

# STATE OF THE STATES

January 2007

Building Hope,  
Raising  
Expectations



STATE  
COVERAGE  
INITIATIVES



AcademyHealth  
Advancing Research, Policy and Practice



# STATE OF THE STATES

## 31

### TRENDS IN STATES INITIATIVES

With more states considering moving forward on new reforms, common themes and trends have emerged.

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### SCHIP REAUTHORIZATION

After 10 years of measurable success, SCHIP is up for reauthorization in 2007.



#### About the Photo

State-based efforts to address the uninsured are the result of collaboration between many parties working with different resources, different expectations and, sometimes, on wholly different aspects of the problem. The cover image for this year's State of the States captures the challenges and promise of these efforts—showing the Caduceus in various stages of construction, repair, and renovation. That these efforts are jointly managed and manned by workers in suits and lab coats reinforces the need for collaboration and compromise in current reforms, while the contrast between barely framed and gilded wings illustrates the widely disparate levels of progress and success among states.

#### About SCI

State Coverage Initiatives (SCI) is a national program of the Robert Wood Johnson Foundation (RWJF) administered by AcademyHealth. SCI works with states to plan, execute, and maintain health insurance expansions, as well as to improve the availability and affordability of health care coverage. For more information about SCI, please visit our Web site [www.statecoverage.net](http://www.statecoverage.net).

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### LESSONS

This year's state-based reforms build on at least a decade of state efforts. Previous coverage initiatives provide lessons for policy-makers considering their own state reforms.

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### TIMELINE

Take a look back at the evolution of state coverage strategies over the past three years.

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## Executive Summary

# BUILDING HOPE AND RAISING EXPECTATIONS

The number of uninsured Americans has risen steadily since 2000, reaching 47 million in 2005. While there is little movement toward a national solution for the uninsured, state leaders are increasingly willing to address the issue and are investing in efforts to expand coverage.

**S**tates are motivated by a number of factors, including the continued increase in the number of uninsured, declines in employer-sponsored insurance, an improved economic outlook coupled with increased state revenues, and greater political will among Governors and legislators to tackle the problem.

### HEALTH CARE REFORM MAKES HEADLINES, ILLUSTRATES TRENDS

Early in 2006, Massachusetts captured the attention of media and policymakers alike by passing reforms promising comprehensive coverage. While the Massachusetts bill dominated public consciousness, it is but one example of a larger trend toward health care reform by states. In fact a number of states made great strides in 2006, with state reforms proposing new approaches to covering the uninsured. Although the reform packages of the past year vary in a number of ways, common themes and trends can be seen.

1. Comprehensive state reforms build upon prior efforts and financing mechanisms.
2. Reforms attempt to stem the erosion of employer-sponsored insurance.
3. Successful efforts to enact reforms often expect shared financial responsibility. Some states are beginning to recognize the need for mandatory participation.
4. Expansions in coverage often rely on private insurers to deliver care.
5. Medicaid benefits are being redesigned through the Deficit Reduction Act, but to date these efforts have not included expansions in coverage.
6. Many state reforms address cost and quality in addition to health insurance coverage.

### STATE ACTIONS BRING HOPE, RAISE EXPECTATIONS

Indeed, the efforts of states in the past year have raised hope regarding the role states can play in covering the uninsured as well as the ability of policymakers to find compromises that make reforms happen. State and federal policymakers are looking to Massachusetts, Vermont, Maine, and Illinois—just to name a few—to see what their experiences will be.

With rising hopes come great expectations—expectations that several state-based reforms will quickly come close to or reach universal coverage. However, evidence from prior state experiences suggests that reforms will take time; reducing the uninsured by enrolling them in new initiatives can be a particularly slow process. In this way, the ambitious goals that brought these programs to life may be their biggest challenge; creating an expectation that they will meet these lofty goals in the short term. New state

reforms can be fairly judged only after several years, allowing a realistic length of time to work through implementation challenges. Further, any expectation that state-based reforms will result in a comprehensive national solution for the uninsured should be tempered by the acknowledgment of significant variation across states—including uninsured rates, available state funds to invest in coverage, insurance market structures, and other important factors. It is unrealistic to expect that all states will have equal ability to carry out far-reaching comprehensive reforms without federal assistance.

### **STATES ARE TESTING GROUNDS FOR NEW APPROACHES, BUT A NATIONAL SOLUTION IS NEEDED**

States can act as political and practical testing grounds for new approaches. The headline grabbing bills of 2006 will provide policymakers with important insights into the viability of different reform approaches. These state efforts will provide new lessons on reform, and also allow policymakers to consider what elements are replicable in their own state environments. Again, state variation may be the biggest barrier to replicability of some reforms.

Current reforms build on decades of prior state-based expansion efforts that have had variable degrees of success and challenges. Certain lessons can be gleaned by policymakers considering their own state reforms:

1. State strategies make a difference because they help people access health care.
2. Leadership, opportunity, and readiness to act are all key ingredients to making reform happen.

3. There are no free solutions.
4. There has been little success in addressing underlying costs of health care, but a new focus on chronic care management holds potential.
5. Voluntary purchasing pools, as a standalone strategy, are not likely to be sufficient to expand coverage.
6. It is difficult to find agreement on what services will be covered.
7. Fully addressing the problem of the uninsured needs a national solution.

### **FEDERAL REFORMS HAVE CONSIDERABLE IMPACT ON STATE EFFORTS**

Medicaid is one of the most important programs for state efforts to provide insurance, covering in excess of 53 million people—more than are covered by Medicare. In 2006, the Deficit Reduction Act of 2005 (DRA) was enacted, making some of the most significant changes in the program in its 40 years. The DRA, which is projected to reduce federal Medicaid spending by \$11.5 billion over five years and \$43.2 billion over 10 years, made many important changes in Medicaid policy that have implications for state coverage efforts. During 2006, four states received federal approval for reform proposals under DRA authority. Others are evaluating options for using DRA authority to reform their Medicaid programs. Time will tell how states use the new flexibility provided to them under the DRA and the implications for the people served.

Next year, the State Children's Health Insurance Program (SCHIP) will face serious reauthorization discussions. SCHIP has been an equally important program for state efforts to provide

insurance to children, covering more than 6.1 million children. The program has had positive spillover effects on Medicaid enrollment of children in many states and has played a critical role in offsetting reductions in employer-based coverage. At a time when employer coverage continues to decline and the number of uninsured children has grown for the first time since SCHIP was implemented, states are struggling to cover projected shortfalls in SCHIP funding. In addition, many state health care budgets and coverage initiatives hinge on congressional reauthorization of SCHIP and shorter-term changes to SCHIP financing.

SCHIP has received widespread, bipartisan support. It is unclear whether the Congress will reauthorize the program with few changes, or look at larger, long-term financing and policy reforms. In either case, immediate financing fixes will be critical to address projected funding shortfalls in 2007.

### **LOOKING FORWARD**

The state reforms of 2006 fueled a trend of more state movement on the uninsured that seems likely to continue. Thirty-six new governors were elected, many with platforms that included significant goals to address the uninsured.

With a new Congress, it remains to be seen whether prior proposals to encourage state innovations will move forward, whether more comprehensive strategies will be considered, or whether the status quo will remain.

There is still much to learn from the state initiatives enacted in 2006. The experiences from these states in the years to come are likely to influence the strategies considered by others going forward.





# SURVEYING THE LANDSCAPE

Increasing numbers of uninsured, continued erosion in employer-sponsored insurance, recovering state budgets, and a lack of a federal solution set the stage for state efforts to cover the uninsured in 2006.

In the last few years, state policy leaders have been motivated to take on new efforts to cover the uninsured. While these efforts were enabled by recovery from the severe fiscal crisis that began in 2001, states' efforts are largely fueled by compelling evidence that our employer-based health insurance system is crumbling, resulting in more uninsured with less access to needed health services. Covering the uninsured is also a priority issue for the public and policymakers, whose frustration with the lack of attention to find a national solution is growing. Even national lawmakers are increasingly looking to states to try new strategies in the hopes that they may serve as a practical and political testing ground for new ideas.

## UNINSURED NUMBERS RISE AMID CRUMBLING FOUNDATION OF EMPLOYER-SPONSORED INSURANCE

At the current rate of increase, as many as 56 million Americans will be uninsured by 2013.<sup>1</sup> Although the actual numbers vary widely among states (see

Figure 3), few have been immune to the increase in the uninsured. Data comparing two-year average rates of uninsured show a tripling of the number of states with 23 percent or more uninsured adults.<sup>2</sup> And, while the numbers of uninsured are increasing, the causes of uninsurance remain the same. Escalating medical costs, growing health care premiums, and declining employer-sponsored insurance (ESI) remain important factors contributing to the growth in the uninsured.

There are some unexpected and disappointing stories in this year's statistics. For the first time in seven years, the number of uninsured children increased. This is particularly worrisome as Congress considers reauthorizing SCHIP, which just marked its tenth anniversary. And, although the economy has begun to rebound and health insurance premiums are rising more slowly than at any time since 2000, a decreasing number of private firms are offering insurance to their employees. However, on a positive note, coverage

levels for government programs, primarily Medicaid and Medicare, have remained stable.<sup>3</sup> These programs continue to play an important role in averting additional increases in rates of uninsurance.

The growth in health insurance costs and the rise in out-of-pocket medical expenses continue to have a tremendous impact on individual coverage decisions, as well. An Urban Institute study found that over half of uninsured adults report that the cost of insurance is the principle reason they are uninsured.<sup>4</sup> The findings also underscored the dynamic relationship between employment status and insurance coverage, with the second-most cited reason for being uninsured related to losing a job, changing employers, being self-employed, or not being offered or eligible for ESI.<sup>5</sup> Moreover, almost half of adults of all incomes report being somewhat worried or very worried about paying medical bills in the event of a serious illness.<sup>6</sup>

# UNINSURED IN AMERICA: THE FACTS

## Uninsurance Increasing<sup>7</sup>

- Currently, there are approximately 46.6 million uninsured Americans, up from 45.3 million in 2004.
- In 2005, 15.9 percent of the population was uninsured, up from 15.6 percent in 2004; 18 percent of the non-elderly were uninsured in 2005.
- Uninsured rates among the population still vary significantly across states, ranging from 8.7 percent in Minnesota to 24.5 percent in Texas (see Figure 3).
- The growth in the uninsured populations in Western and Southern states account for the national increase in uninsurance for 2005. Southern states have the highest rates of uninsured residents.

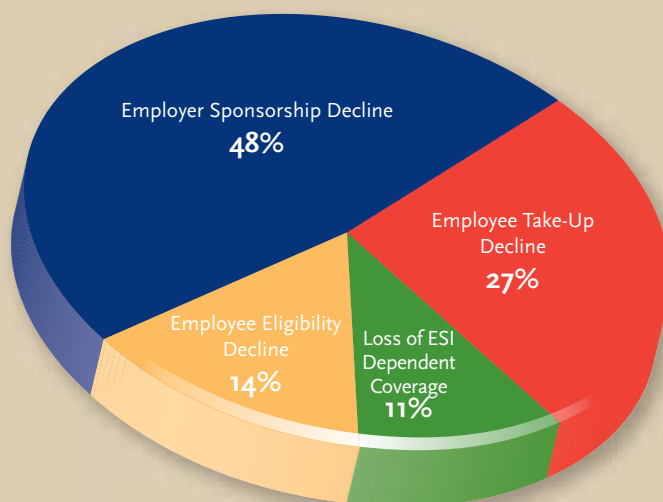
## Children at Risk<sup>8</sup>

- The number of uninsured children increased from 10.8 percent in 2004 to 11.2 percent in 2005.
- 360,000 additional children became uninsured in 2005, nearly reversing the gains in children's coverage achieved between 2000 and 2004 (400,000 children gained coverage during that period).

## Employer-Sponsored Insurance Continues to Decline

- In 2004, 63 percent of individuals had employer-sponsored insurance, representing a decline of 3.4 million individuals since 2000.<sup>9</sup>
- Almost three quarters of this decline in employer-sponsored insurance was due to fewer employers offering coverage and declining eligibility for workers and dependents.<sup>10</sup>
- In 2005, 70 percent of uninsured workers were either ineligible for coverage or did not have access to coverage through their own or a family member's employer.<sup>11</sup>
- While most large firms (those with greater than 200 employees) offer some level of insurance coverage, only 60 percent of small and mid-sized businesses (those employing 3-199 employees) offered employer-based health insurance in 2005—an 8 percentage point decrease from 2000.<sup>12</sup> The greatest decrease in employer offered insurance was among firms with less than 25 workers.<sup>13</sup>

FIGURE 1 REASONS WHY 3-4 MILLION EMPLOYEES LOST INSURANCE BETWEEN 2001 & 2005



Source: "Changes in Employees' Health Insurance Coverage, 2001-2005," Kaiser Commission on Medicaid and the Uninsured, October 2006.



### Health Insurance Premiums Increasing at Lower Rates<sup>14</sup>

- Average family premiums rose 7.7 percent from spring 2005 to spring 2006—the lowest average increase in the past several years. However, premiums are still growing faster than both inflation and wages.
- For individual families, the increase per family varied widely: 42 percent of insured workers saw premium increases of 5 percent or less; but 17 percent were faced with premium increases of 15 percent or more.
- Workers in small firms and mid-sized firms (3-199 workers) contribute significantly more to premiums (\$3,550 annually) than do workers for larger firms (\$2,658).

### No Growth in Consumer-Directed Health Plans

- Of firms who offered health insurance benefits in 2006, 7 percent also provided a high deductible health plan (HDHP) option—either with a Health Reimbursement Arrangement (HRA) or as a Health Savings Account-qualified (HSA) plan.
- Only a small fraction of insured workers (4 percent, or about 2.7 million workers in 2006) are in an HDHP with a savings option.<sup>15</sup> While there has been a shift from HRAs to HSAs in the past year, there has not been a statistically significant increase in the total number of enrollees in these types of plans.<sup>16</sup>

FIGURE 2 **AVERAGE ANNUAL FIRM AND WORKER CONTRIBUTION TO PREMIUMS AND TOTAL PREMIUMS FOR COVERED WORKERS FOR SINGLE AND FAMILY COVERAGE, ALL PLANS, 2006**

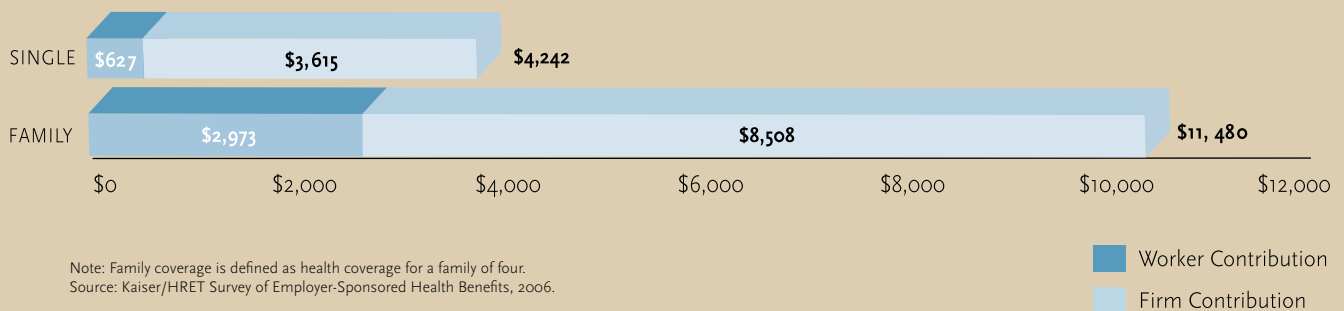
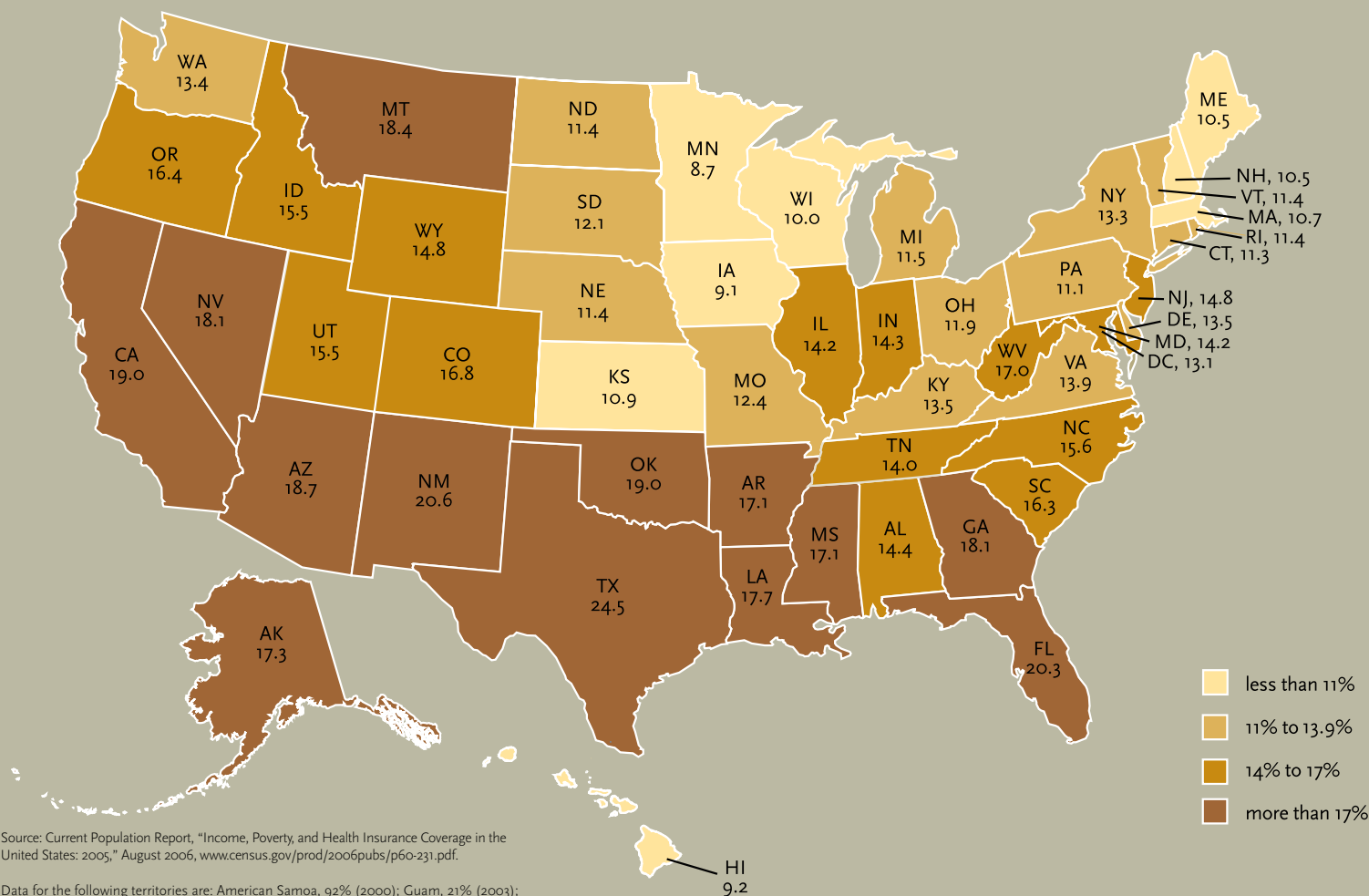


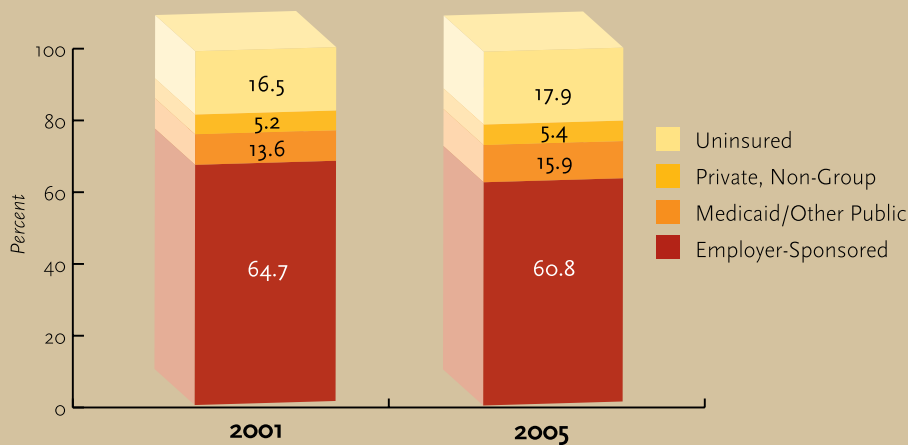
FIGURE 3 **PERCENTAGE OF PEOPLE WITHOUT HEALTH INSURANCE BY STATE, 2004-2005 AVERAGE**



Source: Current Population Report, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," August 2006, [www.census.gov/prod/2006pubs/p60-231.pdf](http://www.census.gov/prod/2006pubs/p60-231.pdf).

