eligibility periods, and establish different benefit packages for different populations in different parts of the state.
- ◆ Improve and streamline the waiver process.
 - Allow states automatic renewal of waivers after five years.
 - For commonly approved waivers (1915b, c, PACE), allow the states to use state plan amendments.
 - Revise budget neutrality and create a new “superwaiver” structure.
- ◆ Congressional constraint for the federal court's ability to supersede state and local governments from managing their Medicaid programs.
- ◆ Design regulatory and legislative fixes to ensure that all states receive fiscal relief from the Medicare Modernization Act and the “clawback” provision.

◆ HRSA State Planning Grant (SPG) program: After six years of funding state planning efforts on the uninsured, no funds were included in either House or Senate budgets. The SPG grants have been an important resource to states and U.S. territories looking to develop strategies to improve insurance coverage in their states. Grantees received funding to collect new state-specific data and study health insurance trends in order to develop coverage options for their uninsured. The last round of grants was awarded at the end of federal fiscal year 2005 and those states will complete their work over the next two years. (For more on the SPG program, see p. 43.)

◆ HRSA Healthy Communities Access Program (HCAP): The Labor-HHS conference report eliminated the Healthy Communities Access Program program. Established in 2002, the Healthy Communities Access Program was modeled after the Community Access Program (CAP), which had been operating as a demonstration grant program since the 2000 fiscal year. Over \$400 million has been invested to develop and strengthen community-based collaborations since the program began.

Beyond the budgetary challenges lawmakers in Washington faced in 2005, in the coming years they will have to confront the reauthorization of the SCHIP program and determine on-going federal appropriations for programs that states rely on for coverage-related activities.

States Struggle with Implementation of Medicare Part D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which established the Medicare Part D pharmacy benefit, represents the most significant change to the Medicare program since its inception in 1965. Medicare Part D will provide drug coverage for many individuals who previously had none. Officially launched on January 1, 2006, it has also created a number of implementation and coordination challenges for the states, beginning with the need to understand its complexities and communicate them to beneficiaries.

Many government officials are touting the new drug coverage as a landmark improvement to Medicare, highlighting the broad array of choices available to seniors. November 15, 2005, marked the beginning of the open enrollment period for Part D. However, for most Medicare recipients, navigating the plethora of options and deciding whether Part D is right for them has proven to be more difficult than anticipated.

“There are just a lot of different options—and options within options—that make it complicated for the average beneficiary,” said Jack Hoadley, a research professor at the Health Policy Institute at Georgetown University.⁵⁸

While the administration and many congressional leaders promoted the roll-out of the new benefit, others have called for changes in the benefit or endorsed delays in implementation.

CHALLENGES TO STATES

As of January 1, 2006, states no longer receive federal matching funds through the Medicaid program to provide prescription drugs to the dual-eligible population (i.e., individuals covered by both Medicare and Medicaid).⁵⁹ The MMA requires state Medicaid programs to determine eligibility for new groups of low-income Medicare beneficiaries and contribute to the cost of federal prescription drug coverage for these dual eligibles.

Instead of relying on Medicaid “wrap around” (i.e., help paying for all or a part of) for prescription drugs not included in the general Medicare benefit, the dual eligibles must select a new Medicare Prescription Drug Plan (PDP), since the Medicaid program can no longer provide this group prescription drug coverage. As of January 2006, the states have had to transition more than 7 million dual-eligible individuals to a new PDP.

In 2003, states spent approximately \$15 billion on prescription drugs (50 percent of all state prescription drug costs) for dual eligibles.⁶⁰ With many Medicaid programs focused on pharmacy management, moving this benefit to Medicare will affect states’ cost-containment strategies. Further, Medicaid agencies will no longer have access to the pharmacy data that are critical to coordinating care and carrying out many of the disease management activities previously undertaken by states.

Many states are concerned that the new Medicare drug benefit will increase the dual eligible caseload given these new MMA

Glossary of Terms

Clawback – A monthly payment made by each state to the federal government to help fund the Medicare Part D benefit.

Doughnut Hole – A gap in prescription drug coverage under Medicare Part D wherein enrollees are covered for up to \$2,250 of spending, then are on their own until they reach \$5,100.

