A Newsletter of

STATE COVERAGE INITIATIVES

A National Initiative of The Robert Wood Johnson Foundation

Number 6

October 2001

SCI Announces Demonstration Grant Recipients

Four States Awarded Up to $1.5 Million to Expand Coverage

The State Coverage Initiatives *program has awarded the first of its large demonstration grants — $1 million to $1.5 million to support the design and implementation of significant coverage expansion programs — to Arkansas, New Mexico, Oregon, and Rhode Island. The four states, which were chosen among nine applicants, were given official news of their awards this October.*

Although tremendously varied in their geography, political and fiscal environments, and approaches toward addressing the uninsured, the awardees share a commitment to finding new solutions to an old problem. "With states facing the continuing consequences of high rates of uninsured, especially among low-wage workers, we see them testing new approaches that take advantage of public-private partnerships," says David Helms, director of SCI and president and CEO of the Academy for Health Services Research and Health Policy.

SCI's demonstration grants are targeted to states that are ready to implement major expansions. The program chose states that were in a position to make substantial progress toward a sizable coverage objective, such as expanding eligibility to all children in the state, achieving near universal access to coverage, or demonstrating an innovative coverage model or partnership.

"We wanted to encourage states to really push the envelope to increase the reach of their coverage programs," says Pamela Dickson, senior program officer at The Robert Wood Johnson Foundation. SCI is a three-year, $6 million initiative of the Foundation that was launched in December 1999. Its goal is to help state governments develop and implement expansion policies by providing them with both financial and technical assistance.

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

Each demonstration project will last a maximum of three years, and will be divided into

Continued on page 2

In this issue:

"We wanted to encourage states to push the envelope to increase the reach of their coverage programs."

Pamela Dickson, The Robert Wood Johnson Foundation.

Continued from page 1

STATE COVERAGE INITIATIVES

This newsletter is prepared by the Academy for Health Services Research and Health Policy under a grant from The Robert Wood Johnson Foundation. As a non-profit health policy center and membership organization, the Academy specializes in the dissemination of health research and demonstration findings to national, state, and local policymakers.

Program Director
W. David Helms

Deputy Director
Vickie S. Gates

Senior Technical Assistance Team
Deborah J. Chollet
Anne K. Gauthier
Kevin B. Piper

Managing Editor
Christina E. Folz

Assistant Editors
LeAnne B. DeFrancesco
Carole C. Lee

Contributing Writers
Madeleine Konig
Brian Zipser

ACADEMY FOR HEALTH SERVICES RESEARCH AND HEALTH POLICY

1801 K St., N.W.
Suite 701-L
Washington, DC 20006
Tel: 202-292-6700
Fax: 202-292-6800
E-mail: SCI@ahsrhp.org
Web: www.statecoverage.net

design and implementation phases. The states will match 25 percent of their award through direct or in-kind support. Applications for SCI's second and final round of demonstration grants, which will be awarded to another four states, are due on July 1, 2002. For more information, see www.statecoverage.net. To follow are descriptions of the first-round recipients' demonstration projects.

Oregon: Using Federal Flexibility to Move Toward Universal Coverage

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

The OHP, which has been in operation since 1994, was created to extend access to affordable health care to all state residents with incomes below the federal poverty level. To fund the plan, the state created a priority list of treatments and conditions that are covered.

Using its demonstration grant funds, Oregon hopes to be one of the first states to use the new waiver guidance from the Centers for Medicare and Medicaid Services (CMS) to create two separate benefits packages for OHP; this will help the state to afford further expansions. "For more than 15 years, there has been a focus on benefits in our state," says Santa. "Our citizens understand the difficult choices we must make to work toward universal coverage."

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

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

A third project initiative will be to gain federal approval to insure families under a single policy, even when parents and children are eligible for different programs. The State Children's Health Insurance Program's (SCHIP) current screen-and-enroll requirements often do not make this possible. Each policy initiative will require CMS approval; Oregon expects to submit a request in January of 2002 and for the waiver to be awarded in May or June of that year.