Data for the following territories are: American Samoa, 92% (2000); Guam, 21% (2003); Puerto Rico, 7% (2005); U.S. Virgin Islands, 30.1% (2005). Data for other U.S. Territories are unavailable.

FIGURE 4 **HEALTH INSURANCE COVERAGE OF THE NONELDERLY POPULATION, 2001 & 2005**



SOURCE: "Health Insurance Coverage in America: 2002 Data Update," The Kaiser Commission on Medicaid and the Uninsured, December 2003. KCMU/Urban Institute 2003. "The Uninsured: A Primer," The Kaiser Commission on Medicaid and the Uninsured, October 2006.

### STATE BUDGETS ON SOLID GROUND, FUTURE LESS CERTAIN

Fiscal year (FY) 2006 was a year of fiscal health for states fueled by stronger than expected revenue growth. States endured a period of harsh fiscal conditions from 2001 to 2004, when state revenues fell and Medicaid spending and enrollment ballooned. But state revenues began a recovery in 2005 that continued into this past year. With an improved fiscal outlook, some Medicaid programs are restoring benefit and eligibility cuts that they made over the past several years. At the same time that a number of states are using their newfound fiscal health to

implement or explore modest coverage expansions, others are still struggling with poor economic conditions that portend future revenue slowdowns and spending restrictions.

As they emerge from the financial difficulties of the last several years, many states are pursuing initiatives that would expand coverage to underserved populations, especially low-income women and children. “The fiscal pressure on Medicaid is dramatically diminished compared to a few years ago,” explains Vernon Smith, principal at Health Management Associates. “States are no longer singularly focused on reducing rates of growth in Medicaid. Instead, they are beginning to look at health care reforms and initiatives other than just tweaking Medicaid benefits and eligibility requirements.”

Despite a stable financial outlook, overall states express concern that current revenue growth will slow and that they will again face increasing pressures from spending needs that include health care, education, and infrastructure among other spending requirements. States are also facing fresh threats, in the form of accounting changes for their retiree health benefits, concerns about the mounting federal deficit and its possible impact on state programs, and a Medicaid population that will need more pharmaceutical and long-term care services as it ages.

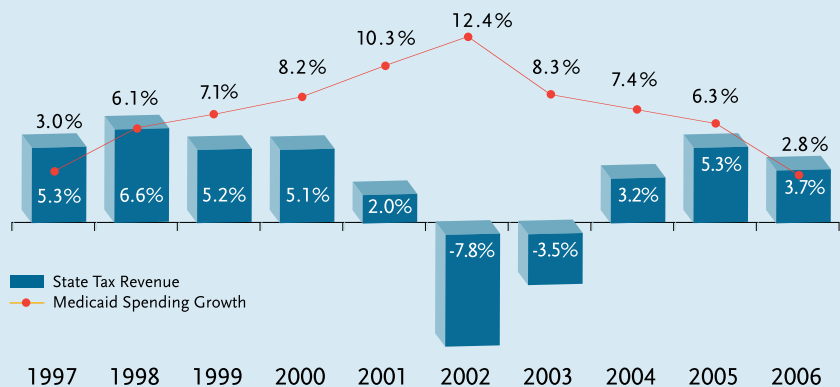
### FEDERAL POLICYMAKERS LOOK TO STATE BLUEPRINTS

As the 110<sup>th</sup> Congress begins its session, it remains to be seen whether comprehensive national health reform will be addressed amid a myriad of competing national priorities. Instead,

## MEDICAID SPENDING GROWTH SLOWS TO RECORD LOW

For the first time since the late 1990s, growth in state revenues outpaced Medicaid spending growth, according to a recent survey by the Kaiser Family Foundation’s Commission on Medicaid and the Uninsured. The survey found that a slowdown in Medicaid enrollment and implementation of the Medicare drug benefit—which shifted prescription drug spending for dual eligibles from Medicaid to Medicare—contributed to a near-record low 2.8 percent growth rate in Medicaid spending for fiscal 2006. And while Medicaid remains a critical safety net, enrollment growth slowed to 1.6 percent, the lowest growth since 1999.<sup>17</sup> “The cumulative effect of aggressive cost containment initiatives undertaken by states in 2003 and 2004 is another major reason for the low rate of Medicaid spending,” explains Vernon Smith, one of the authors of the Kaiser Family Foundation study.

FIGURE 5 STATE TAX REVENUE AND MEDICAID SPENDING GROWTH, 1997-2006



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. Preliminary estimate for 2006.

SOURCE: KCMU Analysis of CMS Form 64 Data for Historic Medicaid Growth Rates and KCMU / HMA Survey for 2006 Medicaid Growth Estimates; Analysis by the Rockefeller Institute of Government for State Tax Revenue.

With passage of the DRA in early 2006, states also began to grapple with the prospect of Medicaid changes related to benefits, cost sharing, program integrity, and other provisions designed to save the federal government \$11.5 billion over the next five years. The DRA could result not only in significant reductions in federal and state spending for Medicaid, but also in health care access and coverage changes for Medicaid beneficiaries. The impact of these changes depends in part, however, on whether states adopt new benefit and cost sharing options available to them under the DRA.

it appears as though many are looking toward states to find solutions to address the uninsured. Former (HHS) Secretary Tommy Thompson has said that in the absence of federal action, he believed that states will take the lead on health care reform.<sup>18</sup> Other health policy experts have also promoted the concept of federally supported state experimentation as a promising way to make progress.<sup>19</sup> Recent legislation introduced in the House and Senate also appears to

support the idea of states as the testing ground for new innovations.

In the absence of any consensus or movement at the federal level on comprehensive health reform, many states have moved forward to develop strategies to expand insurance coverage. While there is broad recognition that states cannot comprehensively address the problem of the uninsured on their own, many state policy leaders are not waiting for national reform.





## State Strategies

# EXPANDING COVERAGE THROUGH INNOVATION, EXPERIENCE, AND COMPROMISE

Early in the year, Massachusetts captured the attention of the nation by enacting groundbreaking reform. Although it is perhaps the best known reform of 2006, Massachusetts is far from alone. In fact, the Commonwealth's efforts are just one example of a larger trend toward bold and comprehensive state health care reform.

**A**mong the current round of state reforms (see Figure 6) are a variety of new approaches to covering the uninsured, including:

- New mechanisms to subsidize coverage for low-income families;
- New variations of employer and personal responsibility for insurance coverage; and
- New strategies to ease the purchase of health insurance for small employers and individuals without access to employer-sponsored insurance.

Like Massachusetts, several state efforts are characterized as comprehensive because they attempt to reach near-universal coverage, accomplishing this task through broad system reforms that include quality initiatives, cost

containment efforts, and strategies to control the underlying cost of health care. Other states are moving ahead with incremental approaches such as providing universal coverage for children or public-private partnerships to insure low-income workers or encourage small businesses to offer insurance.

### COMPREHENSIVE REFORMS

#### Northeastern States Break New Ground

The most ambitious reform proposals enacted in 2006 came from the Northeast and demonstrate the capacity for breaking ground in a bi-partisan manner. Massachusetts and Vermont passed comprehensive reforms in 2006 that have ambitious goals for covering the uninsured. Meanwhile Maine, which was one of the few states to take on comprehensive reform in 2003 when most states were dealing with severe

deficits, continued to move toward its goal of universal coverage by 2009. When building their current reforms, all three states had relatively low rates of uninsured compared to the nation—due, in part, to a history of previous efforts to reduce the number of uninsured, including establishing relatively generous Medicaid eligibility levels.

The comprehensive reforms in these three states go further toward helping low-income families purchase health insurance than in any other states. One of the key elements shared by all three reforms is that they subsidize coverage for families with annual incomes up to approximately 300 percent of the federal poverty level (FPL). Each has also coupled their subsidized products with other reforms that reflect the distinct priorities in each state.



## Massachusetts – Commonwealth Care Massachusetts’

reform legislation is aimed at covering 95 percent of state residents without insurance within three years and represents a culmination of more than a year of negotiations and compromise between lawmakers and Governor Mitt Romney (R). The need to find compromise and act on comprehensive reform was made more urgent by the potential loss of \$385 million in federal matching funds that had been previously used to fund care for the uninsured. In what has been referred to as a demonstration of ‘unusual political maturity’<sup>20</sup> and a ‘serendipitous collision of interests,’<sup>21</sup> the state’s comprehensive plan includes provisions to increase access to health insurance, contain health care costs, and improve quality. In fact, the very ability of policymakers in Massachusetts to reach bi-partisan consensus on landmark reform fueled new hope for the possibility of health care reform and put state efforts at center stage of the national debate on the uninsured. This notable political feat has many policymakers watching closely as the state finalizes the program design and rolls out the first phases of implementation.

Massachusetts’ reform package is built on six key elements:

- **An individual mandate that all who can afford insurance obtain it**  
Massachusetts broke new ground with its requirement that individuals purchase health insurance. Individuals who can afford insurance are required to obtain health insurance by July

1, 2007 or risk the loss of their personal exemption for 2007 income taxes. In subsequent tax years, the penalty will include a fine equaling 50 percent of the monthly cost of health insurance for each month without insurance.

- **An employer requirement for ‘fair and reasonable’ contributions toward employees’ health coverage**  
Massachusetts had a high rate of employer-sponsored insurance relative to the rest of the nation prior to the current reforms. Building on this foundation, the state added several provisions to share responsibility with employers.

Employers with 11 or more full-time employees (FTE) that do not make a “fair and reasonable” contribution toward their employees’ health insurance coverage will be required to make a per-worker contribution, not to exceed approximately \$295 per FTE annually. Employers will pass the “fair and reasonable” test if at least 25 percent of full-time employees are enrolled in the company’s group health plan and the employer contributes toward the premium. Should employers not meet that criterion, they still can pass if they can demonstrate that they offer to pay at least 33 percent of their full-time employees’ health insurance premium.

In addition, by January 1, 2007, all employers with 11 or more workers must adopt a Section 125 “cafeteria plan” that (as defined in federal law) permits workers to purchase health care with pre-tax

dollars, saving approximately 25 percent on the cost of premiums. If these employers do not “offer to contribute toward or arrange for the purchase of health insurance,” they may be assessed a “free rider” surcharge if their employees or employees’ dependents access free care. The surcharge will exempt the first \$50,000 of free care that the employees use but, after that threshold is met, the employer will be charged from 10 to 100 percent of the state’s cost of the free care, as determined by the Division of Health Care Finance and Policy.

- **The creation of a Commonwealth Health Insurance Connector Authority to improve availability and affordability of coverage**

The state coined the term “health care connector,” which effectively communicated how many different elements of a complex reform package must come together. The Commonwealth Health Insurance Connector will be a vehicle to help individuals and small businesses find affordable health coverage. Plans participating in the Connector will be able to develop new benefit packages, designed to make coverage more affordable. The Connector will facilitate the process of small employers offering Section 125 plans. Part-time and seasonal workers can combine employer contributions in the Connector as well. One of the unique features of the Connector is that it allows individuals to keep their policy (and therefore, their health care providers), even if they switch employers.



The Connector will be the sole entity enrolling uninsured low-income populations in the Commonwealth Care Health Insurance Program.

- **Subsidies to assist low-income populations**

The Commonwealth Care Health Insurance Program will provide sliding scale subsidies to individuals with incomes below 300 percent FPL beginning January 1, 2007. No premiums will be imposed on those individuals with incomes below \$9,800 (100 percent FPL). Additionally, an existing premium assistance program, the Insurance Partnership, will raise eligibility for employee participation from 200 percent to 300 percent FPL. In October 2006, the state announced that the average monthly premiums for products offered through the Connector will range between \$276 and \$391 before the subsidies are applied.

- **Insurance market reforms designed to reduce premiums and create new options**

The health care reform bill also includes a number of insurance market reform provisions. Starting in July 2007, the non- and small-group markets will be merged, although a study of this merger must be completed before that date to assist insurers in planning for the transition. Policymakers estimate that this action will reduce premiums for people currently purchasing in the individual market by at least a quarter of their current cost. The bill also will allow

Health Maintenance Organizations (HMOs) to offer coverage plans that are linked to Health Savings Accounts (HSAs) and HMO products with co-insurance. In addition, under the bill, young adults may remain on their parents' policy for two years past the loss of their dependent status, or through age 25, whichever occurs first. Carriers will also be designing new products with fewer benefits, as these products are thought to be more attractive to young adults between the ages of 19 and 26.

- **Financing strategies that rely on state, federal, employer, and individual contributions**

The reform will be financed via several significant sources. First, \$385 million in federal matching funds previously used to fund the safety net and uncompensated care will be redirected to cover the subsidies. Additionally, the state will invest \$308 million in general fund revenues over three years and will collect individual and employer contributions as well.

The plan will be implemented in three phases. On October 2, 2006 enrollment began for the nearly 62,000 residents requiring a full subsidy. Starting in January 2007, the state will begin enrolling residents with annual incomes between 100 percent and 300 percent FPL. This group will pay premiums on a sliding-scale basis. Finally, the last phase will occur in July 2007, when the individual mandate becomes effective.



## **Vermont – Catamount Health**

To some degree over-shadowed by Massachusetts' reform, Vermont passed a far reaching health reform plan called

Catamount Health in May 2006. Vermont's successful bi-partisan compromise is notable in part because it reflects the determination and the tenacity of state policymakers who pressed forward after the passage, and subsequent gubernatorial veto, of the Green Mountain Health plan in the 2005 legislative session.

The successful Catamount Health plan set a goal of assuring insurance coverage for 96 percent of Vermonters by 2010.

The plan includes:

- **Catamount Health Product**

This new individual market product is designed to be affordable and comprehensive for people who have been uninsured for 12 months (with some exceptions). Coverage is based on the typical non-group market product offered in the state, but with much less cost sharing by the individual or family. The Catamount Health law specifies the specific service and cost benefits that must be included—e.g., for individual coverage, the plan cannot have more than a \$250 deductible, 20 percent coinsurance, \$10 office visit co-pay, no prescription drug deductible, no out-of-pocket for preventive and chronic care, and an out-of-pocket maximum of \$800 per year.<sup>22</sup>

- **Subsidies for low-income, uninsured**

Catamount Health Plan subsidies will be provided for uninsured individuals and families with incomes up to 300

FIGURE 6 KEY FEATURES OF STATE REFORMS

State	Initiative	Key Features
<b>Comprehensive Reforms</b>		
Massachusetts	Commonwealth Care	<ul style="list-style-type: none"> <li>• Individual mandate</li> <li>• Employer Fair Share assessment</li> <li>• Free Rider surcharge</li> <li>• Health Insurance Connector</li> <li>• Insurance market reforms</li> <li>• Commonwealth Care*</li> </ul>
Maine (2003)	Dirigo Health	<ul style="list-style-type: none"> <li>• DirigoChoice*</li> <li>• Cost containment reforms</li> <li>• Maine Quality Forum</li> </ul>
Vermont	Catamount Health	<ul style="list-style-type: none"> <li>• Employer assessment</li> <li>• Premium assistance for low-income workers</li> <li>• Catamount Health Plan*</li> <li>• Chronic care initiatives</li> </ul>
<b>Covering All Kids</b>		
Illinois	All Kids	<ul style="list-style-type: none"> <li>• Universal coverage for children</li> <li>• Sliding scale premiums based on family income</li> </ul>
Pennsylvania	Cover All Kids	<ul style="list-style-type: none"> <li>• Universal coverage for children</li> <li>• Sliding scale premiums based on family income</li> </ul>
Tennessee	CoverKids	<ul style="list-style-type: none"> <li>• Separate stand-alone SCHIP program for children in families with incomes up to 250% FPL</li> <li>• Buy-in for children in families above 250% FPL</li> </ul>
<b>Public-Private Partnerships</b>		
Arkansas	ARHealthNet	<ul style="list-style-type: none"> <li>• Safety Net benefit package</li> <li>• Provided through private insurers</li> <li>• Open to businesses with 2-500 employees that have not offered insurance within last 12 months</li> <li>• Subsidy provided for workers with incomes below 200% FPL</li> </ul>
Montana	Insure Montana	<ul style="list-style-type: none"> <li>• Purchasing pool with a subsidy available to previously uninsured firms (2-9 employees) that have not offered insurance for 24 months</li> <li>• Employer and employee premium subsidies</li> <li>• Tax credit available for currently insured small firms (2-9 employees)</li> </ul>
New Mexico	State Coverage Insurance	<ul style="list-style-type: none"> <li>• New subsidized insurance product delivered by Medicaid managed care organizations</li> <li>• Available to low-income, uninsured, working adults with family income below 200% FPL</li> <li>• An individual may enroll through their employer or as a self-employed individual</li> <li>• Premium paid by employer/employee contributions and state/federal funds</li> </ul>
Oklahoma	Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)	<ul style="list-style-type: none"> <li>• Premium assistance voucher available for small firms (2-50 employees) who offer a qualified plan and income eligible employees with incomes below 185% FPL</li> <li>• Individual plan available to uninsured workers whose firm does not offer insurance and self-employed (who earn less than 185% FPL)</li> </ul>
Rhode Island	WellCare	<ul style="list-style-type: none"> <li>• New health plan expected to be 25% below market rates</li> <li>• Assisting Low-Income Small Businesses save an additional 10% through reinsurance pool (legislation passed, but no funding approved)</li> <li>• Making health care cost and quality data more transparent</li> <li>• High Risk Pool</li> <li>• Certificate of Need reform</li> </ul>
Tennessee	CoverTN	<ul style="list-style-type: none"> <li>• New affordable health insurance product for working uninsured and small firms that do not offer coverage</li> <li>• At least two statewide private plans</li> <li>• High Risk Pool</li> <li>• Cost limited to \$150/month, split by employer, employee and state</li> </ul>
Utah	Utah Premium Partnership for Health Insurance (UPP)	<ul style="list-style-type: none"> <li>• New premium assistance program under the Primary Care Network</li> <li>• \$150 subsidies for low-income workers enrolled in employer-sponsored insurance</li> <li>• Subsidies up to \$100 for employee's children</li> </ul>

\*includes subsidies for low-income workers

percent FPL. In addition, the state will provide similar premium assistance to low-income individuals with access to employer-sponsored insurance who have previously been unable to afford insurance.

- **Employer requirements**

Employers will pay a \$365 per FTE annual assessment (with increases allowed as Catamount Health premiums change) based on the following parameters:

- Employers without a plan that pays some part of the cost of insurance of its workers must pay the health care assessment on all employees.
- Employers who have coverage must pay the assessment on:
  - ❖ Workers who are ineligible to participate in the plan; and
  - ❖ Workers who refuse the employer's coverage and do not have coverage from some other source.

The assessment exempts eight FTEs in 2007 and 2008; six FTEs in 2009; and four FTEs thereafter.

- **Vermont's Chronic Care Initiatives**

This coverage expansion is paired with multiple chronic care initiatives, which are aligned with the state's Blueprint for Health. The Blueprint (see box, Blueprint for Health), managed by the Vermont Department of Health, is a public-private collaborative approach that seeks to improve the health of Vermonters living with chronic diseases and prevent the increase of chronic disease by utilizing the Chronic Care Model<sup>23</sup> as the framework for system changes.

## VERMONT BLUEPRINT FOR HEALTH

The Vermont legislature and Governor Jim Douglas (R) recognized the potential to control the growth of health care costs and improve the quality of care delivered in the state by making chronic care management a focus of reform efforts. To provide incentives to residents to focus on monitoring their health, no cost sharing will be imposed for preventive services or use of the management program within Catamount Health. For all Vermonters, the program includes additional benefits that include free immunizations and a Healthy Lifestyles insurance discount.

The Blueprint targets patients, providers, communities, and the health system in the following ways:

- **Patient Self Management**

Encouragement of the use of decision support tools and other education designed to create informed, active, and prepared patients.

