



**ASSESSING STATE STRATEGIES
FOR HEALTH COVERAGE EXPANSION:
PROFILES OF ARKANSAS, MICHIGAN, NEW MEXICO,
NEW YORK, UTAH, AND VERMONT**

Sharon Silow-Carroll, Emily K. Waldman,
Heather Sacks, and Jack A. Meyer
Economic and Social Research Institute

FIELD REPORT

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ABOUT THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE

The Economic and Social Research Institute (ESRI) is a nonprofit organization that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at enhancing the effectiveness of social programs, improving the way health care services are organized and delivered, and making quality health care accessible and affordable.

ABOUT THE AUTHORS

Sharon Silow-Carroll, M.B.A., M.S.W., is a senior research manager at ESRI. Ms. Silow-Carroll's areas of expertise include health care reform strategies and meeting the needs of vulnerable populations. Her recent projects include: assessing state and local efforts to promote employment-based insurance; analyzing potential consequences of Internet-based tools for purchasing health insurance; reviewing community-based efforts to reduce financial and non-financial barriers to care; and developing a comprehensive strategy for expanding access to health care for at-risk populations. She is the author of an ESRI book analyzing the corporate/employer role in providing health care coverage to workers and families from economic, social, and cultural perspectives. She has also authored numerous reports and articles analyzing public- and private-sector initiatives aimed at enhancing access, containing costs, and improving quality of health care. Ms. Silow-Carroll received a master's degree in business administration from the Wharton School, University of Pennsylvania, and a master's degree in social work from the University of Pennsylvania School of Social Work.

Emily K. Waldman, M.H.S., is a senior policy analyst at ESRI. Most recently, Ms. Waldman has researched state and local initiatives to expand health coverage for the working uninsured. She also has evaluated public- and private-sector strategies to improve access to health insurance coverage and health care delivery for the District of Columbia Mayor's Health Care Systems Development Commission. Ms. Waldman also has conducted policy research and analysis on the issues confronting urban safety net institutions and academic medical centers, as well as studied the implications of managed care programs for people dually eligible for Medicare and Medicaid. Ms. Waldman received a master's degree in health sciences from the Johns Hopkins University School of Hygiene and Public Health.

Heather Sacks, M.P.P., is a research associate at ESRI. Ms. Sacks has conducted considerable research on the State Children’s Health Insurance Program (CHIP), disease management programs, the working uninsured, and women’s reproductive health issues. Her primary interests include promoting and ensuring the access and availability of women’s health services. Ms. Sacks received a master’s in public policy from the Georgetown Public Policy Institute.

Jack A. Meyer, Ph.D., is the founder and president of ESRI. Dr. Meyer has conducted policy analysis and directed research on health care access issues for several major foundations as well as federal and state government. He has led projects on community-wide reforms covering all regions of the United States. Many of these projects have highlighted new strategies for overcoming barriers to health care access and innovative designs for extending health insurance coverage to the uninsured. Dr. Meyer is the author of numerous books, monographs, and articles on topics including health care, welfare reform, and policies to reduce poverty. Dr. Meyer has also directed recent studies on building quality improvements into employer purchasing, Medicaid managed care for people with disabilities, the State Children’s Health Insurance Program to extend coverage to lower-income children, and assessments of reform proposals to extend health coverage to workers in small firms. Dr. Meyer received a Ph.D. in economics from Ohio State University.

OVERVIEW

The Economic and Social Research Institute (ESRI) examined the experiences of six states—Arkansas, Michigan, New Mexico, New York, Utah, and Vermont—that have made significant progress in health coverage expansion.¹ An earlier report presented case studies of expansions in four states—Oregon, Rhode Island, New Jersey, and Georgia.² The main goal of the project was to determine the key factors that appear essential for success. ESRI researchers sought to assess the political, economic, and other “ingredients” that facilitated coverage expansion efforts in each of the states, as well as the barriers that hampered those efforts. The underlying question was whether common themes and lessons would emerge from a review of the experiences of these states, despite their different circumstances and strategies.

The research did reveal common themes across all or some of the sites studied, as well as lessons that emerge from individual state experiences. These are described in a companion report, *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times*, published by The Commonwealth Fund in December 2002 and available on their website, www.cmwf.org. The experiences of these states may provide guidance for other states with limited resources as they consider how to address a growing uninsured population and how to prepare for more ambitious initiatives under better economic conditions.

¹ Most of the interviews and review of materials took place in early to mid-2002. In some cases we later updated the profiles as circumstances changed. While we tried to reflect major changes up to the time of publication, state health policy is dynamic, and there may be recent developments that we did not capture.

² *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia*, The Commonwealth Fund, November 2002. Available at: http://www.cmwf.org/programs/insurance/silow-carroll_statestrategieslong_565.pdf

WEBSITES FOR FURTHER INFORMATION ON CASE-STUDY STATES

To learn more about the health insurance programs and initiatives discussed in the case studies that follow, please log on to the following websites:

Arkansas

Arkansas Department of Health: www.healtharkansas.com

Arkansas Center for Health Improvement: www.achi.net

Michigan

Michigan Department of Community Health: www.michigan.gov/mdch

New Mexico

New Mexico Human Services Department, Medical Assistance Division:

www.state.nm.us/hsd/mad/GenInfo.htm

New York

New York State Department of Health:

www.health.state.ny.us/nysdoh/research/research

Utah

Utah Department of Health: www.health.utah.gov

Vermont

Vermont Department of Health, Division of Community Public Health:

www.healthvermonters.info/cph/cph.shtml

ARKANSAS

Overview and Summary

Arkansas, with its historically high proportion of low-income residents, low levels of employer-sponsored insurance, very limited Medicaid coverage for adults, and relatively poor health status statewide, is a striking example of a state that has “turned around” to become active and innovative in pursuing coverage expansion in recent years. Its experiences provide encouragement and lessons to other states that seem to have “a long way to go” in health reform (Tables 1 and 2).

The turnaround began, arguably, when the ARKids First Program was established in 1996 to provide coverage to children in families with incomes up to 200 percent of the federal poverty level (FPL).³ The state then took an important step with the 1998 establishment of the Arkansas Center for Health Improvement (ACHI). Jointly sponsored by the Arkansas Department of Health and the University of Arkansas for Medical Sciences, ACHI was intended to provide needed support for state and local policy development and implementation, professional education program development, and public advocacy to improve the health of Arkansas residents. Working with a broad-based group of private and public organizations called the Coalition for a Healthy Arkansas Today (CHART), ACHI led a campaign that resulted in a successful 2000 ballot initiative that secured \$63 million in annual tobacco settlement funds for health-related programs, including a large portion for Medicaid expansion. The effort also raised consciousness about health improvement in communities across the state.

Also in 2000, the Arkansas Health Policy Roundtable was established to guide a Health Insurance Expansion Initiative, supported by a Health Resources and Services Administration (HRSA) State Planning Grant (SPG), to identify, evaluate, and prioritize options for coverage expansion. Although HRSA funding has ended, the state is continuing to develop financing and implementation strategies for two of the roundtable’s recommendations through a Robert Wood Johnson Foundation (RWJF) State Coverage Initiatives (SCI) grant. The initiatives being pursued involve Medicaid expansion to low-income adults and an innovative and potentially groundbreaking model for an employer buy-in to Medicaid.

³ “ARKids First-A” refers to the traditional Medicaid program for the lowest-income families; “ARKids First-B” refers to a combination Medicaid expansion/CHIP program with virtually the same benefits and nominal copays based on a sliding scale (Table 2).