New Mexico: Pooling Purchasing to Provide Private Coverage

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

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

Another advantage to New Mexico's approach is that it allows the state to pool purchasing for enrollees, so that it can leverage federal dollars to

provide both public and private coverage. "By using the Medicaid program as a mechanism to provide private coverage, this will be, in the truest sense, a public-private partnership," says Monson. Moreover, the program will reduce some of the administrative obstacles normally associated with employer buy-ins. Because the state will contract with insurers directly, it will have first-hand access to information about benefits and premium contributions, which is needed to track enrollment and perform cost-effectiveness analyses.

The project will build on the work of an SCI policy planning grant that runs through February of next year. (For more on SCI's planning grants, see box on p. 4.) That grant brought together 36 stakeholders to analyze options for expanding coverage to adults with incomes up to 235 percent FPL.

The demonstration project team anticipates that the state legislation needed to implement the buy-in will be passed in early 2002. It plans to test market the model in the fall, and phase in implementation beginning in January 2003.

Rhode Island: A Cutting-Edge Employer Buy-In

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

RIte Share was created in February of this year to alleviate the fiscal crisis that the state's Medicaid/SCHIP demonstration program — RIte Care — experienced in the late 1990s due to instability in the private market. In 1998, the state expanded RIte Care to include parents of eligible children with incomes up to 185 percent FPL (previously only children up to 250 percent FPL were covered), and officials became concerned that public coverage was partially substituting for private. "We took things as far as we could in the full coverage mode," says Leddy.

Under Health Reform 2000, the legislation that included the formation of RIte Share, all individuals and families eligible for RIte Care and with access to employer-sponsored coverage must enroll in the buy-in. RIte Share pays the employees' premium share and reimburses providers directly for wrap-around benefits not included in employers' plans.

RIte Share has several design features that make it less administratively burdensome than other buy-ins. Cost-effectiveness is assessed at the program level, based on an average family rate, rather than calculated for each individual family. Rhode Island has also worked closely with insurers to streamline the benefit certification process.

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

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

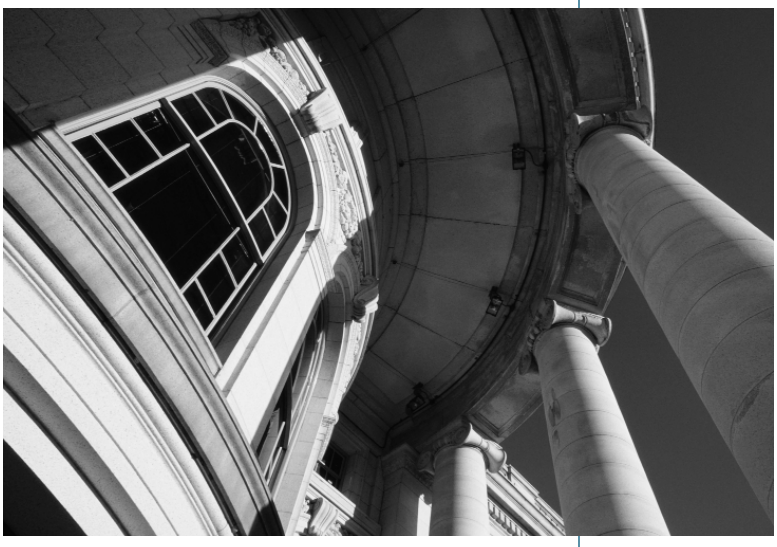
Arkansas: A Multi-Faceted Approach

SCI awarded the Arkansas Center for Health Improvement (ACHI), sponsored by the Arkansas Department of Health and the University of Arkansas for Medical Sciences (UAMS), a demon-

Continued on page 4

"Our citizens understand the difficult choices we must make to work toward universal coverage."

John Santa,
Office for Oregon Health Plan Policy and Research.