- **Provider Practice**

Education of providers, office staff, community partners, and other stakeholders to better serve and support patients in self-management of their conditions through the use of evidence-based medicine.

- **Community Activation and Support**

Support for physical activity and healthy lifestyles by issuing grants to communities to develop evidence-based physical activity programs—such as walking programs—and linking these with other community and municipal initiatives to improve the built environment, such as linking walking and biking paths to community centers where people live, work, shop, and go to school.

- **Health Information System**

Development of a statewide database containing chronic care information and a patient registry for individual and population-based disease management.

- **Health Care System**

Initiatives to support system change, including payment for quality as a key requirement for Blueprint sustainability. The state Medicaid agency has also been charged with increasing provider reimbursements for primary care and provider participation in care coordination programs.

- **Funding**

Funding for the Catamount Health program will come from several sources including an increased tobacco-product tax. Vermont also intends to use federal matching funds that are expected to be available through the Global Commitment to Health waiver approved by CMS in 2005. Under this waiver the state agreed to a cap on Medicaid growth in exchange for the ability to use funds for health care investments

The goal is to take the Blueprint statewide by 2009 by incrementally working with hospital service areas and their community partners. In addition, the legislation requires that a chronic care management program, based on Blueprint standards, be implemented for the Medicaid population, and that the new Catamount Health Plan and the state employee health plan have chronic care management programs aligned with Blueprint standards.



## WILL COMPREHENSIVE REFORMS WORK HERE?

The comprehensive health reform plans of 2006 have led to the inevitable question of whether one state's reforms can be replicated elsewhere.

Certainly, states' efforts can test coverage strategies, informing and providing lessons for other states and national leaders. However, the variation among states is far too great for state-by-state reform to result in a comprehensive solution for the 47 million uninsured.

Key Variables:

- **Uninsurance Rate**

States leading the way with comprehensive solutions all have uninsured rates lower than the national average, largely because of the ongoing strength of employer-based coverage in these states and previous increases in their Medicaid eligibility levels. However, a few states have uninsured populations that are close to a quarter of their population, making it unlikely that they will be able to consider universal coverage goals similar to those states that have pursued comprehensive reform.

- **Funding and Resources**

There are significant differences in the resources states have at their disposal to address the problem of the uninsured. Substantial variation exists across the states in funding for Medicaid and the safety-

net. Maine, Massachusetts, and Vermont all had higher Medicaid eligibility levels for low-income adults than the national average prior to implementing their most recent reforms. Other investments beyond Medicaid, such as charity care funds, can also play a significant role if they can be re-deployed into other programs, as was the case for Massachusetts and the \$1 billion it was spending on its safety net fund.

Conversely, states that have not made significant prior investments in coverage often have to find new funding sources. The search for funding can be the greatest challenge, since there is very different revenue-generating capacity across states, reflecting differences in income distribution as well as historic differences in the states' tax bases. Without federal financial assistance to help low income states, some will be unable to act.

- **Insurance Market Structure**

States have different insurance markets and regulatory structures that affect how various reforms may work in their state. For example, those familiar with Massachusetts' insurance market have noted that over time, the state implemented various regulatory mechanisms in the small

group and non-group insurance markets including guaranteed issue, modified community rating, and medical underwriting prohibitions, creating an environment that makes the individual mandate much more feasible. Other states that use medical underwriting, experience rating, and non-guaranteed issue would find it more challenging to implement a mandate.<sup>28</sup>

And so, while it is unlikely that comprehensive reforms will be adopted in full by other states, there are elements of these reforms which are more transferable than others.

- **Connector**

Massachusetts' creation of a health care Connector sparked renewed interest by policymakers in the concept of facilitating the purchase of insurance for small businesses and individuals. While some may consider the Connector to be a purchasing pool, Massachusetts' state officials describe it more as a purchasing mechanism. The Connector does not pool risk. Rather, it streamlines the administrative aspects of purchasing insurance.

There is a long history of states attempting purchasing pools. Unfortunately, evidence suggests that pools alone are not sufficient

such as the Blueprint and expansions of coverage to the uninsured. The state projections assume that the cap negotiated with CMS is sufficient to allow for some of these health care investments.<sup>24</sup> Finally, a portion of the Catamount subsidy will be financed through enrollee premiums and the employer assessment.



### Maine – Dirigo Health

Maine is continuing to implement the Dirigo Health Reform Act, which was enacted in 2003. Dirigo, the state motto meaning “I lead” in Latin, includes strategies to control costs, improve quality,

and expand coverage. In contrast to the other comprehensive reforms of Massachusetts and Vermont, Maine has relied exclusively on voluntary measures to expand insurance coverage. There is no individual mandate nor are there assessments on employers who do not provide coverage for their employees.

- **The DirigoChoice health insurance product**

As the centerpiece of the state's efforts to expand coverage to the uninsured, DirigoChoice is available to small businesses, the self-employed, and eligible individuals without access to employer-

sponsored insurance. DirigoChoice is available exclusively through Anthem, by far the largest carrier in Maine. The program offers discounts on monthly premiums and reductions in deductibles and out-of-pocket maximums on a sliding scale to enrollees with incomes below 300 percent FPL.

- **Cost-Containment and Quality**

Maine implemented several cost-containment measures, including rate regulation in the small group market, voluntary caps on cost and operating margin of insurers, hospitals, and practitioners,

to drive down health costs and may actually have a negative impact on the insurance market if they attract a different risk profile than the rest of the market.<sup>29</sup>

Although new affordable products for small businesses will be accessed inside and outside the Connector, it is the sole mechanism through which individuals can access the subsidized Commonwealth Care insurance product. The state anticipates that the subsidy provided through Commonwealth Care could be as high as 80 percent, providing significant incentive for individuals to seek care through the Connector, if they are eligible. By allowing greater choice and portability for the consumer, the Connector will ease the administrative complexities that come with switching jobs. It also provides a way to reach non-traditional workers such as part-time and seasonal workers.<sup>30</sup> These reasons provide significant incentives for individuals to purchase coverage through the Connector.

The experience of the Connector will test how purchasing arrangements coupled with subsidies and the other incentives (mainly the individual mandate) will increase enrollment and whether it will

build purchasing power. States are likely to continue to look to the Connector as a model, but should recall the limited success of purchasing pools as standalone strategies and consider the Connector as part of a larger strategy to improve insurance coverage.

- **New Benefit Designs and Delivery Mechanisms**

Many recent state strategies propose new insurance products and programs for currently uninsured individuals and/or small business, experimenting with new ways to encourage coverage. For example, Maine contracts with one insurer to provide their Dirigo product and provides a subsidy for low-income individuals. Vermont will allow at least two private carriers to offer their Catamount subsidized product and rely heavily on chronic care management strategies to encourage healthy behaviors and lower costs. Other states use the Medicaid Managed Care Organizations to deliver a subsidized insurance product to low-wage workers. Arizona is testing a choice of different benefit designs as part of changes they have made to the Healthcare Group, the state's coverage initiative for small businesses. If these benefit

designs and delivery mechanisms are able to encourage new businesses to offer coverage or enroll a significant portion of the uninsured, they could serve as examples for other states.

- **Individual mandate**

Ironically, the individual mandate is the feature of the Massachusetts reform that has generated the most interest nationally, but for several reasons it may be the most difficult element to export to other states. Massachusetts had significantly fewer uninsured (10 percent versus the national average of 16 percent). That, coupled with the state's ability to provide subsidies to address the problem of affordability, made it possible for the state to consider a broad-reaching requirement for individuals to have health insurance.

The efforts in Massachusetts, Maine, and Vermont have demonstrated that compromise is possible. When states consider what elements, if any, they may be able to adapt for their state, they must maintain the appropriate expectations for what any one state can achieve.

and a global budget for capital improvements as well as a one-year moratorium on Certificate of Need activity. The Dirigo reforms also created the Maine Quality Forum charged with advocating for high quality health care and helping Maine residents make informed health care choices.

- **Funding**

Funding for the Dirigo coverage, cost, and quality initiatives combines employer contributions, individual contributions, state general funds, and federal Medicaid matching funds for those

individuals who are eligible. The original reform envisioned that future premium subsidies for DirigoChoice would be funded through the 'savings offset payment' which is generated through the recovery of bad debt and charity care and other voluntary savings targets set by the state.<sup>25</sup>

Maine was ambitious in its goal of expanding coverage to all uninsured Mainers by 2009. The program drew criticism for enrolling only 12,000 to date, a number much lower than the state had anticipated.<sup>26</sup> However, considering the small population of

Maine, the numbers enrolled in the program are impressive. After the first year of operation, most were low-income individuals who were able to benefit from the subsidies available.<sup>27</sup> Still, state officials had hoped for larger enrollment and had not anticipated the continuing resistance from groups that are philosophically opposed to a publicly sponsored insurance initiative and to the program's financing strategy. Improving outreach and marketing strategies for the DirigoChoice program are a main focus of Maine's ongoing efforts to increase enrollment. In addition, state officials are hoping that administrative changes effective in early 2007 will

help streamline the subsidy process and make it easier for individuals to participate in the program.

In its second year of operation, Dirigo faced a lawsuit that challenged the savings offset payment. Although the savings offset payments were designed to recapture savings to the health system from the Dirigo reforms, insurance companies and Dirigo officials disagreed about how much savings the program generated and whether offset payments were the best way to finance the program. This disagreement prompted a legal challenge, although the court dismissed it. The case is being appealed. Clearly, Maine's experience underscores how difficult it is to capture and redistribute savings, let alone establish consensus on what constitutes captured savings.

To further the mission of Dirigo Health and ensure that health care continues to be accessible and affordable for the people of Maine, the Governor appointed a new Blue Ribbon Commission in 2006 charged with making "recommendations with respect to long term funding and cost containment methods." The commission will consider various funding alternatives, including the savings offset payment strategy.

### INCREMENTAL COVERAGE PROGRAMS

In 2006, several states moved forward on incremental reforms that sought to increase coverage for specific uninsured groups. As in past years, many of these efforts focused on low-wage workers and their lack of access to employer-sponsored insurance. The variety of different approaches states have taken to expand coverage reflects the different regulatory and market environments of

each state as well as the compromises that policy leaders were able to craft. The majority of state efforts to expand coverage rely on private insurers to deliver services, including those that use Medicaid funds. Building on the popularity of SCHIP, other incremental strategies focused on making insurance accessible to all uninsured children, regardless of income.

### PUBLIC-PRIVATE PARTNERSHIPS: TENNESSEE, RHODE ISLAND, MONTANA, UTAH

#### Tennessee



In June 2005, as the state began rolling back eligibility under its Medicaid program, TennCare, an estimated 161,000 individuals lost coverage.<sup>31</sup> On the heels of these major changes and reductions, Governor Phil Bredesen (D) proposed the Cover Tennessee initiatives, intended to cover some individuals who lost coverage and also help small businesses to offer coverage.

Aimed at filling in existing coverage gaps for 600,000 uninsured, Cover Tennessee included several strategies to reach different segments of the uninsured population—including high-risk individuals, low-wage workers without access to employer-sponsored insurance, and children. In June 2006, the Governor signed Cover Tennessee into law.

The Cover Tennessee program contains several components.

- **CoverKids**

The CoverKids Act creates a separate, stand-alone health care program for all children age 18 and under in Tennessee. This will be a SCHIP Program.

- **CoverTN**

This program aims to provide new, portable, and affordable coverage for the working uninsured in Tennessee who earn less than \$41,000 per year, as well as for small firms that do not currently offer insurance. While CoverTN is a limited benefit plan, covered services will include, at a minimum, physician services, hospital services, outpatient services, mental health services, lab services, and generic pharmaceuticals. Under the CoverTN program, workers would be able to continue participation when they change jobs.

During the first three years of the program, premium amounts charged to employers, employees, and individuals may not increase more than 10 percent per year to maintain affordability. The program is based on the three-share concept whereby participating employers, the State of Tennessee, and the individual each contribute one-third of the premium. The state will contract with statewide carriers to offer two products with an average \$150 premium per month. Premiums vary around this average based on age, tobacco use, and weight or body mass index. The benefit package will emphasize primary and preventive services with no deductibles and modest co-pays. At the time this report went to print, the state was in the process of contracting with participating health plans.

- **AccessTN**

The new legislation also creates a high-risk pool called Access



Tennessee. Tennessee, prior to TennCare, operated a high-risk pool but it was disbanded when the state chose to cover uninsurable individuals under its TennCare waiver. The new pool will be funded by a combination of premiums, assessments on carriers and third party administrators, state appropriations, and possible federal funds pending grant release from CMS. Premiums charged to pool enrollees will be between 150 percent and 200 percent of a commercial benchmark plan after moderate medical underwriting. The state also authorized a premium assistance program to subsidize individuals who cannot afford the premiums.

The legislation authorizes the administrators of the pool to develop two benefit packages: one modeled after the state employees Preferred Provider Organization (PPO) product, and an alternative option that is a high-deductible health plan coupled with a health savings account.

- **Other Programs**

The appropriation bill associated with CoverTN also continues funding for Tennessee's safety net program for affordable prescription drugs, with a focus on high priority populations with chronic diseases that require ongoing medication for daily functioning. The drug program will be available for adults who earn less than 250 percent FPL. In addition, the bill includes the Project Diabetes program, which funds endowment grants to high schools and health care entities to combat the epidemic of diabetes and obesity in the state.



## Rhode Island

In 2006, Governor Donald Carcieri (R) signed into law a number of new health initiatives including several coverage expansions focused on providing premium relief for small businesses. First, the Health Insurance Commissioner is empowered to work with business, insurance, and other stakeholders to develop a new, affordable health plan, called The Wellness Health Benefit Plan. The legislation sets a target premium of 10 percent of wages, while at the same time providing benefits that meet the following affordability principles outlined in law:

- Promoting primary care, prevention and wellness;
- Actively managing the chronically ill;
- Promoting the use of the least costly, most appropriate setting; and
- Use of evidence-based, quality care.

Meeting this legislatively-defined price point is expected to reduce premiums for all small businesses to approximately 25 percent below market rate through a combination of enhanced negotiating leverage via premium rate controls, administrative cost reductions, and innovative plan design elements. In addition, eligible low-wage small businesses (those with average wages in the bottom quartile) will save an additional 10 percent of premium through a state-sponsored reinsurance program. This reinsurance program passed into law during the 2006 legislative session; however, it is contingent upon the identification of a new funding source during the coming year. Finally, the Health Insurance

Commissioner is authorized to seek federal funds for the creation of a high-risk pool in the individual market.

Rhode Island's coverage expansions are part of a larger health care reform package that also includes:

- **Massachusetts Reform Review Task Force:** This panel will explore the potential transferability of the Massachusetts reforms to the State of Rhode Island.
- **Wellness:** The legislation restricts the sale of sweetened beverages in school vending machines, creates an adult flu vaccination program, and encourages insurance coverage of tobacco cessation products.
- **Transparency:** The legislation expands quality and cost data reporting to all licensed health facilities in the state to enable patients with deductibles and co-insurance to make informed decisions.



## Montana

Montana also implemented a program in 2006 to reach the growing number of uninsured employees working in the state's small businesses. Insure Montana was a joint initiative of Governor Brian Schweitzer (D) and former State Auditor John Morrison (D). The program, administered by the State Auditor's Office, uses two different mechanisms to assist small businesses of two to nine employees to afford the cost of health insurance.

- **Tax Credits**  
Qualifying small businesses that are currently providing health insurance to their employees are eligible for

refundable tax credits. About 600 businesses will be served under the tax credit aspect of the initiative for the first round of funding, totaling approximately 2,200 lives. Approximately 40 percent of the available Insure Montana funding per year is designated for the Employer Tax Credit.

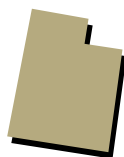
- Purchasing Pool**

For qualifying small businesses that previously have been unable to afford health insurance for their employees, Insure Montana provides a monthly assistance payment for both the employer's and the employee's portion of the health insurance premium. This assistance is available to small employers who have not offered insurance in the past 24 months.

Under the purchasing pool program, an employer must pay, before the state Employer Premium Incentive payment, at least 50 percent of an employee-only policy. The Employer Premium Incentive payment pays the employer up to 50 percent of the employer's contribution for each covered employee. Each employee receives a monthly Premium Assistance Payment with amounts ranging from 20 percent to 90 percent, based on a sliding scale tied to the employee's annual family income.

The insurance product under this program is available through one of the two Blue Cross Blue Shield of Montana plans offered by the State Health Insurance Purchasing Pool or through a qualified Association Plan. The size of each employee's Premium Assistance Payment is determined by Insure

Montana staff, based on a formula approved by the Insure Montana Board of Directors.

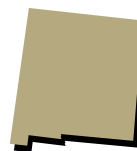


#### Utah

In November 2006, Utah announced a revised premium assistance program, the Utah Premium Partnership for Health Insurance (UPP). A prior version of the premium assistance program, called Covered at Work, was initially created in 2002 under the state's Primary Care Network program.<sup>32</sup> The peak monthly enrollment under the initial Covered at Work program was 79 individuals. Many attributed this modest number to the \$50 subsidy being too low to attract participants. Now, the new UPP program will provide a significantly larger subsidy of up to \$150 per adult for low-income workers enrolled in employer-sponsored insurance whose premiums represent more than 5 percent of their annual income. Subsidies are also available for employees' children at amounts of up to \$100. If dental services are covered in their parents' employer-sponsored plan they may be eligible to receive an additional \$20 per child. Currently, the state has funding to enroll 1,000 adults and an estimated 250 children.

#### LEVERAGING MEDICAID TO EXPAND COVERAGE TO WORKING UNINSURED: NEW MEXICO, OKLAHOMA, AND ARKANSAS

New Mexico, Oklahoma, and Arkansas have begun implementation of unique public-private partnerships to cover low-income workers, leveraging individual and employer contributions as well as Medicaid funds.



#### New Mexico – State Coverage Insurance

New Mexico was the first state to receive a Health Insurance Flexibility and

Accountability (HIFA) waiver in 2002 to expand coverage to low-income, uninsured, working adults with Medicaid funds. Because of operational challenges and difficulty securing state matching funds, New Mexico implemented their program, State Coverage Insurance, in July 2005.

The program is now 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 by contributions from the employer and employee in combination with state and federal funds. Self-employed workers must pay the employer as well as the employee portion of the premium. The benefit package is comprehensive, with an annual benefit maximum of \$100,000. Services are provided through private managed care organizations and cost sharing is designed to ensure that low-income participants have access to care. The program opened in July 2005 and close to 4,400 workers are currently enrolled in the program.