Meanwhile, the 2001 Arkansas General Assembly passed a series of health reforms providing for scaled-down insurance policies (exemption from state-mandated coverage benefits), small-employer purchasing groups, and a demonstration project allowing communities to self-insure to provide coverage.

A number of key factors facilitated the surge of health reform activity in recent years. A supportive governor and tireless efforts by leadership at the ACHI were instrumental in organizing and implementing the many projects and initiatives. The active participation of a coalition of state agencies, public health advocacy organizations, business groups, provider groups, and academic institutions was another essential ingredient for progress. The coalition's success in passing a public referendum then bred confidence to take on new challenges. Also helpful was a staged process for allocating money toward health care and educating state residents about public health and the benefits of investment in health.

Nevertheless, the state had to overcome a number of obstacles. In addition to lack of resources, low levels of employer-sponsored insurance (ESI), and the flight of insurance carriers, the state had to battle lack of knowledge among the general populace about health promotion and prevention, limited technical experience and expertise within the state, and resistance by legislators to using funds to support long-term strategies.

Arkansas successfully addressed many of these obstacles through its public education campaign and a compromise on long-term and short-term strategies. In addition, participating in grant programs (SPG, SCI, the RWJF Southern Rural Access Program, HRSA's Community Access Program, and others) helped bring in funds and expertise from outside the state for necessary research and policy work. This work has led to the current drive to design, finance, and implement the Medicaid expansion and employer buy-in to Medicaid. Although contingent on further policy work and federal approval, the latter represents an important lesson the state has learned regarding the need to bridge public and private initiatives.

Table 1. Arkansas State Profile and Overview, 1999–2000

	Arkansas	United States
Total Population	2,574,760	275,740,020
Population Under 65	2,217,000	242,761,980
Percentage Under 200% of FPL	44%	34%
Percentage Under 100% of FPL	20%	15%
Portion of Children that Are Uninsured	12%	12%
Portion of Nonelderly Adults that Are Uninsured	19%	18%
<i>Insurance Distribution Among Nonelderly</i>		
Employer-Sponsored Insurance	65%	69%
Individual	6%	5%
Medicaid	12%	10%
Uninsured	16%	16%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2000 and 2001 Current Population Surveys.

Table 2. Arkansas's Major Health Coverage Programs

	Medicaid: Adults	ARKids First-A	ARKids First-B
Program Type	Medicaid	Medicaid	Medicaid expansion and CHIP
Waivers/ Legislation Required			Established as Title XIX Section 1115 waiver, portion converted to Title XXI CHIP
Time Frame			Began in 1997
Enrollment	226,812 ^a (as of 6/02)		54,581 (as of 6/02)
Eligibility Criteria	Adults to 22% of FPL \$2,000 asset limit	Children ages 0–6 and pregnant women to 133% of FPL Children ages 6–18 to 100% of FPL Asset limits	Children ages 0–6 with family incomes 133%–200% of FPL Children ages 6–18 with family incomes between 100%–200% of FPL
Benefits/ Subsidies	Comprehensive	Comprehensive	Same benefits as Medicaid, with nominal copays at higher income levels
Financing	State and federal Medicaid funds (73% federal contribution, 27% state contribution)	State and federal Medicaid funds (73% federal contribution, 27% state contribution)	State and federal Medicaid funds for ages 0–15 to 150% of FPL State and federal CHIP funds for ages 0–15 above 150% of FPL and all children ages 16– 18 (82% federal contribution, 18% state contribution)

^a Adult Medicaid enrollment number includes 74,640 individuals in a family planning (FP) demonstration program who receive FP services only.

Source: Arkansas eligibility database, Division of Medical Services.

New Initiatives

Two new initiatives, proposed during the SPG process and continuing to be developed under the SCI grant, are being pursued to expand public and private coverage.

- 1. Expansion of Medicaid to low-income adults** would extend eligibility for limited benefits to adults ages 19 to 64 with incomes from 22 percent up to a maximum of 100 percent of the FPL and to pregnant women with incomes from 133 percent to 200 percent of the FPL, and would extend prescription drug coverage for certain noninstitutionalized elderly. These initiatives were outlined within the Tobacco Settlement Proceeds Act of 2000 that was supported by two-thirds of Arkansas voters.
- 2. The employer buy-in to Medicaid** would allow employers with low-wage workers to buy in to a state-run Medicaid Primary Care Case Management program, with a requirement for employers that 100 percent of employees have coverage. Federal matching dollars (at 73%) would provide a large subsidy, supplemented by employer and employee contributions depending on the income level of the employee, as follows:

Up to 100 percent of the FPL, the employee pays nominal copays, the employer pays a subsidized premium;

Between 100 percent and 200 percent of the FPL, the employee pays premiums on a sliding scale; and

Over 200 percent of the FPL, the employee and employer cover the entire premium.

The state requires a federal waiver to implement these approaches, and is seeking federal approval through the Health Insurance Flexibility and Accountability (HIFA) waiver authority.

Elements that Facilitated Health Reform

Champions for Reform

The strong leadership of G. Richard Smith, M.D. (Director), Kate Stewart, M.D. (Associate Director), and Joseph Thompson, M.D., M.P.H. (Associate Director) of the ACHI has been critical for health reform in Arkansas. With the encouragement of a supportive governor, and coincident with the tobacco industry settlement of \$65 million per year, Thompson and his colleagues developed a plan for using the funds to improve

health. Over 18 months, Thompson brought stakeholders together and mounted political and educational campaigns to direct all the funds toward health care in the state.

Staged Process

Thompson found that employing a staged process was key to directing tobacco settlement funds toward health reform and health improvement. The first stage involved obtaining agreement on principles. This was achieved through a statewide educational campaign culminating in a ballot initiative that locked the state into spending the tobacco funds on health-related efforts. The second stage was the development of a plan for how to spend the money—a task made easier after the funds were already secured.

Broad-Based Coalition

A loosely organized core group of individuals and organizations supported a number of health initiatives over the past decade.⁴ Including business representatives, hospitals, providers, universities, and insurance companies, this group became CHART and was instrumental in the drive to secure tobacco settlement funds for health care. CHART members, along with several state government agencies and advocacy groups, formed the interdisciplinary Project Team for the Arkansas Health Insurance Expansion initiative under the state's SPG program. This group represents about 300 organizations and has become a political force.

The coalition went beyond formal meetings. Representatives were invited (and at times pressured) to join the statewide bus campaign to educate state residents about health care issues. Virtually forced to sit together en route to community meetings around the state, members discussed issues and built relationships that have lasted beyond the campaign. Success with the tobacco initiative gave CHART confidence to take on the next major challenge—expanding insurance coverage.

Educating the Public with Data and Personal Messages

To build public support for using tobacco funds for health-related investments, CHART engaged in 20 community forums around the state. The meetings generally were organized by a hospital association or chamber of commerce. CHART organizations invited local members to attend the meetings. Arkansas General Assembly members also were invited, and the meetings were open to any individuals interested in how the tobacco money would be spent.

⁴ Initiatives included a Soft Drink Tax in 1992 (the revenues from which were dedicated to health), the Governor's Health Reform Task Force, the merging of the State Teachers and State Employees health insurance plans, and the establishment of ARKids first.

People representing a broad group of public and private organizations conducted the meetings to educate local residents about the importance of health-promoting behaviors and access to coverage. The sessions were intended to encourage participants to become agents in their communities. Presenters used health statistics and simple messages. They found it helpful to make the message “personal,” for example, by using local data to stress how specific communities would be affected by new tobacco funds dedicated to health care coming into the local economy.