SCI Policy Planning Grants

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

West Virginia: to conduct survey analysis, target public programs for expansion through buy-ins, and analyze private market options;

Hawaii: to analyze data sets and prioritize coverage options, hold a policy summit for stakeholders to communicate progress and get buy-in, and hold focus groups;

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

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

West Virginia and Hawaii were just awarded their grants this August. Maine and New Mexico hope to finish theirs by early-to-mid 2002.

Continued from page 3

stration grant of $1.5 million. Arkansas will use the funds to implement a multitude of public and private initiatives — including Medicaid expansions and employer- and community-based partnerships — designed to attack the problem of the uninsured from different angles.

Arkansas is characterized by a disproportionate number of small businesses and individuals without health insurance and a population whose poor health status relates to its lack of coverage. Historically, the state has lacked the funding, infrastructure, and policy and technical expertise to implement long-term expansion strategies, but that has begun to change.

In November of 2000, Arkansans demonstrated their commitment to the uninsured by passing a ballot initiative that allocated a large portion of the state's tobacco settlement proceeds to public coverage expansions. Legislators subsequently passed enabling legislation for Medicaid expansions that totalled more than $30 million in state and federal funds. In addition, last year Arkansas received one of the Health Resources and Services Administration's (HRSA) one-year State Planning Grants to gather quantitative and qualitative data on their uninsured.

Arkansas' multi-faceted demonstration project will allow the state to test which expansion strategies hold the most long-term promise, while at the same time reaching out to both very low-income individuals and the working uninsured.

"Historically, as a nation, we've relied on either the private or the public sector to address the uninsured. But the answer will probably be with approaches that bridge the two worlds," says Dr. Joseph Thompson, professor of pediatrics at UAMS and ACHI and project leader for both the SCI and HRSA grants.

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

Demonstration initiatives focused on increasing public coverage include: expanding Medicaid to 19- to 64-year-olds to 100 percent FPL and pregnant women up to 200 percent FPL. These public initiatives alone, which will be largely financed through tobacco settlement proceeds, will decrease the number of uninsured Arkansans by 3,000 pregnant women and 30,000 other adults per year.

The state also plans to implement three recently legislated private-sector initiatives. These include: creating community-based health insurance purchasing pools to support small employers; allowing communities to self-insure a limited benefits package on a sliding scale (i.e., local providers would assume risk for a community-based health plan); and allowing carriers to offer plans without state-mandated benefits. In addition, the state hopes to create a Medicaid employer buy-in program. Arkansas will begin its demonstration work, which it expects to continue for three years, this fall.

"Historically, we've relied on the private or public sector to address the uninsured. But the answer will probably be with bridging the two worlds."

Joseph Thompson, University of Arkansas for Medical Sciences.

HHS Gives States More Flexibility to Expand Coverage

When former Wisconsin governor Tommy Thompson took over at the U.S. Department of Health and Human Services (HHS) in February, he pledged "to reach out to state and local governments." With his first year as Secretary nearly over, Thompson has made good on his promise. At the August 4 opening session of the National Governors' Association's (NGA) annual meeting, Thompson announced the Health Insurance Flexibility and Accountability (HIFA) 1115 demonstration proposal.

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

Specifically, HIFA allows states to tailor benefits packages for optional and expansion populations, but it does not change the benefits that states must offer to core Medicaid and State Children's Health Insurance Program (SCHIP) populations.

Still, some stakeholders have pointed out that the difference between mandatory, or "core," populations is not the same as between poor and rich. According to one participant in a recent Children's Defense Fund conference call, "Some individuals that fall under optional populations can be quite poor and unable to afford the potential cost-sharing increases that the initiative allows state to impose."

As with other 1115 demonstration waivers, HIFA projects will be approved for an initial five-year period from the date of implementation. Under the program, which offers no additional financial support to states, HHS has pledged to:

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

State officials and advocates greeted the HIFA initiative with measured optimism, although they cannot assess its full value until HHS provides more details about how it will work. Because the initiative does not include additional funds, some observers question its potential impact.

"In a time of serious state fiscal situations, without the enhanced match, few states will be able to come up with the money to propose significant expansions," says Matt Salo, director of health legislation at NGA. But he acknowledges that "[The HIFA] flexibilities will be important in helping transform the Medicaid program into one that meets the needs of 21st century health care."