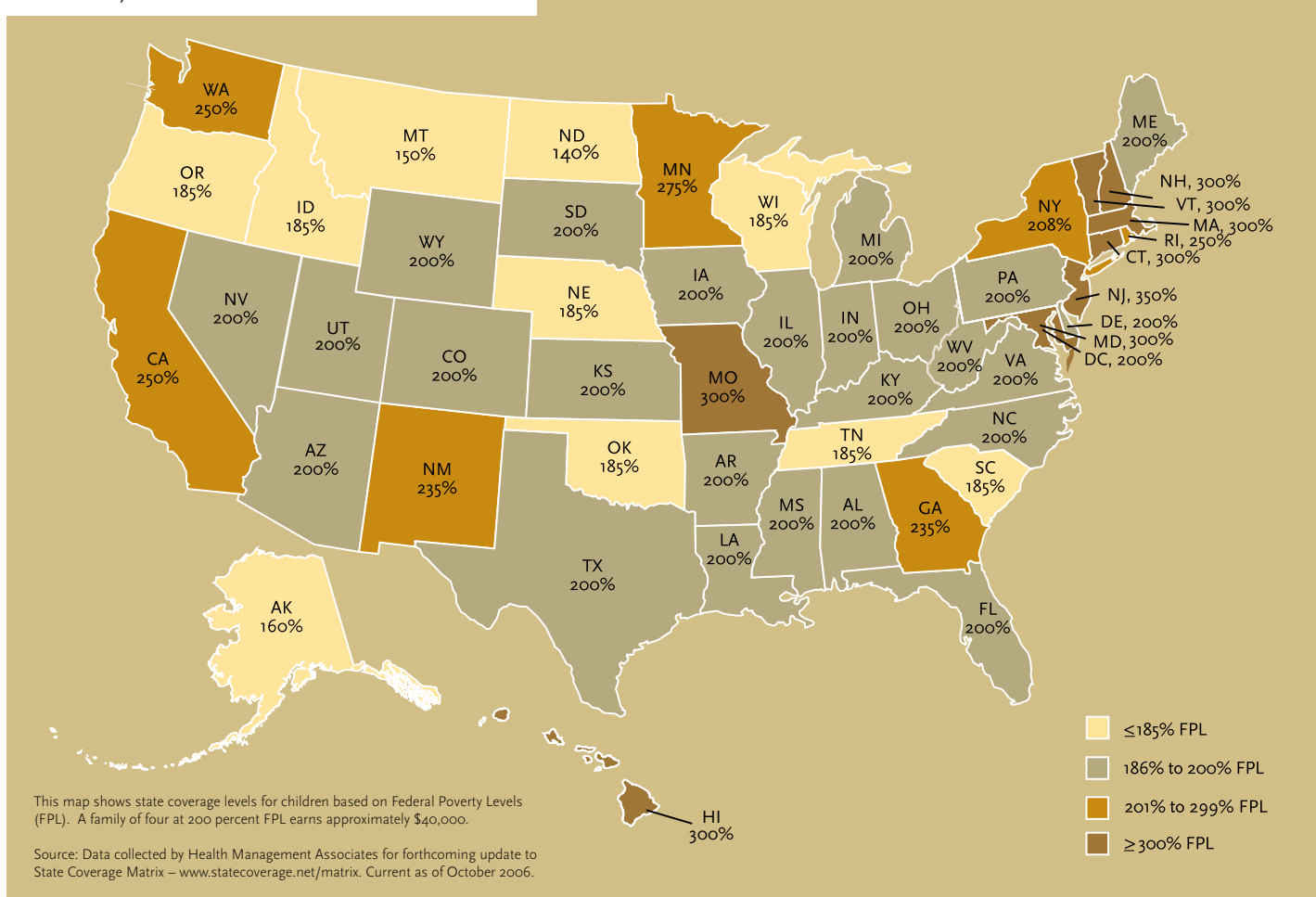


#### Oklahoma – Employer/Employee Partnership for Insurance Coverage

On September 30,

2005, Oklahoma received CMS approval of their HIFA waiver, the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). O-EPIC is intended to provide health insurance coverage to 50,000 low-wage, working adults in Oklahoma using either a

FIGURE 7 **COVERAGE LEVELS FOR CHILDREN**



premium assistance program or an individual plan. O-EPIC is funded by state general fund revenues generated by a tobacco tax, along with federal matching funds under Title XIX and employer and employee contributions.

The Premium Assistance program, launched in November 2005, helps qualified employees in small businesses of 50 or fewer employees purchase health insurance coverage through their employer. The employer works with an insurance agent to choose a qualified private health plan to offer its employees. The Premium Assistance program pays 60 percent of the health insurance premium for qualified employees with incomes below 185

percent FPL and 85 percent of the premium for the qualified enrollee's spouse. Employers are expected to contribute 25 percent of the employee's premium and employees are expected to contribute up to 15 percent for themselves and 15 percent for their spouses.

The Individual Plan will be launched shortly and is designed as a safety net health plan for qualified individuals with incomes below 185 percent FPL and who are ineligible to participate in O-EPIC Premium Assistance. The Individual Plan includes self-employed individuals not eligible for small group health coverage; workers at small businesses who are either not eligible

to participate in their employer's health plan or whose employer does not offer a qualified health plan; and unemployed individuals who are currently seeking work. The Individual Plan also provides coverage to working individuals with a disability whose income exceeds the Medicaid eligibility level but is below 200 percent FPL, and who meet "ticket to work" requirements.<sup>33</sup> The Individual Plan provides coverage through private managed care plans that also serve the Medicaid program; however, the benefit package is less comprehensive than Medicaid or most products offered in the commercial market.

FIGURE 8 **ENROLLMENT EXPERIENCE OF SELECT STATE COVERAGE PROGRAMS**

Target Population	Program (start date)	Eligibility	Enrollment Fall 2006 (individuals)
Small Business	Maine DirigoChoice (2005)	Small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance and with incomes below 300 percent FPL	12,000
	Insure Montana (2006)	Previously uninsured firms (2–9 employees) that have not offered insurance for 24 months	6,995
	New Mexico State Coverage Insurance (2005)	Low-income, uninsured, working adults with family income below 200 percent FPL; participating employers must have ≤50 employees and have not voluntarily dropped a commercial health insurance in the past 12 months	4,400
	Oklahoma Employer/ Employee Partnership for Insurance Coverage (2005)	Workers and their spouses, who work in firms with 50 or fewer workers; self-employed; unemployed individuals currently seeking work; and individuals whose employers do not offer health coverage with household incomes at or below 185 percent FPL  Small employers must contribute at least 25 percent of eligible employee's premium costs and offer an O-EPIC qualified health plan	1,200
	West Virginia Small Business Plan (2005)	Small businesses (2–50 employees) that have not had health benefit coverage for their employees during the preceding 12 months; employers must pay at least 50 percent of the premium cost	1,200
	Arizona Healthcare Group (1986)	Small business, the self-employed, and political sub-divisions. No income limits apply, but HCG does have employee participation requirements and crowd-out requirements	24,000
	Healthy New York (2001)	Small employers that have previously not offered insurance and with 30 percent of workers who earn less than \$34,000 annually; sole proprietors and working individuals without access to ESI who earn less than 250 percent FPL and have been uninsured 12 months	125,000
Low-Income Adults	Washington Basic Health (1988)	Individuals with family incomes below 200 percent FPL	100,000
	Pennsylvania adultBasic (2001)	Adults with incomes up to 200 percent FPL who have been without health insurance for 90 days prior to enrollment	55,000
	Minnesota Care (1992)	Families with children up to 275 percent FPL under Medicaid and childless adults up to 175 percent FPL	117,000
	Maryland Primary Care (2006)	Individuals below 116 percent FPL	23,000
	Utah Primary Care Network (2002)	Adults below 150 percent FPL	Waiver capped at 25,000
	District of Columbia Alliance (2001)	Uninsured individuals with family incomes below 200 percent FPL	35,000
Children Above SCHIP Income Levels	Illinois AllKids (2006)	Any child uninsured for 12 months or more with family income above the SCHIP level (200 percent FPL)	28,600
	Connecticut Husky B Buy-In (1997)	Allows uninsured children in families above 300 percent FPL the opportunity to buy-in to the state's SCHIP program, Husky B	800





### Arkansas – ARHealthNet

In March 2006, Arkansas received approval from CMS for the establishment of a program that will allow use of state and federal Medicaid funds to provide low-cost health coverage to small businesses. The original application was submitted to CMS in January 2003. During the negotiation phase with CMS, the Arkansas Department of Health and Human Services made some changes to the waiver design; however, the central goal of providing an affordable health coverage option to businesses that are not currently providing insurance remained intact. The new program, ARHealthNet, will be open for employer enrollment in late 2006 with plans to begin offering benefits to enrollees in early 2007. Arkansas is the third state to use a Medicaid HIFA waiver to expand insurance options for businesses and low-wage workers.

ARHealthNet will be open to employers who have not offered group health insurance to their employees during the preceding 12 months. The program requires employers who participate to guarantee coverage for all full-time employees regardless of income. While all employees are eligible to enroll in the new product, a subsidy is only available to those employees with annual incomes below 200 percent FPL.

The ARHealthNet benefit plan, best described as a safety net benefit design, offers limited coverage compared to what would typically be available through commercial plans or through the Medicaid program. It will include six clinician visits, seven hospital

days, two outpatient procedures or emergency room visits per year, as well as two prescriptions per month. The state has contracted with a commercial third-party administrator to administer ARHealthNet and to develop and implement a marketing plan using the existing Arkansas private carrier health insurance broker network.

Arkansas originally envisioned that private insurance carriers would accept all medical cost “risk” associated with this plan. However, in acknowledgement that the program represents a new operating model in Arkansas, the state subsequently elected to initially retain the “risk” in order to enhance acceptance by the private marketplace.

The program will be implemented in sequential phases during the five year demonstration period. Phase I will operate for a period of 12 to 24 months with an enrollment cap of 15,000. Phase II will operate for the remainder of the demonstration with enrollment capped based on availability of funding.

### COVERING CHILDREN

A growing number of states are interested in covering children above federal SCHIP levels. Since 1997, many have focused on increasing outreach and enrollment for their SCHIP programs. However, states were generally not focused on covering children with family incomes above SCHIP levels. Until recently, Connecticut’s Husky B program, the state’s SCHIP program, was the only program in the nation that allowed uninsured children in families above 300 percent FPL the opportunity to buy into the program.<sup>34</sup>

In November 2005, Illinois Governor Rod Blagojevich (D) signed the Covering All Kids Health Insurance Act, making insurance coverage available to all uninsured children. The All Kids program was designed to cover an estimated 50 percent of uninsured children in Illinois who reside in families with incomes above 200 percent FPL—the state’s SCHIP level. On July 1, 2006, the program officially began covering children. Of the 250,000 eligible uninsured children in Illinois, the state predicts that 50,000 children will enroll in the first year of the program. As of January 2007, All Kids will be available to any child uninsured for 12 months or more, with the cost to the family determined on a sliding scale basis.

The program is funded through enrollee premiums and cost sharing and savings from care management. The state continues to seek federal financial participation for those children that are eligible for KidCare (the state’s SCHIP program) and Medicaid. The program is linked with other existing public programs such as FamilyCare (coverage for parents up to 185 percent FPL) and KidCare via their online application. In addition, the state has undertaken a public outreach program called the All Kids Training Tour that will highlight the new and expanded health care programs offered by Illinois.

Illinois’ efforts have catalyzed other states to move forward on similar initiatives. Since then, several governors have proposed initiatives targeted at covering all children in their states. The impetus behind such initiatives is fairly

simple: covering children is a relatively inexpensive investment, and years of experience with simplifying eligibility and conducting outreach for SCHIP programs are a solid foundation for the successful expansion of children's coverage.

In July 2006, Pennsylvania Governor Edward Rendell (D) announced the development of the Cover All Kids program which will allow families to purchase health insurance on a sliding scale basis relative to their income. The Pennsylvania legislature approved \$4.4 million for Cover All Kids for its first year of operation. While CMS has yet to approve the program, the state aims to begin enrollment early in 2007.

Tennessee also passed legislation to cover all children, putting in place a new SCHIP program (SCHIP had previously been a part of the TennCare program). The Cover Kids Act, which became law in Tennessee in 2006, creates a stand-alone SCHIP program for children in families with incomes up to 250 percent FPL and allows children in higher income families to buy into the program.

Other states are considering similar proposals. In late September, Oregon Governor Ted Kulongoski (D) proposed his plan to cover uninsured children through an expansion of the Oregon Health Plan and a private purchasing arrangement for higher income children. Wisconsin Governor Jim Doyle (D) proposed extending the state's Medicaid program, BadgerCare, to all uninsured children by 2007. Similarly, Washington Governor Christine Gregoire (D) and New Mexico Governor

Bill Richardson (D) proposed the goal of insuring all children, but have not yet specified details of how it will be accomplished.

While many of these initiatives still need to be developed in greater detail for enactment or implementation, momentum is clearly building in a number of states to ensure that all children have access to health insurance. The interest in covering all kids is occurring even as many states, including Illinois and Wisconsin, are facing short-term SCHIP federal funding shortfalls. As Congress considers the reauthorization of the SCHIP program, there is rising pressure on federal lawmakers to expand this popular program and address the inadequacy of its current funding. (See page 46.)

#### **IMPLEMENTATION OF NEW STATE STRATEGIES: ENROLLMENT AND SUCCESS TAKE TIME AND COMMITMENT**

Several states are proposing new strategies to expand coverage to the uninsured and some have bold initiatives that seek to achieve near-universal coverage. Reaching the compromise needed to enact coverage proposals is a significant achievement, but much of the hard work lies ahead for state policymakers as they implement new programs. A long history of state initiatives designed to reduce the number of uninsured suggests that enrollment in these new initiatives may take time and they should be evaluated only after they have had time to mature.

Previous state strategies to expand coverage have resulted in a broad range of enrollment experiences (see Figure 8). This can largely be explained

by the different goals of these programs, the diverse populations these programs intend to cover, the length of time they have been in operation, and the amount of funding the state has provided.

However, there are also a number of programmatic design decisions as well as operational practices that impact how many uninsured individuals are ultimately enrolled.

#### **Complex Design**

Many of the new state initiatives have fairly complex program design and participation rules. Often the complexity is a result of efforts to target limited resources to specific segments of the uninsured population or to assure that new public programs do not encourage either employers to cease offering coverage or individuals to drop their coverage. However, these participation rules often lead to additional steps in the enrollment process, which can create operational barriers for the target population as well. Income requirements are a fairly standard condition of eligibility. In addition, eligibility is often limited to individuals who have been uninsured for a specific period of time and who work for an employer of a certain size or that does not currently offer coverage. Many also require employers to participate by beginning to offer coverage. With so many factors in play, the underlying complexity of the program design can frustrate success, despite the best efforts to reach out to the eligible population.

The Illinois All Kids program is a notable exception to these complex and targeted efforts. By creating a program that is open to all uninsured children regardless of income, the state

can simplify the outreach message to families. The participation rules are very broad, requiring only that the child be uninsured for 12 months, and the state uses the sliding scale premium to target public subsidies to families with incomes below specific thresholds.

### **Small Businesses are Hard to Reach**

While there has been significant progress by states in improving administrative systems to enroll children in Medicaid or SCHIP, there has been less of a focus on reducing the administrative barriers for initiatives to expand coverage offered by small businesses or to working uninsured individuals. Fewer resources have been available to assist state policymakers in identifying best practices to overcome administrative barriers to enrollment. In the case of initiatives that require employers to begin to offer coverage, it remains unclear what factors inhibit higher enrollment. Two possible explanations are the complex operational barriers to enrollment and the intrinsic challenge of a strategy that focuses only on businesses that have not previously offered coverage and are disinclined to start.

### **Ramp-up Time Needed**

Regardless of program design, past experience demonstrates that it takes time for new coverage programs to enroll uninsured individuals. Working through a new program's start-up challenges can take time, and states are usually further constrained by both short timeframes for implementation and a lack of funding for administrative functions. The history of the SCHIP program bears this out—initial enrollment in most state SCHIP programs was below expectations and most under-spent their federal allotment in the early years. However, current SCHIP enrollment is such that spending exceeds the federal allotment in 40 states.<sup>35</sup> (See page 48.)

Small business initiatives may take even more time to build enrollment. For example, Healthy New York, originally established in 2001, is now one of the largest coverage initiatives for small businesses and low-wage workers in the nation. After initial slow enrollment, and following modifications to the design of the program in 2003 that resulted in lower premiums, enrollment grew quickly. In August 2006, enrollment in

Healthy New York exceeded 125,000.<sup>36</sup>

While the enrollment changes that occurred during this time can be attributed to the more affordable premiums, it also may be due to the amount of time it took for the state to market the program and earn a degree of confidence from businesses and residents. In focus groups, small business leaders have indicated that they are willing to commit to providing health insurance through a state program only after it has demonstrated program stability.<sup>37</sup>

### **Balancing Vision and Realistic Expectations**

It often takes ambitious goals by state policymakers to build support for new coverage strategies. The challenge for policymakers is to balance initial expectations with maintaining support for the initiative in the difficult, early years of implementation. Policymakers' desire to demonstrate early success can make it hard to encourage stakeholders to stay the course over the long term; however, it is only over the long-run that strategies can be fairly evaluated.

# STATE COVERAGE STRATEGIES: EVOLVING WITH TIME

2006

**Massachusetts and Vermont demonstrated that bi-partisan compromise and comprehensive reforms are possible at the state level. Several other states approved or began implementing coverage initiatives focused on children**

**Arkansas** – CMS approved a waiver to allow Arkansas to receive federal Medicaid funds for a program that will provide low-cost health coverage to small businesses.

**Idaho** – Taking advantage of the state plan amendment process provided in the DRA, the state split the Medicaid and SCHIP population into three major benefit plans.

**Illinois** – All Kids program implemented. Many other states propose similar plans to cover all children.

**Kansas** – Received federal approval for their reform proposal under the DRA.

**Kentucky** – Moved forward on their Medicaid redesign plans after receiving approval for their state plan amendment under the DRA.

**Maryland** – Legislature over-rode Governor Ehrlich's veto of the "Fair Share Act." Later in the year, the U.S. District court struck down the bill, declaring the measure was pre-empted by ERISA. The state has appealed the decision.

**Maine** – Blue Ribbon Commission on Dirigo Health established to evaluate components of the state-subsidized coverage program for the uninsured, particularly Dirigo's funding mechanism.

**Massachusetts** – Passed a landmark comprehensive bill designed to cover 95 percent of the uninsured in the state within the next three years.

**Oklahoma** – Legislature approved expansion of O-EPIC program to cover businesses with 50 or fewer employees.

2005

**Financial conditions continued to improve for many states and more proposed or implemented coverage initiatives. During this time, the foundation for comprehensive reforms was being laid in Massachusetts and Vermont.**

**Florida** – Received CMS approval for Medicaid redesign plans to be piloted in two counties.

**Georgia** – Legislature passed minimum benefit legislation.

**Illinois** – Legislature passed All Kids program, expanding coverage to children above SCHIP levels and continued to phase-in an expansion of coverage for parents up to 185 percent FPL.

**Iowa** – In exchange for giving up \$66 million in Inter-Governmental Transfers, the state received a waiver from CMS to provide a limited set of Medicaid benefits to adults up to 200 percent FPL.

**Kansas** – Governor Sibelius announced the Kansas Health Care Authority, which streamlined all major health care programs in the state to improve efficiency and allow the state to push for reforms.

**Kentucky** – Legislature passed minimum benefit legislation.

**Maine** – Enrollment began in DirigoChoice.

**Maryland** – Legislature passed the "Fair Share Act," requiring large employers to spend at least 8 percent of their payroll on health care. The bill was vetoed by Governor Ehrlich.

**Massachusetts** – Several health care reform proposals were introduced and each house in the legislature passed its own version of comprehensive reform. State received approval for Mass Health waiver extension establishing a Safety Net Care Pool.

**New Mexico** – State Coverage Insurance program, which is available to low-income, uninsured working adults with family incomes below 200 percent FPL, is implemented.

2004

**In 2004, states began to emerge from the severe fiscal crisis of the previous few years and could refocus on coverage strategies. Several states created new funding sources for future expansions, others moved forward on incremental approaches.**

**California** – Voters approved referendum repealing "pay-or-play" law passed in 2003.

**Colorado** – Voters approved a tobacco tax increase expected to provide \$125 million for health programs.

**Idaho** – Health Insurance Flexibility and Accountability (HIFA) waiver approved, creating the Idaho Access Card and premium assistance programs.

**Illinois** – Increased family coverage for kids from 185 to 200 percent FPL and for parents from 49 to 133 percent FPL.

**Louisiana** – Legislature passed minimum benefit legislation.

**Maine** – Prepared for implementation of the Dirigo reform plan that had been enacted in 2003.

**Maryland** – Legislature passed minimum benefit legislation.

**For more information on state strategies, visit [www.statecoverage.net/matrix](http://www.statecoverage.net/matrix).**



# AND EFFORT

**and working uninsured adults. Several states also took advantage of the flexibility outlined in the DRA to redesign their Medicaid programs.**

**Pennsylvania** – Legislature approved funding for Cover All Kids, a program allowing families with incomes above the SCHIP eligibility level to purchase health insurance for their children on a sliding scale basis based on income. Implementation to begin January 1, 2007.

**Rhode Island** – Legislature passed a number of new health initiatives including several coverage expansions focused on providing premium relief for small businesses.

**Tennessee** – Legislature passed Cover Tennessee program, which includes several expansions to cover children, uninsurable adults, low-income workers, and small businesses.

**Utah** – Revamped its Covered at Work program and introduced the new Partnership for Health Insurance program, which provides subsidies for low-income workers who are enrolled in coverage provided through their employers.

**Vermont** – Reached agreement on Catamount Health with goal of reaching universal coverage by 2010. The program includes an employer assessment, a new insurance product with subsidies for individuals below 300 percent FPL, and several chronic disease management initiatives.