Addressing Obstacles

Resistance to Long-Term Investment

Although the majority of the state legislature supported the proposal to use the tobacco settlement funds for health care, the legislation was held up in the rules committee of the general assembly. This was reportedly because of resistance by some legislators to using the funds for long-term investments in health, including tobacco cessation programs, rather than addressing short-term issues such as increased support for “meals on wheels.” In response, CHART and ACHI went directly to the people of the state, presenting their plan as a referendum. After the public education campaign (described above), the initiative passed. In the end, there was a compromise plan that included both short-term and long-term responses to the health-related problems of the state.

Poor Health and Lack of Knowledge

Advancing a health reform agenda has been made more difficult by generally poor health in the state and a lack of knowledge about health promotion and prevention. Arkansas ranked last in the United States in overall health and access to health care from 1993 to 1998, improving only slightly to a rank of 45th in 1999 and 44th in 2000. Its infant mortality rate is 20 percent higher than the U.S. average.

Advocates for health care reform started to address the lack of knowledge through the bus education campaign (described above). Specifically, organizers put the facts together and presented them in such a way as to emphasize the connections between behavior and health. For example, pairing the finding that about 95 percent of lung cancer deaths are related to smoking with Arkansas’s second-highest lung cancer rate and third-highest smoking rate in the United States seemed to drive the point home.

The state also is pursuing a stronger public health agenda through the creation of a new public health school at the University of Arkansas funded as a “targeted state need” through the Tobacco Settlement Act.

Flight of Insurance Carriers and Escalation of Premiums

A majority of the regional and national carriers that had offered insurance products in Arkansas left the market because of the difficulties in maintaining profits. The private market is now dominated by two carriers: Blue Cross Blue Shield of Arkansas/Baptist Health systems, and QualChoice.⁵ Fewer than 4 percent of state residents receive care through Health Maintenance Organizations (HMOs), and that portion is declining. Facing similar reasons for rising health care costs as other states, compounded by difficulties managing care in rural areas, low employer participation in health coverage, and general poor health of residents, Arkansas has seen a rapid rise in insurance premiums beginning in the late 1990s. One way the state is trying to address increasing premiums is a plan that would allow employers to buy in to Medicaid, which would also bring in federal matching funds to help subsidize the cost.

Limited Technical Experience

Historically, Arkansas has had limited expertise in health policy, planning, and finance. This was manifested in lost opportunities for federal funding. Beginning in the 1980s, for example, it did not pursue Disproportionate Share Hospital (DSH) payments that were available from the federal government, leading to large losses by the state's major teaching and safety net hospital. In addition, the implementation of ARKids First as a Medicaid Section 1115 waiver rather than through the State Children's Health Insurance Program (CHIP) has meant a lower federal match but has allowed broader eligibility through Medicaid for uninsured children. The state has since made changes, and children enrolled from families with higher incomes (150% to 200% of the FPL) are now funded through CHIP rather than Medicaid.

The state has tried to address the lack of expertise by securing external funding for technical assistance in a range of project areas. It obtained a \$1.4 million SPG from the HRSA, which funded major data collection and analysis, development of health coverage policy options, and recommendations for state and federal reforms. It has secured a \$1.5 million SCI grant (funded by the RWJF), and is contributing an additional \$500,000 of state money to design programmatic and funding strategies to implement SPG recommendations and to help evaluate those reforms. In addition, a RWJF-funded Southern Rural Access Program grant and a Community Access Program (CAP) grant have provided technical assistance and funds for a variety of local initiatives.

⁵ QualChoice has provider agreements with St. Vincent's Hospital System and the University of Arkansas for Medical Sciences.

Looking Ahead: Primary Challenges

Similar to many other states, expanding health insurance in a time of budget constraints is the major challenge ahead. Unlike some states, however, Arkansas's budget shortfalls in 2001 were relatively small (less than 10%), and it already has dedicated its tobacco settlement funds toward coverage expansion and other health-related endeavors. Nevertheless, policymakers are seeking ways to get the most coverage "bang" for their limited "bucks," such as the proposed limited benefit package that would allow the state to offer Medicaid coverage to more low-income adults. Some advocates, however, are opposed to any reductions in Medicaid benefit packages (generally associated with HIFA waivers), fearing inadequate coverage and a slippery slope toward greater cutbacks.

The employer buy-in being pursued will require a federal waiver as well as state legislation, two significant challenges. Program designers are excited about the plan, however, viewing the model as a true public/private partnership that would expand coverage in a way that distributes the burden fairly with limited financing demands on the state.

Another challenge will be for ACHI—the catalyst for health reform in Arkansas—to maintain its autonomy. Much of its success has come from its relatively independent status and image as an "honest broker." Whether it can maintain stable funding without becoming a government agency, or part of the University of Arkansas, is an open question.

Finally, according to one expert, the next public health challenge after coverage expansion will be to address the high incidence of obesity and lack of exercise among state residents.

Lessons for Other States

Several lessons emerge from Arkansas's experience in recent years. It shows that a state *can* make inroads despite high poverty rates, poor health, lack of public health knowledge, limited choices in the private insurance market, and low levels of employer coverage. It provides evidence that individuals and organizations dedicated to reform can overcome legislative roadblocks and take an issue directly to the public. It also proves, however, that such a route requires strong leadership, broad-based coalitions, a step-by-step approach, and an effective educational component that informs communities how they can benefit from change. Arkansas's experience also shows how a state can address very limited resources by pursuing grants that bring in outside dollars and expertise. A state also must be creative in its efforts to obtain long-term, stable funding.

According to one health care expert, Arkansas has learned that efforts that are solely public or solely private are doomed to be limited in impact because of the systemic problems facing the entire citizenry. The best solution for Arkansas, particularly given that very little had been done for low-income adults in the past, was to combine public subsidies with employer contributions in a way that leveraged federal dollars with minimal financial burden on the state. If Arkansas's program is approved and implemented, other states may want to monitor its experience and perhaps pursue similar models of coverage expansion.

Sources

Arkansas Health Insurance Expansion Initiative, Roundtable Report, Arkansas Center for Health Improvement, March 2002.

Arkansas State Coverage Initiatives grant application, May 31, 2001.

Arkansas State Planning Grant application, July 7, 2000.

Personal communication with Joseph Thompson, M.D., M.P.H. (Arkansas Center for Health Improvement).

MICHIGAN

Overview and Summary

Michigan has lower levels of uninsurance among children and nonelderly adults than the nation as a whole, reflecting relatively high rates of employer-sponsored coverage as well as several coverage expansions that were implemented over the past decade. The primary mechanisms for public coverage have been Medicaid (which includes a program called Healthy Kids), the State Children's Health Insurance Program (MIChild), a series of county-based indigent care programs that cover local residents who would otherwise be uninsured and, most recently, a prescription drug coverage program for seniors (Elder Prescription Insurance Coverage, or EPIC). All public programs in Michigan are coordinated by the Michigan Department of Community Health (Tables 3 and 4).

As in most states, policymakers are worried about rapidly escalating public program costs. One state official estimated that Medicaid costs represent about 20 percent of the state budget. In addition to the increasing costs of providing services such as prescription drugs, one state official estimated that Michigan is enrolling about 10,000 people per month in its public programs. Michigan state officials, however, also remain committed to expanding coverage for the uninsured. Thus, in an effort to continue to expand coverage while not exacerbating the problem of budget shortfalls, Michigan submitted a Health Insurance Flexibility and Accountability (HIFA) Section 1115 demonstration waiver, although this application was put "on hold" pending review by a newly elected governor in November 2002. This profile will first outline current access programs in Michigan and then look at how the state planned to build on its current infrastructure using the new federal flexibility allowed under HIFA demonstration authority.