The new flexibility will allow policymakers to "dust off options" that have been previously put

Continued on page 6

"[The HIFA] flexibilities will be important in helping transform the Medicaid program into one that meets the needs of 21st century health care."

Matt Salo, National Governors' Association.

"Our goal is to give governors the flexibility they need to expand insurance coverage to more Americans."

Tommy Thompson, U.S. Department of Health and Human Services.

Continued from page 5

State officials cannot assess HIFA's full value until HHS provides more details about how it will work.

aside, adds Paula Roy, executive director of the Delaware Health Care Commission. Bob DiPrete, director of the Oregon Health Council, also appreciates HHS' clear attempt to allow states flexibility to try unconventional expansion approaches. However, he says, it is still not clear how much flexibility the vague language of the initiative will translate into.

Oregon officials are also concerned about the proposal's explicit prohibition of state-only programs being brought under the HIFA umbrella. Oregon, which has a long history of progressive health care reform efforts, currently finances its premium assistance program with state funds only.

SCI will follow HIFA developments and offer insight and analysis as additional information becomes available. An application template for the HIFA waiver is available on the HHS web site at http://www.hcfa.gov/medicaid/hifatemp.pdf.

SCI Workshop Focuses on Public-Private Partnerships

On July 19th and 20th, the *State Coverage Initiatives* program hosted a workshop in Westminster, Colorado that brought together health policy officials from 32 states to discuss strategies for expanding coverage through the employer-based system. The workshop highlighted both the promise and the challenge of developing premium-assistance programs. It was coordinated by the Academy for Health Services Research and Health Policy.

The workshop also explored other policy mechanisms for increasing the number of people insured through their employers, including direct and indirect employer subsidies, insurance market reforms, and purchasing pools. "At this meeting, state officials were immersed in the best and most current thinking on employer-based coverage. I am confident that they will have much to take back to their states and share with their colleagues," says Anne Gauthier, Academy vice president and SCI senior consultant.

Officials from Colorado, New Jersey, Oregon, Rhode Island, and Wisconsin talked about their states' experiences with premium-assistance programs. The state examples covered design and implementation issues associated with various types of buy-ins, including those that use federal State Children's Health Insurance Program (SCHIP) funds to cover employees' premium share, those that use Medicaid dollars, and those funded solely by the state.

Dr. John Santa, administrator for the Office for Oregon Health Plan Policy and Research, spoke about the Family Health Insurance Assistance Program, a state-only premium-assistance program. Although state-only programs have complete flexibility in their design, enrollment is often limited because they lack federal funding. Largely for this reason, the Oregon program's waiting list is three times the size of its actual enrollment. State officials are currently exploring ways to gain federal financial support for the program.

Barbara Ladon, director of the Colorado Office of Program Development, explained why her state opted not to build an employer buy-in into their SCHIP program. According to a feasibility study, it would cost the state more to meet the federal requirements necessary to develop the program (e.g., to provide wrap-around benefits) than to cover potentially eligible children through regular SCHIP. (For an example of a state that has implemented a Medicaid buy-in, see story on p. 10 about the Pennsylvania HIPP program.)

Sandra Shewry, executive director of the California Managed Risk Medical Insurance Board, pointed out that organizing employer purchasing pools is another way states can promote employer-based coverage. Purchasing pools use employers' combined buying power to negotiate with insurers for affordable premiums.

Because they are voluntary, private-sector initiatives, purchasing pools can be established quickly with low overhead and no government mandates. However, states should apply the same marketing and regulatory rules inside and outside the pool, says Shewry. If rules within the pool are stricter than those on the open market, employers may be reluctant to join it.

Together, the presentations underscored what one participant called "the good, the bad, and the ugly" of state initiatives to build on employer-based coverage. Although public-private partnerships can be administratively complex and difficult to coordinate with employers, they are an invaluable opportunity to expand coverage to low-wage workers — a group often stuck between where public programs end and private coverage begins.