**West Virginia** – Moved forward on Medicaid redesign plans after receiving CMS approval for their state plan amendment under the DRA.

**Federal:**

- Medicare Part D implemented. States are no longer responsible for providing prescription drug coverage to dual eligibles.
- Congress passed the DRA which authorizes states to implement a variety of changes to their Medicaid programs.
- The Medicaid Commission proposed long-term solutions to address Medicaid's escalating costs.

**Maryland passed “Fair Share” legislation, sparking interest in several states regarding employer responsibility. Spurred by continued budget challenges and the threat of federal changes to the Medicaid program, many states also developed Medicaid reform proposals.**

**Montana** – State implements Insure Montana, an initiative using tax credits and a purchasing pool to help small businesses afford the cost of health insurance.

**Oklahoma** – The O-EPIC program waiver is approved by CMS.

**Pennsylvania** – Signed an agreement with Blue Cross Blue Shield insurance plans to spend close to \$1 billion in surplus funds over six years on varying health programs in the state, including adultBasic.

**Tennessee** – Granted a waiver amendment to end coverage of uninsured and uninsurable adults in the TennCare program and began disenrolling approximately 320,000 individuals.

**Vermont** – Governor Douglas vetoed the Green Mountain Health bill, which would have provided primary and preventive services to the uninsured. The state also received approval for their Global Commitment to Health waiver.

**West Virginia** – The Small Business Plan began enrollment. The state also established the WVAccess high-risk pool.

**Federal:**

- Secretary Leavitt established the Medicaid Commission charged with recommending ways to cut \$10 billion from the program over five years.

**One state, Maine, continued to work on comprehensive reform plans. Passage of the Medicare Modernization Act (MMA) handed tremendous responsibility to state officials.**

**Michigan** – Received CMS approval for Adults Benefit Waiver program covering childless adults at or below 35 percent FPL.

**Minnesota** – Joined with health purchasers to form the Smart Buy Alliance focusing on health purchasing strategies and rewarding quality and value within the system.

**Montana** – Voters approved a tobacco tax increase to support a pharmacy program and a coverage program for small businesses.

**Oklahoma** – Voters approved a tobacco tax increase, which provided funding for a new coverage program.

**Texas** – Legislature passed minimum benefit legislation.

**Washington** – Legislature passed minimum benefit legislation.

**West Virginia** – Legislature passed Small Business Plan, which allowed carriers to access the state's public employees agency reimbursement rates, enabling businesses to find more affordable coverage.

**Federal:**

- The MMA passed in late 2003, providing seniors and people living with disabilities a prescription drug benefit under Medicare and created health savings accounts, part of a growing trend toward broader consumer participation in health care decisions.
- During 2004, state officials sorted out the implications of the new drug benefit and the discount card program.



# TRENDS IN STATE INITIATIVES & LESSONS FOR POLICYMAKERS

While the situation and proposed solutions in each state vary widely, a nationwide review of efforts to address the problem of the uninsured reflects current trends and hard learned lessons that can inform future strategies.

**A**lthough the reforms of the past year vary in a number of ways, common themes and trends can be seen.

## 1. Comprehensive state reforms build off prior efforts and financing mechanisms.

States that are attempting to reach near-universal coverage usually build these reforms on prior efforts. The comprehensive reforms in Massachusetts, Vermont, and Maine are all examples of coverage initiatives that built on previous initiatives as a foundation for more comprehensive action. In these states, Medicaid eligibility for adults was expanded over time to income levels well above the national average. Likewise, each had strategies in place to improve access to care or contain costs. In Massachusetts, as much as \$1 billion was historically spent annually on the safety net with much of this funding now being shifted to insurance coverage. In Vermont, a prior

Medicaid waiver is expected to provide some of the flexibility for funding the new expansion efforts.

## 2. Reforms attempt to stem the erosion of employer-sponsored insurance.

Many state efforts to expand coverage focus on compelling evidence that the increase in the uninsured is due in large part to the decline in employer-sponsored insurance. During the past several years, many states have collected and analyzed their own data about the uninsured. These state studies, as well as national reports, indicate that more than 80 percent of all nonelderly uninsured are either workers or living in families with working individuals<sup>38</sup>—a finding that has led state leaders to focus most of their efforts to expand coverage to the working uninsured. These strategies either encourage small businesses to offer insurance or target low-income workers or their dependents without access to employer-sponsored insurance.

States have used a number of voluntary measures to help small businesses to offer insurance. Many allow small employers to offer a more affordable product to their employees either through a group purchasing arrangement, leveraging the buying power of the state, offering subsidies, or allowing insurers to offer limited benefit packages. For example, DirigoChoice in Maine and the Connector in Massachusetts enable small employers to purchase insurance through new purchasing arrangements as well as subsidizing premiums for low-income workers. Massachusetts and Vermont go farther: they are the only states yet to require businesses to pay modest assessments toward state-offered coverage if they fail to provide insurance for their workers.

States look to the employer-based system for these coverage strategies for three main reasons. First, employer contributions to premiums can leverage public funds. Second, employers and



employees both derive tax advantages from employer-sponsored coverage, offsetting a significant portion of the premium. Finally, where employers are already offering health insurance, the new programs can take advantage of the administrative structures already in place.

What is troubling is that an increasing number of employers are not offering coverage to their workers, and the voluntary strategies states have tried to date have had limited success enticing employers to begin offering coverage. Therefore, many of the new strategies targeted at helping small businesses now also provide a means to assist low-income workers even if their employer is not willing to participate. Oklahoma's O-EPIC Individual Plan, New Mexico's State Coverage Insurance, and all of the comprehensive proposals allow uninsured individuals to enroll if they do not have access to employer-sponsored insurance. Even the states expanding coverage for children are reaching out to working families who no longer have access to employer-sponsored insurance.

### **3. Successful efforts to enact reforms often expect shared financial responsibility. Some states are beginning to recognize the need for mandatory participation.**

Even though employer-sponsored insurance has declined, 63 percent of working age adults still get insurance through their employer.<sup>39</sup> Recognizing the essential funding employers provide, none of the efforts to expand coverage in 2006 were exclusively financed with public funds. States have moved forward on initiatives that expect both employers and individuals (based on their income) to contribute. Some also included

elements of consumer-driven purchasing to increase consumer involvement.

Many state initiatives include a role for employer contributions to health care coverage on a voluntary basis. However, Massachusetts and Vermont explicitly require employers to contribute to the costs of health care through their employer assessments, albeit only a modest amount compared to the actual cost of health insurance premiums. Maryland's Fair Share Act tried to go further in requiring employer responsibility, but it was struck down by the courts.<sup>40</sup>

The attention given to Massachusetts's requirement that all individuals have health insurance demonstrates a growing recognition that voluntary programs are not likely to reach all of the uninsured. As a result of Massachusetts' groundbreaking reform, policymakers seem more willing to consider mandatory insurance requirements for individuals, sparking a public debate about who is ultimately responsible for assuring coverage.

### **4. Expansions in coverage often rely on private insurers to deliver care.**

Whether or not states move forward with incremental or comprehensive reforms, private insurers clearly will continue to play a major role. Commonwealth Care, Catamount Health, and DirigoChoice each contract with private insurers to bear risk. Even states that are largely using Medicaid financing for expansion efforts have carefully crafted the delivery of services through private health insurers, such as New Mexico's State Coverage Insurance and Oklahoma's O-EPIC.

While the aforementioned expansions use private insurers, there continues to be some question whether private plans are the most efficient platform to expand coverage. In the case of Vermont's reform, policymakers questioned the extent to which the expansion of coverage would use private health plans or be administered by the state. A compromise was crafted: the state's commission on health care reform can deem that rates offered by carriers are not a cost-effective method of providing coverage—allowing the state to pursue self-insuring. Maine contracted out DirigoChoice to the largest carrier in the state, Anthem, but has more recently examined whether DirigoChoice should self-insure to achieve greater efficiency.<sup>41</sup> Arkansas made the decision to self-insure but privately administer, at least for the first two years, to avoid uncertainty about the health profile of the population that will enroll.

### **5. Medicaid benefits are being redesigned through the DRA, but to date these efforts have not included expansions in coverage.**

A current focus for Medicaid policymakers is the new flexibility that states were given under the DRA to redesign benefits for current populations. West Virginia, Kentucky, and Idaho were the first states to propose changes to their benefit design for currently covered populations with approved state plan amendments in 2006.

These reforms are likely to have a significant impact on coverage for low-income individuals and may change their access to care. However, to date, none of these reforms change Medicaid



beneficiaries' eligibility level for the program. In fact, the flexibility provided to states through the DRA is clearly targeted to currently covered populations versus expansions to wholly new populations.

Medicaid continues to be an important source of funding for strategies to cover the uninsured. Several incremental approaches leverage Medicaid financing to expand coverage. Furthermore, all of the comprehensive reforms include some level of Medicaid financing.

#### **6. Many state reforms address cost and quality in addition to health insurance coverage.**

As states struggle with reforming their health care systems, the issue of coverage has become more deeply entwined with quality and cost issues than ever before. Access to health care is fundamentally a question of affordability and states are trying to determine the level of efficiency and value they would like the health care system to provide. As such, states are creating programs that go beyond just coverage to include aspects of quality and cost containment.

Early on, Maine concluded that sustainable health care reform required addressing all three issues of access, cost, and quality concurrently. So, while they created DirigoChoice to improve access to insurance through a subsidized insurance product, they also founded the Maine Quality Forum and pursued a number of cost containment initiatives.

A large part of Vermont's reforms addresses the issue of chronic care management both to improve the health of Vermont's population and to help control one of the main

underlying cost drivers in the health care system. Other states have created task forces and commissions to focus on cost and quality—including the new Massachusetts Health Care Quality and Cost Council to promote health care quality improvement and cost containment and West Virginia's Interagency Health Council charged with addressing issues related to access, cost control, quality, and equitable financing.

Across the country, many states are collecting data to measure health plan and provider performance and disseminating that information to the public. Medicaid agencies are involved in various activities including performance measurement, financial incentives based on those measures, and encouraging programs to directly improve clinical care for their beneficiaries. In addition, the public health agency in most states is focused on population-based clinical quality improvement. Finally, in some states, the agency that administers the state employee health plan also is working on quality initiatives, many times as part of a larger coalition of other employers in their state.

#### **LESSONS FROM DECADES OF EXPANSION EFFORTS**

This is not the first time states have taken the lead in attempting to improve insurance coverage in their states. This recent round of reform builds on at least a decade of state efforts, ranging from comprehensive attempts such as Massachusetts' 1988 pay-or-play requirements to the TennCare expansions and from the Oregon Health Plan to numerous incremental approaches. These efforts have had variable degrees of success and challenges that provide lessons for

policymakers considering their own state reforms.

#### **1. State strategies make a difference because they help people access health care.**

Programs that provide access to coverage for previously uninsured populations make a difference in people's lives. The research demonstrating the link between insurance coverage, access to health care, and improved health outcomes is irrefutable.<sup>42</sup>

State Medicaid and SCHIP growth have prevented what would have otherwise been a larger increase in the uninsured.<sup>43</sup> Many states have used these programs to expand coverage to new populations.

State efforts to expand coverage occur within a broader, more challenging environment. With health insurance premiums growing almost three times faster than workers' wages and a continually declining base of employer-sponsored insurance, it is no surprise that these larger trends in health coverage make it difficult to assess the impact of specific state efforts to improve coverage.<sup>44</sup> Nonetheless, it is clear that more previously uninsured individuals have coverage today as a result of state initiatives (see Figure 8).

#### **2. Leadership, opportunity, and readiness to act are all key ingredients to making reform happen.**

No state reform occurred without a champion clearly articulating the need for significant change. Many examples illustrate this imperative—including

## MANDATES: HOW THEY WORK AND WILL THEY WORK?

With continued erosion of employer-sponsored insurance, many states have attempted to encourage employers to offer and contribute to employee health benefits programs through voluntary measures such as tax credits, purchasing pools, and income-based subsidies for low-wage workers. However, because voluntary employer incentives generally have not been able to close the increasing gaps in coverage, some states have begun to consider more mandatory “pay-or-play” strategies, assessing employers that do not provide coverage.<sup>48</sup>

In part, states have reexamined the concept of employer mandates out of concern that the uninsured will end up on public programs or require uncompensated care which results in cost-shifting to those with private coverage. Several states conducted analyses, attempting to determine whether a significant number of uninsured, large-firm employees receive Medicaid, SCHIP, or uncompensated care. Some have discovered that many employees of a few large firms are enrolled in public programs.<sup>49</sup>

The idea of employer mandates to reduce the number of uninsured is not a new concept: many states have enacted legislation calling for an employer mandate but were unable to implement such programs. In 1988, Massachusetts enacted but never implemented an employer mandate, which ultimately

was repealed in 1996. Oregon passed an employer mandate in 1989, but it expired before being implemented. Washington followed suit in 1993 with an employer mandate, but it too was repealed in 1995. In 2004, California voters narrowly rejected an employer mandate that would have required businesses with more than 50 employees to pay a fixed fee for workers whom they did not insure.

To date, Hawaii is the only state that has implemented an employer mandate, the Prepaid Health Care Act of 1974, and Hawaii has one of the highest employer offer and coverage rates. The 1974 law required nearly all employers in Hawaii to provide health benefits to employers who work more than 20 hours per week.

### MARYLAND'S ATTEMPT AND THE ERISA CHALLENGE

On January 12, 2006, Maryland became the first state to require an employer to spend more on health care for its employees. The Maryland General Assembly over-rode Governor Ehrlich's veto to pass a bill (S.B. 790/H.B. 1284) during the 2005 legislative session requiring private-sector for-profit employers with 10,000 or more employees in the state to spend at least eight percent of their payroll (or six percent in the case of a nonprofit employer) on health care.

It quickly became known as the “Wal-Mart Bill” as Wal-Mart was the only employer in the state on which it would

have an effect. According to the bill, those employers that fall below the requirement would be required to pay the difference between their health insurance expenses and the percentage threshold into a new Fair Share Health Care Fund, which would direct the funds into the state's Medicaid program. The Retail Industry Leaders Association (RILA) filed suit against the bill and, in a ruling on July 19, 2006, the Maryland Act was struck down, with the judge declaring that the measure was pre-empted by the Employee Retirement Income Security Act (ERISA) and was therefore invalid.<sup>50</sup>

Nevertheless, Maryland's legislative attempt caught the attention of many other states where bills similar to the Maryland law were introduced in 2006—including a bill in California that was passed by the legislature but was vetoed by the governor in September.<sup>51</sup>

With the court's ruling on the Maryland legislation, few states are likely to pass an employer requirement crafted in the same way. Still, legal experts believe that it is still possible for states to propose ideas that could survive an ERISA challenge.<sup>52</sup> Of note, both Massachusetts and Vermont included requirements on employers in their comprehensive reform plans. Both states have an assessment on employers over a certain size that fail to provide health benefits. Although, in both cases, the employer assessment is well below the cost of actually

providing insurance. In Vermont's Catamount Health plan, employers will be required to pay an assessment even for those employees who are eligible for coverage they offer, but are not enrolled and therefore are uninsured. In Massachusetts, such employees will be required to purchase insurance. Vermont will assess the need for an individual mandate in future years.

Massachusetts also requires employers to set up a Section 125 benefit plan (cafeteria plan) or potentially pay a portion of the cost of uncompensated care used by their uninsured employees. Employers are not required to necessarily contribute to the cost of health care, but solely to set up the mechanism for the individual employee to purchase insurance with pre-tax dollars.

The architects of the Massachusetts legislation (see State Strategies section) have commented on the necessity of an individual mandate to effect change.<sup>53</sup> Voluntary measures may not be sufficient to encourage take-up and, despite the presence of a subsidized and affordable insurance product, some people will still go without coverage. Massachusetts survey data indicates that approximately 40 percent of the uninsured earn more than 300 percent FPL and presumably could afford to purchase insurance. The state has engineered a strategy to ensure that every taxpayer contributes to the cost of health care coverage in some fashion

and to finance any remaining "free-rider" effect by adding new premium dollars into the health system. In addition, the state is hoping that individuals who are healthy yet currently uninsured will enter the insurance risk pool, stabilizing costs for everyone.

The concept of employer and individual mandates provoke sharp political dialogue about where the balance of responsibility for health insurance coverage lies.

Interest in employer mandates continues as policymakers attempt to reverse the trend in declining employer-sponsored insurance and maintain the largely employer-based insurance system. The interest that has been generated by Massachusetts's passage of an individual mandate portends a readiness by some policymakers to explore focusing responsibility in insurance coverage on individuals.

## MORE INFORMATION ON ERISA

More detailed information on ERISA implications for state coverage strategies is available in *ERISA implications for State Health Care Access Initiatives*. The publication, written by Patricia Butler, JD, DrPH, explores the implications of the recent federal court decision finding that ERISA preempts Maryland's "Fair Share Act." The paper discusses in detail:

- ERISA preemption principles;
- The Maryland law and RILA vs. Fielder court decision;
- Implications for state health care access initiatives involving employers in financing; and
- Arguments that may be raised to challenge and defend such state programs.

*ERISA Implications for State Health Care Access Initiatives* is part of a continuing series of policy papers on ERISA published by the Robert Wood Johnson Foundation's State Coverage Initiatives program and the National Academy for State Health Policy.

Please visit <http://www.statecoverage.net/publications.htm> to access a PDF version of the brief.

Massachusetts, where the Governor and legislative leaders were able to come together and make health reform a priority. Making reform happen requires leaders who are committed to a solution, but not so focused on a specific strategy that they are unwilling to look to other options. Ultimately, success requires working through the reality of the political process.

For better or worse, there is an element of serendipity in the reform process, creating new opportunities to move forward. For both Massachusetts and Vermont there was an alignment of forces in each of the states that pushed forward reforms. Both enacted their reforms after several years of major discussion with engaged stakeholders driving a reform agenda. In Maine, a new governor came to office with a promise to address health reform and a public mandate for change. However, beyond the opportunity is the ability to act and be prepared to move quickly once the policy window opens. These states had policymakers and analysts who had a profound understanding of the problems they intended to address and an appropriate framework of options to consider.

### 3. There are no free solutions.

States experienced fiscally challenging times during past few years and many states attempted to address the issue of the uninsured and expand coverage using strategies that did not require additional spending—including enacting laws that allowed carriers to sell limited benefit products, creating purchasing pools, and instituting outreach and education initiatives. However, these ‘no cost’ strategies have had little, if any, apparent impact. Significant strides in reducing the number of uninsured require a significant

financial investment. As states emerge from their fiscal crisis, some are ready to invest new funds to expand coverage.

### 4. There has been little success in addressing underlying costs of health care, but a new focus on chronic care management holds potential.

Affordability of health insurance is one of the main contributors to a growing uninsured population. The data are compelling. While health insurance premiums are growing more slowly (7.7 percent) than in prior years, they still are growing three times faster than wages.<sup>45</sup> The data for low-income workers are even more striking. The annual premiums for family coverage reached \$10,880 in 2005, eclipsing the gross earnings for a full-time minimum-wage worker (\$10,712).<sup>46</sup> Providing insurance coverage to all of the uninsured will require more effective strategies to control the growth of underlying health care costs.

Commercial insurers and state programs have responded to rising health care costs with changes in benefit design that shift more financial responsibility to consumers or eliminate benefits altogether.<sup>47</sup> None of those efforts reduce the actual cost of health care.

More recent state reforms have focused on improving services and reducing underlying health care costs. Vermont has led the way by including chronic care management as part of its reform efforts. By targeting patients, payers, communities, and the greater health system, Vermont hopes to control the growth of health care costs and improve the quality of care (see page 17). Another example is Arkansas which has become a national model for its focus on health

and, in particular, for its efforts to halt the obesity epidemic that has been identified as a major contributor to health care cost increases.<sup>54</sup>

While these new strategies hold promise, they still are untested and it will take time to demonstrate outcomes. The question remains whether the current efforts can advance beyond current disease management strategies and contain long term cost growth.

