

STATE ^{OF} THE STATES

January 2008

Rising To the
Challenge



Robert Wood Johnson Foundation



AcademyHealth

STATE ^{OF} THE STATES



About the Photo

This year's cover image reflects both the struggle and determination of state efforts to expand coverage to the uninsured. With high expectations for blue sky ahead, a number of states are rising to the challenge of moving forward with meaningful health care reform – rocky, sometimes perilous terrain. States are climbing largely alone, with little Federal support and only the experience of their peers and predecessors to guide them. However, their grip is sure and their eyes are looking up. The status quo is no longer an option.

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.

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Executive Summary

RISING TO THE CHALLENGE

For the sixth year in a row, the number of uninsured grew, reaching a recent high of 47 million. In 2007, states intensified their efforts by implementing planned reforms, passing new legislation, and debating ambitious reform proposals.

Governors, legislators, and stakeholders demonstrated renewed optimism as they moved forward with planning, enacting, and implementing a wide array of reforms. Their actions demonstrated that the status quo is no longer an option: the lack of national movement to address the issue of the uninsured, combined with growing political will among Governors and legislators fueled momentum for state coverage reforms. Stable financial conditions also played a role, allowing many states to move forward in ways that were not possible during the early years of this decade when harsh fiscal conditions forced states to retrench.

State approaches to reform vary considerably, often depending on the political and fiscal environment; demographic characteristics, insurance market dynamics, and other economic variables also impact a state's capacity to act. Yet almost universally, states are considering health care reform in a very pragmatic way. A single-payer system is generally not considered a politically viable option; however, neither are reforms that rely completely on a free market, consumer-driven health care system. Instead, most state reforms look to

politically feasible proposals that build on the current, mixed public-private health insurance system.

Despite new efforts to think beyond the current paradigm and find new tools to address health care reform, historically difficult policy questions remain. States currently considering the applicability of comprehensive reforms in their state will have to identify and prioritize their goals, address the challenges of financing, determine the viability of mandates, and define affordability. It is the solutions to these questions that will create the building blocks for state health care reforms to come.

Overall, states' reform activities can be grouped into three categories:

- **Comprehensive reforms.** Maine, Massachusetts, and Vermont forged ahead with ambitious reform programs that aim to provide residents with universal or near-universal coverage.

Massachusetts continued to capture the nation's attention with the implementation of a sweeping reform program that emphasizes shared financial responsibility

for obtaining health care coverage among individuals and employers. Already, the state has achieved several remarkable

Employer-Based Coverage Stabilizes, but Children Continue to Lose Ground

The year capped a period of unprecedented declines in employer-based coverage, which dropped to 59.7 percent in 2006. And while a stable economy and slowing premium growth have stemmed the erosion of employer-sponsored insurance, it remains to be seen whether the declines of the past few years will be reversed. These steady declines are mirrored by an increase in the number of uninsured over the course this decade. Children continued to lose ground, swelling the ranks of the uninsured by 600,000 in 2006 and accounting for more than one-quarter of the growth in uninsured. These figures lent renewed determination to states' efforts.



milestones: strong enrollment in its low income subsidy program, and the launch of the Commonwealth Health Insurance Connector, which helps small employers and individuals purchase affordable insurance. Many states have expressed interest in the Connector model and its promise of easing the access and market hurdles so often experienced by the uninsured. In fact, although the Massachusetts model was initially viewed as unique and holding little potential for transferability, other states are now borrowing key components of Massachusetts' approach.

While Massachusetts garnered the most headlines, Maine and Vermont moved forward quietly with ambitious coverage reform agendas of their own. Maine continued to encounter challenges with its Dirigo Health Program, which has experienced disappointing enrollment and has suffered from a controversial funding mechanism. Vermont began enrollment in its Catamount Health plan, which like Massachusetts' approach, includes mandatory requirements for employers. Policymakers are watching closely the results of the state's outreach efforts and the success of protections designed to discourage crowd out of employer-based insurance.

The climate appeared right for reform elsewhere, as significant new coverage proposals emerged from California, Pennsylvania, and New Mexico. Governor Schwarzenegger captured national headlines at the start of 2007 with his vision of a sweeping reform proposal that would achieve coverage for all Californians, while ensuring affordability and promoting wellness.

■ **Substantial reforms.** In 2007, a handful of states moved forward with substantial reforms that not only expanded coverage, but also undertook

private market reforms and launched new purchasing mechanisms. For example, Washington enacted significant legislation that provides access to coverage for all children by 2010, and begins a premium subsidy program for families. The state also plans to develop a Massachusetts-style Connector to increase opportunities for employers to offer affordable coverage to low-income workers. In Oregon, Governor Ted Kulongoski specified a detailed timeline for developing a full-scale health reform proposal. A slew of other states are gearing up to undertake substantial reforms in 2008 and beyond.

■ **Incremental strategies.** Many states moved forward with incremental reforms that expanded health coverage for subpopulations within the uninsured. In 2007, momentum continued for guaranteeing access to health coverage for all children. The Illinois All Kids program, the first program of its kind to guarantee universal coverage to children, exceeded enrollment expectations but faces several challenges as it tries to maintain the momentum of its inaugural year. Following in the footsteps of Illinois, a variety of states are pursuing expansions aimed at children, including Hawaii, Missouri, and Texas. New York created the nation's highest ceiling for the State Children's Health Insurance Program (SCHIP) by raising the eligibility requirement from 250 percent of the federal poverty level (FPL) to 400 percent. Connecticut will also be raising its SCHIP eligibility to 400 percent FPL.

A number of states—Connecticut, Idaho, Indiana, Maine, Maryland, Montana, and Washington—expanded coverage to young adults by changing the definition of 'dependent' and extending access to insurance for young adults older than 18.

Many of these states used Medicaid as a vehicle to expand coverage, taking advantage of the new flexibility offered by the Deficit Reduction Act (DRA) of 2005. States also used SCHIP expansions as a strategy for expanding coverage, although uncertainty in the long term financing of SCHIP may limit those efforts moving forward. (After months of negotiation, lawmakers could not agree on a reauthorization plan the SCHIP program; the program has been extended in its current form until March 2009.)

A discussion of coverage in 2007 would not be complete without addressing the wealth of state activities aimed at system-wide improvements in quality, care coordination, and cost containment. Increasingly, states are coupling coverage expansions with strategies that target chronic conditions, wellness and prevention, the uptake of health information technology, and public reporting of information on cost and quality. With these efforts, states are aiming not only to improve quality, but also to control costs and improve the value of public and private programs.

LOOKING FORWARD

With the number of uninsured continuing to rise, employer-sponsored coverage continuing to weaken, and no federal action in sight, state health care reform will continue to play a critical role in decreasing the number of uninsured individuals in the United States. States have played a critical role in increasing the urgency surrounding conversations about improving health care coverage for the country's uninsured and underinsured. Yet, given the future fiscal picture, it is unclear how much further states can go. While states have been the nation's laboratory for testing new ideas—both politically and practically—their ability to create momentum and provide direction for a national policy solution is also significant.



SURVEYING THE LANDSCAPE

Meeting the health care coverage needs of the uninsured remains a difficult national problem, yet the prospects for federal reform are dim. In addition, more than ever, rising health care costs are increasingly threatening to undermine coverage of those currently insured.

Nonetheless, states have persisted in their efforts to devise innovative solutions to maintain or extend health care coverage to their populations. In 2007, improved fiscal conditions, combined with only modest Medicaid spending increases, enabled states to turn their attention to program improvements and coverage expansions that have been out of reach in recent years.

This section uses various data sources to illustrate the current landscape. While there is some variation in the data across these sources, the overall trend is consistent. In general, this section reflects the story at the national level; however, it is important to consider that state-level data may provide greater insight into a specific state's situation.

UNINSURED NUMBERS CONTINUE TO INCREASE

With the number of uninsured reaching a recent high of 47 million nationally in 2006 (increasing from 15.3 percent to 15.8 percent between 2005 and 2006), solutions to cover the uninsured remained a top priority for many states in 2007. The latest census figures show that, in 2006, the ranks of the uninsured increased by 2.2 million from the previous year.¹ Seventeen million

uninsured Americans have gone without coverage for at least four years.²

NUMBER OF CHILDREN LOSING COVERAGE GROWS

Of particular concern, children under age 18 lost coverage again in 2006, increasing the uninsured by more than 600,000 and continuing a disturbing trend that began in 2005, when 360,000 additional children became uninsured.³ Between 2004 and 2006, the uninsured rate for children increased from 10.8 percent to 11.7 percent. Together, these figures more than reverse the expansion in children's coverage achieved between 2000 and 2004, when 400,000 children gained coverage.

UNDERSTANDING EMPLOYER-SPONSORED INSURANCE TRENDS

Employer-sponsored insurance coverage rates reflect interplay between employer offer rates, employee eligibility levels, and employee take-up rates. Eligibility rates and take-up rates have remained relatively stable; however, employer offer rates decreased substantially between 2000 and 2005 before stabilizing during the past two years. This information is averaged for employers of all sizes; offer, eligibility,

and take-up rates vary substantially between small and large firms, with small firms seeing greater decreases in all these variables.⁴

The majority of Americans continue to receive health insurance through their employers. However, the period of 2000 through 2006 brought unprecedented erosion in the percentage of people covered through their employer — decreasing from 64.2 percent to 59.7 percent.^{5,6} The economic downturn that began in 2001, along with rising health care costs and premiums, accelerated the decline in employer offer rates. Not surprisingly, the steady decline in employer-sponsored health coverage is mirrored by an increase in the number of uninsured individuals for the same period.

Over the last two years, the number of employers offering health coverage has stabilized somewhat as premium growth decreased and the economy strengthened. It is unclear, however, whether the erosion in employer-sponsored insurance that occurred from 2000 to 2006 can be reversed and what conditions might encourage an increase in the number of

UNINSURED IN AMERICA: THE FACTS

Number and Percentage of Uninsured Increases

- The total number of uninsured increased to 47 million in 2006, up from 44.8 million in 2005. The percentage of people without health insurance increased to 15.8 percent in 2006, up from 15.3 percent in 2005.⁷
- One in every six Americans under age 65 is uninsured.⁸
- The increase in the number of uninsured reflects the second consecutive year in which employer-sponsored insurance decreased with no significant increase in Medicaid or SCHIP programs.⁹
- Rates of uninsurance continue to vary dramatically across the country. Texas had the highest percentage of people lacking health insurance (24.1 percent), and Minnesota had the lowest (8.5 percent), although Minnesota's rate was not statistically different from uninsured rates in Hawaii (8.6 percent), Iowa (9.3 percent), Wisconsin (9.4 percent), and Maine (9.5 percent).¹⁰
- Twelve states showed statistically significant increases in the number of uninsured: Alabama, Arizona, Arkansas, Florida, Louisiana, Mississippi, New Jersey, New Mexico, New York, North Carolina, North Dakota, and Utah.¹¹

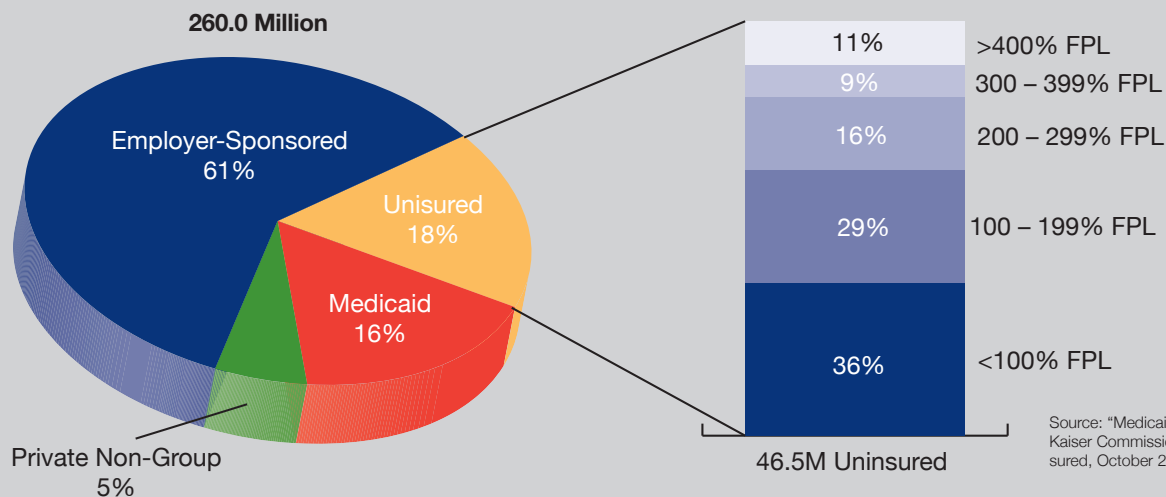
Employer-Sponsored Coverage Still Decreasing

- In 2006, the percentage of people covered by employer-sponsored insurance for some or all of the year totaled 59.7 percent, which is statistically lower than the 2005 level of 60.2 percent.¹²
- In 2007, 60 percent of employers offered health insurance. While the offer rate has remained relatively stable over the last few years as premium growth has moderated, it is nonetheless substantially lower than the 69 percent offer rate in 2000.¹³
- While most (99 percent) large businesses with 200 or more employees offer health insurance coverage, fewer than half (45 percent) of small businesses with three to nine employees offer coverage.¹⁴

Health Insurance Premiums Rise Less Rapidly¹⁵

- Health insurance premiums rose by 6.1 percent in 2007, less than 2006's increase of 7.7 percent and the slowest rate of premium growth since 1999. Still, premium increases outpaced growth in employee wages and overall inflation.

FIGURE 1 THE NONELDERLY UNINSURED AS A SHARE OF THE POPULATION AND BY POVERTY LEVELS, 2006

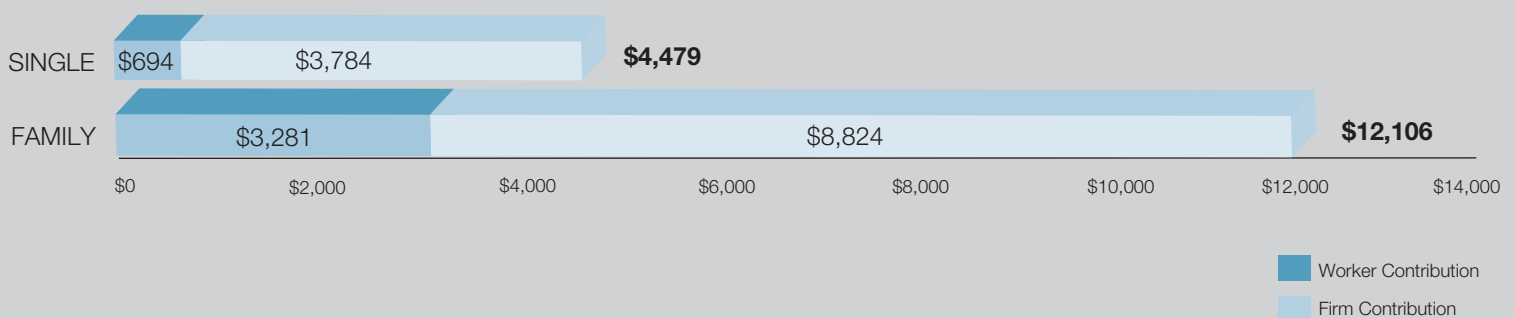


- Since 2001, the cumulative cost of health insurance has increased by 78.4 percent as compared to a cumulative inflation rate of 16.7 percent and a cumulative wage growth rate of 19.3 percent over the same period.
- With an average annual premium for family coverage topping \$12,106 in 2007, health insurance coverage is becoming increasingly unaffordable for many families and businesses. The average annual premium for family coverage significantly eclipsed the gross earning of \$10,712 for a full-time, minimum-wage worker. The annual premium for single coverage averaged about \$4,479.
- While the percentage of employee premium contributions has remained constant for several years, the average annual contribution for single and family coverage increased significantly between 2006 and 2007 from \$627 and \$2,973 to \$694 and \$3,281, respectively.

Number of Uninsured Children Grows¹⁶

- The number of children under age 18 without health insurance increased by 611,000 between 2005 and 2006, reaching a total of 8.7 million (11.7 percent).
- Children accounted for more than one-quarter of the growth in the number of uninsured in 2006.
- Children covered by employer-sponsored health insurance declined at all income levels.¹⁷
- Children living in poverty (100 percent FPL and below) appear especially vulnerable, with over 19 percent of them being uninsured.
- Slightly more than one-fifth (22.1 percent) of Hispanic children lack health insurance, a much higher percent as compared to non-Hispanic white (7.3 percent), black (14.1 percent), and Asian (11.4 percent) children.

FIGURE 2 AVERAGE ANNUAL FIRM AND WORKER CONTRIBUTION TO PREMIUMS AND TOTAL PREMIUMS FOR COVERED WORKERS FOR SINGLE AND FAMILY COVERAGE, ALL PLANS, 2007



Note: Family coverage is defined as health coverage for a family of four.
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007.