To view the conference agenda, presenters' slides, and summaries of the Question and Answer Sessions, go to: www.statecoverage.net/meetingreports.htm.

SHADAC Helps States Understand Uninsured

At One Year, Program Reflects on Past Accomplishments and Future Goals

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

As it turns out, SHADAC's timing was impeccable. The same month it started, the Health Resources and Services Administration (HRSA) announced that 11 states had been selected to receive funds through its State Planning Grant (SPG) program. The one-year planning grants are intended to help states measure and analyze health insurance trends and develop new options for expanding coverage.

SHADAC also came into existence at a time when the U.S. Census Bureau was expanding and revising its Current Population Survey (CPS) — the most widely used instrument for measuring health insurance in the country — to better accommodate states' needs. (See Box on p. 8.)

Instead of having to search out states, "we were inundated with requests for assistance," says Blewett, an assistant professor in the Division of Health Services Research and Policy at the University of Minnesota School of Public Health (where SHADAC is located). "We feel that the program is right on target and is really filling a need."

Indeed, SHADAC has played a key role in helping the 11 HRSA grantees — and nine others who were subsequently funded through the SPG program — to gather data on the uninsured and underinsured that can be effectively translated into health policy.

A Partnership with State Coverage Initiatives

SHADAC's goal of helping states to collect and analyze insurance information complements that of the *State Coverage Initiatives* program, which helps states use those findings to develop and implement policies for expanding coverage. SCI provides financial and technical assistance to states through its demonstration and planning grants (see article on p. 1), on-site consultations with state governments, regional workshops, publications, and a web site (www.statecoverage.net).

Together, the staffs of SHADAC and SCI hope to provide states with comprehensive support that covers all aspects of the expansion process. The two programs coordinate their efforts through regular conference calls and jointly sponsored technical discussions with states.

Improving State Data

Traditionally, states have relied primarily on federal and privately funded surveys to measure the

Continued on page 8

"We feel that the program is right on target and is really filling a need."

Lynn Blewett, University of Minnesota School of Public Health.

"States want timely access to micro-level data."

Kathleen Call, SHADAC.

Continued from page 7

What Do CPS Revisions Mean for States?

In the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Congress allotted $10 million to the U.S. Census Bureau's FY 2000 budget to address weaknesses of the Current Population Survey (CPS). In addition to a monthly household survey, which primarily covers labor force data, the CPS includes an annual demographic component — the March CPS Supplement — which reports income, work experience, Medicaid, Medicare, and employer-provided health insurance.

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

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

The verification question, which was added in March 2000, is intended to correct for overreporting of uninsurance, which likely occurred because respondents either did not recognize their source of coverage on the survey or reported their current rather than past insurance status. According to Blewett, the recent drop in the CPS's 1999 estimates of the uninsured do not represent an actual decline, but rather the difference in how the uninsured are being counted.

Visit www.shadac.org for tables comparing CPS state-specific health insurance rates with and without the question. The site also contains issue briefs that assess the impact of CPS revisions on state health insurance estimates, and other relevant topics.

For more about survey tools that states can use to measure the number and characteristics of the uninsured, see SCI's March 2000 newsletter, p. 5, "A Survey of Surveys: What Does It Take to Obtain Accurate Estimates of the Uninsured?" It is available online at http://www.statecoverage.net/pdf/sci0300.pdf.

number and characteristics of their uninsured, but that has begun to change. Many states, including West Virginia, Ohio, and most of the HRSA states, are now developing their own surveys, largely because they have become frustrated with the limitations of national ones. States are trying to improve on small state-specific sample sizes, a lack of timeliness, and inconsistent results among surveys due to methodological differences.

"States want timely access to micro-level data," says Kathleen Call, co-principal investigator of SHADAC. By developing surveys that capture larger samples and cover more sub-state locations, states can make more precise coverage estimates and assess their uninsured at the county and regional levels. They can also design surveys that gauge people's eligibility for public programs — something the CPS doesn't address — in order to identify subgroups to whom outreach can be targeted, says Call, who developed Minnesota's statewide household survey in 1995.