Dual Eligibles – Beneficiaries who qualify for both Medicare and Medicaid.

Woodwork Effect – An increased number of new beneficiaries who come on to a program because of a change in program rules (the addition of prescription drugs) for the target population.

Wrap Around – Medicare and Medicaid jointly pay for individuals who are dually eligible for both programs. Medicare serves as the primary payer, and Medicaid “wraps around” that coverage to provide additional benefits and pays most or all Medicare co-payments.

requirements. And a significant number of new individuals applying for Medicaid coverage because of the increased benefits offered by Part D—known as the woodwork effect— could further exacerbate state budget woes.

In addition, the law has implications for states that currently have state pharmacy assistance programs (SPAPs) for low-income elderly. For states that had already established SPAPs for seniors prior to the passage of Part D, work has focused on re-configuring their programs to coordinate with the new Part D benefit. SPAPs can “wrap around” the Part D premiums, deductibles, and cost-sharing in and out of the “doughnut hole” (a coverage gap between \$2,250 and \$5,100 per year, where the consumer must pay for prescription drugs entirely out-of-pocket). This also applies to off-formulary drugs or out of network pharmacies not covered by the plan. Unlike other payers, if an SPAP elects to help Medicare recipients pay for drugs when the Part D doughnut hole is in effect, the state’s contribution can be counted toward true out-of-pocket costs, which helps beneficiaries reach the Medicare catastrophic coverage sooner.

STATES SEEK SOLUTIONS

Despite the very real problems and concerns of states as the new Medicare prescription drug benefit is implemented, many are responding to these changes and challenges in innovative ways. According to Kimberley Fox, senior policy analyst at the Muskie School of Public Service at the University of Southern Maine, the

strategic challenge for states is to make their dollars go as far as possible and to reconfigure benefits to make sure that SPAP beneficiaries maintain the coverage they had with minimal burden.

In surveying SPAP directors, Fox found that the vast majority of states are mandating that SPAP enrollees enroll in Part D and apply for the low-income subsidies to be eligible for state assistance. A few states have also attempted to simplify the process for beneficiaries by collecting information to apply for the low-income subsidy on their behalf and/or by facilitating their enrollment into Part D plans that are best suited to their existing drug needs. Only a handful of states have eliminated their SPAPs altogether and most of these did so because Medicare offered a better benefit to their enrollees.

Prior to the establishment of Medicare prescription drug coverage, several states had received Pharmacy Plus waivers from the Centers for Medicare and Medicaid Services (CMS), which allowed them to receive federal matching funds for their pharmacy programs. Wisconsin had a Pharmacy Plus waiver, called SeniorCare, and is currently the only state to date that has received a waiver to continue their SeniorCare program alongside Medicare Part D. Under the waiver, through June 2007, current SeniorCare enrollees will have a choice between SeniorCare and Medicare PDPs and can switch programs without incurring a financial penalty.

State officials also have faced the challenge of education, outreach, and enrollment for specific populations eligible for the low-income subsidy.⁶¹ The subsidy is available to two subgroups: a full subsidy is available with those individuals with incomes up to 135 percent FPL. A partial subsidy is available for those with incomes from 136 percent up to 150 percent FPL.⁶² Local Social Security Administration offices and CMS have undertaken large-scale education and outreach programs that include mailings to Medicare beneficiaries, Web-based products, and outreach handbooks. State Medicaid agencies will also take low-income subsidy applications.

THE CLAWBACK PROVISION

As part of the new benefit, the states are required to submit monthly payments to the federal government called the phased-down state contribution or “clawback.” The clawback opens a new chapter in federalism, as states will now be partially responsible for funding Medicare. Clawback payments are the single largest transfer of state dollars to the federal government, surpassing Medicare Part A and B premiums.⁶³

Each state received notice in the fall of 2005 detailing their respective clawback payments, which will be deposited into the Medicare Part D Trust Fund. These payments will partially finance the low-income subsidy. Although the clawback payments will affect states differently, depending on their budget and spending, all states will face immediate budget challenges as a result of this new provision. Consequently, the clawback formula has provoked considerable debate among the states as the first payment date approaches. It already faces several legal and political challenges. Some states are openly resisting the payment both

on the grounds that the formula is unfair and that the payment is unconstitutional.