FIGURE 3 PERCENTAGE OF PEOPLE WITHOUT HEALTH INSURANCE BY STATE, 2005-2006 AVERAGE

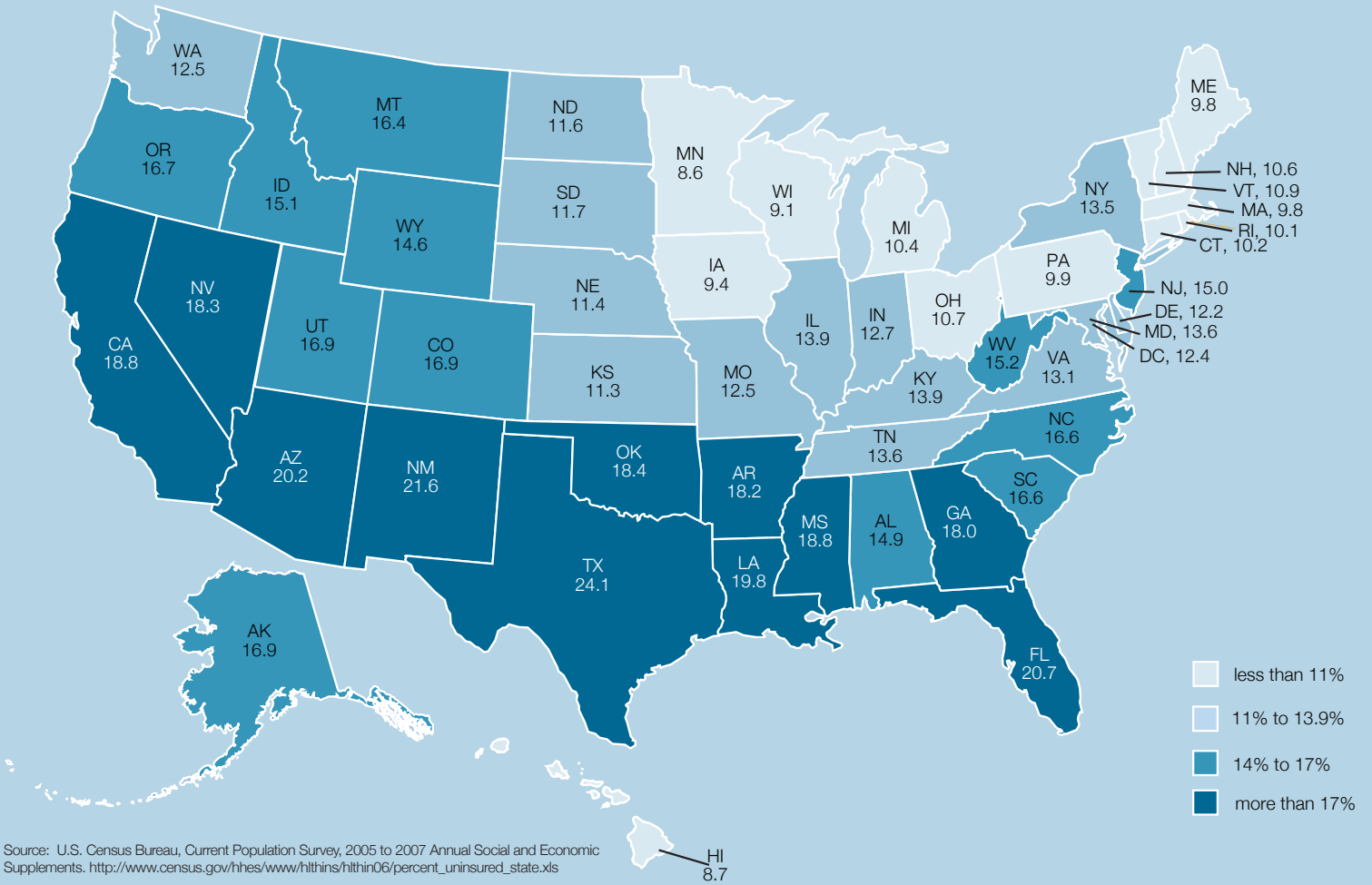
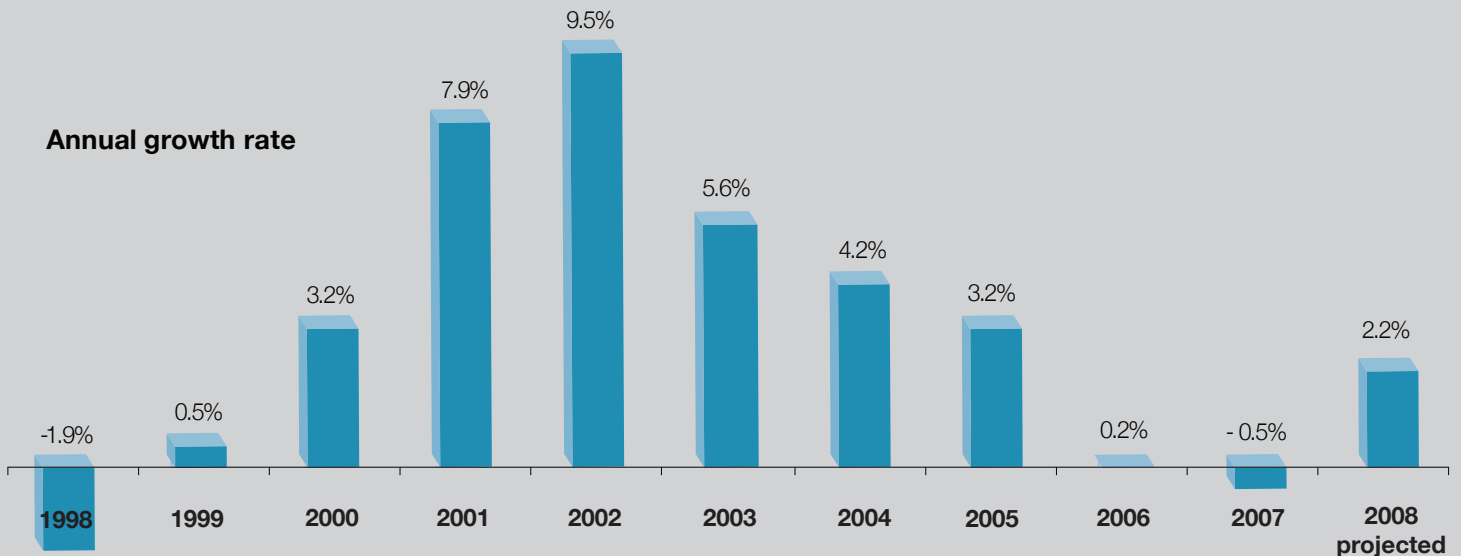
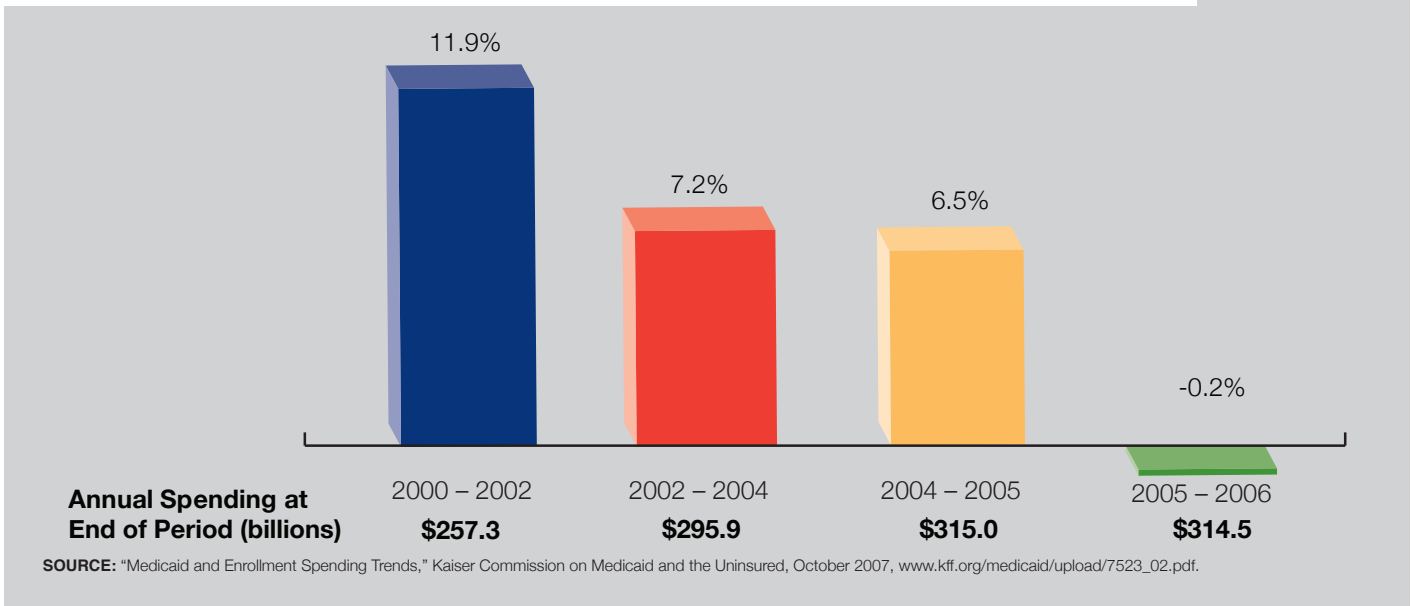


FIGURE 4 PERCENT CHANGE IN U.S. MEDICAID ENROLLMENT, FY 1998 – FY 2008



Note: Enrollment percentage changes from June to June of each year. Source: For 1998-2006: *Medicaid Enrollment in 50 States: June 2006 Data Update*, Kaiser Commission on Medicaid and the Uninsured (KCMU), October 2007. FY 2007 and FY 2008 based on KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2007.

FIGURE 5 **OVERALL AVERAGE ANNUAL TOTAL MEDICAID SPENDING GROWTH, 2000-2006**



employers offering health insurance.¹⁸ Rising health benefit costs and a jittery economy may make it difficult to increase employer-sponsored insurance coverage levels in the near future.¹⁹

While employer-sponsored coverage experienced significant erosion between 2000 and 2004, public program enrollment expanded during that time thus averting additional increases in the rate of uninsurance. However, since 2004, the decline in employer coverage has not been offset by public program expansions.²⁰ This trend may herald the beginning of a disquieting shift whereby the number of uninsured grows at a faster pace in part because public programs are no longer expanding to offset declines in employer coverage.²¹

FISCAL STABILITY IN 2007, WORSENING OUTLOOK FOR 2008

From a budgetary perspective, most states experienced healthy revenue growth in fiscal 2007, but some are already seeing worsening economic conditions and their fiscal 2008 budgets reflect a slowdown in revenue and expenditure growth.²² Many states are feeling the effects of the

nation's weakening housing market and expect lower tax revenues. Others must address underfunded state employee pensions, aging populations, and failing infrastructures.²³ Added to this mix is the certainty that health care spending will continue to rise for the foreseeable future.

Even amid states' recent focus on coverage expansions, Medicaid enrollment declined slightly in fiscal year 2007, accounting for the first decline in enrollment in nearly a decade. The drop likely resulted from both an improving economy with lower unemployment rates and the impact of new Medicaid citizenship documentation requirements. The decline was accompanied by a 2.9 percent growth in Medicaid spending in fiscal year 2007, after record-low spending growth (1.3 percent) in fiscal year 2006.²⁴ The upturn in spending is attributable to state expansion efforts, increases in provider reimbursements, and increasing enrollment after temporary declines in fiscal year 2006.^{25,26} Despite moderate growth in the program, many states are feeling pressure to increase their general fund allocation for Medicaid in the face of a declining federal matching rate. In fact, states' general fund spending on

Medicaid jumped on average from 3.2 percent in 2007 to an average 7.8 percent for their 2008 appropriations.²⁷

Looking forward, Medicaid continues as the major force in state spending, exerting pressure on state budgets and promising future fiscal challenges.

In general, states' major funding concerns fall into two categories: (1) financing coverage expansions for the uninsured; and (2) increased Medicaid expenditures. States have other health care worries as well, including an aging population that will demand more health care services, health care cost increases and their impacts on those currently insured, reductions in federal funding for public health programs, workforce shortages, and the uncertain long-term outlook for SCHIP funding, to name just a few. Recent CBO projections suggest that health care spending will continue to rise at an average annual rate of 8 percent through fiscal year 2017.²⁸ With Medicaid accounting for 22 percent of state budgets, the annual increase promises to continue exerting pressure on state budgets.²⁹

ACCESS BARRIERS PERSIST IN RURAL AREAS

Approximately one-fifth of the U.S. population lives in rural areas.³⁰ Rural residents are uninsured at higher rates than their urban counterparts, and are uninsured for longer periods of time than residents in urban areas. Among non-elderly rural residents, 19 percent are uninsured, compared to 16 percent of urban residents. And while more urban than rural residents report that they have never had health insurance coverage, rural residents lack coverage for longer periods of time. More than one-third of rural residents have been uninsured for more than three years, compared to just over a quarter of their urban counterparts.³¹

Furthermore, research shows that rural residents who have private coverage are at higher risk of being underinsured than their urban counterparts. Generally speaking, the research categorizes individuals as being underinsured if family out-of-pocket

spending for health care exceeds 10 percent of family income or, for low-income families below 200 percent FPL, out-of-pocket costs exceed five percent of family income. In fact, 12 percent of rural residents who do not live adjacent to urban areas are underinsured compared with 10 percent of rural residents who live adjacent to urban areas and 6 percent of urban residents. Even when researchers controlled for socioeconomic and other characteristics, they found that the chances of being underinsured remained 70 percent higher for rural nonadjacent residents than for their urban counterparts.³²

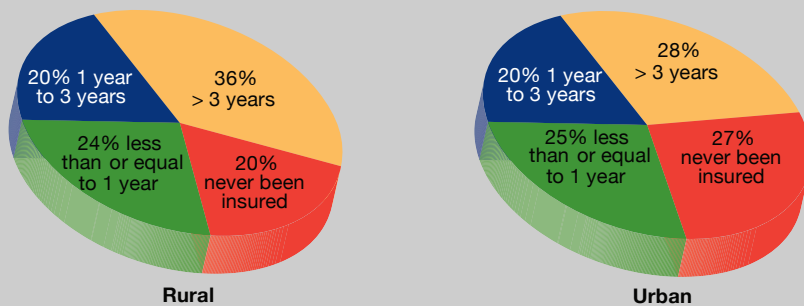
For predominately rural states, the uninsured pose a significant and complex problem. In Montana and Maine, for example, more than 70 percent of the states' uninsured live in rural areas. For these residents, Medicaid and SCHIP play a critical role in ensuring health care

coverage. Public programs provide health care coverage to 16 percent of remote rural residents compared to 10 to 11 percent in other areas.

Rural areas of the country experience persistent barriers in improving access to health care services. Hospital closures, poor public transportation, and physician and dentist shortages all contribute to these barriers. Furthermore, rural residents are less likely to have health insurance because they are less likely to have employers that offer such coverage. In fact, when offered health insurance, rural residents — both those living adjacent to and not adjacent to urban areas — are just as likely to enroll in coverage as their urban counterparts.

State health care reforms to address the uninsured need to take into account key economic, workforce, health status, and health delivery system characteristics that differentiate rural regions from urban areas.

FIGURE 6 LENGTH OF TIME THAT THE RURAL AND URBAN POPULATIONS UNDER AGE 65 HAVE BEEN UNINSURED



Source: Data Profile, Rural and Urban Health, Center on an Aging Society, Georgetown University, Number 7, January 2003.

- *Small businesses form the backbone of rural economy.* The disparity between rates of uninsured in rural versus urban areas may result from the fact that rural residents are more likely to work for an employer that does not offer private health care coverage, for example a small business or agricultural enterprise.

WHO ARE THE (NON-ELDERLY) UNINSURED? ³³

While the number of uninsured is growing rapidly, the economic and social factors that place individuals at risk for being uninsured have remained remarkably consistent.

- The majority (71 percent) of uninsured are members of working families with one or more full-time

workers. In fact, only 18 percent of the uninsured are members of families that do not participate in the workforce.

- The poor and near-poor are the most likely to be uninsured. About two-thirds of the uninsured are either poor (below 100 percent FPL) or near-

poor (100 to 199 percent FPL). The near-poor are especially vulnerable to being uninsured because they are less likely to be Medicaid-eligible.

- Minorities are more likely to be uninsured than whites. Almost one-third of Hispanics and Native Americans lack health insurance coverage

- *Rural areas experience persistent workforce shortages.* Rural areas have fewer providers—less than 11 percent of physicians practice in rural areas—translating into less access for rural residents to health care services. Over 20 million rural Americans live in health professional shortage areas with a provider-to-patient ratio of 1 to 3,500 or worse. While states may be able to devise approaches for providing affordable health coverage options, poor access to services may stymie these efforts. Traveling long distances is not an effective solution, particularly for the elderly. Physician workforce shortages have a disproportionate effect on already fragile rural health care infrastructures and the affordability and accessibility of coverage options for rural residents.

- *Rural residents are older and report worse health status.* Rural Americans are older and in poorer health than their urban counterparts, engage more frequently in risky health-related behaviors, and suffer slightly higher rates of chronic conditions. Fewer rural adult residents receive screening for certain types of cancer, including prostate, breast, colon, and skin cancer. Given these findings, it is not surprising that a larger proportion of rural than urban residents report “fair to poor” when

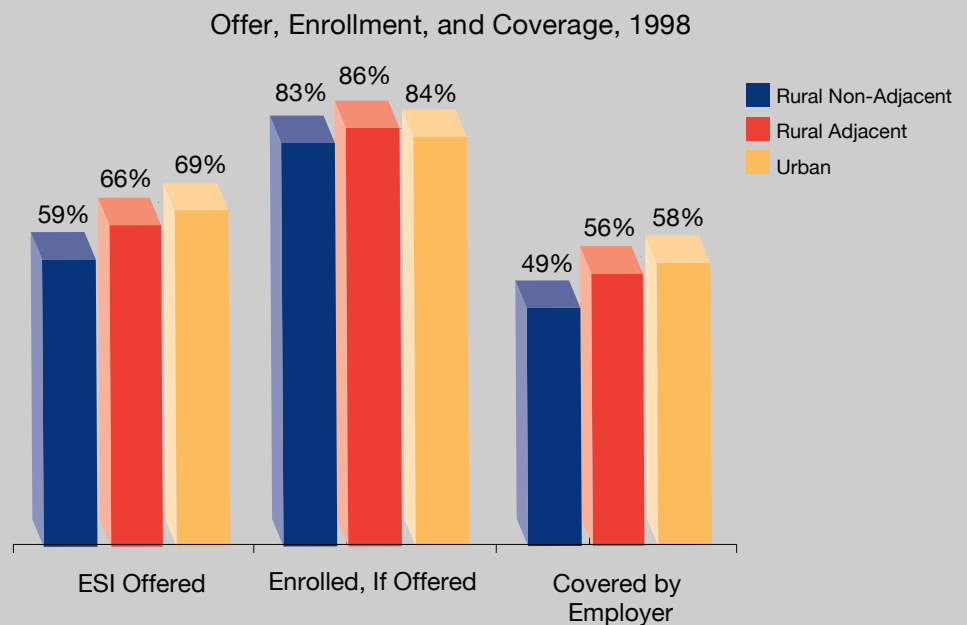
asked about both their physical and mental health status.

- *Strong safety net is critical to meeting needs of rural uninsured.* States need local safety nets in rural areas to ensure the success of statewide health coverage reforms. Some states are trying to promote linkages between Critical Access Hospitals (CAHs), federally-qualified health care centers, home health agencies, and other local service providers. CAHs receive cost-based reimbursement from Medicare in order to improve their financial performance and

reduce hospital closures. State-certified as necessary providers, CAHs are located in rural areas and meet geographic criteria. The federal Flex program encourages states to create a rural health plan, providing grants to states to encourage the development of rural health networks, the improvement of EMS systems, and the implementation of quality improvement initiatives.

Adapted from “Data Profile, Rural and Urban Health”, Center on an Aging Society, Georgetown University, Number 7, January 2003, and The “Uninsured in Rural America,” Kaiser Commission on Medicaid and the Uninsured, April 2003.

FIGURE 7 MANY RURAL WORKERS NOT OFFERED EMPLOYER-SPONSORED HEALTH INSURANCE



as compared with 14.5 percent of whites. African Americans are also uninsured at a higher rate (19.4 percent) than whites.³⁴

- While the number of uninsured children is growing, adults are still more likely to be uninsured than children. Non-elderly adults account for 80 percent of the uninsured with almost

half aged 19-34. Many low-income children qualify for public programs; however, in general, low-income adults qualify for Medicaid/SCHIP only if they are disabled, pregnant, or the parents of dependent children.

- Young adults aged 18-24 and 25-34 have the highest uninsured rate at 29.3 percent and 26.9 percent, respectively.

- The uninsured who suffer from chronic conditions are less likely to receive medical and dental care and have substantially higher unmet health care needs than their counterparts with health insurance coverage.³⁵



KEY POLICY AND DESIGN ISSUES: THE BUILDING BLOCKS FOR REFORM

Despite new efforts to think beyond the current paradigm and find new tools to address health care reform, historically difficult policy questions remain.

Over the past year, the momentum among states to address the uninsured continues to build. The reason for continued efforts are two-fold: the successful enactment of reforms in several states in 2006 raised expectations for progress while, as in previous years, the growth in the number of uninsured, rising health care costs, declining employer-sponsored insurance, and lack of response at the federal level have left states with no choice but to address health care reform themselves.

State approaches to reform vary considerably, often depending on the political and fiscal environment; demographic characteristics, insurance market dynamics, and other economic variables also impact a state's capacity to act. Yet almost universally, states are considering health care reform in a very pragmatic way. Extremes, it appears, are out. A single-payer system is generally not considered a politically viable option; however, neither are reforms that rely on a completely free market, consumer-driven health care system. Instead, most state reforms look to politically feasible proposals that build on the current, mixed public-private health insurance system.³⁶

Amidst this activity, it is helpful to remember one of the primary “Lessons Learned” from last year’s *State of the States* report: new state reform initiatives may take time to reach goals and they should be evaluated only after they have had time to mature. New policy and design lessons will emerge from state experiences and help inform policymakers wrestling with reform models over time.³⁷ While states can learn from each other during both development and early implementation stages, they will continue to experiment given their own particular circumstances. The challenges may be greater than some states can overcome; however, it is important for them to take risks and explore new terrain to inform each other and the national dialogue.

States currently considering the applicability of comprehensive reforms in their state will have to identify and prioritize their goals, address the challenges of financing, determine the viability of mandates, and define affordability. Affordability of premiums and underlying health care costs are major driving factors for state health care reform. Many of the policy discussions laid out in this section — including those pertaining

to benefit design, subsidies, insurance market reforms, and cost containment strategies—are all approaches intended to address the affordability issue. It is the solutions to these questions that will create the building blocks for state health care reform.³⁸

DO DIFFERENT POPULATIONS REQUIRE DIFFERENT SOLUTIONS?

One way that states are approaching comprehensive, substantial, or even incremental reform is to think about the uninsured in three general population categories: those who have very little resources to bring to the private insurance market; those who have some resources but cannot bear the full cost of insurance premiums; and those who have sufficient incomes to participate in the insurance market on their own. Various solutions are being considered to address the needs of these diverse populations.

State discussions often involve determining where the demarcations between these populations fall. In general, states commonly use the eligibility levels of their Medicaid and SCHIP programs to establish the lowest tier—those who have very little resources to bring to the private insurance market. For children, this level is

generally is between 100 and 300 percent FPL; there is substantial variation for both SCHIP parents and childless adults across states, ranging from 12 percent to 275 percent FPL. Recognizing the limited resources of this population, many states at the lowest end of the range may be striving to raise the eligibility levels of their public programs.

States are exploring many strategies to facilitate participation in the private insurance market by those that have some resources but cannot bear the full cost of insurance premiums. This population is defined differently among states, but generally builds from their public program eligibility levels and has a ceiling of 300 to 400 percent FPL. Because a significant percentage of this uninsured population are in working families, state strategies look to both increasing employer offer rates and employee/individual take up rates. Subsidies and other methods to reduce premiums are at the heart of these strategies.

Finally, for those who have sufficient incomes to enter the insurance market on their own, states are either trying to encourage voluntary participation or mandating that individuals purchase insurance.

A ROADMAP FOR REFORM: WHAT ARE THE GOALS?

It is important for states to have a clear vision of what they are attempting to achieve. States need to identify their goals and how to prioritize them. Some goals are oriented toward specific populations such as:

- Universal or near-universal coverage;
- Reduce the number of uninsured who are currently eligible but not enrolled in public programs;
- Increase, or at least maintain, the number of small employers who can afford to offer coverage;
- Help low-income workers afford to take-up their employers' offer; and
- Make coverage more accessible and affordable for high cost (or high risk) individuals.

Other goals create parameters to guide the development of a framework for health care reform. For example, are the reform programs:

- Affordable given a particular state budget situation?
- Likely to be sustainable over the long-term?
- Producing the highest ratio of individuals covered per state dollar spent?
- Minimizing the replacement of public coverage for private coverage (crowd-out)?

- Building on successful existing institutions and administrative structures?
- Creating new institutions and structures to oversee reform?

Understandably, states' established priorities will vary because of their environments: market dynamics, political will, and their fiscal situation all play a role in framing if, and how, a state can tackle health care reform.

SUBSIDIES AND FINANCING – WHO WILL PAY? WHO WILL BENEFIT?

Another lesson from last year's *State of the States* is that there are no free solutions. Low to moderate income uninsured individuals need either public program support or some level of public subsidization. States realize that, even with the best plan at hand, the cost of implementing reforms can be daunting. Certainly no comprehensive reform can occur without significant state investment and some type of assurance that funds will remain available for the life of the program. So determining who will pay, and how much, is a key question for policymakers.

Should there be shared responsibility among different stakeholders? If so, who will share in covering the costs—individuals, employers, the federal government, state government, health plans and insurance companies, providers?