But SHADAC's purpose isn't to advocate for state-based surveys. Rather, it seeks to help states find the most effective way to bring data to bear on their policy development discussions.

"Not every state is in a position to conduct its own survey," notes SHADAC Center Director Kelli Johnson, so "we help them use other available information in the best way possible."

SHADAC has helped state officials from Arkansas and Arizona, for example, to extract components of the CPS relevant to their states. The program has also assisted researchers in other states in interpreting data from employer surveys they conducted under their HRSA grants. Employer surveys are harder to conduct than household surveys, because surveyors often find it difficult to reach the person who knows about a given business's employee benefits and insurance take-up. Nonetheless, as premium-assistance programs and tax credits have become bigger policy priorities, states have been increasingly interested in undertaking employer surveys.

Whichever approach states take to measure their uninsured, they shouldn't base their budget forecasts on a single data source, says Blewett, because no survey is without its flaws. Many states rely solely on the CPS, for example, particularly in relation to State Children's Health Insurance Program expansions, and doing so can throw off budgets significantly.

"You've got to be careful about the information you use for your budget forecast. Use a range of estimates derived from multiple data sources, not point estimates," Blewett says.

A Coordinated Approach

One of SHADAC's goals is to work toward the development of surveys that will yield comparable data across states. According to Linda Bilheimer, senior program officer at The Robert Wood Johnson Foundation, "One of the reasons we developed this project is that many states were conducting their own surveys with no standardization of definitions, questions, or methods. That strategy may make the national picture more, rather than less, confusing."

This August, the program hosted a workshop that brought together researchers and policy analysts from 10 states to discuss, for the first time, the possibility of developing a uniform method for measuring the nation's uninsured on a state-by-state basis. The participants agreed that a good way to start was to work toward a set of best practices — a core group of survey questions that all states could use to monitor policies affecting their uninsured. States could then build additional questions into their surveys to address their unique coverage challenges.

"We decided to work toward as much consistency as possible while still meeting states' individual needs," says workshop participant Dave Dorsky, health policy specialist at the Ohio Department of Health. The group gave top priority to developing standard measures of coverage and demographic characteristics of the uninsured.

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

Workshop participant Ray Goldsteen, professor of community medicine at West Virginia University School of Medicine, says that SHADAC provides a needed forum for states to collect consistent data. "We need our work to be not only displayed, but to become more professional, and to be assessed in a peer-reviewed atmosphere," Goldsteen says. "SHADAC can help very much in that."

Looking Ahead

SHADAC plans to expand its role during its second year. In addition to providing targeted technical assistance, the staff hopes they can give states more global advice based on what they have learned so far. "Now that we've gotten a feel for what states need, we'd like to take a more proactive role in helping them," says Johnson.

Not that the states are complaining. According to Colorado's HRSA grant project director Sue Williamson, "SHADAC has been instrumental in providing us with technical assistance on structuring and administering our survey [a household survey of 10,000 Coloradans]. We wouldn't be where we are without SHADAC in the field."

The SHADAC web site (www.shadac.org) provides states with links to private and national surveys and policy research organizations, state data resources, issue briefs on data collection issues, and technical assistance and survey information. SHADAC can help states design a survey instrument, select a vendor, and develop a sampling strategy. The program is also available to review and provide feedback on requests for proposals and survey questionnaires. For more information, call (612) 624-4802 or email email@shadac.org.

SCI Welcomes New Research Assistant

Madeleine Konig joined the *State Coverage Initiatives* team in July 2001. Her responsibilities include background research for publications, site visits, and technical-assistance projects. She also writes articles for the SCI newsletter and designs and maintains web-based products.

Madeleine was previously an intern at the U.S. Agency for International Development in the Bureau of Program and Policy Coordination, Center for Population, Health, and Nutrition. She graduated with honors from the University of Pennsylvania, where she received a B.A. in Philosophy, Politics, and Economics. She also speaks Italian and French.