Kentucky Attorney General Greg Stumbo (D) became the first to challenge the clawback provision when he filed suit with the U.S. Supreme Court in October 2005. Stumbo criticized the clawback on a number of grounds, citing the formula as unfair and inaccurate in reflecting savings. He also accused the clawback of being an unconstitutional tax that violates states’ rights. Kentucky will owe CMS approximately \$7 million per month and approximately \$88 million in 2006.⁶⁴

“It is my job to protect taxpayers from unlawful demands on their money,” Stumbo said. “Never before has the federal government made such a bold and, I believe, unconstitutional, attack on Kentucky’s right to control the spending of its own tax money.”

Texas Governor Rick Perry (R) used his line-item veto on the Texas clawback appropriation, estimated at \$444 million. He also objected on the same grounds as Kentucky’s Stumbo. Governor Perry expressed doubt that the federal government could do a more cost-effective job of providing prescription drugs than Texas. Citing rising Medicare prescription drug plan cost projections, he argued that the state of Texas had an excellent record of controlling the cost of prescription drugs. At the time of publication, the veto still stands, and Texas has not authorized a clawback appropriation.

New Hampshire has also taken action. In a companion to the state budget, the legislature specifies that “no payments shall be made to the federal Medicare program unless a court has determined that the provisions are constitutional.”⁶⁵ The state deposited its clawback payments into the rainy day fund, and payments will require additional legislative action.

Throughout 2006, states will be forced to confront these challenges and find solutions to maintain coverage while working within their already limited budgets.

The Nuts and Bolts of the New Part D Benefit

- ◆ Medicare-eligible individuals voluntarily enrolled in private prescription drug plans (PDPs).
- ◆ Enrollment began in November 2005.
- ◆ Coverage effective January 1, 2006.
- ◆ Enrollees pay a monthly premium, a \$250 deductible, co-payments, and coinsurance.
- ◆ The plan has a coverage gap—referred to as the “doughnut hole”—between \$2,250 and \$5,100 per year, where the consumer must pay for prescription drugs entirely out of pocket.
- ◆ Individual drug plans may vary as long as they are actuarially equivalent to the benchmark.
- ◆ A low-income subsidy is available to those that qualify to help pay premiums and cost-sharing before and during the coverage gap.

Taking a Closer Look at Not-For-Profit Health Insurers

The extent to which not-for-profit health insurers and health systems reinvest in the communities they serve is an emerging issue for states. Non-profit providers and health insurance plans are expected to provide benefits to their community in return for being exempt from most taxes. In 2004, many lawsuits were challenging non-profit hospitals on their provision of charity care. Active discussions on community benefit obligation have occurred more at the local level than at the state level. However, in 2005, this issue fell under the scrutiny of state officials. The emphasis of these discussions changed focus from mainly being directed toward providers to now looking at plans as well.

“There currently is no standard that determines how much surplus is excessive. Given today’s climate where carriers are experiencing record profits, yet health insurance premiums continue to rise faster than the rate of inflation, we need to ask, how much is too much?”

- Mike Kreidler, Washington State Insurance Commissioner

The level and the impact of community benefit activities remains largely undocumented.⁶⁶ Several states—Connecticut, Maryland, Massachusetts, and Minnesota—have requirements for hospitals and managed care plans to report on the extent of their community benefit activities. In Connecticut, the results of this reporting effort found that hospitals were extensively involved in providing free or subsidized health services. The same survey, however, found that Connecticut hospitals rarely subsidized health insurance premiums to make them more affordable for local residents.⁶⁷ In addition, managed care plans in Connecticut appeared to have few community benefit activities. In fact, the plans viewed the concept with skepticism, and resisted the state’s reporting requirements.