Although some would say that there is enough money within the current health care system to cover the costs of insuring everyone, the reality is that redistribution of resources within the current system is politically problematic. This redistribution can affect both financial responsibility (i.e., who will pay) and income (i.e., who will get paid).³⁹ So, while states are considering some level of financial redistribution, most are searching for new funding sources.⁴⁰

TABLE 1 2007 HHS POVERTY GUIDELINES FOR 48 CONTIGUOUS STATES AND D.C.

| Persons in Family or Household | 100% FPL | 200% FPL | 300% FPL |
|--------------------------------|------------|----------|----------|
| 1 | \$10,210* | \$20,420 | \$30,630 |
| 4 | \$20,650** | \$41,300 | \$61,950 |

*For Alaska: \$12,770; Hawaii: \$11,750 ** For Alaska: \$25,820; Hawaii 23,750
SOURCE: Federal Register, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148

Federal income guidelines do not reflect the variation in median household income or cost of living across states that particularly impacts low-income individuals and families.

As in the past, states will continue to look to the federal government for Medicaid waivers that will bring in federal matching funds to cover new low-income populations. However, as health care costs continue to rise faster than wages and inflation, states must scramble to find sources of continuous funding that will not run counter-cyclically with poor economic conditions.

Massachusetts was able to redirect substantial money from its Free Care Pool (in which it had invested heavily in prior years) but many states do not have that sort of option available to them.

Some states, like California, have considered provider taxes as a way to infuse the system with more resources and Governor Schwarzenegger had recently proposed leasing the state lottery to provide annuities to support his reform proposal. In Pennsylvania, Governor Rendell is looking to surpluses from a malpractice fund to help finance his proposed reforms.

Employer payroll taxes are another option that states like Pennsylvania and California are considering. While employer assessments and other financial requirements are always attractive as a funding source, states must consider how the federal Employee Retirement Income Security Act (ERISA) may impact their ability to implement those requirements (see page 42).⁴¹

Other taxes are also being tested as revenue models. “Sin” taxes such as tobacco and alcohol taxes have been passed in several states; however, relying on income from sources whose use is discouraged by higher taxes and, at least in the case of tobacco products, pressure from public health campaigns, is problematic as well. The governor of Illinois originally proposed using a gross receipts tax. Maine

experimented with its Savings Offset Payment as an explicit redistribution mechanism to fund subsidies for its expansion program; however, that has been a financing model fraught with legal and political challenges.

As states grapple with financing issues in the short and intermediate term, they are also focusing on what policies can be implemented that will achieve cost savings over the long run. Inevitably, states are looking to greater systems improvement strategies and chronic care management in the hopes that they will help create a more efficient health care system and a healthier population. However, an upfront investment must still be made in order to ultimately reap savings in the long-term.

SHOULD HEALTH INSURANCE COVERAGE BE REQUIRED FOR INDIVIDUALS?

The individual mandate included in Massachusetts’ reform has generated significant interest nationally, yet the idea of making insurance compulsory is a complex one. It is perhaps the most difficult element of recent reforms to translate into other states. Beyond the challenge of determining the political feasibility of a mandate, a state’s economic circumstance can determine the likelihood of requiring coverage. A state’s median family income is correlated with both the number of uninsured and the revenues available to support subsidies for those who cannot afford the products available in that state. States with lower median family incomes tend to have higher uninsured rates and a smaller tax base while the opposite is generally true in wealthier states.⁴² It is important to note that this issue impacts not only the question of an individual mandate, but also any type of subsidy program that a state may consider.

If the aim of states is to reach close to 100 percent coverage, two elements that must be addressed are the price of the product

and a mandatory requirement to purchase insurance.⁴³ Most states are not ready to pursue an individual requirement and are attempting to create a ‘culture of insurance,’ using education and outreach activities to convince those uninsured people who can afford insurance to purchase it. In addition, states continue to explore how to make the concept of insurance easier to understand for consumers so that they will purchase the coverage. In the end, while states hope that voluntary measures will result in increased coverage, experience so far has demonstrated that a voluntary system will not yield universal or near-universal coverage.

The requirement that individuals have health insurance has also been called either unenforceable or an impingement on individual freedom.⁴⁴ A variety of mandatory activities (e.g., automobile insurance, child support, childhood immunizations, filing income taxes, minimum wage) have been examined by researchers who found that, in general, “[t]he effectiveness of a mandate depends critically on the cost of compliance, the penalties for noncompliance, and the timely enforcement of compliance.”⁴⁵ Regarding personal freedom, the trade-off is that of fairness. Free-riders in the insurance system penalize those who are responsible and do the ‘right thing’ by purchasing insurance; uncompensated care the uninsured receive is shifted onto the premiums of those who are insured (the “hidden tax”)⁴⁶; and, if the uninsured are healthy, their healthy risk is not part of the risk pool, which could help mitigate premium increases for those in the pool.⁴⁷

Finally, a critical element of any individual requirement to purchase insurance is that the state provides some level of subsidization or includes a process where those who cannot meet a defined affordability threshold are exempted from the requirement.

WHAT SHOULD BE THE EMPLOYERS' ROLE IN HEALTH CARE REFORM?

In an attempt to maintain a strong base of employer-sponsored insurance, some states continue to consider more mandatory “pay-or-play” strategies, which essentially tax employers but provide a waiver from the tax if the employer provides access to coverage.⁴⁸ In part, states are examining 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. Both Massachusetts and Vermont have implemented employer requirements; however, neither are substantial in terms of the financial impact on employers nor in terms of state revenue gained. Likewise, some employers, by virtue of their small size, are exempted. On the other hand, employer requirements have an enormous political impact in underscoring the importance of shared responsibility.

Aside from Hawaii's Prepaid Health Care Act of 1974, which requires nearly all employers in the state to provide health benefits to employees who work more than 20 hours, currently, the most substantial employer requirement in place is the Massachusetts Section 125 benefit plan requirement. To be eligible for a waiver from a mandatory assessment, employers are not required to contribute to the cost of health care, but instead must set up the mechanism for the individual employee to purchase insurance with pre-tax dollars.

Because employer contributions currently play a significant role in financing health care coverage, there continues to be an interest in maintaining the employer-based insurance system. However, as health care costs increase in a competitive marketplace, and employer-sponsored insurance decreases, the role of employers in financing coverage will continue to be

debated within the larger discussion of health care reform.⁴⁹

WHAT IS AFFORDABLE COVERAGE?

The enactment of an individual mandate in Massachusetts brought the affordability issue to the forefront: the mandate in that state is meaningless if the available coverage products are not affordable. In part because of Massachusetts' experience, the issue of affordability has emerged as one of the more challenging components of state reform. Put simply: what is considered affordable from the perspective of individuals, families, and employers? (The issue of affordability in terms of a state's budget is addressed in the section above on subsidies and financing.)

The experience of the Massachusetts Connector Board is the most recent example of an effort to create affordability standards for sliding scale subsidies, but it is the first to do so in the context of an individual mandate. The state must provide subsidies to those without the means to purchase coverage; and those subsidies are based on a specific benefit price threshold that must be compared to income levels. Therefore, the need for an affordability standard is related to both the mandate and the subsidies being provided.

Unfortunately, the issue of affordability is more complex than considering only premiums in and of themselves; out-of-pocket costs including deductibles, coinsurance levels, and co-payments are also part of the equation. There is considerable debate about the appropriate levels for all of these cost variables but, in general, there is agreement that levels of both premium and out-of-pocket costs should somehow be related to income and the ability of individuals to afford those costs. Some experts believe that out-of-pocket costs should not count towards affordability standards.⁵⁰ Nonetheless, to set affordability standards, it is important

to consider certain parameters such as levels of individual or family income. For example, a \$5,000 deductible for a person earning the U.S. median family income (\$48,000) may be too onerous.⁵¹

States considering an individual mandate must address the affordability question. Policymakers will have to consider how to provide subsidies to assist those with insufficient incomes to purchase the affordable product and understand that some individuals may have to be exempted from the requirement, as Massachusetts did.

Another factor for policymakers to consider when determining affordability is determining what constitutes an appropriate benefit design, both in terms of how it impacts the mandate and the subsidy. As states work through these issues, they may propose affordability standards and benefit designs that vary widely across the states.

WHAT IS THE MOST APPROPRIATE BENEFIT DESIGN?

Regardless of whether states are pursuing strategies to make health insurance compulsory, the overall cost of health insurance remains an issue of great concern. However, more and more stakeholders in the health care system are not just concerned strictly about the cost of a coverage but the value of that plan – that is, what set of services are being purchased for a specific amount of money. The design of the benefit plan is a lever that is constantly being considered to reduce premiums, encourage efficient and appropriate consumer behavior, and even change insurance plan and provider behavior. Benefit design includes what services are included and excluded, the types of cost-sharing incorporated, and how access to providers is structured.

In the past, many states used the straightforward method of allowing

premium reductions to be based on limiting the benefits included in the plan. This was done primarily by allowing insurance carriers to sell plans that included either no or very limited mandated benefits; however, these plans are not perceived as worth their value because, in order to reduce the premium sufficiently, they often exclude the very benefits that consumers want.⁵² More recently, states are seeing greater take-up of products that are allowed to exclude some mandated benefits but still remain relatively comprehensive. In addition, some states are approaching the concept of limited benefit plans in other ways. For example, the CoverTN program starts with the premise of requiring a maximum \$150 premium per month and has built the product design around that requirement; the New Mexico State Coverage Insurance product looked to limit the benefits by imposing a \$100,000 annual cap. Increasingly, there is an effort to determine which benefits should be included in a plan based on medical evidence; however, evidence-based benefit design is still in its infancy and, for the most part, has yet to be fully implemented.⁵³

High-deductible health plans (HDHPs) that provide for catastrophic coverage are another type of benefit plan design that results in lower premiums. Essentially developed to protect assets in the event of a catastrophic event, HDHPs have always been available in the open market but have not been very popular for lower-income individuals since they have very little assets to protect. In addition, lower-income individuals often do not have the resources to afford the cost of the services that are incurred prior to the deductible being met; in effect, they feel like they are paying a premium in order to still be uninsured.

More recently, health reimbursement arrangements (HRAs) and health savings accounts (HSAs), coupled with high-

deductible plans, have been introduced in the market. While still not accounting for a significant percentage of the insured market, they fill some or all of the gap between first dollar coverage and the deductible level that was seen, by lower-income individuals, as a disadvantage of high-deductible plans on their own. According to Internal Revenue Services (IRS) rules, many preventive services can be covered before reaching the deductible. The premise of these accounts is that policyholders will reduce any over-utilization that was occurring because of third-party payments (i.e., by insurers or self-insured employers) under a first-dollar coverage plan (i.e., plans with low or no deductibles).⁵⁴ Likewise, the ideal of this approach is that patients will become more savvy consumers of health care services—demanding lower costs and higher quality—and market forces will motivate providers to improve their quality based on the desire to have favorable public information published about them. However, in order for patients to be able to choose wisely among hospitals and practitioners, useful price and quality information is necessary. This information, while increasingly more public, is still not widely available and there is a lot of work to be done to make it easily accessible and understandable to consumers.

Other states are looking to encourage certain patient behavior more directly through benefit design. Rhode Island has legislated “wellness health benefit plans” that require policyholders to participate in wellness programs, such as smoking cessation, weight loss, and disease management programs, as well as to select a primary care physician and complete a health risk appraisal. In exchange, deductibles, co-pays and co-insurance are reduced to amounts normally seen in plans with much higher premiums (see page 49). Maryland has enacted a similar law that provides subsidies to

small employers that offer a “wellness” benefit that is designed to prevent disease, reduce poor clinical outcomes, and promote health behaviors and lifestyle choices. It should be acknowledged that there is inherent tension between short-term yearly insurance contracts and the state’s long-term strategies for prevention and chronic care management. There is little incentive for carriers to implement these long-term strategies. With many policyholders moving between carriers, no single carrier believes it will recoup the short-term costs over the long run.

Interest in how a health plan organizes its network of providers continues to be discussed. New forms of managed care that emphasize primary care, preventive care, and chronic care management are being encouraged to improve health and reduce costs in the long term. Tiered networks that motivate policyholders to use those providers with the best value (price and quality) are also being increasingly incorporated into the benefit design.

According to a recent study by the Kaiser Family Foundation, evidence indicates that the ideal cost-effective insurance plan has three features, including: 1) high initial cost-sharing (with deductible or coinsurance); 2) an income-related out-of-pocket cap; and 3) up-front coverage of chronic care maintenance.⁵⁵ It will be interesting to see if more plans incorporate these elements.

HOW CAN RISK BE POOLED?

Another key policy issue that states must consider is how to achieve adequate orders of magnitude in pooling risk. Private insurance is fundamentally based on the idea of risk pooling or risk spreading. Pooling across various levels of risk allows insurance to function because it guards against potential exposure to high costs brought about by adverse selection (i.e., only the high risk, high cost individuals will seek insurance).

Large employer groups are naturally formed risk pools that generally include a broad enough range of risk that adverse selection is mitigated. The federal employee or state employee benefit program is another example of an employer-based risk pool that has sufficient numbers of enrollees to spread the risk. In the non-group (individual) and the small group markets the risk pool is limited, so insurance carriers have devised practices to avoid the inherent risk of adverse selection found in those markets.

Medicaid, a public program for the very poor and disabled, functions more like a subsidy mechanism, rather than a risk pool. Because of the overall poor health of the lowest income Medicaid beneficiaries, adverse selection is impossible to avoid. However, at higher levels of income eligibility in Medicaid and SCHIP, risk pooling strategies can be more effective as beneficiaries exhibit a broader range of risk.

Discussions by state policymakers about pooling risk focus primarily on those uninsured whose incomes are too high to qualify them for public programs and who do not have access to or cannot afford private insurance. Consequently, some states look to use their public program as the risk pool for moderate-income individuals, while other states want to subsidize employer-sponsored insurance or some other purchasing mechanism. However, for those individuals with adequate resources to afford insurance, the private market should act as their pool and states are examining strategies to encourage their participation.

Allowing or encouraging group purchasing arrangements has been widely viewed as a viable strategy to provide coverage and a number of states still use this strategy.⁵⁶ Some arrangements are established through state legislation or regulation,

while others are formed by associations of employers and/or individuals. The theory behind the older purchasing cooperative models relied on the idea that if a number of small employers were pooled together, efficiencies could be gained and a more competitive premium rate could be obtained from insurers. Health purchasing cooperatives or purchasing pools were created around the country, but most were not deemed successful at constraining health insurance premiums, achieving adequate market share to maintain efficiencies, or reducing the number of the uninsured. Many closed their doors after failing financially and, in general, the model did not live up to its promise.⁵⁷

As discussed above, having an individual mandate and subsequent market regulation can ensure that the pooling mechanism spreads risk evenly and discourage insurers from ‘cherry picking’ only the healthy risks. However, since most states are not considering an individual mandate, they may need to consider what mechanisms should be instituted to deter adverse selection and market segmentation.

While pooling risk continues to be a critical aspect of healthcare reform, some states are considering broader health insurance market reforms, such as a Connector-style purchasing mechanism or the merger of the non-group and small group markets, to achieve some of the same results.

DO INSURANCE MARKETS NEED TO BE REFORMED OR REORGANIZED?

As states work toward expanded coverage, they are looking beyond the use of public programs such as Medicaid and SCHIP. Inevitably, they turn to the private insurance markets to examine how those markets are functioning and whether any changes could lower premiums, expand choice of plans and products, or

increase efficiencies. Any changes made to insurance markets are complex, and can have substantial repercussions, as a change implemented in one part of the insurance market may have unintended consequences in other areas of the health care system.

Nevertheless, states continue to consider how revisions to insurance market rules can improve access and decrease costs. Some insurance market reform strategies currently under discussion include implementing a minimum insurance medical loss ratio (i.e., the percentage of the premium dollar that a health plan must spend on medical care versus administrative costs, taxes, and profit); changing the definition for commercial insurance of dependents and extending coverage beyond the age of 18 for students and non-students;⁵⁸ the merging of the non-group and small group markets;⁵⁹ guaranteed issue with risk equalization to counteract potential adverse selection;⁶⁰ and efforts to find savings through administrative simplification and standardization.

States have different insurance markets and regulatory structures that affect how various reforms may work. For those states considering an individual mandate, various regulatory mechanisms in the small group and non-group insurance markets—including guaranteed issue, modified community rating, and medical underwriting prohibitions—can make the adoption of that reform more feasible. Other states that allow medical underwriting, experience rating, and non-guaranteed issue would find it more challenging to implement a mandate.

As noted above in the discussion of risk pooling, a purchasing mechanism can have numerous advantages in helping to make markets work more efficiently. If structured appropriately, it can offer

the advantage of allowing the pooling of premium contributions from various sources (e.g., for workers with multiple employers), providing a purchasing option for part-time workers ineligible for employer-sponsored insurance, and giving employees and individuals a choice of among several health plans rather than a single option. Purchasing through a mechanism such as Massachusetts' Connector can create portability of a plan that currently does not exist in the small group and non-group markets. Some states are even considering the possibility of requiring their entire small group or non-group market to purchase through an exchange. A connector or exchange also provides a mechanism for simplified enrollment and administrative efficiency for employers who would like to offer health care coverage but do not have the resources for benefit management.

Many states are also exploring the aspect of the Massachusetts reform that requires most employers to set up Section 125 plans to allow employees to have their insurance premium contributions withheld on a pre-tax basis (see page 42).

WHAT ARE THE BEST MECHANISMS FOR COST CONTAINMENT AND OVERALL SYSTEMS IMPROVEMENT?

The relationship between cost containment, increased access, and quality improvement has been well established by health policy researchers and policymakers; however, in the past, the predominant belief was that any

two of those goals could be achieved simultaneously but always at the expense of the third. Increasingly, policymakers underscore the idea that improving access cannot take place unless cost-containment and systems improvement initiatives are pursued at the same time. Yet, there is still a general feeling that coverage expansions should not be held hostage to the other two goals.⁶¹ For the political dialogue to advance, long-term strategies to reduce costs and improve quality must be implemented in order to sustain coverage expansions.

In their quest for a more effective and efficient health care system, states are increasingly focusing on a variety of strategies to improve quality and contain costs.⁶² These strategies include: prevention and wellness programs; improved care coordination for chronic conditions; public health initiatives that target specific diseases and conditions such as obesity, tobacco use, diabetes, and asthma; value-based purchasing and other payment reforms; medical error reduction, health-care acquired infection reduction and other patient safety initiatives; data collection and reporting of price and quality information; and, administrative and regulatory efficiencies. Many states are also speeding the adoption of electronic systems and other health information technologies to improve the efficiency, effectiveness, and coordination of medical care.

Some states are moving ahead with cost control strategies while simultaneously

expanding coverage, but most have not implemented fundamental cost containment activities. The reality is that controlling costs is a more elusive problem than improving coverage and quality. States will continue to explore different mechanisms to decrease the cost increase trend; however, it may be possible to promote coverage expansions in the short term while continuing to focus on cost control and systems improvement in the long run.

CONCLUSION

The policy questions posed in this section are interrelated and must be considered in aggregate—contributing to the complexity and challenges of state health care reform. States must consider which of these elements to tackle first and under what timeline. As states move forward with reform proposals, many of them are not in the position to enact comprehensive reform in one fell swoop. However, as evidenced by one of the lessons noted in last year's *State of the States*, states attempting to reach near-universal coverage usually build these reforms on prior efforts. So states that are working on health care reform would do well to enact some of these building blocks upon which future reforms can be added. While this may appear to be a somewhat incremental approach, it goes beyond just those limited strategies because they are conceived with comprehensive reform in mind. Sequential reforms are those that move toward universal coverage with a vision and deliberate, realistic steps to achieve it.

STATE COVERAGE STRATEGIES: EVOLVING WITH

Both Massachusetts and Vermont began implementing their new reforms. California worked toward comprehensive reform while a number of states continued developing proposals or refining models hoping to enact new reforms in 2008 and 2009.

California—Governor Schwarzenegger announced a comprehensive health care reform proposal, prompting significant state and national debate. Special session of the state legislature convened to address health care reform; revised proposal introduced. Assembly passes reform bill.

Colorado—The Blue Ribbon Commission for Health Care Reform approved a set of recommendations, which would require state residents to purchase health insurance or face a tax penalty, and would expand eligibility for the state's public programs.

Connecticut—Passed reform bill increasing Medicaid reimbursements for physicians and hospitals, expanding eligibility levels for pregnant women and children, and requiring automatic enrollment of uninsured newborns in HUSKY, the state's Medicaid and SCHIP program. New Authorities charged with developing recommendations for overall health care reform and for strengthening the safety net.

Hawaii—Passed several bills that expand health coverage to infants and children, raise the reimbursement rate for Medicaid providers, and reestablish insurance rate regulation provisions.

Illinois—Following the collapse of agreement with the legislature, Governor Blagojevich began implementing, through executive authority, an expansion of the state's FamilyCare plan and other reforms.

Indiana—Reforms enacted that increase tobacco taxes, providing funding for immunization programs, Medicaid expansions, increased Medicaid reimbursement rates, tax credits for employers that establish Section 125 plans, and tobacco prevention and cessation programs. The state received federal waiver approval for the Healthy Indiana Plan.

Kansas—Passed a bill that creates a phased-in premium assistance program that provides subsidies to Kansans who make below 100 percent FPL for purchasing private insurance actuarially equivalent to the state employee health plan. The Kansas Health Policy Authority presented health reform recommendations to the legislature.

Maine—Governor Baldacci signed a bill allowing the DirigoChoice program to be self-administered.

Maryland—Governor O'Malley signed into law a bill that will expand Medicaid eligibility and offer subsidies to small businesses to offset the cost of providing coverage to employers.