Michigan provides several interesting lessons for other states. First, state policymakers believe strongly in the concept of devolution and the importance of allowing health care decisions to be made at the local level. As a result, the counties in Michigan form a critical piece of the health care infrastructure, and the state's most recent coverage initiative relies heavily on those counties to experiment with strategies to cover the uninsured. Second, as with other states exploring the use of HIFA waivers, Michigan has tried to take advantage of the new federal flexibility to expand coverage and match covered services to the needs of the populations being served. This has involved many discussions on what constitutes an appropriate and affordable benefit package for the various populations, and the state has faced some of the same struggles and ideological issues that have confronted other states. Michigan has taken a slightly different tack, however, in that it has developed a greater number of benefit packages for the different

populations than some other states. Finally, employers have always played a large role in providing coverage in Michigan and state officials have tried to avoid disrupting employer-sponsored coverage and to address employers' reluctance to become more involved with coverage expansions than they already are.

Table 3. Michigan State Profile and Overview, 1999–2000

	Michigan	United States
Total Population	10,032,090	275,740,020
Population Under 65	8,930,150	242,761,980
Percentage Under 200% of FPL	29%	34%
Percentage Under 100% of FPL	13%	15%
Portion of Children that Are Uninsured	8%	12%
Portion of Nonelderly Adults that Are Uninsured	13%	18%
<i>Insurance Distribution Among Nonelderly</i>		
Employer-Sponsored Insurance	74%	69%
Individual	4%	5%
Medicaid	11%	10%
Uninsured	11%	16%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2000 and 2001 Current Population Surveys.

Table 4. Michigan Medicaid Program and CHIP

Program Type	Medicaid	MIChild (CHIP)
Waivers/ Legislation Required		Title XXI state plan Separate CHIP program
Time Frame		Implemented in May 1998
Enrollment (August 2002)	1,168,185 enrollees total	30,053 enrollees
Eligibility Criteria	Children ages 1 through 18 <150% of FPL (Healthy Kids) Children under age 1 <185% of FPL Pregnant women <185% of FPL ^a Caretaker relatives <50% of FPL Aged and disabled <100% of FPL	Children through age 18 with family incomes between 150–200% of FPL
Benefits/ Subsidies	Comprehensive Medicaid benefits	Similar to the state employee benefit package (with some enhanced benefits for vision and dental services) No copayments \$5 monthly premium per family for families with incomes between 150–200% of FPL ^b
Financing	Medicaid federal share (FY 02): 56.36% Medicaid state share: 43.64% Nondisabled children 16 through 18 are funded through CHIP	CHIP match: federal share (FY 02): 69.45%, state share: 30.55%

^a Pregnant women, depending on their income, are enrolled in: (1) Healthy Kids; (2) Group 2 Pregnant Women, a program that allows pregnant women to spend down to Medicaid eligibility; or (3) MOMS (Maternity Outpatient Medical Services), which covers outpatient services only and allows pregnant women to access prenatal care while their Medicaid application is pending, covers teens who choose not to enroll in Medicaid because of confidentiality concerns, and covers noncitizens who are otherwise only eligible for emergency services.

^b Does not matter how many children are in the family; American Indians and Alaska Natives are exempt from the premium payments.

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from HCFA-2082 reports (for Medicaid enrollment numbers); Michigan Title XXI State Plan Fact Sheet (available at www.cms.hhs.gov/schip/chpfsmi.asp), and enrollment updates from the Michigan Department of Community Health.

Other Existing Access Programs

County-Level Indigent Care Programs

After a successful program spearheaded by Michigan’s Wayne County, state and local policymakers began promoting the concept that all health care is local and that county-based indigent care programs provide a way to maximize resources (broadly defined). The state’s role has been to provide funding incentives for counties to develop their own programs. The primary funding streams have been disproportionate share hospital (DSH) funds and upper payment limit (UPL) strategy payments. As of September 2002, about 16

counties had developed indigent care programs and approximately 30 more had expressed interest in developing some type of program with the state.

The counties, with federal and state money available, have developed a series of indigent care programs that utilize local resources to best fit the needs of the local populations. For example, in Ingham County, the Ingham Health Plan provides outpatient hospital care and a limited pharmacy benefit to county residents with incomes below 250 percent of the federal poverty level (FPL) (with no cost-sharing for those with incomes below 100% of the FPL and some cost-sharing for those with incomes above that level). The plan has about 13,000 enrollees, representing about half of the eligible uninsured population in the county. The program is funded with DSH and state and county funds and receives some private foundation support. In addition, because the county has a large number of students, efforts have been made to develop coverage products for them.

In contrast, Wayne County has focused more on working with employers and has developed a program called HealthChoice, which provides coverage to uninsured workers in low-wage firms (e.g., more than 50% of the firm's workers earn less than \$10 per hour). In HealthChoice, the employer and the employee each pay one-third of the cost of coverage, with the remainder funded by DSH and county and state funds. About 20,000 people were enrolled in HealthChoice in 2000 and about 30,000 were enrolled in PlusCare, another Wayne County program for indigent residents ages 21 through 64 with incomes below \$250 per month.

State Medical Program

The State Medical Program (SMP) is aimed at low-income, childless adults who do not qualify for Medicaid. SMP provides basic outpatient medical care and does not cover inpatient hospital services. There is an income limit of 35 percent of the FPL and a cash asset limit of \$3,000. Although SMP is offered statewide and is financed by the state, in some counties, eligible individuals must be enrolled in the county health plan to receive SMP services (although those services may be supplemented by the county health plan).

Elder Prescription Insurance Coverage (EPIC)

The Elder Prescription Insurance Coverage (EPIC) program was a legislative initiative supported by the governor and his health policy staff and was developed as a way to help low-income seniors afford prescription drugs.⁶ EPIC replaced two existing drug coverage programs for seniors without access to prescription drug coverage: the Michigan Emergency Pharmaceutical Program for Seniors (MEPPS), which was only available to seniors three times a year, and the Prescription Drug Tax Credit Program, which offered

⁶ For more information about EPIC, see www.miepic.com.

an annual rebate on medications. Although seniors with incomes up to 200 percent of the FPL are eligible to enroll in EPIC, the program began in October 2001 by enrolling seniors who had been enrolled in MEPPS. In December 2001, seniors using the tax credit program were enrolled. Since then, enrollment has been closed so that as a practical matter, EPIC is being used only by seniors with incomes up to 150 percent of the FPL. The state estimates that about 15,000 seniors are enrolled, at an average cost of \$2,100 per year, and that 43 percent of the enrollees are over 80 years of age. The program is funded by state general revenues and tobacco settlement funds. Other eligibility requirements are that the applicant is over 65, has been a Michigan resident for three months prior to application, is not residing in an institution, has no other insurance coverage for prescription drugs, and is not currently receiving Medicaid benefits. The state would like to reopen enrollment but as of summer 2002 it did not have sufficient funds to do so.

EPIC currently covers most Federal Drug Administration (FDA)-approved prescription drugs and enrollees pay a monthly copayment that is tiered based on income. The program is managed by a pharmacy benefit manager, First Health Services Corporation, which also oversees program enrollment. Michigan has established over 150 Senior EPIC centers throughout the state (with at least one in every county) to promote enrollment efforts.