Across the nation, several states are grappling on the role of not-for-profit insurers not only in terms of their charitable contributions but also the tendency to maintain extremely high reserve funds. During the summer of 2005, lawmakers in Michigan were looking at the \$2.2 billion surplus of non-profit health insurer Blue Cross Blue Shield of Michigan as a source to financially sustain state health care programs in light of the state’s budget crisis. Senate Appropriations Chairwoman Shirley Johnson (R-Troy) stated that she would consider introducing legislation to

revoke the tax-exempt and non-profit status of Michigan’s largest health insurer if it did not voluntarily contribute funds to the state.⁶⁸ Although no action has yet been taken, the issue is still under consideration.

Washington state also is considering whether health insurer surpluses should be regulated. “Regulators look at carriers’ surplus to be certain it’s sufficient to protect policyholders and the market,” said Insurance Commissioner Mike Kreidler. “There currently is no standard that determines how much surplus is excessive. Given today’s climate where carriers are experiencing record profits, yet health insurance premiums continue to rise faster than the rate of inflation, we need to ask, how much is too much? Excess surplus is an emerging issue which I believe deserves a closer look and is one of my top policy priorities for 2006.”

In Pennsylvania, the state’s four not-for-profit Blue Cross and Blue Shield plans came under investigation for having accumulated capital surpluses that stakeholder groups considered excessive. An analysis of the plans’ activities noted, however, that there is no “right” amount of accumulated surplus for health insurers. In 2005, the Pennsylvania Insurance Commissioner moved to define acceptable levels of surplus capital for the four Blues plans.

On February 7, Pennsylvania Governor Edward Rendell (D) signed the agreement with Blue Cross Blue Shield (BCBS) that states that the four BCBS insurance plans in Pennsylvania will spend approximately \$1 billion in surplus funds, representing more than 1 percent of their premium revenues, over six years on different health programs in the state. This new Annual Community Health Reinvestment fund will donate \$85 million in 2005 alone, allowing approximately 29,000 new state residents on the wait list to enroll in the adultBasic program, a state-funded program available to residents between the ages of 19 and 64 who have not had health care coverage for more than 90 days and who have incomes at or below 100 percent FPL.

Pennsylvania is the first state to initiate and successfully negotiate such a program with health insurers. Clearly, the Community Health Reinvestment fund is unique and may have the potential to be replicated in other states and provide them with the needed revenues to preserve necessary and critically needed health care programs.

CoverThe
UninsuredWeek MAY 1-8
2005
 Let's Get America Covered

CoverTheUninsuredWeek.org

The Robert Wood Johnson Foundation (RWJF) held its third “Cover the Uninsured Week” May 1 – 8, 2005. This national effort mobilized a broad range of stakeholders including business owners, educators, students, hospital staff, and faith leaders united on behalf of America’s 45 million uninsured to send a message that health care coverage for all must be a priority. Former Presidents Carter and Ford once again served as Honorary Co-Chairs for the week.

“Cover the Uninsured Week” events included news conferences, health and enrollment fairs, seminars for small business owners, campus seminars, and interfaith activities. RWJF President and CEO, Risa Lavizzo-Mourey, described the week as “the largest non-partisan, community mobilization ever to secure affordable health care coverage for every man, woman, and child in America.”

A total of 2,240 events were held in communities across the country. In Albany, N.Y., medical students marched from Albany Medical College to the New York State Capital steps using a 60-foot banner to advocate for the uninsured. In Lansing, Mich., the Access to Care Community Coalition and Rep. Rich Brown invited Michigan representatives and senators to discuss covering the uninsured in Michigan. Legislators met with medical care access agencies in their respective districts and heard presentations describing models that are working to cover the uninsured. In West Monroe, La., a low- to moderate-income working-class neighborhood was targeted for door-to-door LaCHIP outreach led by Rep. Mike Walsworth. A central location was set up to provide personal assistance with application completion.

Local press events kicked off the week on Monday, May 2. These events announced the communities’ participation in the week and highlighted local events. News stories generated from the events are estimated to have reached more than 400 million people.

Seminars for small-business owners highlighted the challenges this group of employers is facing in providing coverage. RWJF, in collaboration with the Healthcare Leadership Council, prepared free resource guides to provide small-business owners with important information about coverage, including the various plan options, tax incentives for providing coverage, and tools to help estimate the cost of providing coverage.