Massachusetts—Massachusetts' individual mandate to obtain health insurance took effect July 1. Minimum creditable coverage and affordability standards were determined by the Connector board.

Missouri—Passed a reconfigured state Medicaid system called MO Health-Net. The Legislature restored coverage and benefits to some populations whose services were eliminated two years ago.

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 and working uninsured adults.

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.

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.

2007

2006

2005

TIME AND EFFORT

* While this timeline aims to highlight the major activity in states; it is not inclusive of everything that has occurred in the past few years.

Congress and the administration failed to reach agreement on the reauthorization of the State Children's Health Insurance Program (SCHIP).

Minnesota—Governor Pawlenty announced his Healthy Connections proposal to make the state's Medicaid program more affordable for children, and expand eligibility. Other features include rewards for healthy behaviors, a requirement that small businesses establish Section 125 plans, and a Massachusetts-style Connector.

New Mexico—Governor Richardson unveiled a comprehensive reform proposal that would require all state residents to purchase coverage.

New York—Finalized a budget that will expand health insurance coverage for children by raising eligibility from 250 percent FPL to 400 percent FPL, the nation's highest ceiling for SCHIP eligibility.

Oklahoma—Governor Henry signed legislation expanding income eligibility for adults from 185 to 250 percent FPL and for children up to 300 percent FPL under the Insure Oklahoma/O-EPIC program, which provides health insurance subsidies to businesses and self employed individuals. Currently, the program has implemented this expansion up to 200 percent FPL.

Oregon—Governor Kulongoski signed the Healthy Oregon Act, providing a timeline for comprehensive health reform recommendations, and establishing the Oregon Health Fund Board. Ballot Measure 50 failed, leaving in question funding for a children's coverage expansion.

Pennsylvania—Under his "Prescription for Pennsylvania" plan, Governor Rendell began pursuing an ambitious coverage expansion, alongside health systems improvements and efforts to promote healthy behavior.

Rhode Island—Launched HealthPact RI plans that encourage small businesses to offer health coverage to workers. Initiated a series of stakeholder meetings designed to result in recommendations to the 2008 General Assembly related to cost containment and affordable coverage for uninsured residents.

South Dakota—Legislatively-created Zaniya Project Task Force developed a plan, including action steps and timelines, to provide health insurance to uninsured South Dakota residents.

Tennessee—Launched Cover Tennessee program which includes several expansions to cover children, uninsurable adults, low income workers, and small businesses.

Vermont—Vermont began enrolling eligible residents into Catamount Health on October 1, 2007.

Washington—Passed several bills to provide access to coverage for all children in the state by 2010, and to create a Connector-like program called the Washington Health Insurance Partnership (WHP).

Wisconsin—Increased the cigarette tax by \$1 per pack, providing funding to expand health care coverage to nearly all children in the state through the state's new Badger-Care Plus program.

Federal:

- Bush administration proposed reforming the tax code to allow standard deductions for private health insurance in an effort to make insurance more affordable.
- CMS awarded Transformation Grants to states to improve effectiveness and efficiency in state Medicaid programs.
- Numerous states began jointly pursuing legal challenges against the Bush Administration for violating provisions of the federal SCHIP program.
- SCHIP reauthorization stalled. Stop-gap funding was approved to fund the program until March 2009.

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.

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

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 170,000 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.



STATE STRATEGIES: THE STATUS QUO IS NOT AN OPTION

If last year's big story was the passage of comprehensive reform, then this year's must certainly be, at least in part, the story of implementation. However, while states like Maine, Massachusetts, and Vermont work through the questions and challenges of implementation, many states are still in the process of thinking about how coverage expansions fit within broader health care reform.

More than ever before, governors, legislators, and stakeholders resoundingly agree that the status quo is simply not an option. The bipartisan nature of recent reforms has also motivated policymakers in other states to seek common ground.

Fortunately in 2007, fiscal conditions in many states continued to stabilize and improve, providing more resources for sustaining and expanding health coverage. In fact, 42 states reported efforts to expand health insurance coverage, according to a survey released by the Kaiser Commission on Medicaid and the Uninsured.⁶³ These efforts ran the gamut from expansions aimed at particular groups such as uninsured children to comprehensive proposals that would not only ensure near-universal coverage for all state residents but also aim for system-wide reforms addressing quality improvement and cost-containment.

The story of what occurred across the states in 2007 is a preface to a larger story that will unfold over the next few years. While most governors' proposals were not enacted, they stimulated new dialogue in state capitals that could well lead to meaningful reforms in the coming years. This year's reform

initiatives point to a greater understanding among policymakers that the issues facing the states cannot be remedied by focusing solely on coverage and access issues; however, there is also increasing recognition that coverage expansions are necessary to have an effective and efficient health care system. Consequently, many states are combining coverage expansions with strategies aimed at improving quality while controlling costs. Likewise, states are demonstrating an increasing awareness that reform efforts targeted to cost containment can also promote healthy behaviors and more effective management of chronic disease.⁶⁴

This section characterizes state reforms into three major categories: comprehensive, substantial, and incremental. It is important to note that these categories reflect a general effort to organize and distinguish the range of reforms being pursued.

COMPREHENSIVE REFORMS: NORTHEASTERN STATES FORGE AHEAD WITH IMPLEMENTATION

In 2007, the nation watched as Massachusetts, Maine, and Vermont continued their quests to provide residents with universal or near-universal coverage. While the three states' reform initiatives

differ on major elements, they share several important similarities in the structure of the reforms and some lessons learned.⁶⁵ Chief among the lessons is that comprehensive reforms take time and must build on difficult experiences gained along the way.

Among the similarities, all three states have focused their reform efforts on stemming the erosion of employer-sponsored insurance. Both the Massachusetts and Vermont reform models include strict requirements for employers, including payment by employers who do not currently contribute to their workers' health care costs. Maine is considering modifications to its Dirigo Health program that would include both an employer requirement and an individual mandate in 2008 and 2009, respectively. The three states broke new ground with the passage of health care reform — no easy feat for any state — and have entered the uncharted terrain of implementation.

Massachusetts: Implementation Begins

In a unique reform that has drawn the nation's attention, Massachusetts is the first state to implement an individual mandate. With a goal of covering nearly all residents, Massachusetts continued to

implement its comprehensive reform plan during 2007. Four major principles guide the state's health care reform initiative:⁶⁶

- *Public/private partnership.* Massachusetts describes the importance of the “tent,” a process that requires “the participation, support, and collaboration of a wide range of stakeholders,” including employers, health care industry representatives, community-based groups, and consumer advocacy organizations. The tent — or partnership — also requires the dedication of both federal and state funds to ensure subsidized coverage. Working closely with the employer community, the state designed its reforms with the goal of mitigating the crowd-out of private insurance. For example, the state does not permit individuals with access to employer-sponsored insurance to qualify for its subsidized Commonwealth Care program, and employers with 11 or more full-time equivalents who do not offer health insurance may be subject to an annual assessment.
- *Transparency.* Massachusetts's health care reform offers the promise of greater transparency around health care quality and costs. In 2006, the state launched a Health Care Quality and Cost Council charged with establishing statewide goals for improving health care quality, containing health care costs, and reducing racial and ethnic disparities. By 2012, the Council seeks to ensure that Massachusetts will consistently rank among the states achieving the highest levels of performance in health care.
- *Shifting from free care funding to insurance funding.* A major objective of the reform is redirecting public funds previously used to fund uncompensated care into coverage for individuals in an insurance-based system.

- *Shared responsibility.* To promote a culture of insurance and personal responsibility, Massachusetts developed a system wherein everyone “plays his or her part,” including the government, employers, individuals, health plans, and health care providers. Massachusetts is the first state to require individuals to obtain health care coverage and to use an individual mandate, in combination with employer requirements, to provide near-universal health coverage for its residents.

Initially viewed as a unique model with little potential for replicability, Massachusetts' reform is now the subject of great interest as policymakers in other states have begun borrowing some elements of the reforms.⁶⁷ In addition, the state's groundbreaking efforts both to create a comprehensive benefit design under Commonwealth Choice and help residents obtain affordable coverage through the Connector have generated strong interest among other states, with many adopting these components of the Massachusetts plan in their own reform proposals. At the same time, the complexity of the Massachusetts' undertaking has “sparked a broader debate over the merits and feasibility of comprehensive reform.”⁶⁸

With only a little over a year of implementation experience, Massachusetts has reached several remarkable milestones.

- *Low-income subsidy program enrollment growing rapidly.* Enrollment in Commonwealth Care began in October 2006 for adults with income at or below 100 percent FPL. In January 2007, enrollment expanded further to adults with income between 100 and 300 percent FPL. As of December 2007, the program covered close to 160,000 previously uninsured individuals. Given the strong enrollment in the subsidy program, costs associated with the state's free care pool dropped by 15

percent in fiscal year 2007. Such strong enrollment in a relatively short period is a significant achievement, but it comes at a cost to the state. As a result of higher-than-expected enrollment, the state faces a possible budget shortfall of approximately \$147 million. Despite mechanisms to address the shortfall, including the authority to shift funds from the Health Care Safety Net Trust Fund, the Connector will continue to monitor expenditures and assess next steps. Chair Leslie Kirwan states that “it's too early to make any departure from the health reform plans. We will follow the trends and adjust, if needed.”⁶⁹

- *Connector begins offering non-subsidized plans through the Commonwealth Choice program.* One of the primary objectives of the Commonwealth Choice program is to provide individuals with a choice in the selection of a health plan. To that end, Commonwealth Choice offers six carriers' non-subsidized health insurance plans.

To help consumers compare the many options available to them, the plans are organized into four tiers with varying premiums, copayments, coinsurance, and deductibles. Plans in the “gold,” “silver,” and “bronze” tiers are available for purchase through both the Connector and the open market. Plans in the fourth “young adult” level are available only to adults aged 18-26 and only through the Connector; they may not be purchased in the open market.

In general, plans with lower monthly premiums involve higher levels of cost-sharing and are more likely to require an annual deductible. All plans offer comprehensive coverage, including inpatient and outpatient medical care, emergency care, mental health services, rehabilitation services, hospice services, and vision care.

THE NUTS AND BOLTS OF MASSACHUSETTS HEALTH CARE REFORM

In 2006, the Commonwealth of Massachusetts passed landmark legislation with the goal of covering nearly all of its residents within three years. The law represented the culmination of more than a year of negotiations and compromise between lawmakers and former Governor Mitt Romney. The law required the participation of both employers and individuals by a) placing responsibility on residents for acquiring coverage through an individual mandate that requires all who can afford insurance to obtain it, and b) requiring employers to make an annual “fair share” contribution. (For more information on affordability standards, see page 18).

- *Creation of Commonwealth Health Insurance Connector Authority (Connector).* The Connector is an independent, quasi-governmental state entity charged with helping small employers and individuals purchase affordable health insurance. Initially funded by \$25 million in state seed money, the Connector will eventually be funded by an administrative load collected from both the subsidized and private products it sells.⁷⁰ The Connector facilitates the process of small employers offering Section 125 plans (see page 42) and offers newly developed Commonwealth Choice plans which are unsubsidized. Part-time and seasonal workers can combine employer contributions within the Connector. It also allows individuals to keep their policy even if they switch employers. The Connector is also the sole entity enrolling uninsured low-income populations (below 300 percent FPL) in the subsidized Commonwealth Care Health Insurance Program.
- *Individual mandate to purchase insurance.* When the individual mandate to obtain health insurance

took effect on July 1, 2007, the Massachusetts plan reached an important milestone.⁷¹ In fact, the state required individuals to begin purchasing coverage no later than July 1, 2007 but set December 31, 2007 as a deadline to obtain coverage or face financial penalties. With the six-month grace period, the July deadline became more of a “call to action,” according to Health Insurance Connector Authority Chair Leslie A. Kirwan.⁷² Residents who do not purchase coverage by the end of 2007 will lose their personal exemption allowance for tax year 2007 and, in subsequent tax years, incur a fine for each month without insurance equal to 50 percent of the lowest cost insurance product that the individual is deemed able to afford.

- *“Fair and reasonable” employer contribution.* The reforms are coupled with an employer requirement for “fair and reasonable” contributions to employees’ health insurance coverage. Employers with 11 or more full-time workers who do not contribute to their employees’ health care coverage must pay an annual “fair share” contribution capped at \$295 per full-time equivalent (FTE). Small businesses with fewer than 11 employees are not subject to this requirement. In addition, employers with 11 or more workers are required to adopt Section 125 cafeteria plans that permit workers to purchase health insurance with pre-tax dollars. This requirement is true regardless of whether or not employers offer health insurance to their employees. Employers with 11 or more employees who do not adopt a Section 125 plan may be assessed a “free rider” surcharge if their employees incur uncompensated care costs.⁷³

- *Insurance market reforms.* Insurance market reforms are an important component of the Massachusetts strategy; in July 2007, the state merged the individual and small-group insurance markets. A mandated study on the impact of the merger concluded that, on average, health insurance premiums for small employers would increase by about 1.5 percent but that premiums for individuals would decrease by 15 percent.⁷⁴
- *Premium subsidy and Medicaid expansion.* The various employer requirements and insurance market reforms are coupled with the establishment of a premium subsidy program (Commonwealth Care) and Medicaid expansion. With approximately 170,000 eligible adults, Commonwealth Care offers subsidized insurance to adults who otherwise lack access to health care coverage through an employer, Medicaid, Medicare, or the Veterans Administration. It aims to shift funding from direct payment of safety net providers (via the state’s free care pool reimbursements) to individuals through a subsidized insurance mechanism. It is important to note that the health plans currently serving the Commonwealth Care population are Medicaid Managed Care Organizations (MCOs) that include many of those safety net providers originally receiving direct payment through the free care pool.⁷⁵ In fact, one of the program’s goals was to insure 54,000 adults who had previously received services paid for by the state’s free care pool. The program is available to adults with family income at or below 300 percent FPL.

Commonwealth Choice plans may be purchased through the Connector through any of the following three methods:

- By an individual without the involvement of an employer.
- By an employee using a pre-tax payroll deduction, with no employer contribution; by using pre-tax dollars, an individual may save up to 40 percent.
- By an employee using a pre-tax payroll deduction, with the employer contributing to the monthly premium. (This program is scheduled to begin in 2008 and will be available to small employers with 50 or fewer employees.)

While the new Commonwealth Choice plans provide individuals a wider choice of plans than what was previously offered in the non-group market, the high-deductible components, which have helped reduce premiums, have led to some concern. Some critics,

referring to the high deductibles as “a blunt and crude way to make coverage affordable,” have noted that the high deductibles could prevent individuals from obtaining needed care.⁷⁶ However, out of a total of 30 non–young adult plan designs (six carriers x five designs), half require no deductible, eight have a \$2,000 deductible, and the rest fall in between with deductibles varying between \$500 and \$1,500. In addition, it is important to note that all plans cover preventive care visits, and most cover all primary care visits before triggering the deductible.

- *Significant reduction in free care pool use and costs.* Massachusetts has created a Health Safety Net Trust Fund that will act as successor to the state’s Uncompensated Care Pool (free care pool) by combining uncompensated care funds with other Medicaid funds, including Medicaid Disproportionate Share Hospital Funds.⁷⁷ As an important

component of the state’s reforms, the Trust Fund will reimburse acute-care hospitals and community health centers for care provided to the residual uninsured and underinsured. Over time, as more uninsured gain coverage under the state’s reforms, the state will shift funding from the trust fund to Commonwealth Care. The state has already seen a significant reduction in free care pool use and costs. The number of people using the free care pool dropped by 20 percent between 2006 and 2007 mostly because many former pool users were automatically enrolled in Commonwealth Care or signed up voluntarily.⁷⁸ As a result, the state reduced funding for the Trust Fund by 30 percent for fiscal year 2008.

In addition, the free care pool is instituting copayments and deductibles that mirror the cost-sharing requirements in Commonwealth Care, thereby encouraging people who continue to seek care through the free care pool to enroll in the Commonwealth Care program through the Connector. Policymakers have expressed some concern about the effectiveness of the Trust Fund, and it remains to be seen whether transferring Uncompensated Care Pool funds to subsidies for coverage will in fact result in a decline in free care over the long term.

Massachusetts has grappled with several implementation challenges that provide policymakers with valuable lessons. While the sweeping legislation that created the reform plan provided a blueprint for the state’s move to universal coverage, it did not lay out the specific details of program implementation, including what level of coverage is needed for the individual mandate and what constitutes affordable coverage.⁷⁹ These design issues were left

TABLE 2 COMMONWEALTH CHOICE PLANS

| Tier (# of plan designs per carrier) | Cost-Sharing | Monthly Premium* |
|--|--|---|
| Gold (1) | Low copayments No annual deductible | \$289–\$549 with drug coverage |
| Silver (2) | Moderate copayments Some have an annual deductible | \$232–\$406 with drug coverage [^] |
| Bronze (2) | Higher copayments Most have an annual deductible | \$167–\$280 with drug coverage \$148–\$256 without drug coverage ^{^^} |
| Young Adult (age 18 - 26) (2) | Higher copayments Most have an annual deductible Most have an annual benefit maximum | \$135–\$230 with drug coverage \$110–\$193 without drug coverage |

* Monthly premiums are based on the individual premium for a 35-year-old for December 2007. Actual monthly premiums vary by age, region, and health plan.

[^] All Silver plans offer prescription coverage. While each carrier offers two plan designs, the range in premiums is the same for both design options. The two plan designs have varying benefit and deductible structures.

^{^^} Beginning in February 2008, Bronze plans without prescription drug coverage will no longer be offered in order to comply with the state’s “minimum creditable coverage” standards.

to the board of the Connector, which initially struggled to strike a balance between ensuring adequate coverage and maintaining an affordable level of benefits.

In May 2007, the *Wall Street Journal* described the Connector's 10-person board as a "motley panel" with representation from business, labor, academia, and state government. However, the board's diversity has not stopped members from compromising successfully on several key issues. *The Wall Street Journal* described the tough choices made by the board, noting that members accomplished something "unusual" by "finding ways to compromise on some of their most cherished positions and reach common ground." The article recounted how board member Celia Wcislo of the Service Employees International Union fought hard for lower premiums but ultimately voted in support of the proposed premium levels in order to ensure board unity. It is this type of consensus that ultimately is positioning Massachusetts to become the first state to achieve near-universal coverage. The display of unity is extraordinary given the board's responsibility for making decisions in a public forum — decisions that inevitably will affect all residents of Massachusetts.⁸⁰

Minimum Creditable Coverage. Among its various responsibilities, the board was required to define minimum creditable coverage in order to set criteria for the development of new benefit plans to be offered through the Connector and to determine whether existing coverage of state residents can meet those criteria. After deliberations, the board determined the minimum creditable coverage as comprehensive benefits, including prescription drug coverage. Amid concerns that some residents would need to enhance their current coverage to meet the new standard, especially with regard to the prescription drug benefit, the board has

GROWING INTEREST IN CONNECTORS

The Commonwealth Health Insurance Connector is only one part of the Massachusetts 2006 comprehensive health care reform law, but it is a significant aspect that has sparked nationwide interest. Massachusetts legislators designed the Connector to improve the ease with which small employers and individuals may purchase affordable insurance. In addition, the Connector:

- reduces paperwork;
- provides for portability and pre-tax treatment of premiums; and
- combines subsidies or contributions from several sources.

Although the exact structure of the Massachusetts Connector may not succeed elsewhere, other states are closely watching the Connector's operation and hope to learn from the Massachusetts Connector experience to inform their own efforts to provide improved access for the uninsured.

States are interested in learning about both the history of the Connector and how it can address the access and market hurdles experienced by the uninsured. The Massachusetts Connector has its genesis in the health purchasing cooperatives of the early 1990s. Massachusetts based its Connector design on the Health Insurance Plan of California (HIPC). The HIPC, like other first-generation purchasing cooperatives, operated on the premise that small-employer pooling would result in greater market efficiencies and more competitive insurance premiums. The first-generation purchasing cooperatives, however, did not succeed in reducing either premiums or the number of uninsured residents. In fact, many of these cooperatives failed.

The Massachusetts Connector differs in several important respects from the early purchasing cooperative experiments.

- *Not a purchasing pool.* First, the Connector is not a purchasing pool but rather is an exchange and does not assume any risk for the insurance products it offers. Instead, participating insurers pool their Connector plan experience with their other small-group and non-group business, thereby offsetting potential risk-selection problems. As an exchange, the Connector is not responsible for negotiating better rates for its members compared to the outside private market.
- *Insurance market reforms.* The Massachusetts insurance market provides an important backdrop to the Connector's design. Among other reforms, the 2006 reform law merged the small-group and non-group insurance markets. In addition, the state's insurance markets had undergone significant reform in the past; today, Massachusetts' insurance market includes modified community-rating and guaranteed-issue requirements.

The Connector design has captured the interest of other states, partly because of its unique combination of insurance market reforms and premium subsidies. It is unlikely that a Connector-like structure on its own would solve the problems of the uninsured, although the Connector offers the potential for combining some of the elements required to meet the needs of the uninsured as part of a reform effort.

Adapted from Lischko A., "Health Insurance Connectors & Exchanges: A Primer for State Officials," State Coverage Initiatives, September 2007.

postponed enforcement of the coverage requirements until January 2009.

Affordability. For the board, tackling the issue of affordability has proven to be a difficult task: defining affordability impacts several components of the overall reforms including appropriate premiums for both subsidized (Commonwealth Care) and unsubsidized commercial plans (Commonwealth Choice), as well as to determine exemptions to the individual mandate. (For more details on affordability policy issues, see page 18).