MIFamily HIFA Proposal

Michigan's HIFA proposal is relatively broad in scope and would affect several different populations (Table 5).⁷ The goal of the HIFA waiver is to provide coverage to an additional 210,500 Michigan residents. In addition to the coverage changes noted in Table 5, children enrolled in Medicaid's Healthy Kids program would have 12 months of continuous eligibility, which is currently only available to children in MICHild and which the state hopes would improve continuity of care for this population. The role of the counties in MIFamily is explained in more detail below.

Because HIFA waivers must be budget-neutral to the federal government, current spending on health care in Michigan would be reallocated to cover the cost of insuring new groups. More specifically, the waiver would be financed through reallocation of existing state spending for the caretaker relative group, low-income adults, and disproportionate share hospital (DSH) dollars; use of any unspent CHIP funds; and redeployment of county funds allocated for health care. In addition, some savings would

⁷ As of September 2002, the HIFA waiver had been placed on hold and is pending advice of the newly elected governor taking office January 2003.

be achieved through increased cost-sharing and reductions in the benefit package for some current beneficiaries.

Another component of the HIFA proposal is a voucher program that would allow people eligible for coverage under the waiver to enroll in employer-sponsored coverage if that coverage is available to them. The employer plan would have to cover physician, pharmacy, and inpatient hospital services, and the amount of the voucher would be equal to the state’s cost of providing these services. If the enrollee joined the employer-sponsored plan, he or she would no longer receive benefits through a state-contracted health plan. The voucher also would be available to childless adults with access to employer-sponsored coverage who otherwise would be receiving services through a county-based plan. The idea is that the enrollee would directly receive a check in the voucher amount each month and the employer would not be involved.

Table 5. MIFamily HIFA Proposal

Population	Currently Covered by Medicaid	New Coverage Under MIFamily	Changes to Benefit Package^a
Disabled Adults	<100% of FPL (under Aged and Disabled Care)	Working disabled adults <350% of FPL	None—will continue to receive full Medicaid benefits
Parents and Caretaker Relatives	Caretaker relatives <50% of FPL covered as an optional group under Medicaid	Parents and those acting as parents <100% of FPL	HMO benefit to those under 50% of FPL HMO-like benefit with reduced inpatient coverage for those between 50–100% of FPL
Pregnant Women	Pregnant women <185% of FPL	Pregnant women <200% of FPL	None—will continue to receive full Medicaid benefits
Childless Adults	Not eligible ^b	Childless adults <35% of FPL Childless adults 35–100% of FPL	Outpatient, mental health, and substance abuse services Counties may partner with state to develop coverage options

^a All groups receive a pharmacy benefit; a voucher option will be available to buy in to existing employer-sponsored coverage.

^b Those adults living at <35% of FPL can, however, access the State Medical Program, which provides basic outpatient medical care. MIFamily will replace the SMP.

Source: Michigan HIFA waiver submitted March 1, 2002, available at www.michigan.gov/mdch.

Elements that Facilitated Coverage Expansion

Building on County-Based Indigent Care Programs

A unique aspect of the Michigan HIFA waiver is the role of the counties. One goal of the MIFamily program is to cover people, such as low-income, childless adults, who do not qualify for Medicaid. Although eligibility for the existing county-based programs varies by

county, the state believes that many childless adults do not have access to coverage, are not employed, have high rates of substance abuse, and have significant mental health problems. Building on the process of devolution described above, the state is relying on the counties to voluntarily develop programs for these childless adults with incomes between 35 and 100 percent of the FPL. For the group below 35 percent of the FPL, the state has established a uniform benefit package that includes outpatient, mental health, and substance abuse services to address what state policymakers believe are the most serious needs of this population. Although counties that choose to participate cannot provide less than this minimum benefit package, they can supplement the package and they are responsible for choosing the delivery mechanism for services (e.g., either fee-for-service or using the Medicaid managed care delivery system).

The state met with the counties throughout the development of the waiver and there are a number of issues still to be worked out between the state and the counties. Although county participation would be voluntary, state policymakers note that counties seem enthusiastic about participating in MIFamily. In addition, given that MIFamily would be a continuation (at least in some counties) of programs that are already in place and that there would be financial incentives provided by the state to encourage participation, the state believes this program will work at the county level. The state estimates that, at minimum, seven counties would participate in the first year of the waiver, up to 47 counties might participate in the second year, and the remaining counties would be phased in over the final three years of the waiver so that all 83 counties would be participating by the end of year five.

As part of this initiative, the state has been exploring the idea of a voucher program (described below) that could be used by these adults to help defray the cost of employer-sponsored coverage. Although the general idea is that enrollees with access to employer-sponsored coverage could enroll in that coverage in lieu of the county health plan, further details about how this would work are not available.

Strong Political Leadership

In his State of the State Address in January 2002, Governor Engler announced that he wanted the state to submit a HIFA waiver in March to address the problem of the uninsured in Michigan. Although the governor has outlined a short time frame in the past to pass health reform legislation (such as MICHild), one reason for the extremely short time frame was that the governor was under term limits and would be leaving office at the end of 2002. To ensure that this initiative would be on its way to implementation by the end of the year, the governor needed the agreement of the state legislature. Therefore, he

and his staff met with key legislators, who generally agreed with the principle behind the waiver. Because the legislature's highest priority with respect to health reform was to maximize the number of people covered, there were some disagreements over details of the waiver, however, with such strong support from the governor and general buy-in from the legislature, it was possible to submit the waiver to the federal government in March 2002. It is not yet clear, however, whether the newly elected governor will continue to pursue this waiver.

Stakeholder Involvement

After the governor's announcement in January 2002, the state worked with stakeholders throughout February to respond to concerns about the proposed coverage expansion. This included conducting forums with over 400 people in attendance, publishing information in 11 newspapers in the state, and meeting with stakeholder groups as well as individuals. In addition, the state let various stakeholders review drafts of the waiver and had the waiver draft posted on a website for review and to allow for the submission of questions and concerns. The state's answers and responses then also were posted on the website.

After March 2002, the state continued to meet with stakeholders (including individuals, plans, hospitals, and others such as mental health providers and advocacy groups) as well as with the counties. The state acknowledges that it was a learning process and that stakeholder involvement was critical to the submission of the waiver. Some of the primary concerns of stakeholders are addressed in the discussion of benefits below.

Federal Flexibility

Michigan state policymakers emphasized that they appreciated the flexibility afforded them by the federal government under the new HIFA guidelines. Such flexibility allowed Michigan, even in a time of tight budget constraints, to expand coverage because of the budget neutrality requirement. Because the waiver had budget allocation neutrality, the state did not have to expend additional state funds and so did not have to go to the legislature with a request for increased funding. This avoided political divisions over new spending.

Challenges to Expansion

Employer Reluctance

Michigan employers, as in many other states, have been facing double-digit premium increases for health insurance and are reluctant to take on more administrative responsibilities to ensure that their employees have coverage. Anticipating employers' unwillingness to get more involved with health coverage than they already are, Michigan

has been working on developing a voucher program to provide employees with state-subsidized vouchers that could be given directly to plans offered by their employer. The details have not yet been determined, but because the outline of the plan does not place additional administrative burdens on employers, they have not expressed opposition to the waiver plan.