### 5. Voluntary purchasing pools, as a standalone strategy, are not likely to be sufficient to expand coverage.

The creation of a Connector in Massachusetts sparked renewed interest by policymakers in the concept of facilitating the purchase of insurance for small businesses and individuals. While some may consider the Connector to be a purchasing pool, Massachusetts’ state officials describe it more as a purchasing mechanism. The Connector does not pool risk. Rather, it streamlines the administrative aspects of purchasing insurance. However, states have a long history of creating pooling arrangements and the evidence suggests that pooling alone is not sufficient to drive down health costs. In fact, voluntary purchasing pools may attract higher risk enrollees than the rest of the market, contributing to a segmentation of risks.<sup>55</sup>

Until recently, California operated one of the largest and longest running purchasing pools—PacAdvantage. Enrollment in PacAdvantage reached more than 100,000 in August 2006, but evaluations of the initiative indicated that it had done little to expand coverage to uninsured individuals.<sup>56</sup> In 2006, PacAdvantage announced that it would cease operations,



saying the “withdrawal of participating health plans has left PacAdvantage unable to continue offering competitive healthcare coverage choices for California’s small business employees.”<sup>57</sup> The withdrawal of plans was caused by numerous factors including an adversely selected risk pool the led to increasing financial losses for those carriers.

Florida’s experience with purchasing pools in the 1990s demonstrated the potential harm this strategy can have on the insurance market. Florida created eleven Community Health Purchasing Alliances (CHPA) in 1993 as part of a small-group market reform. Enrollment peaked in 1998 with 92,000 covered lives and an average group size of two. Due to the regulatory environment in Florida, the CHPAs enrolled a disproportionate amount of groups of one as an alternative to the individual market. This raised concerns about adverse selection for the participating health plans. Over time, participating carriers began to withdraw, citing concerns about adverse selection, among other reasons. Subsequently, enrollment fell quickly and premiums increased significantly, leading the CHPAs to disband in July 2000.<sup>58</sup>

It is important to note that Massachusetts’ Connector provides several financial incentives to attract enrollees, including providing access to subsidies only available to those covered through the Connector. This may result in a different outcome than prior efforts. The experience of the Connector will test whether purchasing arrangements coupled with financial incentives will affect enrollment and build purchasing power.

## FEDERAL PROPOSALS TO SUPPORT STATE INNOVATIONS

The idea of fostering innovation in states is not a new idea for Congress. From 2000–2005, Congress appropriated \$76 million dollars for the Health Resources and Services Administration (HRSA) State Planning Grant Program (SPG) which provided funding for state planning efforts related to covering the uninsured. Over the course of the program, the SPG program provided funding for 47 states and four territories to collect new data and study health insurance trends in order to develop coverage options for their uninsured. The program ultimately was defunded, after being evaluated and criticized for not meeting goals that far exceeded what states could have accomplished solely with resources for planning.

However, the seeds of many of today’s state innovations have roots in the SPG initiative, which provided state officials from virtually every state with a greater understanding of the uninsured and an increased technical capacity to address the issue. Since the SPG program was dropped from the HHS budget last year, new federal proposals have emerged to foster state innovation.

During the 109<sup>th</sup> Congress, three bills were introduced that would provide federal grant funds to states to propose and pilot new health reforms. A fourth bill, the Catastrophic Health Protection Act, also allows states to pilot demonstration projects to expand coverage within a federal framework. (See Figure 9).

One fundamental issue for fostering state innovation is how new state strategies will be financed—including whether states will be required to find savings to finance expansions in coverage. Some congressional

proposals provide federal funding for implementation, but it is not clear whether this is short-term support during the life of the grant or whether federal financing will continue. The potential for on-going federal financial support is an essential consideration for states that would expand coverage under such programs.

Other congressional proposals indicate that state demonstrations will need to be budget neutral, in effect requiring states to fund new initiatives by finding savings elsewhere in their programs. States are already facing difficult choices such as limiting benefits to currently covered individuals or taking funds from an under-funded safety-net system.

The potentially significant costs to the federal government for supporting new coverage initiatives make it difficult to select just a handful of states to pilot strategies. More states will want to follow the lead of successful demonstrations. Therefore, federal policymakers should be prepared to enact and fund strategies that build on successful state demonstrations.

The introduction of these bills clearly bolsters a trend toward developing solutions to the problem of the uninsured at the state level rather than in Washington, D.C. Time will tell whether the new Congress is ready to provide the federal resources necessary to encourage state innovation, whether the current bi-partisan agreements at the state level are able to encourage even broader federal action, or whether the status quo will prevail. Regardless of what occurs in the nation’s capitol, states are likely to continue to feel public pressure to increase coverage and experiment with new health reforms.

FIGURE 9 **FEDERAL LEGISLATION TO SUPPORT STATE DEMONSTRATIONS**

Legislation	Description	Funding
<p><b>State-Based Health Care Reform Act</b> S. 3776</p> <p><b>Sponsor:</b> Sen. Feingold (D-Wis.)</p>	<p>States would apply to a federal health reform task force for state demonstrations to ensure access to high quality health care coverage for uninsured individuals. States would be required to submit a plan to the Task Force designating the specific strategies to achieve their goals and describing the benefits and cost sharing requirements.</p>	<p>Provides \$32 billion in federal funds for states to develop 5-year pilot programs. States are required to match 25 percent of costs and meet maintenance of effort requirements.</p>
<p><b>Health Partnership Through Creative Federalism Act</b> H.R. 5864</p> <p><b>Sponsor:</b> Rep. Baldwin (D-Wis.), <b>Co-sponsors:</b> Rep Price (R-Ga.), et al.</p>	<p>Creates a State Health Coverage Innovation Commission that will review state applications. States could propose a variety of different approaches, but all must have a commitment to cover the uninsured. The commission’s recommendations would be “fast-tracked” and receive expedited legislative review.</p>	<p>Funding for federal grants would be determined by congressional appropriation. However, proposals must be budget neutral for the federal government beyond the grant.</p>
<p><b>Catastrophic Health Coverage Promotion Act</b> S. 3701</p> <p><b>Sponsor:</b> Sen. Smith (R-Ore.), <b>Co-sponsor:</b> Sen. Wyden (D-Ore.)</p>	<p>Requires the Secretary of HHS to establish no more than six demonstration projects. The Secretary would design programs to subsidize individuals who earn less than 200 percent FPL, who are not eligible for Medicare or Medicaid, and who have exceeded \$10,500 in out-of-pocket health care costs in a year. The programs will subsidize these individuals to purchase catastrophic coverage through a combination of state risk pools, reinsurance, or other public-private partnerships. States would apply to the Secretary to participate in one of these demonstrations.</p>	<p>Up to \$50 million in unspent Disproportionate Share Hospital funds maybe used for demonstrations.</p>
<p><b>Health Partnership Act</b> S. 2772</p> <p><b>Sponsor:</b> Sen. Voinovich (R-Ohio), <b>Co-sponsors:</b> Sen. Bingaman (D-N.M.), et al.</p>	<p>States would apply to a newly formed State Health Innovation Commission. The commission would evaluate proposals and the commission’s recommendations would receive expedited legislative review and procedure. The states have latitude to design coverage expansions.</p>	<p>The legislation does not appropriate a specific amount for grants to states.</p>

## 6. It is difficult to find agreement on what services will be covered.

As states struggle with declining coverage and growing costs, questions about the level of benefits and services that should be covered are central to the discussion of reform. Benefit design has long been debated within the Medicaid and SCHIP programs, as well as in programs that represent public-private partnerships. In the late-1990s, Oregon had an explicit conversation about which benefits would be covered under Medicaid, developing a “prioritized list” of covered services. However, the limitations envisioned in their process have never been fully tested.

Experimentation with limited benefit designs to reach uninsured individuals and small businesses is not a new phenomenon. Since 2001, at least 13 states have enacted legislation allowing insurance carriers to sell limited-benefit plans to small groups. To date, these products have not sold well; anecdotal evidence suggests that insurers are

reluctant to sell these policies, and consumers are uninterested in buying them.<sup>59</sup> Thus, while some states have responded to criticism that too many mandated benefits are increasing costs, savings from eliminating those mandates have not been sufficient to increase take-up rates.

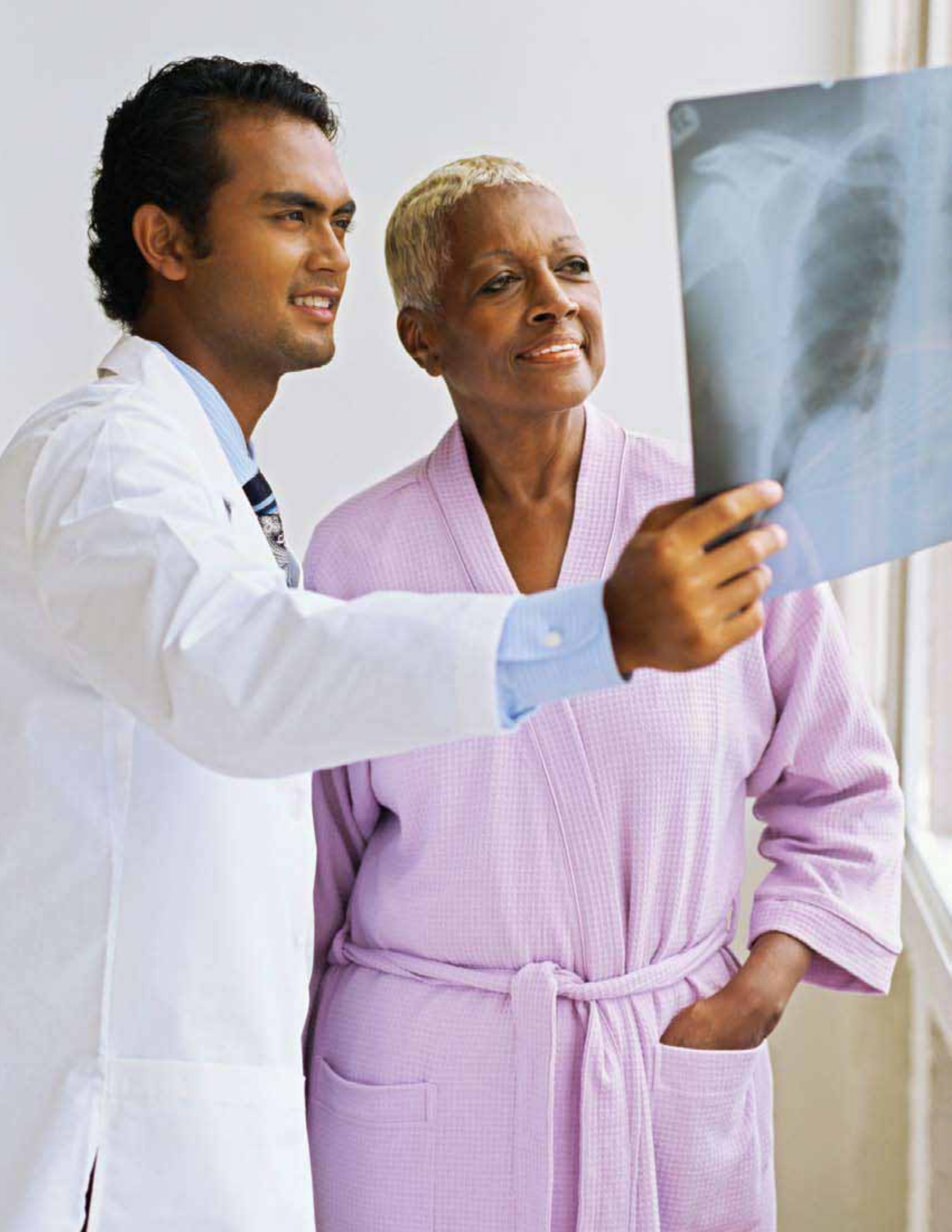
Current reforms continue to struggle with this issue. Massachusetts’s individual mandate only applies if there is an “affordable” product and the state is struggling to define in regulation both what affordable means and the benefits such a product should include. Rhode Island must develop a benefit design that is less than 10 percent of workers’ average wage level. Tennessee’s CoverTN product is envisioned to cost no more than \$150 and, while the state is providing broad parameters for that plan, it is leaving the detailed design decisions in the hands of private carriers.

In addition, though the DRA allows states to be more flexible with their Medicaid benefit packages, it remains to

be seen what sort of benefit designs may emerge. Some states have already added greater cost sharing and consumer-directed features to the Medicaid benefit packages, provoking a debate about the adequacy of the new benefit designs for low-income populations.

## 7. Fully addressing problem of uninsured needs a national solution.

Recent state efforts to implement comprehensive reforms have fueled optimism that states can lead the way in addressing the problem of the uninsured. Certainly, states’ efforts can test coverage strategies both politically and practically, informing and providing lessons for other states and national leaders. However, the variation among states is far too great for state-by-state reform to produce an effective national solution for the uninsured. Without a national solution, it will be virtually impossible for states to bridge the growing gaps in coverage.





# MEDICAID: DEFICIT REDUCTION ACT, REDESIGN, AND FINANCING

With an improved economy, growing state revenues, and slowing Medicaid enrollment and spending growth, 2006 was an important year for Medicaid. The improved fiscal outlook eased some of the pressures to implement Medicaid cost-containment measures and allowed states to increase their focus on other policy areas. A growing number of states explored opportunities to reform Medicaid, using new Federal authority. Several states turned their attention to leveraging Medicaid funding as part of broader state-based health care reform.

In February 2006, President George W. Bush signed the Deficit Reduction Act of 2005, one of the most significant changes to the Medicaid program in its 40 year history. The DRA is projected to reduce federal Medicaid spending by \$11.5 billion over five years and \$43.2 billion over 10 years. The DRA makes many changes in Medicaid policy, several of which have implications for state coverage efforts. (See page 43). The DRA provides states with new flexibility to make certain changes, which would have previously required waiver authority, through the more streamlined state plan amendment process. The DRA does not, however, provide states with a new vehicle for expanding coverage. In fact, the flexibility provided under the DRA is limited to groups covered prior to 2006.

## STATES USE DEFICIT REDUCTION ACT TO CHANGE BENEFITS AND COST SHARING

During 2006, West Virginia, Kentucky, Idaho, and Kansas received federal approval for their reform proposals under DRA authority. All of these proposals use the flexibility in benefit design and cost sharing to tailor benefit packages to specific populations and also encourage greater consumer involvement in health care. Other states are evaluating options for using DRA authority to reform their Medicaid programs. In the 50-State Medicaid Budget Survey conducted by the Kaiser Commission on Medicaid and the Uninsured, nine states indicated that they were re-thinking their previous plans to use waivers in light of the DRA.<sup>60</sup>

### West Virginia

In May 2006, West Virginia received CMS approval to move forward on plans to redesign its Medicaid program. Taking advantage of the flexibility outlined in the DRA, West Virginia utilized the state plan amendment process. A four-year, phased-in implementation began in July 2006.

The West Virginia reform streamlines eligibility and moves healthy children and parents into one of two plans:

- **Basic Plan:** The plan covers all mandatory and some optional services, but benefits are more limited than the state's previous Medicaid benefits package. Children continue to receive services under the Early and Periodic Screening,

Diagnostic, and Treatment (EPSDT) benefit. Enrollees can access additional benefits covered by the Enhanced Plan by signing a member agreement.

- **Enhanced Plan:** For individuals who have signed a member agreement, this plan covers all the services included in the Basic Plan plus mental health services, diabetes care, and prescription drugs above the four-drug limit in the Basic Plan. The Enhanced Plan is comparable to the state's previous Medicaid benefits package.

The cornerstone of West Virginia's plan is the member agreement and the Healthy Rewards pilot program. Enrollees who sign a member agreement, a 'personal responsibility contract,' are enrolled in the Enhanced Plan and receive a fixed amount of credits per quarter in a Healthy Rewards account. The credits can be used to cover medical and pharmaceutical co-pays and bonus credits are added for meeting health goals. Individuals who do not meet their responsibilities are moved to the more limited Basic Plan.

### Kentucky

In May 2006, Kentucky received state plan amendment approval from CMS to move forward on plans to redesign its Medicaid program using DRA flexibility. The new plan, KyHealth Choices, offers four different benefit packages tailored to specific populations, increases cost sharing, and expands access to community-based long-term care.

The new targeted benefit plans replace the Medicaid benefit package with

"Secretary-approved" coverage. The four plans are:

- **Global Choices:** Global Choices is designed for pregnant women, working parents up to 68 percent FPL, foster children, medically fragile children, Supplemental Security Income-related groups, and women with breast and cervical cancer. Global Choices covers basic medical services with new benefit limits and increased cost sharing. Long-term care services are excluded.
- **Family Choices:** Family Choices is designed for most children, including children enrolled in Kentucky's SCHIP program. Family Choices offers the same benefit package as Global Choices except there are no prescription drug limits and there is a higher vision care maximum benefit.
- **Optimum Choices:** For individuals with developmental disabilities and mental retardation in need of long-term care services, Optimum Choices covers all the benefits in Global Choices as well as three levels of long-term care services.
- **Comprehensive Choices:** For the elderly and individuals with disabilities in need of nursing facility level care, Comprehensive Choices offers all the benefits of Global Choices plus two levels of long-term care, including services offered through the state's current home and community-based services waivers.

Kentucky also implemented new cost sharing requirements in June 2006. There are no co-pays for preventive services, and pregnant women and mandatory children<sup>61</sup> are exempt from cost sharing. KyHealth Choices includes new benefit limits; however, services beyond the benefit limits may be approved through a prior authorization process.

KyHealth Choices also includes an employer-sponsored insurance option. Enrollees can choose to receive a subsidy for private plans that meet the state employee plan benchmark and certain "economy and efficiency" criteria, but there is no wrap-around coverage. Enrollees can move back to a Medicaid plan at any time.

The program also includes "Get Healthy Benefits" that allow individual members with specific diseases to access additional benefits, such as vision, dental, smoking cessation, and nutrition visits, if they participate in a disease management program for one year. Enrollees have six months to use their new benefits. Benefits are lost after disenrollment from Medicaid.

### Idaho

In April 2006, Idaho submitted a Section 1115 waiver to CMS. In response to a recommendation from CMS, Idaho tabled waiver activities and made changes using the state plan amendment process under DRA authority. In May 2006, CMS approved several parts of Idaho's reform proposal. Additional components of Idaho's reform are pending additional interpretation of the DRA.

Idaho is enrolling the Medicaid and SCHIP populations into three major benefit plans using the Secretary-approved benchmark benefit option in the DRA:

- **Medicaid Basic Plan:** For low-income children and working-age adults, the Basic Plan covers most primary and acute care services with a few limitations. The Basic Plan does not include services not needed by participants with average health needs, such as case management, hospice, or institutional or home- and community-based long-term care services.
- **Medicaid Enhanced Plan:** For individuals with disabilities or special health needs, the Enhanced Plan covers all the services that were covered under Idaho Medicaid prior to the reform.
- **Medicare-Medicaid Coordinated Plan:** This plan serves elders or those otherwise dually eligible for Medicaid and Medicare who are enrolled in certain Medicare Advantage managed care plans. This plan integrates Medicaid and Medicare benefits to improve access to care. Idaho will pay a capitated rate per enrollee to Medicare Advantage plans for integrated services, Medicare-excluded drugs, and “wrap-around” benefits. The new coordinated plan will be implemented in mid-2007.

Beginning in July 2006, Medicaid and SCHIP enrollees were placed into the Basic Plan or the Enhanced Plan at their annual re-enrollment. New enrollees will also be placed into one of the new

## MAJOR COMPONENTS OF THE DEFICIT REDUCTION ACT

### Cost Sharing and Premiums

- Gives states a new option to charge premiums for certain enrollees with family incomes above 150 percent FPL and to implement cost sharing for some individuals with incomes above 100 percent FPL.
- Provides additional options for states to impose cost sharing on non-preferred prescription drugs and inappropriate emergency room use.
- Allows states to make payment of premiums and co-payments “enforceable” by giving providers the ability to deny services if cost sharing requirements are not met and allowing states to make prepayment of the premium a condition of Medicaid eligibility for non-exempt individuals with incomes above 150 percent FPL.

### Benefits Design

- Allows states to replace standard Medicaid benefits packages with “benchmark” coverage<sup>62</sup> for certain healthy children and adults who were “full benefit eligible” on or before February 8, 2006.
- Requires “wrap-around” coverage for EPSDT services for children under any “benchmark” plan.

plans. Idaho has three triggers that place an enrollee in the Enhanced Plan or that move an individual from the Basic to the Enhanced Plan. They are:

- Physician diagnosis of special health needs;
- Utilization of mental health services up to the limits in the Basic Plan; or

### Medicaid Transformation Grants

- Authorizes grants of \$75 million in both FY 2007 and FY 2008 to encourage states to adopt innovative methods to improve effectiveness and efficiency in providing Medicaid coverage.