First, the board determined the structure of subsidized premiums under Commonwealth Care varying them by income level and by health plan. In 2006, it set a sliding scale subsidy structure and member premiums ranging from a low of \$18 for individuals with annual incomes between 100.1 and 150 percent FPL, to a high of \$106 for individuals with annual incomes between 250 and 300 percent FPL. In early 2007, the board established a new premium structure; it eliminated premiums for individuals with incomes up to 150 percent FPL and provided additional subsidies to those with incomes between 151 and 200 percent FPL.

The development of the Commonwealth Choice plans was inextricably linked to the determination of the aforementioned minimum creditable coverage standards. It was the responsibility of the board to select the final plans for the Commonwealth Choice program that not only met the benefit standards but still remained affordable. Ten carriers submitted bids to the Connector in January 2007. Seven of these carriers received approval by the Board, and six of these carriers signed contracts with the Connector in March of 2007 in order to be offered through the Commonwealth Choice program. The lowest priced plan costs approximately \$175 per month (for ages 35-39) in the

most expensive eastern region of the state. The same plan will cost nearly \$20 less in other parts of the state.

In terms of affordability with respect to the individual mandate, the Board ultimately decided to permit some exemptions. “Health insurance is expensive,” states board member Jonathan Gruber, noting that for a family of four with an income of \$40,000 (200 percent FPL), health coverage would consume almost 30 percent of family income.⁸¹ Even with subsidized rates, the board recognized that coverage would remain prohibitive for some groups. As a result, the board established a series of exemptions that, according to Gruber, effectively resulted in an individual mandate for all young, single persons in the state “while exempting many older individuals and families with incomes between 300 percent of poverty and the state’s median income.”⁸² However, according to the board, approximately 1 to 2 percent of the population — about 60,000 individuals — could be eligible for the exemption. While this is not a small population, the state hopes that 98 to 99 percent of state residents will still have to comply with the mandate.⁸³ The ongoing experience in Massachusetts highlights not only the extent of the challenges associated with implementing a mandate but also the need to allow for exemptions based on affordability concerns.

Maine: Building on Dirigo Health 1.0

In 2003, Maine enacted its Dirigo Health Reform and set forth the ambitious goal of expanding coverage to the state’s estimated 124,000 uninsured residents by 2009. Implementation has not been without complications. Sustainability of the health coverage program, DirigoChoice, in particular, has been of great concern among those involved in promoting and implementing Dirigo.

■ *Geographic and demographic characteristics pose challenges.* In 2007, the *New York Times* examined these challenges, describing them as specific to Maine’s economic and demographic characteristics.⁸⁴ Maine has large rural, elderly, and low-income populations, many of who suffer from chronic health conditions. With many small and seasonal businesses, fewer employers offer health insurance than in other states. And with only a single major carrier (Anthem Blue Cross Blue Shield) offering individual coverage to Maine residents, the program has struggled to offer broad choices. Underlying health care cost growth remains a constant concern as well.

In September 2007, state health officials announced that they would not renew the state’s contract with Anthem; instead, Harvard Pilgrim Health Care, under a fully insured contract, will administer DirigoChoice beginning January 2008. Benefits and the size of the subsidies will not change under the state’s one-year renewable contract with Harvard Pilgrim, a nonprofit health insurer. Maine Governor John Baldacci expressed optimism that Harvard Pilgrim’s presence will encourage competition in the marketplace, thereby moving the state closer to providing affordable insurance for those without coverage.⁸⁵

■ *Controversial funding mechanism.* Financing for DirigoChoice combines a variety of funding streams including employer contributions, individual contributions, a one-time appropriation of state general funds, and federal Medicaid matching funds for Medicaid-eligible individuals. Most of the cost of DirigoChoice, however, is financed through a “savings offset payment (SOP),” which is based on savings

identified by the Dirigo Health reform, including savings associated with activities that reduce uncompensated care.⁸⁶ The state determines the savings offset payment annually through an adjudicated process based on “aggregate measurable cost savings.” Because the aggregate cost savings approved by the Superintendent of Insurance have been lower each year than expected, revenues available to fund subsidies under DirigoChoice have suffered. According to a recent evaluation of the Dirigo Health reforms, “[t]hough conceptually sound, the process for estimating aggregate measurable cost savings, which determine the SOP amount, was vulnerable to criticism about the validity of program impact estimates, many of which cannot be directly observed.”⁸⁷ In fact, the savings offset payment mechanism triggered a court challenge in which the financing mechanism was upheld; however, most stakeholders agree that an alternative funding source is necessary.⁸⁸

- *Voluntary enrollment and small-firm interest fall short.* The program has generated criticism for its disappointing enrollment, which reached a combined total of 28,000 in 2007 for the DirigoChoice program and Dirigo Health’s MaineCare companion plan for eligible parents. This enrollment level is modest when compared to the state’s estimated 124,000 uninsured residents. Furthermore, for low income residents, the fully subsidized Medicaid program has proven more attractive than the partially subsidized DirigoChoice plan. Nearly 80 percent of DirigoChoice members earn family income below 300 percent FPL, qualifying them for coverage subsidies, and 46 percent of all members earn income below 150 percent FPL, qualifying them for substantial discounts.

As of September 2006, the state had enrolled about 700 small firms in DirigoChoice, with an average firm size of seven employees; half of the firms had not previously offered their employees health care coverage. Nonetheless, these businesses represent only 2.5 percent of all eligible businesses, and survey results indicate that very small firms (two to three employees) find DirigoChoice unaffordable.⁸⁹ While the state’s enrollment experience falls far short of policymakers’ hopes for

universal coverage, enrollment totals are still substantial for a voluntary enrollment program. It is important to note, however, that 42 percent of DirigoChoice enrollees came in as individuals, and 28 percent as sole proprietors. While the enrollment experience points to the difficulty of relying on a voluntary approach to achieve universal coverage, the state explicitly chose a voluntary strategy initially recognizing that it would be inappropriate to mandate coverage

DIRIGO HEALTH 1.0: A PRIMER

Adopted in 2003, the Dirigo Health Reform Act sought to make affordable health care coverage available to all Maine residents by 2009. The state’s motto “Dirigo,” which means “I lead,” is a fitting moniker for the program; at the time, Maine was the first state since the early 1990s to enact comprehensive health care reform legislation.

Under Dirigo Health, the state implemented two major coverage initiatives: (1) MaineCare is a Medicaid eligibility expansion for parents of children under age 19 with incomes between 150 and 200 percent FPL; and (2) DirigoChoice, launched in 2005, is a subsidized health insurance program. As the centerpiece of Maine’s health coverage reforms, DirigoChoice is a public/private subsidized health cover-

age program that offers lower-cost plans to small businesses, the self-employed, and eligible individuals lacking access to employer-sponsored insurance. Employers cover up to 60 percent of coverage costs, with employees paying the balance. Residents with annual household incomes below 300 percent FPL qualify for premium subsidies on a sliding scale.



without having cost containment mechanisms in place and adequate resources for subsidies available.

- *Dirigo offers promising features.* Despite the challenges faced by Dirigo, several promising features of the program have emerged, including an effort to reduce hospital costs and improve management of chronic conditions. Maine's three largest health care systems are collaborating to make patients' electronic health records accessible across the three systems, share information about critically ill patients in rural hospitals, and launch preventive health programs for chronic conditions such as obesity and substance abuse, with the aim of reducing high-cost medical interventions.⁹⁰ The state's reform initiatives also created an institutionalized organization—Dirigo Health's Maine Quality Forum—to promote improved quality of care. The Forum is both a clearinghouse of best practices and information to improve health and a health care information resource for providers and consumers. For example, the Forum recently undertook a campaign to raise awareness of heart attack symptoms in response to a state survey showing that the majority of Mainers cannot correctly identify heart attack warning signs.

In early 2007, Governor Baldacci announced new plans for Dirigo Health Reform and termed the initiative Dirigo Health 2.0. In June 2007, he signed into law a bill authorizing Maine's Dirigo Health program to self-insure, in an effort to make the program more affordable for small businesses and uninsured individuals. Enactment of the law does not mean the state program will immediately self-insure, but it is "another very important tool in the tool box," according to Trish Riley, director of the Governor's Office of Health Policy and Finance.⁹¹ The state plans to contract with Harvard Pilgrim Health Care on a fully-insured basis for the time being.

Dirigo 2.0 envisioned shifting the problematic savings offset payment to a surcharge imposed on hospital bills and calls for other reforms, including:

- Allowing the savings offset payment to continue for a transition year and extending the current 2 percent premium tax on insurers to HMOs.
- An employer requirement in 2008 and individual mandate in 2009 for those with income over 400 percent FPL.
- A new requirement that insurance companies must alter benefit packages and cost-sharing.
- An increase in the required medical loss ratio from 75 to 78 percent in the small-group market; those failing to reach the new threshold must refund excess premium amounts to policyholders.
- A new Maine Individual Reinsurance Program that will reinsure all insurance companies offering coverage in the individual market; the program will be funded primarily by a premium tax imposed on all insurance companies in the state.
- Reduction of employer requirements for participation in DirigoChoice.⁹²
- Implementation of clinical care management and managed behavioral health in the MaineCare program.
- Premium discounts for individuals who do not smoke and for small and large businesses that provide approved worksite wellness programs.
- A focus on primary care in the state health plan to improve health/reduce costs.
- Healthy ME Rewards to provide incentives for the previously uninsured to choose a physician and complete health risk assessments.

Unfortunately, the legislature failed to take action on these reforms in 2007, leaving the state with a significant budget shortfall for Dirigo and no changes to Dirigo's program components.⁹³ The 2008 legislative session will again address Dirigo

funding, particularly the fate of the savings offset payment and the challenge of finding agreement on alternative funding mechanisms.

Vermont: Catamount Health Enrollment Underway

In 2005, even as more than 60,000 Vermonters lacked health insurance, the number continued to grow. Half the state's uninsured were eligible for but had not enrolled in state-subsidized programs such as Medicaid. More than two-thirds of the state's uninsured residents lacked insurance for more than a year, and more than three-quarters reported cost as the main reason for their uninsured status.⁹⁴

In 2006, the Vermont Legislature and Governor Jim Douglas responded to these problems by reaching agreement on a series of reforms that aim to achieve near-universal coverage by 2010. The new Catamount Health program is at the center of these reforms, offering a non-group insurance product for uninsured Vermont residents.

The state began enrollment in the Catamount Health plan for eligible Vermonters in October 2007. During the first two months of enrollment, the state fielded 8,400 calls, and the state's health care coverage information Web site recorded nearly 300,000 hits. As of late December 2007, the state had approved more than 2,800 applications and enrolled more than 700 individuals, well on the way to the 4,245 estimated for the first nine months of implementation. Another 300 people have already been given assistance to enroll in their employer's plan, almost 50 percent of the projection for the first year.

Supporters and critics alike are closely watching the state's outreach efforts and the viability of a benefits package that some observers view as too generous. The full cost monthly premium of \$393

VERMONT HEALTH CARE REFORM: AN OVERVIEW

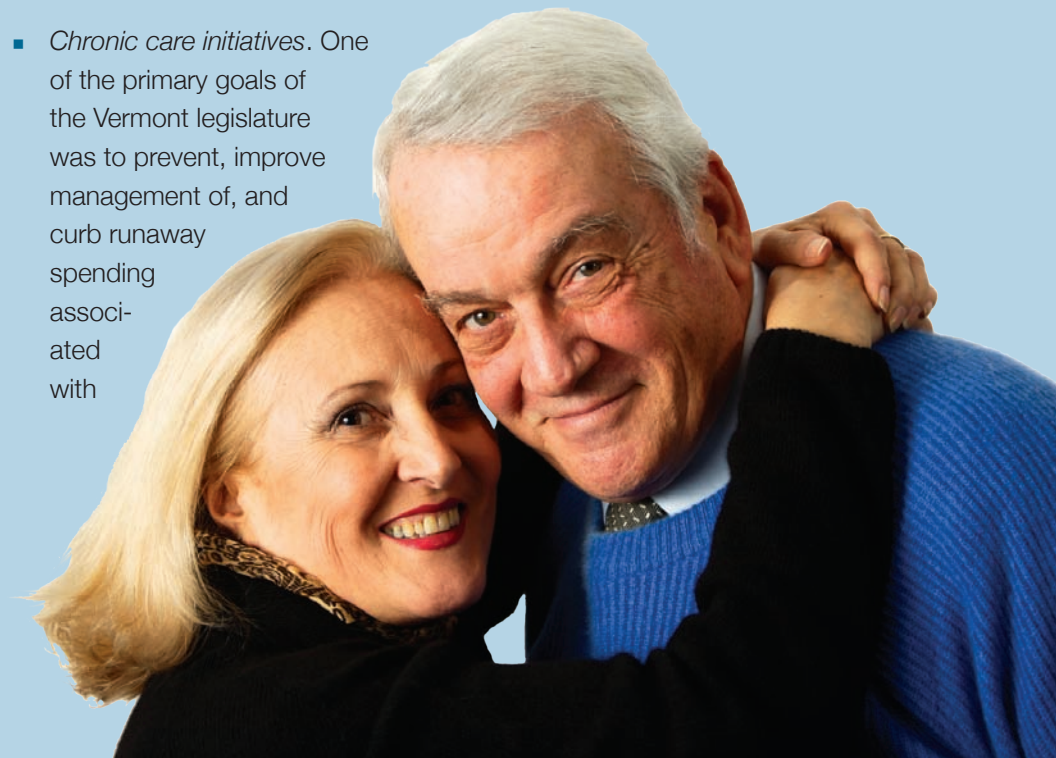
Catamount Health is a preferred provider organization plan offered by two insurers. Residents choose the insurer with which they would like to sign up; both offer a comprehensive benefits package that includes prescription benefits. Vermont residents may purchase Catamount Health if they are uninsured, over age 18, and not eligible for an employer-sponsored insurance plan. Under certain circumstances, residents eligible for their employer-sponsored insurance and with income under 300 percent FPL may purchase Catamount Health.

- *Premium subsidy for low-income uninsured individuals.* A far-reaching health reform initiative, Catamount Health includes a premium assistance product as well as several chronic condition management initiatives. The state's Premium Assistance Program substantially reduces the cost of coverage by offering assistance to individuals whose family income is below 300 percent FPL, including those who have access to employer-sponsored insurance. Premiums are income-based: individuals with family income less than 200 percent FPL pay \$60 per month while those with income between 275 and 300 percent FPL pay \$135 per month. The state provides this premium assistance for the uninsured individual to either enroll in the new Catamount Health Plan or to enroll in their employer's insurance plan, depending on which is more cost-effective to the state. They are also using this mechanism to move current and new Vermont Health

Access Plan enrollees (the Medicaid expansion program that covers adults to 150 percent FPL and adults with children to 185 percent FPL) into their employer's insurance plan, as part of the funding sustainability mechanism for the health care reform programs.

- *Annual employer contribution.* Catamount Health requires employers who do not currently contribute to their employees' health care premiums to help pay for program costs. Employers are assessed \$365 annually for each uncovered full-time equivalent if the employer does not offer coverage or offers coverage only to some employees or if some workers remain uninsured. All businesses with nine or more uninsured full-time equivalents in 2007 and businesses with five or more uninsured full-time equivalents in 2010 must make employer contributions.
- *Chronic care initiatives.* One of the primary goals of the Vermont legislature was to prevent, improve management of, and curb runaway spending associated with

chronic diseases. An estimated 50 percent of Vermonters with chronic conditions account for 70 percent of health care spending in the state, but only 55 percent obtain appropriate care at the right time.⁹⁵ In response, the law endorsed implementation of a statewide program to prevent and manage chronic conditions, based on the pilot Blueprint for Health, launched in 2003. The goal of the Blueprint is to have a standardized system of care for the treatment of chronic conditions across all providers and public and private payers in the state by 2011. Under the Vermont reforms, Medicaid, Catamount Health plans, and the state employee health plan must contract for chronic care management that is aligned with the Blueprint approach. The use of health information technology is a cornerstone of this initiative's effort to improve quality.



is more than 20 percent higher than the original \$320 projected by the legislature, raising the specter of higher-than-planned program costs. Nevertheless, the Governor and key legislators agreed to use state general funds to implement the program as planned, even though they received an unexpected decision by the Centers for Medicare and Medicaid Services (CMS) in August to only provide federal support for premium assistance up to 200 percent FPL.

Policymakers are also closely monitoring the impact of Catamount's eligibility rules and whether the program includes sufficient protections to discourage the crowding out of employer-based insurance.⁹⁸ In addition, the state began implementation of an employer assessment in April 2007. As of October 2007, the state had collected 78 percent of estimated first-quarter revenues, but hundreds of employers had not yet completed the necessary paperwork.⁹⁶

The state's Blueprint for Health (see page 33) is currently implementing:

- early screening for diabetes, asthma, and other chronic conditions;
- care coordination teams that interface with the provider and patient;
- provider reimbursement that encourages care management;
- information technology tools to provide medical information to better coordinate care; and
- education for both providers and patients on patient self-management tools.

While the Blueprint for Health is reportedly having a positive impact in many communities, uncertainty remains as to the potential of these chronic care programs to impact overall costs associated with health care in the state.^{97, 98}

COMPREHENSIVE PROPOSALS: MOMENTUM CONTINUES TO BUILD

While Massachusetts, Maine, and Vermont continue to implement their reforms, observers are following new proposals for comprehensive reform from a handful of states, including California, Pennsylvania, and New Mexico. Not surprisingly, some of these proposed reforms have prompted significant debate.

California: Debate on Comprehensive Reform Plan

In January 2007, California's Governor Arnold Schwarzenegger announced his vision for creating "an accessible, efficient, and affordable health care system." The governor's plan was based on many of the elements included in other state reforms such as those in Massachusetts and Vermont. His reform plan offers three cornerstones: (1) prevention, health promotion, and wellness (see page 48 for more details); (2) coverage for all Californians; and (3) affordability and cost containment.

The governor's proposal to achieve universal coverage for California's 6.8 million uninsured residents emphasized shared responsibility with an individual mandate to obtain and maintain coverage, employer financing requirements, provider fees, guaranteed issuance of all insurance products, consumer contributions, and an expansion of public programs.

While the governor's plan received much media and policymaker attention during the legislative session, the session adjourned in fall 2007 before any action was taken on the proposal. Following the close of the state's legislative session, the governor called the legislature into "special session" to address health care reform and released an update of his reform plan. In early November, California's legislative leaders (Nunez, Perata) introduced AB X1 1; a compromise measure that builds on many

of the concepts in the Governor's proposal. In mid-December, the California Assembly approved AB X1 1. The bill is pending review by the State Senate. The Senate leader delayed action on the bill and called for an independent review of the financing of the plan and its impact on the overall state budget. That analysis is expected to be issued in January.

California law requires a two-thirds vote by the legislature to establish new fees or taxes. Given that Republican members of California's legislature are opposed to the imposition of new fees/taxes, and their votes are needed to achieve a two-thirds majority, the financing for the reform plan must be approved through a statewide initiative. The initiative requires collection of signatures to be placed on the ballot and is expected to be on the ballot in November 2008.

AB X1 1 includes:

- *Individual mandate, benefit design, and subsidies.* The proposal requires all individuals to have insurance coverage; the definition of coverage adequate to fulfill the mandate will be determined by the Managed Risk Medical Insurance Board (MRMIB). Persons with incomes under 250 percent FPL whose premiums exceed 5 percent of income are exempt from the mandate. Hardship and other exemptions to the mandate would be defined by MRMIB. The state would subsidize coverage for adults with annual income at or below 250 percent FPL. All children up to 300 percent FPL would be eligible for subsidies. No premiums would be charged for persons receiving subsidized coverage with income below 150 percent FPL. Lower-income workers with incomes between 250-400 percent FPL who do not qualify for subsidized coverage but whose health insurance premiums for a minimum benefit plan exceed 5 percent of family income would receive a tax credit.

- *Financing.* The financing for the proposal will be carried in a ballot initiative. On Dec 29, 2007, the initiative was filed with the State Attorney General (AG) for review. After the initiative receives a “Title and Summary” from the AG, signature gathering will begin. If proponents gather and submit 694,354 valid signatures by April 21, 2008, the initiative will appear on the November 2008 statewide ballot. Financing would be derived from several sources. Employers who do not provide health coverage to their employees would be subject to a 1 to 6.5 percent health care contribution fee based on the size of the employer’s payroll; tobacco taxes would be raised by \$1.75 per pack; hospitals would pay a fee of 4 percent of revenue; and county governments would contribute up to \$1 billion. Over \$4 billion in federal Medicaid funds will augment state revenues to finance the plan.

- *Cost containment.* As with the Massachusetts reforms, the plan envisions a requirement that employers establish Section 125 plans to permit some tax savings for both employers and their employees. Individuals would also be able to make pre-tax contributions to HSAs. The state intends to work with both providers and insurers to improve efficiency and reduce overall health care costs. In addition, like Vermont, the reform proposal emphasizes implementation of health information technology and goes even further, stipulating a goal of achieving 100 percent electronic health data exchange in the next 10 years. It also looks to increase Medi-Cal reimbursement rates to reduce cost-shifting and what has been referred to as the ‘hidden tax’ on private payers, and to impose an 85 percent medical loss ratio requirement on health plans.

- *Health insurance carriers and plans.* The reform imposes new rules on insurers, requiring them to guarantee issue coverage to any Californians who are subject to the mandate, regardless of pre-existing conditions.

The California climate appears ripe for reform, with 69 percent of California residents believing that reforms are needed and 72 percent favoring Governor Schwarzenegger’s proposal.⁹⁹

If AB X1 1 bill passes, and voters approve the financing for the plan in November 2008, it will be the largest expansion of coverage since the creation of Medicaid and Medicare, extending health coverage to approximately four million uninsured Californians.