Madeleine replaces Sarah Molinari, who is pursuing an MHA/MBA degree in health administration at the University of Florida.

Pennsylvania's Buy-In: A Model of Efficiency and Savings

System Automation Eases State's Administrative Burden

"Although it took a lot of time and effort to develop, system automation paid off over the long-term."

Joanne Slesser, Pennsylvania HIPP Program.

Pennsylvania's Health Insurance Premium Payment (HIPP) program has emerged as a model for an efficient and financially successful employer buy-in program. HIPP programs, which were established as part of the 1990 Omnibus Reconciliation Act, use Medicaid funds to subsidize employee premiums, co-payments, and deductibles for employer-sponsored insurance. Five other states — Iowa, Missouri, Texas, Virginia, and Wisconsin — have active HIPP programs, but they have generally enrolled only a few thousand families and achieved moderate savings.

The Pennsylvania program, which was implemented in 1995, enrolled more than 18,000 clients (of 1.7 million individuals on medical assistance) in FY 2000 and generated over $64.2 million in savings.

Joanne Slesser, Pennsylvania's HIPP manager, credits the program's success to its automated processes for enrolling and tracking participants. Using information stored in computerized databases, the program's staff can rapidly perform cost-effectiveness analyses, generate program referrals, schedule payments, and calculate savings.

"Although it took a lot of time and effort to develop, system automation paid off over the long-term," Slesser said. "Once you have the process in place, enrollment moves quickly."

Increasingly, states are turning to employer buy-ins such as HIPP programs as a means of extending coverage to working people who are unable to afford their portion of employers' insurance plans. In recent years, the likelihood that these individuals will be eligible for public insurance has increased as federal eligibility for public programs has expanded — through Medicaid Section 1931, Section 1115 waivers, and the State Children's Health Insurance Program (SCHIP). As a result, states are looking to partner with the private sector to provide coverage to more, higher-income families.

Proving Cost-effectiveness

One of the most complicated administrative tasks states face when running an employer buy-in is proving that the program is cost-effective, as federal legislation requires them to do. In other words, states must demonstrate that it would cost less for them to enroll a family in a buy-in than to cover them through regular Medicaid. (States are also required to ensure that participants will be offered the equivalent of the full Medicaid benefits package — which means that states must provide employees with additional wrap-around benefits to cover what employer-based plans do not.)

Pennsylvania's HIPP program uses a computerized matrix containing information on the benefits programs of employers in the state to simplify the cost-effectiveness analysis. Program staff calcu-

late the average Medicaid cost per client from insurance data in the matrix, which can be organized by employees' age, insurance category, and geographic location. They then compare that estimate to HIPP program costs, including premiums, deductibles, co-payments, and administrative fees.

For fee-for-service Medicaid, expenses are calculated yearly and compared with the HIPP program's paid claims history database. For managed care Medicaid, cost effectiveness is determined by comparing the average cost of Medicaid's health plan with that of the employer.

Automated Referral System

Pennsylvania also uses automated computer systems to generate HIPP program referrals. Referral letters are automatically created for individuals who report on their Medicaid applications that they or their family members are employed or recently had employment.

To identify potential high-cost users, the system also tracks those who report a pregnancy or serious illness in their family. Based on this information, Pennsylvania sends out 4,200-4,500 referral letters to potential enrollees each week. The letters ask people to fill out the referral with more eligibility specifics and return it to the program.

Program Benefits All Stakeholders

According to state officials, Pennsylvania's HIPP program has yielded extensive benefits for all involved. Its cost savings have been passed on to tax payers and have helped the Department of Welfare to fund expansions of other public programs. Its high enrollment rates mean that managed care organizations can spread risk. Its larger member pools mean that employers pay less for group insurance.

And, most important, the program's employer-based approach means many individuals gain access to otherwise unaffordable coverage without the stigma often associated with public insurance programs.