### Health Opportunity Accounts

- Directs the Secretary to establish a Health Opportunity Accounts demonstration program in which up to ten states would set up defined contribution accounts similar to HSAs.

### Family Opportunity Act

- Gives states the option to allow parents of certain children with disabilities to “buy-in” to Medicaid for their children if they have a family income at or below 300 percent FPL.

DRA included numerous other provisions, including imposing new Citizenship Documentation Requirements (see page 44), providing Katrina relief and making changes related to long-term care, pharmacy, targeted case management, provider taxes, and home and community-based services.

- Receiving other forms of assistance from the Idaho Department of Health and Welfare or other public assistance, such as Social Security Disability.

All enrollees in the Basic and Enhanced Plans receive services through a primary care case management program known as “Healthy Connections.”

## NEW CITIZENSHIP DOCUMENTATION REQUIREMENT IN MEDICAID

The DRA included a new citizenship documentation requirement that became effective on July 1, 2006. Federal law now requires that most individuals applying for or renewing their Medicaid eligibility provide certain evidence documenting citizenship.<sup>66</sup> While this new rule was intended to deter illegal immigrants from fraudulently enrolling in Medicaid (ensuring that federal Medicaid funding is spent on U.S. citizens and certain qualified immigrants) some state officials, providers, and advocates are concerned that it may result in delays or denials of Medicaid coverage for many citizens.

- The Congressional Budget Office estimated that the requirement would result in a loss of coverage for 35,000 Medicaid enrollees.
- In July 2006, a class action lawsuit challenging the new requirement was filed in U.S. District Court in Chicago. All but one count was dismissed in September, but the judge will likely issue a preliminary injunction to exempt foster children from the documentation requirement.<sup>67</sup>

Prior to the DRA, only four states (New York, New Hampshire, Georgia, and Montana) required any form of citizenship documentation for Medicaid eligibility; all other states allowed applicants to declare their citizenship under penalty of perjury.<sup>68</sup>

- New York found that most applicants were able to comply with its pre-DRA documentation requirements as a result of the flexibility of its rules and the application support the state provides.
- New York also found that certain special populations (e.g., elderly, mentally ill, homeless, and drug addicted individuals) were more vulnerable to losing access to Medicaid coverage and needed help with gathering documentation.<sup>69</sup>

In response to concerns that the documentation requirement will add barriers to Medicaid enrollment and potentially increase the number of uninsured citizens, states have taken steps to lessen the new requirement's impact.

- States are conducting outreach to enrollees and potential applicants about the new rules and are working one-on-one with individuals to find citizenship documentation.
- Some states have provided grace periods for submitting documents and some are cross-matching with other state and federal databases to get citizenship documentation when possible.
- Some states are streamlining the application process for infants born in the U.S. to undocumented immigrants or legal immigrants who have been in

the country for fewer than five years. Prior to July 2006, these infants were automatically enrolled in Medicaid.

Although states now have several months of implementation experience, it is not yet clear what the early impact of the new documentation requirement has been. More than half of Medicaid directors reported that they expect the requirement to have a negative impact on Medicaid enrollment.<sup>70</sup> In October, Washington D.C. reported that there had been no drop in the number of children enrolling in Medicaid.<sup>71</sup> However, Virginia reported that the number of children enrolled in Medicaid had dropped by almost 12,000 as of November.<sup>72</sup> According to Lisa Nablo, director of Maternal and Child Health at Virginia's Department of Medical Assistance Services, "these new rules are the single greatest factor for why children haven't been able to enroll."<sup>73</sup> It will be important to continue to track the impact of the citizenship documentation requirement over the months to come.

In addition, many states have created public-private partnerships using Medicaid funding to reach the working uninsured. Many of these programs use private insurers and have tried to adopt enrollment practices more commonly used in the commercial market (e.g. Arkansas, New Mexico, and Oklahoma). The documentation requirements may complicate these efforts.

Idaho's Medicaid reform includes multiple components in addition to its new benefit plans, including a new "preventive health assistance" benefit similar to Kentucky's "Get Healthy Benefit." This benefit is designed to encourage tobacco cessation, weight management, and current well child

checks and immunizations. Idaho has also implemented a self-directed service model for individuals with disabilities, a pay-for-performance pilot program, new purchasing strategies such as "best price" for supplies and outsourced dental services, a new "Healthy Schools" program that provides preventive

services to all students in school districts with a high percentage of low-income students, and other reforms authorized through a recent state plan amendment.

### Kansas

In September 2006, Kansas received approval from CMS to establish a



benchmark benefit for its Working Healthy Ticket to Work Medicaid Buy-In program.<sup>63</sup> The benchmark benefit was approved as a state plan amendment under DRA authority. Working Healthy provides working individuals with disabilities who have incomes below 300 percent FPL the State Plan Medicaid coverage, in addition to the following benefits:

- Personal assistance services, which can be self-directed or agency-directed, including a “Cash and Counseling” model;
- Assessment to determine personal assistance and related service needs;
- Independent living counseling; and
- Assistive services (e.g., environmental modifications such as wheelchair ramps, etc.).

After four years of efforts to develop the Kansas Medicaid Buy-In program for working individuals with disabilities, the DRA provided Kansas with the flexibility it needed to target a tailored set of benefits to a specific group of individuals. In particular, the DRA allowed Kansas to avoid modifying its existing 1915(c) Home and Community-Based Services waivers while ensuring it meets CMS’s personal assistance services requirements for the Ticket to Work population.

## OTHER MEDICAID REFORM PROPOSALS

While the DRA has given states new flexibility to redesign their Medicaid programs, some states are continuing to use Section 1115 waivers as a vehicle for comprehensive Medicaid reform. Compared to 2005, however, states’ use of 1115 waivers has slowed.

### Florida

Florida moved forward on a Medicaid reform plan considered to be one of the most ambitious plans that any state had considered. The goal of the reform was to provide more consumer choice, increase access, improve quality, and stabilize cost. The plan was approved in October 2005 under an 1115 waiver.<sup>64</sup> The program was initially launched in Duval and Broward counties on July 1, 2006 and will extend to Nassau, Clay, and Baker counties in 2007—with a goal of eventually implementing the reform state-wide. Initially the Florida reform will be mandatory for Temporary Assistance for Needy Families (TANF) and Aged and Disabled eligibility groups.

Florida’s Medicaid reform changes the program from a defined benefits approach to a defined contribution approach. Florida’s reform also includes Enhanced Benefit Accounts to reward enrollees for engaging in certain healthy behaviors such as not smoking and getting immunizations. A new low-income pool is included in the reform to pay for safety net services for the uninsured.

### South Carolina

In October 2004, South Carolina submitted an 1115 waiver proposal to CMS that sought to restructure the Medicaid program to increase consumer involvement in health care purchasing.<sup>65</sup> The proposal, entitled “South Carolina Healthy Connections,” was later revised and re-submitted to CMS. Waiver approval is still pending. In September 2006, the state submitted a Medicaid reform concept paper to CMS that brings together many of the elements of the 1115 proposal with new opportunities that were created by the DRA. The state is currently seeking guidance from CMS on what elements

of the South Carolina reform can be addressed through an 1115 waiver and what can be addressed through a state plan amendment and a Health Opportunity Accounts demonstration.

Under the proposal, most South Carolina Medicaid enrollees (except dual eligibles and children in foster care) would be provided a Personal Health Account. The size of the account would be based on current levels of fee-for-service spending and would be risk-adjusted for gender, age, eligibility category, and, in some cases, health status. Enrollees would receive assistance from enrollment counselors in choosing among four options for using their Personal Health Account—private insurance, medical homes network, employer-sponsored insurance opt-out, or self-directed care opt-out.

The self-directed care opt-out represents a new approach for Medicaid benefit design, relying heavily on the concepts of consumer-directed care. Under the self-directed care opt-out, adult enrollees with medical homes, no history of unstable acute care crises, and reasonable understanding of their health care needs could use Personal Health Accounts to purchase services directly from providers. A portion of the Personal Health Account would be deducted to cover major medical insurance, including inpatient hospital care and related costs, as well as preventive care. If an enrollee were to exhaust the funds in the Personal Health Account, they would be accountable for purchasing other needed services up to \$250 annually. If the \$250 limit were reached, the individual would be enrolled in a private insurance plan or Medical Homes Network. South

Carolina is proposing to pursue the self-directed care opt-out using a Health Opportunity Accounts demonstration.

### Wisconsin

Wisconsin has proposed to merge its Medicaid and SCHIP programs (respectively called BadgerCare and Healthy Start) to form BadgerCare Plus, a comprehensive health insurance program for low income children and families. The state submitted a BadgerCare Plus concept paper to CMS in August 2006 and is currently seeking guidance from CMS on a framework for federal approval. The state may implement some of the changes through a state plan amendment, potentially using some of the new flexibilities granted under the DRA. Other parts of the reform may be implemented through a waiver process. Coverage will be expanded to seven new populations:

1. All children (birth to age 19) with incomes above 185 percent FPL, with cost sharing scaled to family income;
2. Pregnant women with incomes between 185 and 300 percent FPL;
3. Parents and caretaker relatives with incomes between 185 and 200 percent FPL;
4. Caretaker relatives with incomes between 44 and 200 percent FPL;
5. Birth parents of children in foster care with incomes up to 200 percent FPL;
6. Youth (ages 18 through 20) aging out of foster care; and
7. Farmers and other self-employed parents with incomes up to 200 percent FPL, contingent on depreciation calculations.

BadgerCare Plus will include two plans:

- **Standard Plan (existing Medicaid benefit package):** This plan will cover children, parents and caretaker relatives, youths aging out of foster care, and pregnant women with incomes up to 200 percent FPL.
- **Benchmark Plan:** This plan will cover children and pregnant women with incomes above 200 percent FPL, and certain self-employed parents with incomes under 200 percent FPL.

In addition, Wisconsin intends to streamline eligibility; improve employees' ability to purchase employer-sponsored coverage; and provide incentives for healthy behaviors. The state estimates that the expansion will be budget neutral as a result of enrolling all participants in managed care and reducing administrative expenses. The state anticipates one-time savings of approximately \$16 million over the first two years of the program. The target implementation date is January 1, 2008.

### COMPREHENSIVE HEALTH CARE REFORMS INCLUDE MEDICAID FINANCING

Medicaid was an important source of financing for states that pursued comprehensive health care reforms. Massachusetts' reform followed through on Medicaid financing strategies that were included in a waiver they received in 2005, allowing them to preserve approximately \$385 million in federal financing for coverage. Vermont used the financing flexibility provided to them under the Global Commitment waiver, approved in 2005, to support

some of the subsidies provided under their comprehensive reform effort. The Global Commitment waiver includes a cap on Medicaid growth in exchange for the ability to use funds for health care investments such as the state's Blueprint for Health chronic care initiative and expansions of coverage to the uninsured. A prior waiver received by Maine allowed the state to use some Medicaid funds to support subsidies to individuals now covered under their DirigoChoice insurance product. Finally, several states that pursued incremental strategies also relied on Medicaid financing, including Arkansas, Oklahoma, and New Mexico (see page 22).

### SCHIP: AN IMPORTANT VEHICLE FOR CHILDREN'S HEALTH COVERAGE UP FOR REAUTHORIZATION

Since its inception in 1997, SCHIP has been an important source of coverage for uninsured children who do not qualify for Medicaid and cannot afford private coverage. In its 10-year history, SCHIP has had many accomplishments (see facing page). SCHIP is scheduled for reauthorization in 2007 and the upcoming year is likely to be a critical time for the program. In addition to reauthorization, a number of states are looking to SCHIP as a vehicle for expansion at the same time that SCHIP faces significant funding challenges.

SCHIP has played a crucial role in offsetting increases in the number of uninsured children, despite a steady, nationwide increase in the number of uninsured adults. However, for the first time in seven years, the U.S. Census report revealed an increase in the number of children without health insurance in 2005 (11.2 percent, up from 10.8 percent in

## SCHIP ACHIEVES MEASURABLE SUCCESS DURING ITS FIRST 10 YEARS

### Increased Coverage

- SCHIP has played an enormous role in offsetting the decline in private health insurance coverage, contributing to a reduction in the rate of uninsured children, from 14 percent in 1997 to 11 percent in 2005.<sup>74</sup>
- Enrollment in SCHIP has exceeded original goals. When SCHIP was authorized, CMS estimated 5 million children would be enrolled in FY 2005. Today, SCHIP covers approximately 6.1 million children.<sup>75</sup>
- SCHIP programs also cover close to 640,000 adults, mostly parents of SCHIP or Medicaid-eligible children.<sup>76</sup>
- SCHIP has had positive spillover effects on Medicaid enrollment of children in many states.

### Improves Access, Quality, Patient Satisfaction, and Addresses Disparities

- In an evaluation report for CMS, many state SCHIP programs were found to have achieved Healthy People 2010 goals for ensuring children have a usual source of care.<sup>77</sup>
- Case studies of the experiences of children with special health care needs early in SCHIP implementation indicated that these children were generally able to access primary health care and routine specialty services without problems.<sup>78</sup>
- In a study of asthma care of children enrolled in New York's SCHIP program, children experienced a reduction in asthma attacks, urgent care, and asthma-related hospitalizations.<sup>79</sup>
- A survey of families of children who disenrolled from Oregon's SCHIP program indicated that more than 85 percent of families would have kept their children enrolled in SCHIP had it been possible.<sup>80</sup>
- A study of the impact of SCHIP enrollment on racial and ethnic disparities found that SCHIP enrollment eliminated disparities in access to care among children in New York.<sup>81</sup>

### Enrollment and Outreach Successes

States have used many different enrollment and outreach strategies to increase coverage under SCHIP.<sup>82</sup> States strategies have included:

- Establishing continuous eligibility provisions to increase enrollment spans and reduce lapses in coverage;
- Developing short, simplified applications for Medicaid and SCHIP;
- Streamlining eligibility determination processes by eliminating face-to-face interviews and resource tests;
- Permitting self-declaration of income and electronic submissions of applications;
- Implementing passive renewal systems; and
- Using outreach strategies such as mass media campaigns and a variety of community-based efforts, including initiatives to provide application assistance at locations convenient to families with children (e.g., schools, health clinics, child care centers).



2004).<sup>83</sup> This equates to slightly more than 8.3 million U.S. children who did not have health insurance in 2005. This appears to be an indication that state SCHIP programs are no longer able to keep up with the increasing erosion of employer-sponsored insurance

### SCHIP FINANCING

Financing is expected to dominate SCHIP reauthorization discussions. The Balanced Budget Act of 1997 authorized approximately \$40 billion in capped federal SCHIP funding over 10 years. States receive enhanced federal allotments that are distributed on a fiscal year, state-specific basis. State allotments are generally available for a three-year period. Any state's unspent allotments are subject to redistribution to those that have used up their allotments.

While SCHIP's block-grant structure has provided spending predictability for the federal government and the enhanced federal matching rate has given states incentives to expand coverage, it has also created many challenges for states. As enrollment increased over time, the amount of funds available for redistribution has decreased.

- In FY 2006, redistributions were not sufficient to cover shortfalls in 12 states. Congress appropriated additional SCHIP funding through the DRA of 2005 to cover these shortfalls.
- In FY 2007, between 14 and 17 states were projected to experience a shortfall. In December 2006, at the very end of the 109<sup>th</sup> Congress, lawmakers approved the redistribution of 2004 and 2005 unspent SCHIP allotments to cover

states through May 2007. The new Congress will need to consider longer-term funding solutions in the months ahead.

- Congressional analysts estimate that an additional \$12 billion in federal funding will be needed between 2008 and 2012 to eliminate future shortfalls. This estimate is based on the President's budget assumption that SCHIP funding will remain at approximately \$5 billion per year and will not include additional funding to expand SCHIP beyond current levels.
- Without additional funding, it is estimated that 36 states will run out of federal SCHIP funding by 2012 and 1.5 million children may lose coverage.

As SCHIP reauthorization is debated, state and federal policymakers will likely raise many concerns with SCHIP financing. Policymakers are generally uneasy about the projected federal funding shortfalls and inequities among states. Many think the allotment formula should be revised and the deadlines for spending redistributed funds should be adjusted.

### OTHER SCHIP CHALLENGES

Despite many SCHIP successes, the program still faces a number of other challenges going forward. One such challenge relates to the 6 to 7 million children who are eligible for, but not enrolled in, the program. Additional outreach efforts targeting these children will be difficult to implement and sustain as states face ongoing budget pressures.

Meanwhile, many states' health care budgets and coverage initiatives hinge on congressional reauthorization of SCHIP

and shorter-term changes to SCHIP financing. West Virginia, for example, has passed legislation to expand its SCHIP program to cover more children, but has said that it will not implement its expansion until Congress reauthorizes SCHIP. West Virginia currently anticipates a federal funding shortfall of \$11 million in 2009. Other states are pursuing strategies that build on SCHIP to insure all children; strategies that may also be jeopardized if necessary federal action is not taken. (see page 25).

While SCHIP financing will be a critical topic during reauthorization discussions, other topics will likely also surface. Discussions with SCHIP directors convened by the National Academy for State Health Policy suggest that there is state interest in examining several policy areas, including:

- Redefining and prioritizing SCHIP core populations, including an examination of the role of SCHIP in covering uninsured parents and childless adults;
- Providing increased SCHIP enrollment flexibility;
- Providing wrap-around coverage through SCHIP for under-insured groups; and
- Covering new groups like Medicaid-eligible children, children of state employees, and legal immigrant children.

Overall, SCHIP has received widespread, bipartisan support. Thus, Congress may reauthorize the program with few changes, or may look at larger, long-term financing and policy reforms. In either case, immediate financing solutions will be critical to address projected short-term funding shortfalls.



## COVER THE UNINSURED WEEK MOBILIZES ADVOCATES



For four years, Cover the Uninsured Week has served as a national platform for discussion and debate about the need to cover America's uninsured. During one week each year, people from all sectors of society and from all 50 states join together to demand that our nation's leaders make the issue their top priority. In small and large communities across the country, federal, state, and local government officials declared May 1–7, 2006 Cover the Uninsured Week.

Each year, the momentum grows as more people engage in the issue and voice their will for change. Below are highlights from the 2006 week.

**Cover the Uninsured Week's first goal was to raise public awareness and concern.** Concern about "access to affordable health insurance and coverage" among D.C. opinion leaders has risen almost 30 percent (12 percent in 2001 to 41 percent in 2006). Targeted advertising in 2006 caused a 20 percent jump in people who believe that "access to affordable health insurance and coverage" should be the nation's top priority (54 percent among those who saw the ad versus 34 percent among those who did not).

**Cover the Uninsured Week is meeting its next challenge: encouraging action on the issue.** Cover the Uninsured Week has evolved from raising awareness to motivating action. As a result, more than 175 elected officials participated in the Week by holding events, making floor speeches, participating in target market activities and more. Uninsured individuals came to Washington, D.C. to meet with members

of Congress. Concerned citizens sent more than 60,000 messages to members of Congress through the Cover the Uninsured Week Web site. More than 2,700 health and enrollment fairs were held nationwide to enroll eligible families in Medicaid and SCHIP. An unprecedented number of applications were submitted for low-cost or free health coverage at Cover the Uninsured Week events.

### Highlights of Cover the Uninsured Week 2006

- More than 4,700 events and activities elevated the issue of health coverage on the national agenda and were held in all 50 states and the District of Columbia.
- More than 175 elected officials participated in the Week by holding events, making floor speeches, participating in target market activities and more.
- Nearly 200 national organizations supported the Week.
- More than 60,000 e-mails, representing every state, were sent to the U.S. Congress.

Cover the Uninsured Week is the largest national platform campaign addressing the plight of the uninsured. Each year the numbers grow. In 2006, events and activities included press conferences, health and enrollment fairs, seminars for small businesses, campus activities, business leader summits, interfaith outreach, and more.

Cover the Uninsured Week 2006 was led by some of the most influential organizations and leaders in the United States. In addition to the Robert Wood Johnson Foundation, national organizations, including the U.S. Chamber of Commerce and the AFL-CIO joined the effort. Former Presidents Gerald Ford (R) and Jimmy Carter (D) served as the

Week's Honorary Co-Chairs, and 10 former secretaries of the U.S. Department of Health and Human Services and Surgeons General from both Republican and Democratic administrations supported the Week.