Pennsylvania: Promoting Health and Containing Costs

Like California, Pennsylvania is debating an ambitious coverage expansion combined with programs to improve health care systems and promote healthy behaviors. In early 2007, Pennsylvania Governor Ed Rendell unveiled his Prescription for Pennsylvania to increase access to affordable health care coverage for all Pennsylvanians, improve the quality of care available in the state, and bring health care costs under control for employers and employees. The governor will consider an individual mandate if the number of uninsured Pennsylvania residents does not significantly decline over the next few years.

- *Cover All Kids.* In October 2006, the General Assembly passed legislation requested by the Governor to provide affordable health care coverage available to all children. In February 2007, Pennsylvania received federal approval of their state plan amendment to subsidize premiums for children in families with incomes at or below 300 percent FPL.

- *Student health coverage.* The “prescription” would require full-time students attending four-year colleges and universities to have health care coverage.

- *Cover All Pennsylvanians.* To increase coverage for the uninsured, the governor proposed an initiative entitled Cover All Pennsylvanians (CAP) that would assist uninsured adults and small businesses in obtaining basic coverage through private insurers. As a new health insurance product, CAP would be delivered through the private market and provide a new option for the uninsured. Businesses would qualify for CAP if they have not offered health insurance to their employees in the past six months, if they have 50 or fewer employees, and if, on average, those employees earn less than the state’s average annual wage. These low-wage businesses may participate in CAP if they enroll at least 75 percent of all employees who work over a specified number of hours per week and pay 50 percent of enrolled employees’ discounted premium. Businesses that join the program would pay approximately \$130 per worker per month, and employees would pay on a sliding scale, ranging from \$0 to \$70 per month depending on income, with state and federal monies subsidizing the balance of the premium. Uninsured self-employed and other uninsured individuals would be eligible to enroll individually in CAP if they meet a “go bare” period requirement.

Uninsured adults earning less than 300 percent FPL and employees of eligible small businesses would receive assistance in the form of discounts and subsidies to help pay their CAP premiums. Uninsured adults earning more than 300 percent FPL could participate in CAP by paying the full cost of the premium, approximately

\$280 per month. The Governor has identified several potential funding sources to finance CAP, including a fair-share assessment on employers who do not offer health insurance to their employees, an increase in the cigarette tax, federal matching funds, utilizing the surplus funds in the Health Care Providers Retention Account,¹⁰⁰ and redirected existing health care dollars. The Governor's proposed coverage expansion program has been introduced in both chambers of the General Assembly.

At the time this report went to print, Governor Rendell, with the support of several legislators, called for the legislature to enact the CAP by February 14, 2008.

- *Systems improvements.* Like the New England states and California, Pennsylvania's proposed reforms incorporate several initiatives aimed at systems improvements and cost containment. Initiatives include a requirement that hospitals work to prevent hospital-acquired infections and adopt an error reduction system and interoperable electronic medical records. The state is also attempting to realign payments to reward the effective prevention and treatment of chronic conditions as well as wellness efforts and more efficient quality care. Additional measures include the provision of integrated treatment to those needing both mental health and substance abuse services and an initiative to provide consumers with real-time price and quality information. The state also proposed to impose a smoking ban on all workplaces, restaurants, and bars.

Several incremental bills were enacted in 2007, including an assisted living facility licensing and oversight law; a comprehensive hospital-acquired

infection control law; several laws that expand the scope of practice for nurses and dental hygienists to encourage an improved team approach to health care; and expansion of the subsidized school breakfast program, wellness mobiles, and seed money for new federal qualified health centers (FQHCs) and nurse-managed centers.

New Mexico: Governor Unveils Universal Coverage Proposal

At the end of October, Governor Bill Richardson unveiled a comprehensive reform blueprint to provide all New Mexicans with health insurance coverage and to redesign the way health care is delivered in the state. Under Richardson's HealthSOLUTIONS New Mexico proposal, state residents would be required to purchase coverage. Those residents who meet income qualifications would be eligible for lower cost state-subsidized plans. The plan would require employers to contribute to a "Healthy New Mexico Workforce Fund" to help fund the proposal, with employers receiving a dollar-for-dollar offset if already contributing toward their employees' health coverage. Other aspects of the proposal include:

- *Insurance reforms.* Governor Richardson's proposal would require an 85 percent medical loss ratio for insurance carriers, guaranteed issue with no exclusion of pre-existing conditions, limiting the rating bands in the small group market, increased transparency and accountability through common data reporting requirements, a moratorium placed on new insurance benefit mandates through 2010, and allowing Indian Health Services and tribal providers to be part of a carrier's provider network.
- *Electronic health transactions and information.* HealthSOLUTIONS New

Mexico would encourage the uptake of medical information technology by requiring electronic claims submission, developing a plan requiring the use and exchange of electronic medical records, and protecting patient privacy and right to information.

- *Health coverage authority.* The proposal would create a single point of accountability for data, analysis, plan management, and policy to increase coverage and access, and control costs.
- *Evaluation.* As an important element to assure accountability, Governor Richardson's proposal calls for implementing an evaluation component to determine that policies and structures are meeting defined goals.

As part of his proposal, the governor signed an executive order that will require contractors doing business with the State to demonstrate that they offer health coverage when working in New Mexico. The order will go into effect in July 2008 and be phased in over three years.

Undocumented immigrants and some legal immigrants who have been in the U.S. for less than five years would not be eligible for coverage under the Medicaid components of the plan due to federal restrictions. Governor Richardson will ask the state legislature to consider his proposal in 2008.

SUBSTANTIAL REFORMS ENACTED

In 2007, several states moved forward with substantial reforms that not only expanded public coverage programs but also called for private sector reforms, including insurance market reforms, subsidized coverage, and new purchasing mechanisms. Many states are also enacting reforms with ambitious systems improvement goals, including cost

containment, improved quality, better management of chronic conditions, and faster implementation of new health information technologies.

Washington: Building a High-Performing System

In pursuit of expanded coverage and improved quality of care for its residents, Washington enacted significant health reform legislation in 2007. The law mirrors certain features of the comprehensive reforms implemented by other states, particularly Massachusetts, while pursuing systems improvements and wellness programs similar to those proposed by California and Pennsylvania.

- *Covering all kids by 2010.* Governor Chris Gregoire signed legislation to provide access to coverage for all children in the state by 2010. The law authorizes funding for intensive education, outreach, and administrative simplification in order to ensure the enrollment of all currently eligible children, who now account for over one-half of Washington's uninsured children. Beginning in January 2009, the law authorizes an expansion of the state's SCHIP program to children in families with incomes up to 300 percent FPL; the current eligibility level is 250 percent FPL. In addition, children in families with incomes above 300 percent FPL will have access to SCHIP at full cost. Premiums would apply to children above 200 percent FPL. The law also includes, if cost-effective, a premium assistance program for families with access to employer-sponsored insurance.
- *Massachusetts-style Connector.* The governor also signed legislation creating the Washington Health Insurance Partnership (HIP), a Massachusetts-style Connector. The HIP increases the

opportunity for small employers (2-50 employees) to offer affordable health insurance to low-income workers. For a small employer to designate the HIP as its health benefits administrator, the employer must have at least one eligible employee (a Washington resident earning less than 200 percent FPL) and set up a Section 125 cafeteria plan. If a small employer meets these two conditions, all employees regardless of income may purchase coverage through the HIP and maintain that coverage even after leaving employment. The law establishes sliding-scale premium subsidies for individuals earning up to 200 percent FPL based on gross family income. The state is studying the feasibility of expanding the HIP to incorporate additional markets — such as the individual market and public programs.

- *Promoting healthy behavior, quality health care and cost-containment.* The law incorporates many recommendations to help make health care accessible and affordable that emanated from the Washington Blue Ribbon Commission on Health Care Costs and Access.¹⁰¹ Recommendations include: a health promotion program for state employees; a health information technology collaborative including grants to expand the use of IT in medical offices; provisions for expanding chronic care management, evidence-based health technology assessment and piloting pay-for-performance in state health programs; a quality forum to promote evidence-based practices and improve transparency of cost and quality information for consumers; reducing unnecessary emergency room utilization; a health opportunity account demonstration for Transitional Medicaid; a demonstration of patient decision aids for shared decision

making; and assessing the feasibility of publicly-funded reinsurance as an approach to address affordability of coverage for high-cost individuals.

Oregon: A Timeline for Full-Scale Reform

In June 2007, Governor Ted Kulongoski signed the Healthy Oregon Act, providing a detailed timeline for developing recommendations for full-scale health reform for consideration during the 2009 legislative session. The legislation provides a framework for the state's reform approach, promising a state health care system that is "affordable, effective, and universal."¹⁰² Legislators envision a system that will control costs and address quality through bulk purchasing, evidence-based practices, implementation of electronic records and other technologies, improved management of chronic conditions, and introduction of market incentives.

- *Establishment of Oregon Health Fund Board.* Appointed by the governor and confirmed by the Senate, the seven-member Oregon Health Fund Board—made up of experts in areas of consumer advocacy, management, finance, labor, and health care—is charged with developing a comprehensive reform and implementation plan. Five subcommittees will make recommendations on financing, delivery system reform, benefit definition, eligibility and enrollment, and federal policy issues and opportunities. In addition, existing state commissions and committees are charged with compiling data and conducting research to inform the subcommittees' decision making.
- *Recommendations for 2009 legislative session.* The various state commissions and committees are to report their findings to the subcommittees by February 1, 2008. Through a public

TABLE 3 ENROLLMENT EXPERIENCE OF SELECT STATE COVERAGE PROGRAMS

For additional information on these programs and other state initiatives, visit www.statecoverage.net/matrix/index.htm

| Target Population | Program (start date) | Eligibility | Enrollment Fall 2007 Updates (individuals) |
|---|---|--|--|
| Small Business (may include workers without access to employer-sponsored insurance) | CoverTN (2007) | Businesses must have less than 25 employees with 50 percent earning \$43,000 a year or less. The plan is available for businesses who have not offered insurance for six consecutive months, or if offered, the employer has not paid 50 percent or more of the premiums. The plan must be offered to all employees. | 12,800 |
| | ARHealthNet (2006) | Employers with 2-500 employees who have not offered a health plan to employees within the past twelve months. At least one employee must qualify for subsidized premiums and have a household income at or below 200 percent FPL, and all employees must participate in the program or provide documentation of coverage. | 2,000 |
| | Insure Montana (2006) | Previously uninsured firms (2-9 employees) that have not offered insurance for 24 months and have no employees who earn more than \$75,000 per year. For employers of small businesses with 2-9 employees offering health plans, a tax credit of up to 50 percent of paid premiums is available. | 5,500 5,000 |
| | 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 past 12 months. | 10,200 |
| | Insure Oklahoma (Previously known as O-EPIC) (2005) | Workers and their spouses, who work in firms with 50 or fewer workers and contribute up to 15 percent of premium costs; self-employed; unemployed individuals currently seeking work; and individuals whose employers do not offer health coverage with household incomes at or below 200 percent FPL. Small employers must contribute at least 25 percent of eligible employee's premium costs and offer an Insure Oklahoma-qualified health plan. | 4,300 |
| | West Virginia Small Business Plan (2005) | Small businesses (2–50 employees) that have not offered health benefit coverage to their employees during the preceding 12 months. Employers must pay at least 50 percent of the premium cost. | 1,500 |
| | Healthy New York (2001) | Small employers that have previously not offered insurance and with 30 percent of workers earning 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. | 150,000 |
| | Arizona Health Care 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. | 26,000 |

| Target Population | Program (start date) | Eligibility | Enrollment Fall 2007 Updates (individuals) |
|---------------------|--|--|--|
| Low-Income Adults | Maryland Primary Adult Care (2006) | Individuals below 116 percent FPL. | 27,500 |
| | Utah Primary Care Network (2002) | Adults below 150 percent FPL. | 17,500 |
| | District of Columbia Alliance (2001) | Uninsured individuals with family incomes below 200 percent FPL. | 49,000 |
| | Pennsylvania adultBasic (2001) | Adults with incomes up to 200 percent FPL who have been without health insurance for 90 days prior to enrollment. | 52,200 |
| | Minnesota Care (1992) | Families with children up to 275 percent FPL under Medicaid and childless adults up to 175 percent FPL. | 128,700 |
| | Washington Basic Health (1988) | Individuals with family incomes below 200 percent FPL. | 124,700 |
| Comprehensive Plans | Massachusetts Commonwealth Care (2007) | Individuals with incomes below 300 percent FPL. | 160,000 |
| | Massachusetts Commonwealth Choice (2007) | All residents, but specifically geared to those above 300 percent FPL. | 10,200 |
| | Vermont Catamount Health (2007) | Residents 18 or older who have been uninsured for at least 12 months, do not have access to employer-sponsored health insurance, and do not qualify for public programs. | 700 |
| | Maine DirigoChoice (2005) | Small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance and with incomes below 300 percent FPL. | 28,000 |

meeting process, stakeholders across the state will review the subcommittee recommendations and provide comments. The governor and legislature will then receive the final plan by October 1, 2008, for introduction in the 2009 legislative session.

- *Failure of Ballot Measure 50.* In 2006, Governor Kulongoski proposed a plan to cover more than 10,000 uninsured children through an expansion of the Oregon Health Plan combined with a private purchasing arrangement for higher-income children. Under the Healthy Kids initiative, the Oregon Health Plan would cover all children with family income under 200 percent

FPL. A premium subsidy program would offer financial assistance to children with family income up to 300 percent FPL. Under Measure 50, the state sought voter support for an increase in the state cigarette tax of 84.5 cents per pack to fund the initiative. The proposal was put on the ballot after Democratic legislators failed to win sufficient Republican support for the tax. In “the most expensive political campaign in Oregon history,” voters soundly defeated the proposed tobacco tax increase by a 3-to-2 margin.¹⁰³ The defeat returns the issue to the governor and state legislators, who will need to find other means to fund the proposal.

Illinois: Governor Pursues Expansions

Following the success of his All Kids initiative, Governor Rod Blagojevich announced a comprehensive coverage initiative called “Illinois Covered” in his 2007 budget address to the legislature. The plan envisioned providing access to affordable coverage to all Illinoisans. Key provisions include:

- Expanded access to childless adults with incomes up to 100 percent FPL;
- Required all managed care plans to offer a state-reinsured, modified community-rated insurance product to individuals without access to employer-sponsored insurance and to small businesses (25 or fewer employees) that contribute at least

AUTO-ENROLLMENT: A PROMISING STRATEGY

Offering health care insurance subsidies and conducting extensive outreach are not sufficient to ensure that eligible but uninsured individuals will enroll in state programs designed to improve their access to health care coverage. States must pay careful attention to enrollment mechanisms; slow uptake can undermine new programs. Without successful enrollment, states will jeopardize the fundamental objective of their health care reform efforts: improved access to health care for uninsured residents.

Auto-enrollment is a promising strategy to ensure that as many eligible individuals as possible take part in states’ coverage programs. The term auto-enrollment refers to a strategy by which eligible but uninsured individuals receive coverage based on information already available to state officials without the burden of completing a formal ap-

plication. Auto-enrollment strategies have been highly successful in both public and private benefit programs, including retirement savings plans, Medicare Part D, and the National School Lunch Program.

Massachusetts experienced early success with automatic enrollment. Commonwealth Care’s Connector automatically enrolls eligible adults in a health plan if they do not select a plan. Enrollees then have up to 60 days to switch health plans. The state has experienced stronger-than-expected enrollment in the program.

Automatic enrollment approaches offer three important functions: identifying the uninsured, checking their eligibility, and enrolling them for coverage. Most important, states can use existing data sources on income and coverage to identify uninsured residents who qualify for

coverage programs and then enroll them, unless they opt out. Automatic enrollment is a relatively new strategy for ensuring the success of state coverage expansions. Closely managing the details of such strategies is critical to their success. States will need to provide strong safeguards that ensure their enrollment systems’ privacy and data security. They will also need to be creative in maximizing federal matching funds to invest in the information technology needed to maintain the systems. Finally, states must undertake thorough testing of their information systems before the implementation of enrollment. Despite these challenges, automatic enrollment could be an important, and often overlooked, potential component of states’ health reform initiatives.

Adapted from Dorn S., Automatic Enrollment Strategies: Helping State Coverage Expansions Achieve Their Goals, State Coverage Initiatives, August 2007.

the minimum required percentage of the premium;

- Increased the eligibility level for parents in the existing FamilyCare program (SCHIP) from 185 to 400 percent FPL;
- Allowed dependents to have access to insurance through their parent's policy until their 30th birthday; and
- Contributed to delivery system improvement and cost containment strategies.

Unfortunately, after four months of negotiations with the state legislature, agreement was not reached. In August 2007, the Governor announced that his administration would use its executive authority to pursue changes aimed at increasing access to health care for thousands of uninsured residents. Legislators have questioned the availability of funding for the program.

The health care initiatives that will be implemented through executive authority include:

- An expansion of the existing breast and cervical cancer program to meet the needs of uninsured women, regardless of income. The expansion provides access to free screenings for breast and cervical cancer to all uninsured women in Illinois. For those who are diagnosed, treatment coverage is provided through the state Medicaid program. The program began enrolling women in October 2007.
- An expansion of the state's FamilyCare program for uninsured parents and caretakers of SCHIP-eligible children under age 19, who have been uninsured for 12 months and have family incomes up to 400 percent FPL. Enrollment for this expansion population began in mid-November 2007.
- An expansion of the Illinois Comprehensive Insurance Program

(ICHIP), the state's high-risk pool, to include children with pre-existing conditions who are aging out of the All Kids program. The state will subsidize their ICHIP premiums up to age 21.

- Establishment of a new program that will provide access to a medical home, through a community health center, to residents with incomes under 100 percent FPL who are uninsured and not Medicaid-eligible. The program will also provide a prescription drug benefit and non-elective inpatient hospital care.
- Establishment of a new premium assistance program aimed at providing relief for middle-income families struggling with rising insurance premiums. The program will provide annual subsidies up to 20 percent of the cost of group health insurance premiums up to \$1000 for families at or below 300 percent FPL.

Indiana: Healthy Indiana Plan

In mid-December 2007, CMS announced the approval of the Healthy Indiana Plan (HIP), an 1115 waiver demonstration project. HIP will be available to uninsured adults between 22 and 200 percent FPL who are not eligible for Medicaid.

A key aspect of HIP is that it utilizes the HSA model combined with comprehensive insurance coverage above the deductible. Individuals will annually receive \$500 of pre-deductible, free preventive care and have a \$1,100 deductible.

The deductible is paid for through a POWER (Personal Wellness Responsibility) Account established in the individual's name. The account will contain the monthly contributions made by participants in addition to a state contribution for a combined total of \$1,100 per adult, which covers the cost of the deductible. The state's contribution

will vary according to a sliding scale based on a participant's financial ability to contribute to the account. The state will subsidize the account to ensure there is a total of \$1,100 per adult in the account. Participants will contribute no more than 5 percent of their gross family income, and will not have any cost-sharing once the deductible is met. At the end of the year, the balance of the POWER account will roll-over to reduce the following year's required contribution, if the participant has received their age-, gender- and disease-specific preventative services. If they have not received these services, only their own pro-rated contribution to the POWER account will roll-over but the state's contribution will be returned to the state. This design is intended to create an incentive for recipients to utilize services in a cost-conscious manner.

Covered services include physician services, prescription drugs, diagnostic exams, disease management, home health services, inpatient and outpatient hospital services, and mental health parity. Individuals may elect to purchase an optional dental and vision rider. They must pay 50 percent of the cost of the premium which is in addition to their contribution to the POWER account. There is a \$300,000 annual limit on coverage and a life-time benefit limit of \$1,000,000. All recipients must be uninsured for at least six months, be a U.S. citizen, and not have access to employer-sponsored insurance.

Maryland: Assisting Small Business and Expanding Medicaid for Adults

On November 19, 2007, Governor Martin O'Malley signed the Working Families and Small Business Health Coverage Act that will offer subsidies to small businesses to offset the cost of providing coverage to employees and expand Medicaid eligibility to certain adult populations. Provisions included in the new law include:

UPDATE ON ERISA COURT DECISIONS

Following two court decisions in 2007, the federal Employee Retirement Income Security Act of 1974 (ERISA) continues to complicate the states' ability to include employers in efforts to reform health coverage financing.

ERISA imposes obstacles on such state health reform efforts through a broad provision that pre-empts state laws that "relate to" private sector employer-sponsored pension and fringe benefits, including health insurance. Congress's objective in enacting the pre-emption clause was to permit employers to sponsor nationally uniform employee benefit plans. As the final arbiter of the meaning of the pre-emption clause, the U.S. Supreme Court has held that a state law relates to employer-sponsored plans if it either refers to such plans or substantially affects their benefits, administration, or structure. For example, courts held that ERISA pre-empted Hawaii's 1974 requirement that employers offer and pay part of the cost of employee health benefits (until Congress amended ERISA in 1983 to authorize the Hawaii law).

An important exception to the Supreme Court's broad reading of the pre-emption clause was the 1995 *Travelers Insurance* decision.¹⁰⁴ In that case, the Court held that ERISA did not pre-empt a state hospital rate-setting law that was not directed at employer-sponsored plans even though the law had an impact on such plans by raising the costs of hospitalization for plans purchasing coverage from commercial insurers (but not from Blue Cross). The Court reasoned first that, as a long-standing area of state authority, hospital rate-setting was not presumed eligible for a congressional override. Then, the Court held that, despite raising the cost of buying commercial insurance, the state law did not compromise an employer-sponsored

plan's ability to choose which insurance to purchase. The reasoning in *Travelers* can be used to defend some types of state laws that require employers to pay a tax or fee to support public health coverage programs if the state allows employers to choose to spend the threshold amount on employee health benefits—a "pay-or-play" approach to health coverage financing.