Senators Bill Frist (R-Tenn.) and Harry Reid (D-Nev.) showed their bipartisan support for the week by issuing a joint letter to their colleagues on Capitol Hill. They urged fellow lawmakers to get involved in the Week by entering statements into the Congressional Record, distributing press releases about the issue of the uninsured, and authoring op-eds in their states’ newspapers.

Cover the Uninsured Week 2006 will be held May 1–7.

Grants Continue to Help Fund State Coverage Activities

One of the ways SCI supports state policy leaders is through direct grants for coverage-related activities. With funding from The Robert Wood Johnson Foundation, the SCI program provides financial support to states as they examine coverage expansion strategies and implement expansion programs. Maine, New Mexico, and West Virginia—all SCI grantees—recently implemented new coverage programs. In addition, SCI awarded four new grants in 2005.

SCI GRANTEES MOVE FORWARD

Maine

Maine was awarded an SCI grant in 2003 to assist with the implementation of the Dirigo Health Reform Act, a statewide health system reform that addresses cost, quality, and access with the goal of establishing universal coverage within six years. The plan is designed to ensure sustainable long-term reform through a comprehensive approach. Dirigo engages stakeholders and the state to rationalize the health care system, ensure appropriate incentives, and build a stronger health care system that serves all Mainers. The program began as a voluntary effort, recognizing that additional actions may be required as the program is implemented. Maine used SCI grant funds to help design the DirigoChoice benefit packages, sliding scale discount program, and the “savings offset payment.”

New Mexico

In 2001, New Mexico received an SCI grant to develop a unique public/private partnership. The funding was used for several different pieces of the program, including waiver design and submission, designing the benefit package and actuarial work, and implementing the program and outreach activities.

In July 2005, the state implemented this program, called the New Mexico State Coverage Insurance (NMSCI). NMSCI is a premium-assistance program that combines premium payments from the employees and employers, as well as state and federal funds to create a commercial benefit package delivered through managed care organizations. The program is available to adults who earn less than 200 percent of the federal poverty level and are not eligible for existing public coverage programs.

West Virginia

In mid-March of 2004, West Virginia passed key legislation intended to help uninsured small businesses provide coverage for their employees. The new law created a public/private partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies that choose to offer the plan. West Virginia’s Small Business Plan allows

2005 SCI Grantees

In 2005, SCI awarded four new policy planning grants:

Arizona plans to use these funds to develop strategies to encourage employers to enroll in the Arizona Healthcare Group program. The grant will help develop an operational framework to link uninsured working individuals and families of small employers in two counties (Yuma and Cochise).

Illinois’ grant will support the development of a partnership between the Illinois Department of Commerce and Economic Opportunity, the Chicagoland Chamber of Commerce, and an insurance carrier to create a low-cost product for small employers.

Washington’s grant focuses on the development of a Small Business Assist initiative, slated to begin in January 2007. The program may include a purchasing pool and premium assistance. The grant will fund necessary actuarial, economic, budget, and legal analysis and modeling of benefit design, financing and funding, and risk management work groups.

Washington, D.C.’s grant will support actuarial analysis of a risk transfer concept in the “Equal Access to Health Insurance Act,” a proposal that creates a purchasing pool that builds on the already existing size and stability of the District’s public employees.

participating carriers to access PEIA’s reimbursement rates, enabling the new small business coverage cost to be reduced significantly. The program started on January 1, 2005.

The design of the Small Business Plan includes coverage in both primary care and major medical at a cost that is 20–25 percent lower than the retail rates. The state hopes that it will expand of the number of covered working persons and their families at no cost or risk to the state.

HRSA STATE PLANNING GRANTS

The federal Health Resources and Services Administration (HRSA), through its State Planning Grants (SPG) program, has annually awarded grants to states and territories to develop plans for providing access to affordable health insurance coverage to all their citizens. Since 2000, 47 states, the District of Columbia, and four territories have received grants.

Starting in 2004, the SPG funding was expanded to include pilot project planning grants. These grants provide funds to states that have already developed policy options through SPG funds and are looking to further refine and plan for implementation.