The Pennsylvania HIPP program maintains four regional offices with 44 staff members. For more information, please contact Joanne Slesser at Jslesser@state.pa.us or (800) 644-7730. For a list of state resources on subsidizing employer-based health insurance, visit http://www.statecoverage.net/employerbased.htm.

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

Medicaid Disease Management: Seeking to Reduce Spending by Promoting Health, August 2001
This issue brief highlights how disease management (DM) has the potential to help states control Medicaid costs while improving health care quality. It guides readers through several aspects of setting up a DM program, such as obtaining federal approval, selecting a chronic disease to "manage," and working through contractual issues. This publication is available at www.statecoverage.net/pdf/issuebrief0801.pdf.

Full-Cost Buy-Ins: An Overview of State Experience
August 2001
This issue brief describes the experience of five states that have developed full-cost buy-in programs and outlines the major design issues involved in establishing an FCBI. It also discusses how to avoid the potential hazards of implementing these programs, such as attracting a disproportionately unhealthy population — which can result in premium increases from adverse selection. This publication is available at www.statecoverage.net/pdf/issuebrief801.pdf

Meeting Reports
SCI convened the meeting "Building on Employer-Based Coverage: A Workshop for State Officials" on July 19-20 in Westminster, Colorado. [See page 6 for a report from that meeting.] The agenda, presentation slides, and Question and Answer summaries from the workshop are posted at www.statecoverage.net/meetingreports.htm. A compilation of other supplemental materials is also available at the same location under "Subsidizing Employer-Based Coverage: State Reports and Resources."

State Reports
SCI continues to compile state coverage-related reports and provide links to them through a web database organized by state; it is also searchable by keyword and category of report. The reports are from a variety of sources, including Blue Ribbon commissions, task forces, coalitions, and state policy offices and departments. Almost 90 reports from more than 25 states are currently posted at www.statecoverage.net/statereports. Please contact the SCI team at SCI@ahsrhp.org if you know of or have reports that should be posted.

General Reports

Two recent reports examine the results of surveys and focus groups that addressed questions about health insurance for children, particularly that provided through the State Children's Health Insurance Program (SCHIP).

What Parents Say: Why Eligible Children Lose SCHIP, Findings from the Focus Group for the SCHIP Retention and Disenrollment SWOT Team Study
National Academy for State Health Policy,
June 2001

Previous reports have indicated that both disenrollment and retention are problems for SCHIP. A new report by the National Academy for State Health Policy (NASHP) attempts to determine why these problems persist.

NASHP held focus groups with current and past SCHIP enrollees in seven states: Alabama, Arizona, California, Georgia, Iowa, New Jersey, and Utah. Opinions of the SCHIP program were "overwhelmingly positive." Although most interviewed enrollees also found the program affordable, monthly variations in household expenses often meant that they were forced to disenroll. Miscommunication between program staff and the enrollee was also a major cause of disenrollment.

For a copy of the report ($20 for government/nonprofit, $35 for all others), contact: NASHP, 50 Monument Square, Suite 502, Portland, Maine, 04101, (207) 874-6524, or e-mail: info@nashp.org.

Survey of American Families: Comparison of Households with Insured Children vs. Uninsured Children Eligible for SCHIP/Medicaid Coverage
Wirthlin Worldwide for *Covering Kids,*
August 2001

Reporting on a survey of 1,662 parents with children under the age of 18, this publication offers an assessment of the impact of uninsurance on a child and his or her family. The results showed that parents of uninsured children are more likely to skip or delay their children's treatment and to keep their children out of a sporting event than parents of insured children. Moreover, parents of children without insurance experience more stress about their ability to pay for basic medical care.

Prepared for the *Covering Kids* program as part of their Back-to-School health insurance enrollment campaign, the complete report will be available to the public soon. The executive summary is available at: http://www.coveringkids.org/bts2001/resources/execsum.pdf.

ACADEMY
FOR HEALTH SERVICES RESEARCH
AND HEALTH POLICY

1801 K Street, NW

Suite 701-L

Washington, DC 20006

Phone: 202-292-6700

Fax: 202-292-6800

Web: www.academyhealth.org