RECENT PRE-EMPTION DECISIONS

In 2007, two federal courts held that ERISA pre-empts some versions of pay-or-play laws enacted by the state of Maryland and by Suffolk County, New York. The 4th Circuit Court of Appeals held in January that ERISA pre-empts the 2006 Maryland Fair Share Act, affirming a July 2006 decision by the Maryland federal district court.¹⁰⁵ The Maryland law required private employers with at least 10,000 employees to spend at least 8 percent of their payroll (or 6 percent for nonprofit employers) on a broadly defined set of health benefits or pay the difference to help fund the state's Medicaid program.

Basing its decision on the bill sponsors' statements and the practical impact of the law, the Court of Appeals held that the purpose of the law was to force Wal-Mart (the only employer subject to the law that did not meet the threshold) to expand its existing ERISA health insurance plan and to maintain records on employee health spending in the state. The court found that the law would interfere with uniform national administration of the employer's health benefits in conflict with the objective of the pre-emption clause, citing several similar proposals in other states and localities. In contrast to the indirect effect of state laws such as hospital rate-setting at issue in the *Travelers* decision, the Court of Appeals said that the Maryland law attempted directly to regulate the structure of employer health plans. Based on the

testimony of Wal-Mart officials, the Court held that the law was not designed to raise revenue for the state but was a penalty designed to give the employer an "irresistible incentive" to increase employee health care spending. One of the three appellate judges would have upheld the law on the grounds that financing Medicaid is an area of traditional state authority and that the law gave the employer an opportunity to pay a fee to the state.

Following the Court of Appeals decision in Maryland, the federal district court for the Eastern District of New York held in July 2007 that ERISA pre-empted a county ordinance with a similar objective. The 2006 Suffolk County law would have required large retail stores with a certain amount of grocery revenues or floor area devoted to selling groceries to make health care expenditures for employees at a rate that approximates the cost to the county's public health system of uninsured workers or to pay the difference to the county.¹⁰⁶ The ordinance's objective was to protect smaller retailers that offer health benefits from unfair competition from larger retailers with either no or limited employee health coverage.

While the law affected many large retailers, local legislators noted that Wal-Mart was one target. Although the ordinance differed from the Maryland law (applying to more firms and calculating the assessment differently), the federal district court held that the laws were "strikingly similar." The appeals court therefore applied the reasoning in the 4th Circuit's decision to hold that ERISA pre-empts the Suffolk County ordinance. The court held that the local law created the same incentive as under the Maryland law for employers to structure their health care plans to meet the minimum spending requirement. Given that the decision character-

ized the county ordinance as essentially identical to the Maryland law and applied the 4th Circuit's decision, it does not appear to break new legal ground.

In 2007, the city of San Francisco enacted a local ordinance requiring all firms with employees in the city to spend a specified amount per hour on behalf of workers on various types of health services or to pay the city.¹⁰⁷ Along with contributions from individuals, the employer assessments will help fund the city's Health Care Access Program by using a network of public and private providers with which the city's uninsured residents can enroll. In late 2007, a federal district court held that ERISA preempts the ordinance because it is "connected with" and "refers to" ERISA plans.¹⁰⁸ The court characterized the ordinance as requiring employers to spend prescribed amounts on behalf of employees—a benefits mandate rather than a requirement to pay the city but credit other health care spending against the city payment level.

In reaching this conclusion, the court relied on the 4th Circuit's *Fielder* decision but also on other federal court preemption case law. The court further held that the ordinance "refers to" ERISA plans because it makes specific reference to ERISA plans in its text and implementing regulations and also requires employers to calculate what they owe the city by taking into consideration what they spend on employee health care. In concluding that expanding health care access was a "laudable goal," the court suggested that the city could impose an employer tax against which employer health care expenditures could be credited.

In early 2008, the Court of Appeals for the 9th Circuit granted a stay of the lower court's order in an opinion indicating

that the city was very likely to prevail in its appeal (to be heard later in 2008).¹⁰⁹ The court characterized the city ordinance as requiring employer payment, not employee benefits. It held that ERISA does not appear to preempt the law, because the choice of paying the city or providing health care to workers is entirely up to the employer, under the reasoning of the *Travelers* decision and case law in the 9th Circuit.

While the Maryland and New York decisions are not helpful to states seeking to include employer financial contributions as a source of health care reform funding, the reasoning in the 9th Circuit opinion (which may foreshadow the ultimate appeal decision) suggests that states could enact laws requiring employers to help finance public health care access programs as long as they allow employers to choose to cover workers.

Furthermore, some analysts argue that the Maryland and New York decisions misapply Supreme Court precedent and would not necessarily persuade courts in other states.¹¹⁰ And, those decisions involve laws narrowly crafted to affect only one or a small number of retail grocers and therefore are distinguished from pay-or-play laws under consideration in other states such as California, where a bill would apply to a large share of employers with a credit for spending on employee health care and finance a broad public coverage program through several funding sources. While the Maryland and Suffolk County decisions limit state options for including employers as a source of funding for health care reform initiatives, other pay-or-play approaches such as the laws enacted in Massachusetts and Vermont or under development in California remain untested.

In the current environment, it appears that state health policymakers should carefully consider the implications of requiring employers to offer health coverage, even indirectly. For example, if a state is considering imposing employer assessments, that state is probably best advised to craft assessments as revenue measures with a credit for health care spending, include a large proportion of employers, and design the assessment to fund broad-based public programs. In general, states risk serious ERISA challenge if they do not maintain neutrality with respect to whether employers pay the assessment or offer health coverage directly. Despite these potential constraints and given the unpredictable manner in which courts ultimately decide whether ERISA pre-empts pay or play laws, states should not hesitate to develop new approaches, even if they run the risk of pre-emption challenges.

CAFETERIA (SECTION 125) PLANS

Many states have expressed interest in making health insurance more affordable by requiring employers to set up "cafeteria plans" under which employees may pay for either individually purchased insurance or their share of employer-sponsored coverage with pre-tax wages as permitted under Internal Revenue Code Section 125. Such plans reduce employees' and employers' share of income, unemployment, and FICA (Federal Insurance Contributions Act) taxes.¹¹¹ Part of the 2006 Massachusetts health reform law required employers to establish Section 125 plans. Some analysts argue that cafeteria plans are ERISA plans and that ERISA would pre-empt state mandates for such plans.¹¹² The U.S. Department of Labor, however, does not consider Section 125 plans to be ERISA plans, and no court has specifically ruled on the matter. Consequently, states would likely be able to defend such employer requirements against a pre-emption challenge.

- The provision of subsidies to small employers and employees of small employers if the employer:
 - has not offered a health benefit plan within the prior 12 months;
 - has two to nine eligible employees;
 - meets certain low-wage requirements to be established through regulation;
 - establishes a Section 125 payroll deduction plan to allow for pre-tax premium contributions; and
 - agrees to offer a wellness benefit that is designed to prevent disease, reduce poor clinical outcomes, and promote health behaviors and lifestyle choices.
- The expansion of Medicaid eligibility up to 116 percent FPL for parents and caretaker relatives with a dependent child living at home;
- The phase-in over four years of Medicaid eligibility up to 116 percent FPL for childless adults—enrollment may be capped and benefits may be limited based on available funding; and
- Financing through a combination of general funds, hospital uncompensated care savings, a one-time surplus from the state’s high risk pool, and federal funds. The availability of general funds for the childless adult expansion depends on the adoption, through public referendum, of a new article to the Maryland Constitution to authorize video lottery terminal gaming (slot machines) in the state.

In addition, the Governor, through an executive order, created the Maryland Health Quality and Cost Council (see page 48 for details).

Wisconsin: BadgerCare Plus

Governor Jim Doyle reached agreement in October on a state budget that would

increase the cigarette tax by \$1 per pack, providing funding to expand health care coverage to nearly all children in the state. A recent state survey found that about 71,000 children in the state were uninsured at some point in time during 2006. Children would be covered through the state’s new BadgerCare Plus program, which merges Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children and families.

Under BadgerCare Plus, the following populations will be eligible:¹¹³

- All children, regardless of income, with sliding scale premiums required for those above 200 percent FPL;
- Pregnant women with incomes up to 300 percent FPL;
- Parents and relatives caring for a child up to 200 percent FPL;
- Young adults in foster care who turn 18 on or after January 1, 2008, will automatically be eligible for BadgerCare Plus until they turn 21, regardless of income;
- Farm families and other families who are self-employed may be eligible under BadgerCare Plus if their income is under 200 percent FPL; and
- Parents whose child/children are in foster care and have a reunification plan in place may be eligible for BadgerCare Plus if their income is below 200 percent FPL.

Under the new expansion, families with incomes that exceed 200 percent FPL will be able to purchase basic health coverage for their children for \$10 to \$68.53 per child per month, depending on their income. Wisconsin plans to subsidize premium costs for those families with incomes up to 300 percent FPL; CMS has approved a waiver that allows federal match for children up to 250 percent FPL

while those between 250 and 300 percent FPL will be subsidized with state-only funds. Families with incomes above 300 percent FPL will be required to contribute the full cost of coverage. Enrollment will start on February 1, 2008.

FRAMING HEALTH CARE REFORMS FOR 2008 AND BEYOND

While Washington, Oregon, Illinois, Indiana, Maryland, and Wisconsin enacted new health reforms in 2007, a slew of states are preparing to undertake health care reforms over the next few years. Even those states with programs already in place continue to explore additional areas for reform. In Vermont, for example, the 2008 legislative session will be focusing on new reforms including: 1) the underinsured and small businesses; 2) increasing access to Catamount Health by expanding eligibility for the uninsured; 3) hospital budgeting and cost containment; and 4) primary prevention.

States appeared especially interested in expanding coverage to uninsured children and establishing entities similar to the Massachusetts Connector. Many of these states are also emphasizing the promotion of healthy behaviors and disease prevention. Typically, states begin the reform process by convening an advisory body that guides the planning process and then makes recommendations to state policymakers.

Colorado. On November 19, 2007, Colorado’s Blue Ribbon Commission for Health Care Reform approved recommendations for comprehensive health reform. The reform agenda focused on cost, quality, and access to health coverage. The recommendations stipulate that efficiency improvements should be phased in before coverage expansions. All told, the Commission’s recommendations would expand coverage to almost 90 percent of the state’s 792,000 uninsured

residents, at an estimated cost of \$1.1 billion. Its 31 recommendations included:

- Providing premium subsidies for low-income, uninsured workers;
- Requiring employers to enable employees to purchase health insurance with pre-tax dollars;
- Reducing administrative costs by standardizing claims forms, insurance application forms and authorization procedures;
- Creating a “connector” and promoting access to information for consumers;
- Developing a statewide health information network focused on interoperability;
- Providing a medical home for all Coloradans;
- Requiring that every resident of Colorado have at least a “minimum benefit plan;”
- Creating a Consumer Advocacy Program; and
- Expanding Medicaid coverage to all legal residents of Colorado in families earning up to 205 percent FPL.

The Commission was established in November 2006 by the state legislature. Its bi-partisan members were appointed by Governor Bill Ritter, former Governor Bill Owens, and leaders in the state legislature. The Commission reviewed five health care reform proposals, ultimately selecting the model that most closely resembles the comprehensive reforms undertaken by Massachusetts. The Commission will present its recommendations to the Colorado legislature in early 2008.

Connecticut. During its 2007 session, the state legislature called for the creation of the HealthFirst Connecticut Authority, an advisory group charged with

responsibility for designing a universal health care system. The authority will convene stakeholders to recommend affordable options for providing coverage to the state’s uninsured and underinsured residents. The state also inaugurated a Statewide Primary Care Authority charged with developing a universal primary care system for all Connecticut residents.

Iowa. The Legislative Commission on Affordable Health Care Plans for Small Businesses and Families, established in 2007, submitted its final report to the legislature with recommendations to be considered during the 2008 legislative session. Among the 79 recommendations, the commission highlighted the need to: develop a plan to cover all children; establish a Health Care Exchange; define parameters of affordability and benefit design; develop a system utilizing medical homes; and strength quality improvement and cost containment strategies.

Kansas. The Kansas Health Policy Authority recently released the “Kansas Health Policy Authority Board Health Reform Recommendations of 2007.” These recommendations to the governor and legislature resulted from not only deliberations of the Authority’s board, but also from meetings of four advisory councils involving 144 members and a listening tour across 22 communities. The priorities for reform include:

- Promoting Personal Responsibility—for healthy behaviors, informed use of health care services, and sharing financial responsibility for the cost of care;
- Promoting Medical Homes and Paying for Prevention—to improve the coordination of health care services, prevent disease, and contain the rising costs of health care; and

- Providing and Protecting Affordable Health Insurance—including expanding Medicaid coverage up to 100 percent FPL for adults without children and encouraging Section 125 plans.

In addition, the report included financing options and recommendations for containing health care costs.

Minnesota. In early 2007, Governor Tim Pawlenty announced his Healthy Connections proposal. The proposal’s overarching goal is to make the state’s Medicaid program more affordable for children and to expand eligibility. In addition, private health plans would offer special accounts to encourage healthy behaviors, and businesses with 10 or more employees would be required to establish Section 125 plans. The governor is interested in establishing the Minnesota Health Insurance Exchange, a Massachusetts-style Connector that would facilitate the purchase of health insurance. Following the announcement of his proposal, the governor’s budget bill provided for the formation of the Health Care Transformation Task Force, which is charged with advising the governor on a plan to transform the state’s health care system. The task force must submit a final action plan in early 2008.

South Dakota. The state enacted a law establishing the Zaniya Project Task Force and charging it with developing a plan to provide health insurance to uninsured South Dakota residents. Loosely translated, Zaniya means “health and well-being” in the Lakota language. The task force recently issued a legislatively-mandated report with recommendations on how to approach comprehensive health care reform. Task force members called for expanded Medicaid eligibility for pregnant women and increased coverage of children and families through premium subsidies or an SCHIP program expansion. The

task force also recommended the creation of a high-risk pool to cover individuals who may be deemed uninsurable in the commercial market.

Virginia. In September 2007, the Governor's Health Reform Commission for the Commonwealth of Virginia submitted its final report, which is intended to serve as a roadmap for reform of the state's health care system. Over the past year, the commission examined the health care workforce; the affordability, quality, and accessibility of health care in the state; the transparency of health information; prevention and wellness efforts; and long-term care. In its final report, the commission laid out several recommendations for the governor's consideration, including the establishment of a health care data workforce center; an increase in funds allocated to the safety net; expanded eligibility for the state's SCHIP program; creation of a private health insurance product for uninsured Virginians with income less than 200 percent FPL and no other access to public or private health insurance; and establishment of a nonprofit foundation to focus on promoting clinical preventive services and healthy lifestyle choices across the state.

In December, as part of his 2008 budget proposal, Governor Kaine proposed a premium support program called Virginia Share. It is designed to help small businesses—with 50 employees or fewer—provide private health coverage to employees who earn up to 200 percent FPL. The state of Virginia will pay one-third of the monthly premium up to \$75 per month. Both employers and employees will contribute one-third of the premium. The Governor estimates that 5,000 additional Virginians will obtain health insurance through the program. He also proposed additional funding for safety net providers, investing more resources into safety net clinics,

dental services, and a significant increase for community mental health clinics (in the wake of the shootings at Virginia Tech). In addition, his budget increases eligibility for Medicaid prenatal coverage from 185 to 200 percent FPL and expands coverage for breast and cervical cancer screenings.

INCREMENTAL APPROACHES

In 2007, several states moved forward with incremental reforms that expanded coverage for targeted groups of uninsured. Most of these reforms expanded coverage for children, although some also targeted parents, the aged, and disabled. Several states expanded coverage by changing the definition of dependent for insurance purposes. While these reforms may not seem as substantial as those being considered or implemented in other states, they represent significant building blocks for future reforms in those states.

States are pursuing expansions through a variety of approaches, including Medicaid, SCHIP, Medicaid waivers, flexibility under the Deficit Reduction Act (DRA), and public/private partnerships. Given that many of the strategies rely on Medicaid to help finance expanded coverage, the future of the various efforts will depend on states' fiscal outlook and the challenges of receiving federal Medicaid and SCHIP waivers to expand coverage to optional populations including childless adults.¹¹⁴ Other funding sources include employer and individual contributions, tobacco taxes, and provider taxes.¹¹⁵

Expanding Coverage to Children

In 2007, momentum continued to build for ensuring access to health coverage for all children and for covering children above federal SCHIP levels. In 1997, Connecticut's Husky B program, the state's SCHIP program, was the first state program in the nation to allow uninsured children in families above 300 percent FPL to buy into the program. In 2005, Illinois

Governor Blagojevich signed the Covering All Kids Health Insurance Act extending insurance coverage to all uninsured children in the state.

In the years since Connecticut's and Illinois' groundbreaking initiatives, several states have considered similar proposals aimed at expanded coverage of children. These states have determined that it is cost-effective to cover children; however some efforts to increase eligibility levels for children have encountered resistance at the federal level. In fact, Oklahoma, Ohio, and Louisiana represent a few states that attempted to get CMS approval to expand coverage to children up to 300 percent FPL and were denied (see page 54 – Medicaid Changes on the Horizon).

- Hawaii's legislature expanded health care coverage to infants and children through two pilot programs. The Hawaii Infant Health Program provides coverage to uninsured newborns up to 30 days of age for up to \$10,000 in health care assistance per infant.
- Connecticut's legislature made several changes to its HUSKY program (Medicaid and SCHIP), expanding coverage for children from 300 to 400 percent FPL at a cost of \$6 million in 2008. The state will also begin automatic enrollment of uninsured newborns in HUSKY and will pay the premium for the first two months, at an estimated cost of \$2.7 million.
- Missouri's General Assembly passed a reconfigured state Medicaid system, called MO Health Net, in early 2007. The law restores coverage and benefits to some of the subpopulations whose services were eliminated two years ago, including 6,000 children who lost coverage because their parents had access to employer-sponsored health insurance. In addition, the law restores

SCHIP coverage to 20,000 children through revised income eligibility requirements.

- New York Governor Eliot Spitzer finalized a budget that would raise the eligibility requirement for the state's Child Health Plus program from 250 to 400 percent FPL. Unfortunately, CMS denied the state's request in September.
- Texas Governor Rick Perry recently signed legislation that will allow families below 185 percent FPL to undergo redetermination only once rather than twice a year; the law also revised the 90-day waiting period requirement so that it applies only to children with health insurance during the 90 days before applying for SCHIP. The revisions may result in the addition of 100,000 children to the Texas SCHIP program. The changes come on the heels of declining enrollment in the state's SCHIP program. Roughly 25,000 children lost coverage during the first six months of 2007.

Increasing Dependent Coverage

Young adults—commonly defined as those aged 19 through 29—are one of the largest and fastest-growing groups of uninsured, totaling nearly 14 million in 2004, an increase of 2.5 million since 2000.¹¹⁶ To address this problem, several states expanded coverage during their 2007 legislative sessions by changing the definition of dependent and extending access to insurance for young adults over age 18. States control the definition of dependent coverage in the commercial insurance market, the state employees' health insurance pool, and other public programs funded by state dollars.

- Connecticut enacted legislation requiring group comprehensive and health insurance policies to extend coverage to children until age 26.

- Idaho expanded the definition of dependent under a new law whereby unmarried non-students can remain on their parents' insurance until age 21. Unmarried, financially dependent, full-time students can remain on parental insurance until age 25.

- Indiana requires commercial health insurers and HMOs to cover dependents until age 24 at the policyholder's request.
- Maine passed legislation requiring insurers to continue coverage for

ILLINOIS' ALL KIDS PROGRAM: AN UPDATE

Implemented in July 2006, the Illinois All Kids program is open to any child uninsured for 12 months or more, regardless of income, health status, or citizenship. Families pay monthly premiums and co-payments on a sliding scale. The expansion is funded exclusively through state funds, using enrollee cost-sharing as well as savings generated from new care management initiatives. As of April 2007, nearly 50,000 children had enrolled in the program. Illinois' experience implementing and operating All Kids offers valuable lessons.

In exceeding initial targets, enrollment has been supported by a strong outreach effort that relies on innovative strategies. One such strategy is an application agent initiative that involves community organizations, medical providers, and insurance agents in completing children's All Kids applications. Outreach activities have also resulted in increased Medicaid and SCHIP enrollment among children previously eligible for but not enrolled in those programs.

A consumer-friendly application spurred early enrollment success.

The program's universality — it is available to all children in the state — enhanced program marketability and consumer understanding during the program's early stages.

The program benefited from the strong leadership of Governor Blagojevich and enjoyed widespread support across a range of stakeholders.

The program faces several challenges at its one-year anniversary. One challenge lies in ensuring the success of the state's new managed care initiatives, which are designed to generate the savings needed to finance the All Kids program. Other states and policymakers will be watching to see whether the program can maintain the momentum of its inaugural year.

Source: Coughlin T. A., and M. Cohen, "A Race to the Top: Illinois' All Kids Initiative," Kaiser Commission on Medicaid and the Uninsured, August 2007.



dependents until age 25 as long as they remain dependent and have no dependents of their own.

- Maryland enacted legislation allowing young adults to remain eligible for insurance until age 25 if the individual resides with the insured policyholder and is unmarried.
- Montana passed legislation providing insurance coverage under a parent's policy for unmarried children under age 25.
- Washington enacted a requirement that any commercial health plan offering insurance coverage must allow the option of covering unmarried dependents until age 25.