In September 2005, HRSA awarded a planning grant to Alaska and the final round of pilot project planning grants. Funding for the program was eliminated in the Federal FY 2006 budget. Pilot projects in these states and territories cover a range of activities:

American Samoa will implement a unique community-based pilot planning process utilizing traditional leaders to develop community-specific plans for coverage and integrate the regional plans to a territory-wide plan.

Idaho will evaluate and expand coverage via the premium assistance program, the Access to Health Insurance program. In addition, Idaho will strengthen participation of county providers in planning and designing the County Medical Care pilot, a primary care program for uninsured adults. Finally, Idaho will use the grant funds to develop a plan for expanding coverage to low-income, uninsured women based on Healthy Mothers, Healthy Babies—a family planning expansion.

Maine will utilize the pilot to further refine and improve the Dirigo Health Reform. The grant will allow the state to increase employer participation in DirigoChoice by testing changes in the benefit package, subsidy, and a new marketing program. In addition, Maine will undertake new cost-containment strategies.

Missouri will use the data collection activities and consensus building strategies from the original SPG and model several employer-based coverage options specifically using the purchasing power of state employees.

New Mexico will work with the Governor's Insure New Mexico Council to develop new coverage options based on the employer system blending public and private programs; evaluate the new State Coverage Insurance program; and implement the new Small Employers Insurance Program.

Oregon will be carefully assessing a sustainable approach to covering more children and non-categorical adults in existing public programs. The program will be looking to maximize enrollment of children eligible in both public and private coverage, and later expand this effort to adults. The state will also provide planning and technical assistance to two committed communities working on community-level expansions by reforming their delivery systems and maximizing finances. Lastly, Oregon will review and improve Oregon's Population Survey (OPS) to ensure its reliability and validity as a tool for monitoring health insurance status in the state.

Rhode Island will design and implement a new private, lower cost insurance product that will be attractive to small employers, employees, and the self-employed that will coordinate with the existing market, RIte Care, and RIte Share.

Tennessee will develop a comprehensive plan for the implementation of a pilot project for the uninsured called "Cover Tennessee." The project will seek to make insurance affordable for small employers, their employees, and individuals through the development of creative reinsurance arrangements with health insurers.

Texas' pilot grant focuses on how to provide a lower cost insurance product for small business. The program will be conducted in conjunction with the Greater Houston Partnership Public Health Care Task Force.

Washington will design a Small Business Assistance program. The focus of the program is a small employer purchasing pool; a component of the program is premium assistance to help low-income families buy into employer coverage.

Wisconsin will research and develop a plan to expand BadgerCare to children (under the age of 21) to 300 percent FPL, and to develop a BadgerCare health insurance premium payment model for children above 300 percent FPL.

LOOKING BACK ON SPG

The SPG program has been an important resource for states to build the capacity to collect, analyze, and interpret critical state-level data on the uninsured. Through this process, there has been a greater understanding among policymakers about the need for state data and inadequacy of current federal data sources.

With new state-specific information, all participating states convened stakeholders and used data to initiate a process to prioritize strategies and populations served, and develop solutions. The new state-level data gave state policymakers new information to appropriately target resources. The downturn in the economy affected many states' efforts to act on these findings. Still, despite severe budget constraints, some states were able to move forward on expansions and others are preparing options to move forward as their state budget recovers. Some initiatives that states are currently pursuing under the Pilot Planning Grants include the use of reinsurance mechanisms, the development of purchasing pools, expansion of coverage through premium assistance programs, and the development of community-based private-public partnerships to expand coverage to low-wage employees.

The SPG program created opportunities for states to learn from one another. This program provided states with essential resources to begin a process that can sustain itself over time and continue to engage and educate stakeholders to work together to address the problem of the uninsured. It has re-energized states to again serve as laboratories for testing strategies to expand coverage and given them the tools to ready themselves for when the policy window opens.

LOOKING AHEAD

It is unclear what challenges and opportunities 2006 will bring for state coverage efforts. In the last days of the year, Congress finally approved a budget reconciliation package that makes changes in Medicaid that are anticipated to save \$4.8 billion over five years. As analysts work through the detailed language of the bill, it is clear that there will be implications for states. With budget reconciliation behind Congress, most people agree that further comprehensive federal action on coverage issues is unlikely.