Concerns About the Benefit Package

The MIFamily program is more complicated than some of the other HIFA waiver programs, in large part because the state has tried to tailor the benefit package to meet the needs of the population being served. This was done in part because the waiver has to be budget-neutral to the federal government, and so the state could not afford to offer the full Medicaid benefit package to all new eligible persons. Therefore, as noted earlier, if a county chooses to participate, primary and preventive services, emergency services, mental health and substance abuse services, and prescription drugs would be mandatory covered services for childless adults with incomes below 35 percent of the FPL, but inpatient hospital services are not covered. The state has, however, included expansion of eligibility for the disabled population (up to 350% of the FPL), with all new enrollees eligible for the full Medicaid benefit package, because the disabled population needs access to many of those services. Newly eligible pregnant women with incomes up to 200 percent of the FPL also would receive the full Medicaid package, again because the state believes that they would use many of the covered services and because adding these women allows for better contracting opportunities with health plans.

These tailored benefit packages, however, have been the subject of some debate throughout the development of the waiver. For example, one specific concern raised has been that benefits for those in the current caretaker relative group with incomes below 50 percent of the FPL would be reduced (because they now receive the full Medicaid benefit package) and some cost-sharing would be imposed. The increased cost-sharing raises two issues. First, some people might delay seeking care if they cannot afford cost-sharing; second, if providers see those patients anyway, the uncollected cost-sharing represents a cost shift to providers. Another issue is that creating several new benefit packages will be administratively complex. Some are concerned about the impact of eliminating the ability to spend down to Medicaid eligibility for certain populations, such as caretaker relatives with incomes above 100 percent of the FPL.

Although the state has tried to engage stakeholders in the discussion on the waiver (and more specifically, on the benefit package), some advocates feel that the state knew what it wanted to do before it started the process and did not leave much time for

discussion. State representatives assert, however, that the benefit package was modified based on discussions with interest groups—for example, lowering the cost-sharing requirements because interest groups felt the cost-sharing was too high as initially envisioned. In response to concerns from advocates for the disabled, the state raised the income eligibility limit for the disabled population and allowed up to \$15,000 to be set aside in a “Freedom Account” that is excluded from assets in calculating income. State policymakers also would argue that it is better for those who are currently getting nothing to receive some benefits, even if it means trimming benefits for those who currently have a more generous package.

Provider Concerns

One challenge to the HIFA waiver has been concern on the part of hospitals that the inpatient benefit is limited for some groups (such as parents and people acting as parents with incomes between 50% and 100% of the FPL) and is not available for others (such as childless adults, unless the counties choose to add it as an optional benefit). The hospitals would have preferred a larger inpatient hospital benefit, but from the state’s perspective, these were groups that had no coverage before and hospitals already were seeing them in the emergency room. Under this reasoning, now the hospitals would receive at least some reimbursement for care that had been previously uncompensated. Another provider concern is the potential for cost-shifting to providers because of uncollected cost-sharing, as noted above.

There have been no major problems with anticipated health plan participation. In the late 1990s, Michigan shifted many of its Medicaid enrollees into managed care as a way to control escalating public program costs. This transition initially was not smooth because there were some problems with the competitive bidding process for Medicaid HMO contracts and with low provider payment rates. These issues were addressed, however, when the state increased payment rates and made changes to the bidding process. Now, although health plans and the state continue to negotiate about specifics, the plans appear ready to offer the new benefit packages outlined in the HIFA waiver.

Looking Ahead

Michigan submitted the MIFamily waiver to the Centers for Medicare and Medicaid Services (CMS) in March 2002; there were some negotiations between the state and CMS about issues raised by the waiver.⁸ The waiver application was placed on hold before the November 2002 elections, and as noted above, continues its “inactive” status pending review and advice by a newly elected governor. Therefore, the state faces uncertainties

⁸For more information, see CMS Questions and Answers regarding the Michigan waiver, posted June 4, 2002, available at the National Health Law Program website, www.healthlaw.org/waiver.shtml.

about whether its current HIFA proposal will be pursued by the new administration, and, if so, whether it would be approved by the federal government

If the waiver initiative does move ahead, several challenges remain. The state would need to work out contracting issues with health plans, as well as administrative issues associated with several new categories of Medicaid eligibility (added to the existing 28 current categories of Medicaid eligibility in Michigan) that require internal system changes. Also, the voucher program would need to be developed and issues concerning county participation for the population of childless adults would need to be addressed. Although voucher programs hold promise, other states have had difficulty with marketing programs that involve buying into employer-sponsored coverage and take-up rates have been low.

The county coverage initiative not only follows Michigan's history of devolution of health care, but allows for innovation at the local level and also allows counties to be responsive to the needs of their residents. There are some risks in this approach, though, because county participation is voluntary and as counties face limited budgets, they may be able to take advantage of the opportunity presented to them by the state.

Lessons for Other States

Unlike some other states that had a longer process for a single coverage expansion initiative, Michigan has had a rapid expansion process. Although there were some benefits to this, the state cautions that a coordinated effort was needed to gather support for the waiver. In addition, its work with stakeholders, while indeed critical to success, took enormous effort, and the support of the governor and key legislators was very important. Michigan's unique approach to working with counties is worth following and may be something other states can explore as an option to take advantage of greater federal flexibility. In the process of developing a waiver program such as MIFamily, however, Michigan (like other states) has had to address concerns about the benefit package and look for ways to work with employers that do not jeopardize the employer-sponsored health care market.

Other states also may be interested in looking at Michigan's prescription drug program as they explore how to expand drug coverage to seniors in the absence of federal action. As state policymakers noted, none of the recent federal proposals offers coverage that is as generous as the state plan. Given that the program is entirely state funded, however, it can cover only a limited number of seniors.

All states are currently struggling with Medicaid. State governors have advanced several proposals to encourage short-term federal assistance, such as increasing the federal Medicaid assistance percentages (FMAP), but there is no clear resolution to the problems facing the Medicaid program. The federal government also has changed some of the regulations surrounding upper payment limit (UPL) methodology, which, coupled with the economic downturn, have put Michigan's Medicaid program in a difficult position financially. Although Michigan has had a reserve fund for Medicaid, it will be exhausted by the end of 2003. Therefore, coverage "solutions" that require no additional federal or state funds, such as the Michigan HIFA proposal, may well be the wave of the future in the absence of federal action.

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NEW MEXICO

Overview and Summary

New Mexico was chosen as a profile state because it is planning a bold (and somewhat controversial) approach to access expansion despite a relatively weak coverage infrastructure and a limited history of public coverage for adults. It is in the first wave of states to pursue a Health Insurance Flexibility and Accountability (HIFA) waiver to expand coverage for working uninsured adults through employer-sponsored insurance (ESI). This profile focuses primarily on the elements that facilitated the development of the proposed HIFA coverage expansion program, the challenges associated with it, and lessons for other states considering coverage expansions for the working uninsured.

Although public coverage for adults in New Mexico has been limited, the state has been generous in expanding eligibility for public coverage to children. New Mexico's Medicaid program covers Temporary Assistance to Needy Families (TANF) adults with incomes only up to 37 percent of the federal poverty level (FPL). Yet Medicaid covers children through age 18 and pregnant women up to 185 percent of the FPL, and the State Children's Health Insurance Program (CHIP), instituted in 1999, covers children through age 18 with incomes between 185 percent and 235 percent of the FPL. All children, regardless of whether they qualify for coverage under Medicaid or CHIP, receive the same benefits and are enrolled in New MexiKids. New Mexico also has implemented several innovative Medicaid programs, including a personal care option under fee-for-service Medicaid that has been effective in offering the elderly a home-based alternative to nursing homes, and a Medicaid program for the working disabled with incomes up to 250 percent of the FPL that allows enrollees to keep working without losing their Medicaid benefits.