Other states that have increased the age until which dependents may remain on their parents' policy include Colorado, Delaware, Massachusetts, New Hampshire, New Jersey, New Mexico, Rhode Island, South Dakota, Texas, and Utah.

A RENEWED FOCUS ON SYSTEMS IMPROVEMENT AND COST CONTAINMENT

The recommendations of Washington's Blue Ribbon Commission and Vermont's Blueprint for Health reflect an emerging trend among states to couple coverage expansions with strategies aimed at chronic condition management, wellness and prevention, patient safety, and transparency through public reporting, and data collection.¹¹⁷ States have been engaged in this work for a long time, and continue to develop innovative programs to control costs, improve quality of care, and improve the value of public and private program benefits.

In fact, many states are making quality improvement a priority within their Medicaid programs, particularly given the availability of nationally accepted quality measure sets such as HEDIS (Healthcare Effectiveness Data and Information Set)

and CAHPS (Consumer Assessment of Healthcare Providers and Systems). According to a survey released by the Kaiser Commission on Medicaid and the Uninsured, 44 states plan to use HEDIS and/or CAHPS performance measures in 2008 to reward improved provider performance.¹¹⁸

States are also turning to chronic care management to address care coordination issues and rising costs associated with asthma, diabetes, and heart disease. Many states are developing weight loss and smoking cessation programs in an effort to curb costs associated with obesity and smoking-related illnesses. And, increasingly, states are including in their basic state-defined benefits package a set of preventive benefits that promote healthy lifestyles, even incorporating incentives or rewards for healthy behaviors.

California: Rewarding Healthy Behaviors

California's ambitious reform proposal envisions covering nearly all Californians through a combination of strategies, including an individual mandate, a premium assistance program, and expansion of the state's Medi-Cal/SCHIP programs. The reforms place an equally strong emphasis on wellness and prevention. To improve health outcomes and implement long-term cost containment strategies, Governor Schwarzenegger is proposing disease management for diabetes, programs to combat obesity and tobacco use, and strategies to improve patient safety.

- *Rewards programs.* Governor Schwarzenegger intends to implement the Healthy Actions Incentives and Rewards programs to address the rising health care costs attributable to preventable disease and disability. The programs will provide rewards — premium reductions, extra benefits, or other rewards such as

gym memberships or transportation vouchers, for example — to participants who practice healthy behaviors and preventive health activities. Rewards under the program will be available in the Medi-Cal, Healthy Families, and state public employees' program (CalPERS).

- *Healthy behavior strategies.* California's proposed rewards program is similar to strategies that are currently being implemented in other states like Vermont. It is coupled with a comprehensive obesity prevention program, including a public awareness campaign, community-based funding, and school-based efforts to promote healthy eating and physical activity. Increased funding for tobacco use reduction programs will improve access through the state's California Smokers' Helpline. A statewide diabetes and "pre-diabetes" program would seek to reduce both the incidence of and costs associated with diabetes through improved screening, prevention, and self-management. California is pursuing these prevention programs in parallel with numerous strategies designed to contain costs.

New State Councils Focus on Cost and Quality

Several states have established formal entities to continue exploring initiatives aimed at reducing costs and improving quality. Maine, with its implementation of Dirigo, was the first state to create an organization, the Maine Quality Forum, specifically dedicated to quality improvement. In their 2006 reforms, Massachusetts followed suit by creating a Health Care Quality and Cost Council to address quality improvement and cost containment on an ongoing basis. Also in 2006, West Virginia created an Interagency Health Council charged with addressing issues related to access, cost control, quality, and equitable financing. Interestingly, Maine enacted a law in

2007 that establishes another entity — the Maine Hospital Cost Commission — that, as an independent executive agency, will examine alternative hospital financing systems designed to contain costs, encourage efficiency and quality, and ensure predictability in service costs.

Other states are moving forward with similar initiatives. The new councils established by Maryland and Louisiana are illustrative of state efforts to push for the adoption of best practices and health information technology even as policymakers debate reforms that would expand coverage.

In 2007, the Louisiana legislature mandated the creation of the Health Care Quality Forum, a new private, not-for-profit organization charged with leading evidence-based, collaborative initiatives to improve the health of the state's population. The Forum was created as a response to the closure of the state's Charity Hospital. It seeks to develop chronic condition care standards and will examine the state's overall health as well as variations in practice patterns across the state. While the Forum does not have authority to regulate physicians and hospitals that fail to meet forum-established quality standards, it will publish best practices for providers to

follow. The Forum's volunteer board represents a cross-section of public and private insurance purchasers, patient advocates, hospitals, physicians, and insurers in the state.¹¹⁹

In October 2007, Governor O'Malley established, by executive order, the Maryland Health Quality and Cost Council. The Council is charged with:

- Coordinating and facilitating collaboration on health care quality improvement and cost containment initiatives by the various stakeholders in the health care system;

HEALTHPACT RI: ENCOURAGING SMALL BUSINESS TO OFFER COVERAGE

As of October 2007, small businesses in Rhode Island have a new, lower-premium option to provide health insurance coverage to their employees—HealthPact RI plans. Legislation passed in 2006 called for the establishment of “wellness health benefit plans,” which would include coverage for physician visits, hospitalization, preventive services, and prescriptions drugs. Two private carriers in the state offer the HealthPact RI plans.

- *New plans target small employers.* Insurers are required to offer HealthPact RI plans to businesses with 50 or fewer employees. The law requires premiums to equal no more than 10 percent of average annual state wages. Employee-only premiums will average \$314, an amount 18 percent lower than that charged by similar plans currently on the market.

- *Benefit design encourages wellness programs.* Blue Cross Blue Shield of Rhode Island and UnitedHealthcare of New England now offer a Basic plan and an Advantage plan. Each employee has the option of choosing between the two types of benefit designs, which are priced at the same level. While premiums for the two plan types are equivalent, Advantage members incur lower out-of-pocket costs but must participate in wellness programs, such as smoking cessation, weight loss, and disease management programs. Advantage members must also take personal responsibility for their health by selecting a primary care physician and completing a health-risk appraisal. For enrollees participating in the wellness programs, deductibles, copayments, and coinsurance are reduced to amounts normally charged by plans with much higher premiums.

- *Tiered provider networks.* The development of new tiered provider networks will reduce costs further. The plans will encourage enrollees to select providers with demonstrated cost-effective, high-quality practice patterns. Rhode Island estimates that between 5,000 and 10,000 small business employees will enroll.



- Making recommendations on health care quality and cost containment initiatives and priorities to policy makers, state and local governmental entities, professional boards, the Maryland Patient Safety Center, industry groups, consumers, and other stakeholders;
- Developing a chronic care management plan to improve the quality and cost-effectiveness of care for individuals with, or at risk for, chronic disease;
- Facilitating the integration of health information technology in health care systems; and
- Examining and making recommendations regarding other issues relating generally to the Council's mission to improve health care quality and reduce costs.

Other Wellness Programs: New York, Texas, Missouri

Parts of California's and Pennsylvania's proposals are similar to initiatives underway in other states. New York will expand resources for disease prevention and primary care by investing in public health programs and prevention programs for cancer, diabetes, obesity, asthma, and other disease. Texas recently enacted a Healthy Lives pilot program that will reward Medicaid patients who complete smoking cessation, weight loss, and other preventive health programs in one region of the state. The pilot program could provide expanded health benefits or establish a reward account for participants in disease management programs, permitting an exchange of rewards for health-related items not covered by Medicaid. Missouri will begin offering cancer screenings and family

planning services to about 90,000 women whose incomes make them ineligible for Medicaid.

CONCLUSION

For states, the age of health care reform continues. As 2008 unfolds and legislatures convene, the nation will likely witness considerable discussion on various approaches to health care reform and, it is hoped, the enactment of reforms across the country. As in previous years, states have taken the lead and are rising to the challenge of pioneering new solutions and reformulating old ones to address the needs of the uninsured and the reform of the health care system. There is still "no rest for the weary." Over half of the battle is actually getting reforms passed upon which political leadership and major stakeholders can agree. Then begins the equally difficult work of implementation.

TABLE 4 KEY FEATURES OF ENACTED AND PROPOSED REFORMS

| State | Initiative | Key Features |
|---------------------------------------|---|--|
| Comprehensive Reforms Enacted | | |
| Massachusetts (2006) | Commonwealth Care | <ul style="list-style-type: none"> ▪ Individual mandate ▪ Employer Fair Share assessment ▪ Employer Free Rider surcharge ▪ Health Insurance Connector ▪ Insurance market reforms ▪ Commonwealth Care* |
| Maine (2003) | Dirigo Health | <ul style="list-style-type: none"> ▪ DirigoChoice* ▪ Cost containment reforms ▪ Maine Quality Forum |
| Vermont (2006) | Catamount Health | <ul style="list-style-type: none"> ▪ Employer assessment ▪ Catamount Health Plan* ▪ Chronic care initiatives |
| Comprehensive Reform Proposals | | |
| California | AB X1 1 | <ul style="list-style-type: none"> ▪ Individual mandate ▪ Employer requirement to offer Section 125 plans ▪ Guaranteed issue ▪ Children covered up to 300% FPL ▪ Adults covered up to 250% FPL ▪ Tax credit for premium costs for certain families ▪ Wellness and systems improvement initiatives |
| Pennsylvania | Prescription for Pennsylvania | <ul style="list-style-type: none"> ▪ All children at or below 300% FPL covered (enacted) ▪ Individual mandate for full-time college students ▪ New insurance product for low-income workers and small businesses ▪ System improvement initiatives |
| New Mexico | HealthSOLUTIONS New Mexico | <ul style="list-style-type: none"> ▪ New health coverage authority ▪ Individual mandate ▪ Employer mandate ▪ Insurance reforms ▪ Mandating electronic claims submissions; electronic medical records ▪ State contractors required to offer coverage** |
| Substantial Reforms Enacted | | |
| Washington | Reforming Health Care System in Washington | <ul style="list-style-type: none"> ▪ Funding to ensure covering all kids by 2010 ▪ SCHIP expansion from 251 to 300% FPL; full-cost buy-in for those above 300% FPL. ▪ Washington Health Insurance Partnership ▪ Health promotion and quality improvement initiatives |
| Oregon | Healthy Oregon Act | <ul style="list-style-type: none"> ▪ Oregon Health Fund Board ▪ Final reform plan recommendations to Governor/Legislature by October 2008. |
| Illinois** | Illinois Covered | <ul style="list-style-type: none"> ▪ Expansion for uninsured parents and care-takers of SCHIP eligible children up to 400% FPL ▪ Expansion of state's high-risk pool for children with pre-existing conditions aging out of All Kids ▪ Medical home program for residents under 100% FPL ▪ Premium assistance program |
| Maryland | Working Families and Small Business Health Coverage Act | <ul style="list-style-type: none"> ▪ Subsidies to small employers and their employees ▪ Medicaid expansion for parents/caretaker relatives ▪ Phased-in Medicaid expansion for childless adults ▪ Maryland Health Quality and Cost Council** |

*Includes subsidies for low-income workers ** Through executive authority



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MEDICAID: A VEHICLE FOR STATE COVERAGE EXPANSIONS

As states' fiscal outlooks continued to improve in 2007, many states looked to Medicaid as a vehicle for expanding health coverage. Since passage of the Deficit Reduction Act (DRA) in 2005, states have taken advantage of the law's new flexibility to design benefits for expansion populations and to use Medicaid Transformation Grants to streamline the Medicaid enrollment process and increase program efficiency and effectiveness.

According to the 2007 Kaiser Commission on Medicaid and the Uninsured's *State Medicaid Budget Survey*, more than half of states improved their Medicaid programs for fiscal years 2007 and 2008 by, for example, increasing income eligibility limits, offering new benefits, and streamlining application and enrollment processes. Forty-two states reported that they plan to expand coverage in the future, most through Medicaid, and no state said that it plans to cut Medicaid benefits in fiscal year 2008.¹²⁰ Several states, including Maryland, Tennessee, Wisconsin, California, Missouri, and Colorado, turned their attention to leveraging Medicaid funding as part of broader state-based health care reform.

DRA FLEXIBILITY TO CHANGE BENEFITS AND COST-SHARING

The DRA generated one of the most significant changes to Medicaid in the program's 40-year history. Among its several changes, DRA provided states with new flexibility to make certain changes through the state plan amendment process that previously had required Section 1115 waiver authority. In particular, states now have a means of combining new flexibility in benefit design and cost-sharing with longstanding Medicaid authority to use

income disregards for expansions.¹²¹ As a result, states may cover higher-income populations under alternative benefit plans without Section 1115 waivers.

Seven states have received federal approval to make program changes under the DRA.¹²² Soon after the law took effect, West Virginia, Kentucky, and Idaho gained approval to implement broad Medicaid redesigns under the DRA's new provisions for flexibility in benefit design and cost sharing.¹²³ These states now offer tailored benefit packages to specific populations and have encouraged greater patient involvement in health care. Kansas, Virginia, and Washington received approval to offer alternative benefit packages that include services such as disease management and personal care for certain populations. South Carolina received approval to offer Medicaid beneficiaries the option of enrolling in a high-deductible health plan under the state employee benefit system.

CITIZENSHIP DOCUMENTATION REQUIREMENT

Along with the new flexibility provided by the DRA, states must deal with a new citizenship documentation requirement. Since July 1, 2006, individuals applying

for or renewing their Medicaid eligibility status must provide evidence of U.S. citizenship. While the requirement was intended to deter undocumented immigrants from fraudulently enrolling in Medicaid (ensuring that federal Medicaid funds support U.S. citizens and certain qualified immigrants), many states have reported that compliance with the requirement has resulted in delays or denials of Medicaid coverage for citizens. Three out of four state Medicaid directors reported that the documentation requirement contributed to slowed growth in Medicaid enrollment in fiscal year 2007.¹²⁴ Several states, including Kansas, Virginia, Wisconsin, and Alabama, reported that the documentation requirement is primarily preventing U.S. citizens, instead of undocumented immigrants, from establishing Medicaid eligibility.¹²⁵

Debate continues about whether the documentation requirement is achieving its intended effect. Since its implementation, several congressional proposals and one federal class action lawsuit have sought to modify or repeal the requirement.¹²⁶ In addition, the vetoed SCHIP reauthorization bills had proposed

to extend the documentation requirement to children in SCHIP.

MEDICAID TRANSFORMATION GRANTS

During 2007, 35 states, the District of Columbia, and Puerto Rico received \$150 million in federal Medicaid Transformation Grants.¹²⁷ The DRA authorized the grants for fiscal years 2007 and 2008 to support innovative methods for improving the efficiency and effectiveness of Medicaid. U.S. Health and Human Services Secretary Mike Leavitt stated, “With these grants states can streamline and modernize their systems, stabilize the exponential growth of the program and protect it into the future.”¹²⁸

Most of the grants focus on health information technology (HIT) and information exchange, fraud and abuse reduction, and chronic care management. Several states are using their grant funds to develop HIT tools specifically focused on e-prescribing.¹²⁹ Illinois and Kansas are using predictive modeling technology to address fraudulent activity while improving quality of health care services. Several states are using their grants to create systems to streamline enrollment and reduce potential enrollment delays and the administrative burdens associated with the DRA’s citizenship documentation requirement. For example, Arkansas, Massachusetts, Michigan, and Rhode Island are developing systems for electronically verifying citizenship and streamlining the documentation process. Oklahoma is using grant funds to establish an online enrollment process to support a recent expansion of its Medicaid program, SoonerCare.

MEDICAID CHANGES ON THE HORIZON

Administrative Cuts. Medicaid programs may face federal cuts of \$11 billion over five years on top of \$11.5 billion in reductions already approved under

the DRA. Recently proposed federal regulations would reduce federal Medicaid spending on rehabilitation services for individuals with disabilities, school-based services (including Medicaid enrollment support provided by public school officials), hospital outpatient care, and Graduate Medical Education. The Medicare Medicaid SCHIP Extension Act (S.2499), signed by President Bush on December 29, 2007, prohibits the Secretary of Health and Human Services from taking any action on cuts affecting rehabilitation and school-based services before June 30, 2008.¹³⁰

Some states fear that these proposed changes will adversely affect their coverage expansion efforts. For example, Massachusetts officials estimate that the proposed regulations could cost the state over \$100 million per year and undermine efforts to enroll the uninsured in Medicaid just as the state is implementing its landmark comprehensive health care reform plan. Robert Siefert of the Center for Health Law and Economics at the University of Massachusetts Medical School noted that the proposed reductions in school-based outreach “would close off a very important outlet for reaching people potentially eligible for MassHealth [and Commonwealth Care].”¹³¹

Restrictions on Expansions. States are facing new obstacles in covering higher-income populations above 250 percent FPL. In an August 17, 2007 letter to state officials, CMS announced that states would be barred from extending SCHIP coverage to children in families with incomes above 250 percent FPL unless they can demonstrate that 95 percent of those eligible under 200 percent FPL are enrolled in the program.¹³² CMS has since cited this SCHIP policy to block Medicaid expansion proposals from several states, including Ohio, Louisiana, and Oklahoma.¹³³

This CMS action coincided with SCHIP reauthorization negotiations during which congressional leaders debated whether the SCHIP bill should establish a Medicaid eligibility threshold at 300 percent FPL, the level at which lawmakers had previously agreed to cap SCHIP eligibility. While there are still no formal rules capping Medicaid eligibility, and no states have expanded Medicaid above 300 percent of FPL, many fear that these Medicaid eligibility restrictions will undermine the broad bipartisan goal of covering more children.

Streamlining Medicaid Enrollment. The SCHIP reauthorization process gave states some hope that they may soon have more options and incentives for streamlining Medicaid enrollment. The vetoed SCHIP reauthorization bills, for example, would have provided performance bonuses to states to enroll more of those eligible for but not enrolled in SCHIP and to streamline Medicaid and SCHIP enrollment processes by coordinating with other public programs. Despite President Bush’s vetoes, bipartisan support in Congress for these ideas will likely remain on the table even though the SCHIP reauthorization debate came to a close in December.

SCHIP REAUTHORIZATION FAILED - PROGRAM EXTENDED TO MARCH 2009

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. SCHIP was scheduled to be reauthorized in 2007 after ten successful years. Many states hoped that reauthorization would bring increased SCHIP funding to support health coverage expansions.

Congress passed two SCHIP reauthorization bills in 2007, but both were vetoed by President Bush. The bills sought to enroll four million additional children through a \$35 billion increase in SCHIP funding over five years, funded by a tobacco tax increase.¹³⁴ Both bills included quality initiatives, outreach grants, and fiscal incentives to encourage states to enroll low-income

children. The second bill added several new provisions to respond to opponents' concerns, including a prohibition on coverage of children with family incomes over 300 percent FPL, additional citizenship verification requirements and crowd-out provisions, and expedited transition of childless adults off of SCHIP. Despite these changes, the President's

veto message cited ongoing concerns with crowd-out, allowing parents in the program, and tax increases.¹³⁵ There were not enough votes in the House to override the President's veto. In the end, SCHIP was extended through March 2009 with a modest spending increase sufficient to cover the estimated 6.6 million children currently enrolled in the program.¹³⁶



LOOKING FORWARD

The reforms enacted in state legislatures and signed in governors' offices over the next two to three years could define state health reform for the coming decade.

The country is at a crossroads with regard to health care reform. As is highlighted in this publication, an enormous amount of activity—more so than in previous years—is occurring in many states right now.

Unfortunately, at the federal level, the status quo is the prevailing and apparently preferred option. Reauthorization of SCHIP did not occur. Instead, the program was extended through March 2009 with a modest spending increase. Consequently, any major policy discussions regarding the reauthorization will not occur for at least another year. Once widely perceived to be a 'slam dunk' in health reform, that program's reauthorization has instead highlighted how increasingly controversial and challenging it is to consider government involvement in health care. The looming question remains: how does the struggle over financing and children's health care reflect upon the federal government's ability to deal with any type of health care reform moving forward?

As we head into one of the most open presidential election campaigns in recent memory, health care continues to percolate to the top of priority domestic issues. Indeed, most of the candidates have submitted proposals to address all or some of the issues related to access, cost, and quality. While there is a certain level of excitement to see momentum building on such important issues, it is impossible to predict whether any major national health reform will actually occur. If there is anything that we have learned from decades of work attempting to do health care reform, it is that health care reform is not inevitable.¹³⁷

Despite the uncertainty at this crossroads in health reform, there is still reason for optimism. While it is fairly certain that no major movement on health care will occur at the federal level in the next year, reform may very well remain a defining issue, motivating greater discussion as we move closer to identifying the 2008 presidential

candidates and party platforms.

Regardless, at least in the short term, a federal solution is far less promising than the ones being undertaken at the state level. States are once again taking on the challenge of increasing coverage for the uninsured, decreasing the health care cost trend, and improving the overall system of care.

The challenges are enormous. And, with new projections of a looming economic downturn, states will have to see if fiscal circumstances will prevent them from moving forward on reform plans. It is our hope that states will continue to keep health care as a priority and look to long-term investments to sustain new programs. Some of the challenges may be greater than many states can overcome; however, their hard work will inform the health care reform discussion for years to come — locally and nationally.



State of the States 2007: Building Hope, Raising Expectations

January 2007

www.statecoverage.net/pdf/stateofstates2007.pdf



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<http://www.statecoverage.net/pdf/tenncare.pdf>

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Agenda and presentation slides available

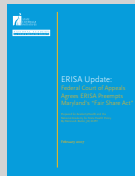
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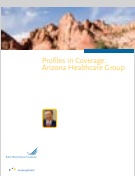
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