The list of challenges for states remains long. States will continue to grapple with their Medicaid programs as those budgets continue to consume more and more of the state funds. We are likely to see more far-reaching Medicaid reform proposals with enhanced flexibility provided under the federal budget reconciliation. The implementation of the Medicare Part D benefit is also of concern and will require states to become accustomed to a new set of protocols and may incur more costs.

On a more positive note, we will see how some new state initiatives play out in the coming year. Massachusetts has come close to instituting an individual mandate for coverage and a broader strategy to decrease the number of uninsured. Illinois also moved forward on an All Kids initiative, which will provide access to health insurance for all children. States' abilities to sustain their programs largely depend on the constituency base that they build, and in measuring and demonstrating the ongoing impact and success of these initiatives. We will watch these states with hopeful eyes in 2006 to see what becomes of these innovative ventures.

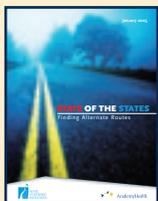
The private insurance market faces its own challenges. With continued erosion of employer-sponsored insurance, policymakers question whether states' efforts to develop public-private partnerships can turn the tide. We will watch programs like Healthy New York, Maine's Dirigo Choice, Oklahoma's waiver program, and other states to see whether they can make a considerable shift in stemming the erosion of private insurance.

If past experience is an indicator for what is to come, states will continue to be at the forefront with their efforts to expand coverage. Unfortunately, it appears that they will do so without the presence of State Planning Grants from the Health Resources and Services Administration.

Getting from where we are now to where we want to be will depend on many things, including the nation's economic situation and garnering political support to address the issue of the uninsured. 2006 will be a year of elections for many state Governors. The election results may be a barometer, reflecting how the country will fare with regard to coverage.

Looking onward to 2006, it is almost impossible to predict where roads will lead us. Some say that it will get worse before it gets better. Regardless, the State Coverage Initiatives program will continue to be a resource to state officials dedicated to helping states forge the path to coverage.

2005 SCI Publications and Meetings



**State of the States 2005:
Finding Alternate Routes**
January 2005
[www.statecoverage.net/pdf/
stateofstates2005.pdf](http://www.statecoverage.net/pdf/stateofstates2005.pdf)

Profiles in Coverage: Healthy New York
Governor George E. Pataki (R) and Insurance
Superintendent Gregory V. Serio answer
questions about the program
January 2005
www.statecoverage.net/newyorkprofile.htm

SCI National Meeting
February 3–4, 2005, Washington, D.C.
Agenda and presentation slides available
at www.statecoverage.net/o2o5agenda.htm

Cyber Seminar: ERISA's Implications for State
Health Care Access Initiatives – Ask the Expert
March 21, 2005
Agenda and slides available at
www.statecoverage.net/cyberseminar/index.htm



**State and Community Collaboration:
Lessons from the Communities in Charge
Program and Other Local Initiatives**
By Isabel Friedenzohn and Terry Stoller
May 2005
www.statecoverage.net/pdf/issuebrief405.pdf

Profile in Coverage: Maine Dirigo
SCI talks with Trish Riley, director of the Governor's
Office of Health Policy and Finance, about Dirigo
May 2005
www.statecoverage.net/maineprofile.htm



More Answers on Reinsurance
*By Donald Cohn, Enrique Martinez-Vidal,
and Deborah Chollet*
June 2005
[www.statecoverage.net/
pdf/infocus0605.pdf](http://www.statecoverage.net/pdf/infocus0605.pdf)

SCI Summer Meeting: Moving Beyond Planning
July 28–29, 2005, Chicago, IL
Agenda and slides available at
www.statecoverage.net/o705agenda.htm

Profile in Coverage: West Virginia Small Business Plan
SCI talks with Sonia Chambers, chair of the West Virginia
Health Care Authority, and Sally Richardson, executive
director of the Institute for Health Policy Research at West Virginia
University, about the West Virginia Small Business Plan
Fall 2005
www.statecoverage.net/westvirginiaprofile.htm

SCI Workshop for State Officials
Understanding Your Insurance Market: What Do You Know?
What Do You Need To Know?
November 15, 2005
Bethesda, MD



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