The state has a long way to go in covering the uninsured; almost one-quarter of New Mexico's population was uninsured in 1999–2000 (24% compared with 14% nationwide for the total population and 29% of nonelderly adults compared with 18% nationwide, as noted in Table 6).⁹ The uninsured rate for children was twice the national rate despite relatively generous eligibility criteria for New MexiKids. Although New Mexico has enrolled a substantial number of children recently and those numbers may not be reflected in these data, it continues to face ongoing barriers to enrollment such as rural remoteness, border problems, language differences, and difficulties in reaching Native

⁹Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys. Total U.S. numbers are based on March 2001 estimates. As cited in Kaiser State Health Facts On-Line (www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?).

Americans who are being served by the Indian Health Service. An additional difficulty the state has faced is keeping children in the program; the state estimates that an additional 50,000 children access Medicaid during the year but their parents fail to reenroll them for the following year even though they remain eligible. Many of these tend to be healthy children whose parents believe that medical care is to be sought only when sick. The state continues to do strong outreach to enroll and retain these eligible children and has a Robert Wood Johnson–funded Covering Kids program to address some of the enrollment barriers just described.

For adults, the high uninsurance rate is related in large part to historically low rates of employer coverage (58% of nonelderly adults have ESI compared with 69% nationally). There are a variety of reasons for this. First, the state’s economy is based in large measure on services, agriculture, and tourism—sectors with typically high rates of uninsurance. Second, the state has many small businesses, which are less likely to offer coverage than large businesses. Finally, employers and employees recently have found coverage increasingly difficult to afford. Faced with these facts, policymakers in New Mexico have been working to develop a coverage expansion program for adults that supports employer-based health insurance.

The new coverage expansion program would be implemented under the new federal HIFA Section 1115 demonstration authority (summarized in Table 7). The waiver was approved in August 2002 and the program is scheduled to begin in February 2003. It would provide a standardized basic commercial benefit package to approximately 40,000 uninsured adults with incomes at or below 200 percent of the FPL. Coverage would be provided through the employer-based system and would be funded using unspent CHIP and Medicaid funds. Existing Medicaid and CHIP beneficiaries will not be affected. The legislature established a Medicaid Reform Committee during the 2002 legislative session that is evaluating the Medicaid program. There is a reference in the New Mexico HIFA waiver that a second phase of the waiver could be proposed based on the recommendations of the Medicaid Reform Committee.¹⁰ Because of this reference, the HIFA waiver has become controversial in the state. Although the Medicaid Reform Committee is still in the preliminary stages of review of the Medicaid program and no recommendations have been made, some in the advocacy community who oppose the waiver fear that

¹⁰ An earlier version of the waiver application stated that a specific plan for phase II would be submitted in the fall of 2002; a revised application submitted in July 2002 stated that a phase II *could* be proposed at a later time. According to a state official, the reason for the revision was that in case Congress did not act to let states keep prior-year CHIP funds, the state would have to finance a portion of the waiver with regular Medicaid funds and that was not made clear in the initial waiver application.

any potential amendment to the waiver will involve reducing the benefit package for current beneficiaries.

Table 6. New Mexico State Profile and Overview, 1999–2000

	New Mexico	United States
Total Population	1,792,150	275,740,020
Population Under 65	1,562,490	242,761,980
Percentage Under 200% of FPL	47%	34%
Percentage Under 100% of FPL	23%	15%
Portion of Children that Are Uninsured	24%	12%
Portion of Nonelderly Adults that Are Uninsured	29%	18%
<i>Insurance Distribution Among Nonelderly</i>		
Employer-Sponsored Insurance	55%	69%
Individual	4%	5%
Medicaid	14%	10%
Uninsured	27%	16%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2000 and 2001 Current Population Surveys.

Table 7. New Mexico's Major Coverage Programs and HIFA Waiver

Program Type	Medicaid^a	CHIP (New MexiKids)	HIFA Waiver
Waivers/ Legislation Required	Section 1915(b) waiver for SALUD! (Medicaid managed care program)	Title XXI State Plan Section 1115 demonstration (Medicaid expansion)	Original HIFA waiver submitted April 2002; revised HIFA waiver submitted July 2002, approved August 2002
Time Frame		Title XXI Plan approved January 1999; effective date March 31, 1999	Scheduled to begin February 2003
Enrollment	346,261 enrolled as of February 2002 ^b	11,548 children enrolled as of February 2002 (includes 1,776 presumptive eligible persons)	Enrollment will be based on available funds; anticipated enrollment is 40,000
Eligibility Criteria	Children birth through 18 <185% of FPL (New MexiKids) Pregnant women <185% of FPL TANF adults <37% of FPL	Children birth through 18 between 185% and 235% of FPL	Adults with incomes at or below 200% of FPL
Benefits/ Subsidies	Medicaid benefits	Same benefits as Medicaid Copayments ranging from \$5–\$25 depending on service ^c	Standardized benefit package similar to a basic commercial benefit plan in New Mexico ^d Premium-sharing and copayments for employee will be tiered based on income: <100% of FPL: no premium-sharing; copays ranging from \$5 to \$25 101–150% of FPL: \$20 premium; copays ranging from \$10 to \$75 151–200% of FPL: \$35 premium; copays ranging from \$20 to \$150 Employers: \$75 per enrollee per month
Financing	Federal share (FY 02): 73.04% State share: 26.96%	Federal share (FY 02): 81.13% State share: 18.87% (from state general fund)	Allocated but unspent federal and state CHIP funds, federal and state Medicaid funds, employer contributions, individual cost-sharing

^a All children enrolled in Medicaid are considered part of the New MexiKids program.

^b This enrollment number includes the New MexiKids children who are funded through Medicaid.

^c Annual maximum copayment amount cannot exceed 3 percent of income for families with incomes between 186 and 200 percent of FPL; 4 percent for families with incomes between 201 and 215 percent of FPL; and 5 percent for families with incomes between 216 and 235 percent of FPL.

^d Services will include inpatient, outpatient, emergency and urgent care, physician's surgical and medical, laboratory and X-ray, pharmacy, OT/PT/ST, behavioral health, substance abuse, DME, and supplies.

Sources: For CHIP information, see New Mexico Title XXI State Plan Fact Sheet (www.cms.hhs.gov/schip/chpfsnm.asp); for CHIP and Medicaid enrollment numbers, see New Mexico Human Services Department, Medical Assistance Administration website (www.state.nm.us/hsd/mad/GenInfo.htm); New Mexico HIFA waiver.

Other Existing Access Programs

New Mexico Health Insurance Alliance

The New Mexico Health Insurance Alliance (NMHIA), created by the state legislature in 1994, is a vehicle to make coverage more accessible to businesses with two to 50 eligible employees, self-employed individuals, and employed and unemployed individuals who have lost their group health coverage. NMHIA contracts with multiple insurance carriers throughout New Mexico to offer a choice of private health maintenance organization (HMO) and indemnity plans to small businesses and eligible individuals. Several features, including guaranteed issue, no medical or industry underwriting, easier employer participation requirements, and rates guaranteed for one year, have helped groups access insurance. The program is financed by an administrative fee withheld from the gross premiums. An administrative assessment on all health insurance carriers in the state may be used to supplement this fee but has not been necessary for the past two years. Enrollment had been as high as 8,800 but the loss of the community-rated HMO plans and subsequent premium increases have had an impact on enrollment. In 2002, the alliance had an enrollment of 5,100.¹¹

New Mexico High-Risk Pool

Operational since 1988, the New Mexico high-risk pool is called the New Mexico Medical Insurance Pool, and premiums are capped at 125 percent of the standard risk rate. People who are medically uninsurable or eligible for Health Insurance Portability and Accountability Act (HIPAA) may participate in the pool. As of June 2000, 1,030 people participated in the pool (989 who were medically uninsurable and 41 who were HIPAA-eligible). This accounts for 1.2 percent of the population enrolled in the individual market and is equivalent to the average enrollment of the 27 states that have high-risk pools.¹² One feature of New Mexico's high-risk pool, offered by only five other states, is that people with incomes below 200 percent of the FPL who are eligible for the pool can receive a subsidy for up to 25 percent of the premium. Currently, about 17 percent of pool enrollees receive the subsidy.