The Week was a time for leaders of both parties to put politics aside and renew their efforts to try to help Americans living without health insurance.

**"Cover the Uninsured Week aims to raise awareness of this national problem and the will to solve it. One in seven Americans...does not have even basic health care coverage. Each day, these men and women hope they do not become sick or are not injured."**

– Congressman Dave Reichert (R-Wash.)

**"Cover the Uninsured Week is a chance for all of us, whether Democrat or Republican, to redouble our efforts to solve this terrible problem."**

– U.S. Senate Minority Leader Harry Reid (D-Nev.)

The Week rallies people from all walks of life. More people get involved each year, including business owners, union members, educators, students, patients, hospital staff, physicians, nurses, faith leaders and their congregants, uninsured individuals and families, and many more. Their voices create a louder and stronger message to our nation's leaders, demanding that they make covering America's uninsured their top priority.

Cover the Uninsured Week 2007 will be held April 23–29, 2007. For more information visit [www.covertheuninsured.org](http://www.covertheuninsured.org).



# LOOKING FORWARD

The state reforms of 2006 fueled a trend for more state action on the uninsured that seems likely to continue. Several signs suggest that more state-based reforms will be introduced in 2007.

Changes to Medicaid and SCHIP, the two cornerstones of the current federal-state partnership to provide insurance for certain low-income populations, will still be playing out in 2007. States are still sorting out the new flexibility they received under the DRA and broader Medicaid reform discussion will likely continue. SCHIP is scheduled for reauthorization in 2007 and, depending on the outcome, may face other changes to which states may need to respond as part of their efforts to provide insurance to more children.

Across the country, 36 governors were elected in 2006—many with significant goals to address the uninsured. While campaigning, several governors and candidates outlined proposals to respond to this crisis, including: creating Massachusetts-style Connectors to facilitate small firms' offering of coverage, using reinsurance to lower costs for small firms, opening their state employees plan to small

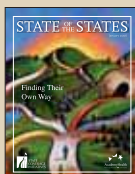
employers, and designing new insurance products with a subsidy for those who are low income.

Because of progress by a few states on comprehensive reform in 2006, many more are going back to the drawing table with new, and some not so new, strategies. However, the real test will be in how these reforms perform and whether they are able to make meaningful progress to reduce the uninsured in their states—assessments which can only be made fairly after some time has passed to work through start-up challenges. Nonetheless, even in the short term, policy leaders are likely to look to the experience of these new coverage programs as they shape their own reform proposals. Time will tell how these comprehensive reforms evolve and whether they are able to maintain support as they move through the difficult stage of implementation. Finally, Congressional leaders looked

to states with several legislative proposals late in the 109<sup>th</sup> Congress that encouraged state reforms and pilots. With a new Congress, it remains to be seen whether these prior proposals to encourage state innovation will move forward, whether national reforms will be considered, or whether the status quo will remain.

The attention to state reforms in 2006 ushered in great hope that states will lead the way in addressing the problem of the uninsured. There is no doubt that states have been an important source of innovation and rekindled a national focus on the issue of the uninsured. Managing expectations of how far the comprehensive efforts of a few states can go in addressing the issue of the uninsured and, given the significant variation across states, whether other states will be able to follow with similarly comprehensive proposals will continue to be a challenge for the future.

# 2006 SCI PUBLICATIONS AND MEETINGS



## **State of the States 2006: Finding Their Own Way**

January 2006

[www.statecoverage.net/pdf/  
stateofstates2006.pdf](http://www.statecoverage.net/pdf/stateofstates2006.pdf)



## **The Pennsylvania Community Health Reinvestment Agreement: Establishing Non-Profit Insurers' Community Benefit Obligations**

August 2006

By Carol Pryor and Catherine Dunham, The Access Project  
[www.statecoverage.net/pdf/monographo8o6.pdf](http://www.statecoverage.net/pdf/monographo8o6.pdf)



## **Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing**

January 2006

By Charles Milligan, Cynthia Woodcock,  
and Alice Burton

[www.statecoverage.net/pdf/issuebriefi06.pdf](http://www.statecoverage.net/pdf/issuebriefi06.pdf)

## **Medicaid HIFA Waiver Comparison: Arkansas, New Mexico and Oklahoma**

Summer 2006

[www.statecoverage.net/waivers.htm](http://www.statecoverage.net/waivers.htm)

## **Reinsurance Institute Kick-Off Meeting**

September 12, 2006, Albany, NY

Agenda and slides available

[www.statecoverage.net/kickoffmeeting.htm](http://www.statecoverage.net/kickoffmeeting.htm)

## **SCI National Meeting**

February 23–24, 2006, Washington, DC

Agenda and presentation slides available

[www.statecoverage.net/o2o6agenda.htm](http://www.statecoverage.net/o2o6agenda.htm)

## **Profiles in Coverage: New Mexico State Coverage Insurance**

March 2006

Pamela S. Hyde, Secretary of the Human Services  
Department, answers questions about the program.

[www.statecoverage.net/newmexicoprofile.htm](http://www.statecoverage.net/newmexicoprofile.htm)



## **Major Changes in Benefit Design: A Plausible Way to Control Costs?**

November 2006

By Cyanne Demchak

[www.statecoverage.net/pdf/issuebriefi1o6.pdf](http://www.statecoverage.net/pdf/issuebriefi1o6.pdf)



## **Uncharted Territory: Current Trends in Section 1115 Demonstrations**

By Teresa Sachs, Jenna Walls, and Isabel Friedenjohn

March 2006

[www.statecoverage.net/pdf/issuebrief3o6.pdf](http://www.statecoverage.net/pdf/issuebrief3o6.pdf)

## **Cyber Seminar: The Deficit Reduction Act of 2005— Implications and Opportunities for State Coverage Efforts**

June 7, 2005

Agenda and slides available

[www.statecoverage.net/cyberseminar/o6o6/index.htm](http://www.statecoverage.net/cyberseminar/o6o6/index.htm)

## **SCI Summer Workshop: State Innovations in Health Coverage**

August 3–4, 2006, Chicago, IL

Agenda and slides available

[www.statecoverage.net/o8o6agenda.htm](http://www.statecoverage.net/o8o6agenda.htm)

## **Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)**

November 2006

SCI interviewed Matt Lucas, Director of the O-EPIC program,  
on how it functions and its experience during the first year of operation.

[www.statecoverage.net/oklahomaprofile.htm](http://www.statecoverage.net/oklahomaprofile.htm)

## **ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland “Fair Share Act” Court Decision**

November 2006

By Patricia Butler

[www.statecoverage.net/SCINASHP.pdf](http://www.statecoverage.net/SCINASHP.pdf)



## **Turning Medicaid Beneficiaries into Purchasers of Health Care: Critical Success Factors for Medicaid Consumer-Directed Health Purchasing**

August 2006

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stateside.htm](http://www.statecoverage.net/stateside.htm)



## ENDNOTES

- 1 Gilmer, T. and R. Kronick. "It's The Premiums, Stupid: Projections of The Uninsured Through 2013," *Health Affairs* Web Exclusive, April 5, 2005.
- 2 Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.
- 3 DeNavis-Walt, C. et al. "Income, Poverty, and Health Insurance Coverage in the United States: 2005," The U.S. Census Bureau Current Population Survey, August 2006.
- 4 Graves, J. and S. Long. "Why Do People Lack Health Insurance." Urban Institute, Health Policy Online No. 14. May 22, 2006.
- 5 "Shifting Ground: Changes in Employer-Sponsored Health Insurance," Compilation report prepared for the Robert Wood Johnson Foundation by the State Health Access Data Assistance Center, University of Minnesota and the Urban Institute. May 2006.
- 6 Commonwealth Fund Survey of Public Views of the U.S. Health Care System, 2006.
- 7 DeNavis-Walt, C. et al. "Income, Poverty, and Health Insurance Coverage in the United States: 2005," The U.S. Census Bureau Current Population Survey, August 2006.
- 8 Ibid.
- 9 "Changes in Employees' Health Insurance Coverage, 2001-2005," Kaiser Commission on Medicaid and the Uninsured. October 2006.
- 10 Ibid.
- 11 Ibid.
- 12 "Employer Health Benefits 2006 Annual Survey," Kaiser Family Foundation and Health Research and Educational Trust. September 26, 2006.
- 13 Clemans-Cope, L., B. Garrett, and C. Hoffman. "Changes in Employee's Health Insurance Coverage 2001-2005." Kaiser Commission on Medicaid and the Uninsured, Issue Paper. October 2006.
- 14 "Employer Health Benefits 2006 Annual Survey," Kaiser Family Foundation and Health Research and Educational Trust. September 26, 2006.
- 15 Ibid.
- 16 Ibid.
- 17 Smith, V. et al. "Low Medicaid Spending Growth Amid Rebounding State Revenues, Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2006-2007," Kaiser Commission on Medicaid and the Uninsured. October 2006, p. 5.
- 18 Hopkins, C. "Former HHS Secretary Says States Will Play Big Role in Health Care Change." *CQ Healthbeat*, October 26, 2006.
- 19 Aaron, H. and S. Butler. "How Federalism Could spur Bipartisan Action on the Uninsured." *Health Affairs*, Web Exclusive. March 31, 2004.
- 20 McDonough, J. et al. "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs*, Vol. 25, No. 6, 2006.
- 21 McGlynn, E. and J. Wasserman. "Massachusetts Health Reform: Beauty Is In the Eye of the Beholder," *Health Affairs*, Vol. 25, No. 6, 2006.
- 22 Vermont Senate. H. 861 An Act Relating to Health Care Affordability for All Vermonters, May 5, 2006, [www.leg.state.vt.us/HealthCare/2006LegAction.htm](http://www.leg.state.vt.us/HealthCare/2006LegAction.htm).
- 23 The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic disease care. These elements are the community, the health system, self-management support, delivery system design, decision support, and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings, and target populations.
- 24 Sachs, T. et al. "Uncharted Territory: Current Trends in Section 1115 Demonstrations," State Coverage Initiative Issue Brief, March 2006.
- 25 The Savings Offset Payment is determined based on all savings that are identified from the Dirigo Health reforms—not just the reduction in uncompensated care. To determine the savings the state measures the savings impact of the moratorium on the Certificate of Need; the implementation of a Capital Investment Fund to limit future Certificate of Needs post-moratorium; the impact of rate regulation in the small-group insurance market; voluntary targets on hospital expenditures; the infusion of new state funds to match Medicaid for increases in physician and hospital payments to reduce cost shifting; and the costs associated with savings in the system resulting from insuring the previously uninsured.
- 26 Bragdon, T. "Eight Challenges for Dirigo Health in 2006," Dirigo Watch, the Maine Heritage Policy Center, January 30, 2006.
- 27 Bowe, T. "DirigoChoice Member Survey: A Snapshot of the Program's Early Adopters," Institute of Health Policy, Muskie School of Public Health, USM, August 12, 2005.
- 28 McDonough, J. et al. "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs*, Vol. 25, No. 6, 2006.
- 29 Wicks, E. "Purchasing Pools in a System of Universal Coverage: Facilitating Consumer Choice," New America Foundation Universal Health Insurance Program, May 2004.
- 30 "The Connector is a breakthrough concept" by Amy Lischko, SCI Summer Meeting, Chicago, IL, August 3, 2006. [www.statecoverage.net/0806/lischko.ppt#347,7](http://www.statecoverage.net/0806/lischko.ppt#347,7).
- 31 According to state officials in Tennessee.
- 32 The Primary Care Network (PCN) has provided primary and preventive care services to approximately 19,000 low-income adults below 150 percent FPL since 2002.
- 33 The Ticket to Work and Self-Sufficiency Program is an employment program for individuals with disabilities who are interested in going to work. The Program was authorized under the Ticket to Work and Work Incentives Improvement Act of 1999, which aims to remove barriers for individuals going to work, including the concern about losing health coverage.
- 34 State Coverage Initiatives Web site, [www.statecoverage.net/matrix](http://www.statecoverage.net/matrix).
- 35 "CHIP at 10: A Decade of Covering Children", Senate Finance Subcommittee on Health, July 25, 2006.
- 36 Swolak, P. "Healthy New York," The Reinsurance Institute.
- 37 Results from focus groups held by HRSA State Planning Grant states.
- 38 "The Uninsured: A Primer," Kaiser Commission on Medicaid and the Uninsured, October, 2006.
- 39 "Changes in Employees' Health Insurance Coverage, 2001-2005," Kaiser Commission on Medicaid and the Uninsured, October 2006.
- 40 Butler, P. "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision", SCI/NASHP Issue Brief, November 2006. [www.statecoverage.net/SCINASHP.pdf](http://www.statecoverage.net/SCINASHP.pdf).
- 41 Maine Senate, An Act to Increase Access to Health Insurance Products, L.D. 1845, May 24, 2006.
- 42 "Coverage Matters: Insurance and Healthcare". Institute of Medicine. October 11, 2001, [www.iom.edu/CMS/3809/4660/4662.aspx](http://www.iom.edu/CMS/3809/4660/4662.aspx).
- 43 The 2005 Current Population Survey, [www.census.gov/cps](http://www.census.gov/cps).
- 44 Palosky, C. and L. Levitt. "Survey Finds Steady Decline in Businesses Offering Health Benefits to Workers Since 2000." Kaiser Family Foundation/Health Research and Educational Trust. September 2005.
- 45 Ibid.
- 46 "Employer Health Benefits 2006 Annual Survey," Kaiser Family Foundation and Health Research and Educational Trust, September 26, 2006.
- 47 Demchak, C. "Major Changes in Benefit Design: A Plausible Way to Control Costs." *AcademyHealth*, Vol. IX, No. 6. November 2006.
- 48 Butler, P. "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision", SCI/NASHP Issue Brief, November 2006, [www.statecoverage.net/SCINASHP.pdf](http://www.statecoverage.net/SCINASHP.pdf).
- 49 Approximately twenty states have conducted this analysis including Massachusetts and Vermont.
- 50 Butler, P. "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision, SCI/NASHP Issue Brief, November 2006, [www.statecoverage.net/SCINASHP.pdf](http://www.statecoverage.net/SCINASHP.pdf).
- 51 "Special Report: About 30 States Considering 'Fair Share' Health Care Legislation". *BNA Pension & Benefits Reporter* Vol 22 etc pp. 829-837, March 28, 2006; "California Governor Vetoes Bill Mandating Premium Contribution by Largest Employers," *BNA Pension & Benefits Reporter*, pp. 2232-2233. September 16, 2006.
- 52 Butler, P. "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision," SCI/NASHP Issue Brief, November 2006. [www.statecoverage.net/SCINASHP.pdf](http://www.statecoverage.net/SCINASHP.pdf).
- 53 [www.roadmaptocoverage.org/pdfs/Roadmap\\_Synthesis\\_Summary.pdf](http://www.roadmaptocoverage.org/pdfs/Roadmap_Synthesis_Summary.pdf).
- 54 Thorpe, K. et al. "The Impact of Obesity on Rising Medical Spending," *Health Affairs*, October 2004.
- 55 Wicks, E. "Purchasing Pools in a System of Universal Coverage: Facilitating Consumer Choice," New America Foundation Universal Health Insurance Program, May 2004.
- 56 Wicks, et al. March 2000. "Barriers to Small-Group Purchasing Cooperatives" Economic and Social Research Institute: [www.esresearch.org/Documents/HPC.pdf](http://www.esresearch.org/Documents/HPC.pdf).
- 57 [www.pacadvantage.org/brokers/closure.asp](http://www.pacadvantage.org/brokers/closure.asp).
- 58 Wicks, et al. March 2000. "Barriers to Small-Group Purchasing Cooperatives" Economic and Social Research Institute: [www.esresearch.org/Documents/HPC.pdf](http://www.esresearch.org/Documents/HPC.pdf).
- 59 Friedenjohn, I. "States' Experience with Benefit Design," State Coverage Initiatives Issue Brief, April 2003.
- 60 Smith, V. et al. Low Medicaid Spending Growth

- Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007, Kaiser Commission on Medicaid and the Uninsured, October 2006.
- 61 "Mandatory children" refers to children that are defined as mandatory Medicaid eligibility groups. In order to get federal matching funds, states are required to cover mandatory eligibility groups. Mandatory children include children in families receiving Temporary Assistance to Needy Families (TANF), children with disabilities meeting Supplemental Security Income (SSI) criteria, infants born to Medicaid-eligible pregnant women, children under age 6 with family income at or below 133 percent FPL, and children ages 6-18 with family incomes at or below 100 percent FPL.
- 62 Benchmark coverage includes standard Blue Cross Blue Shield Plan under the Federal Employee Health Benefits Plan, state employee health benefit, the health benefit offered by the largest commercial HMO in the state, or a Secretary-approved benchmark-equivalent benefit.
- 63 The Ticket to Work and Self-Sufficiency Program is an employment program for individuals with disabilities who are interested in going to work. The Ticket Program was authorized under the Ticket to Work and Work Incentives Improvement Act of 1999, which aims to remove barriers for individuals going to work, including the concern about losing health coverage.
- 64 Florida Medicaid Reform background available at [http://ahca.myflorida.com/Medicaid/medicaid\\_reform/index.shtml](http://ahca.myflorida.com/Medicaid/medicaid_reform/index.shtml).
- 65 South Carolina 1115 waiver proposal available on CMS website at [www.cms.hhs.gov/MedicaidStWaivProgDemoPG1/MWDL/list.asp](http://www.cms.hhs.gov/MedicaidStWaivProgDemoPG1/MWDL/list.asp).
- 66 CMS Guidance to the States on Proof of Citizenship available at [www.cms.hhs.gov/MedicaidEligibility/05\\_ProofofCitizenship.asp#TopOfPage](http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp#TopOfPage).
- 67 Bell v. Leavitt, N.D. Ill., Sept. 14, 2006. [www.healthlaw.org/library.cfm?fa=detail&id=107454&appView=folder](http://www.healthlaw.org/library.cfm?fa=detail&id=107454&appView=folder).
- 68 New Requirements for Citizenship Documentation in Medicaid, Fact Sheet, Kaiser Commission on Medicaid and the Uninsured, June 2006.
- 69 Boozang, P. et al. Citizenship Documentation Requirements In the Deficit Reduction Act of 2005: Lessons from New York, Kaiser Commission on Medicaid and the Uninsured, June 2006.
- 70 Smith, V. et al. Low Medicaid Spending Growth Amid Rebounding State Revenues: Results from a 50-State Medicaid Budget Survey State Fiscal Years 2006 and 2007, Kaiser Commission on Medicaid and the Uninsured, October 2006.
- 71 Jenkins, C. "Rules Deter Poor Children From Enrolling in Medicaid," *The Washington Post*, October 8, 2006.
- 72 McKelway, B. "Fewer Va. Kids Have Medicaid," *Richmond Times-Dispatch*, November 3, 2006.
- 73 Jenkins, C. "Rules Deter Poor Children From Enrolling in Medicaid," *The Washington Post*, October 8, 2006.
- 74 Covering Kids & Families, The State of Kids' Coverage, August 9, 2006.
- 75 CHIP at 10: A Decade of Covering Children, Senate Finance Subcommittee on Health, July 25, 2006.
- 76 Ibid.
- 77 Quinn, A. and M. Rosenbach, Beyond Coverage: SCHIP Makes Strides Toward Providing a Usual Source of Care to Low-Income Children, Mathematica Policy Research, Inc., December 23, 2005.
- 78 The Child Health Insurance Research Initiative, SCHIP Enrollees with Special Health Care Needs and Access to Care, August 2006.
- 79 Szilagyi, P, et al. "Improved Asthma Care After Enrolling in the State Children's Health Insurance Program in New York," *Pediatrics*, February 2006.
- 80 Mitchell, J. et al. "What Happens to Children Who Lose Public Health Insurance Coverage?," *Medical Care Research and Review*, 2006.
- 81 Shone, L. et al. "Reduction in Racial and Ethnic Disparities After Enrollment in the State Children's Health Insurance Program," *Pediatrics*, June 6, 2005.
- 82 Kenney, G. and D. Chang, "The State Children's Health Insurance Program: Successes, Shortcomings, and Challenges," *Health Affairs*, September/October 2004.
- 83 DeNavis-Walt, C. et al. "Income, Poverty, and Health Insurance Coverage in the United States: 2005, The U.S. Census Bureau Current Population Survey, August 2006.

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