Elements that Facilitated Development of the HIFA Waiver

Importance of Grant Funding

The experience in New Mexico illustrates how the availability of grant funding can jump-start a coverage initiative that may not have been possible otherwise. Several years ago, the

¹¹ NMHIA rates are approximately 15 percent to 25 percent higher than those of commercial carriers.

¹² For more information about New Mexico's high-risk pool (and the source of these numbers), see Achman, Lori, and Deborah Chollet, *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools*, The Commonwealth Fund, publication #472, August 2001.

New Mexico Hospitals and Health Systems Association (NMHHSA) applied for and received a Robert Wood Johnson Foundation Communities in Charge (CIC) grant to fund a local initiative that brought together stakeholders in four counties to explore ways to address the problem of the uninsured in the state. To continue the work started in phase one, NMHHSA applied for a phase two CIC grant but was turned down because the foundation felt that it was an initiative that needed to be implemented statewide. Instead, the foundation suggested that New Mexico apply for a State Coverage Initiatives (SCI) grant, a program also funded by the Robert Wood Johnson Foundation. At this juncture, the NMHHSA partnered with the New Mexico Human Services Department (HSD) to create a public/private partnership and applied jointly for an SCI planning and implementation grant. HSD took the lead in the grant application. The planning grant was awarded in April 2001 and the implementation grant in October 2001. The SCI grant has been the primary source of funding for the development of the HIFA waiver.

Stakeholder Involvement and Political Leadership

To work on the SCI grant, the state, through the HSD and NMHHSA, assembled a broad-based coalition of stakeholders and held a series of meetings to include a very broad spectrum of opinion in the planning process. Each meeting was attended by 40 to 50 stakeholders, evidence of the significant interest in the coverage initiative. Stakeholders who participated included representatives from managed care organizations, primary care providers, hospital representatives, state agencies, local government, business groups, and consumer advocates. Although some stakeholders have been more critical than others (see “Politics Surrounding the HIFA Waiver Application,” below), the state has made a concerted effort to include them in the process and to address the concerns they raised.

In addition to stakeholder involvement, there has been political support for the initiative. Although extending health coverage through traditional entitlement expansions to groups other than children has not always been one of his top priorities, the governor has been supportive of this initiative. The HSD also did outreach with politicians and tried to involve the state legislature as an active participant in program development. In the submission of the SCI planning grant application, HSD and NMHHSA specifically partnered with the Legislative Health Subcommittee.

Consideration of Provider Reimbursement Rates

The State Medical Society also has been involved in the process of designing the coverage expansion and, as might be expected, was particularly concerned about reimbursement rates. After extensive discussions on this issue, the state decided to set physician rates at

125 percent of Medicare rates, compared with Medicaid, which is at 95 percent of Medicare rates.

Relatively Stable Managed Care Market

About two-thirds of New Mexico's Medicaid population is enrolled in managed care and the state has three managed care organizations (MCOs) participating in the managed care market.¹³ Only one MCO in the state (Blue Cross Blue Shield) does not participate in the Medicaid managed care program. Unlike some states that have had significant difficulties maintaining managed care plan participation in public coverage programs, New Mexico has not had problems with MCOs withdrawing from the market. This history of plan participation should bode well for the new HIFA waiver, which relies on the participation of the MCOs and their willingness to offer the standardized benefit package proposed by the state.

Sensitivity to the Role of the Employer and the Appearance of a "Private Plan"

When designing the HIFA waiver, the state conducted focus groups with employers to learn more about their concerns since the target of the HIFA waiver is, in large part, working uninsured individuals. After hearing feedback from the focus groups, the state proposed a premium assistance program, with employers paying a fixed amount per month per employee, the employee contributing a portion (tiered based on income), and the remainder covered by unspent CHIP and Medicaid funds. The state has tried to make the program administratively simple for employers. As a result, employers will not have to shop around for a plan; the state has developed a standardized benefit package that will be offered by all participating MCOs. Therefore, if an employer already offers coverage through one of the MCOs, employees who qualify for the program will simply enroll in the standardized benefit package offered by that MCO. If the employer does not offer coverage or does not currently offer a plan from one of the participating MCOs, the employer would choose one and allow the employee to enroll in that plan. Self-employed individuals or the unemployed also could buy in to one of these plans. The state is hoping that creating a process that is relatively simple for the employer will increase take-up rates.

Another consideration was that, although the new HIFA expansion will be funded in part with public dollars and the Medicaid program will contract with the MCOs, the program should look like a private program. In addition to being offered through employers, the plans will be marketed as private plans. This also addressed the governor's opposition to a "public program expansion."

¹³ As of December 31, 2001, 226,523 out of 346,429 (or 65.39%) of Medicaid enrollees were in managed care. See www.hcfa.gov/medicaid/omcpr01.pdf.

Challenges to Expansion

Designing the Benefit Package

For many states considering coverage expansions for non-categorically eligible populations, the benefit package often becomes the subject of much heated debate as states try to balance covering more people with limited state dollars while ensuring that the benefit package includes enough services to provide adequate access to care. New Mexico was certainly no exception. State policymakers heard from both ends of the political spectrum, and while they had anticipated that most of the criticism would come from conservatives, they found that the liberal advocacy groups were more upset about the proposed benefit package. The state also has had to work through how to include the concerns of MCOs and business representatives in the discussion.

As written in the waiver, the benefit package is designed to be similar to a basic commercial benefit package in New Mexico. The package was based on an open discussion of the trade-offs, in the context of budget constraints. In addition, the package was formulated based on results from focus group meetings with businesses and consumers, discussions with MCOs, experience with the UNM Care Plan (a managed care program for the uninsured at the University of New Mexico Health Sciences Center), and much discussion with a Design Work Group. To address concerns about crowd-out, however, the waiver also states that “the basic benefit design was carefully crafted to be somewhat less than most commercial plans so that employers currently providing coverage would not tend to shift to [the new] coverage.”¹⁴ Although many services are included in the benefit package, cost-sharing is viewed by some advocates as nontrivial, raising concerns that high copayments will discourage enrollees from seeking care.

CHIP Funds Versus Medicaid Funds

Although many states have chosen to create a public program that blends CHIP and Medicaid funding and have thought about those programs jointly, the thinking about Medicaid and CHIP in New Mexico appears to be very different. Although the state has unspent CHIP funds that will be used to fund the HIFA expansion and the future of CHIP appears certain, the future of Medicaid and Medicaid enrollees is less clear. As in many other states, Medicaid costs have been rising rapidly. The Medicaid Reform Committee (composed of legislators and an advisory group of community and provider representatives) will be working on recommendations about how to modify the Medicaid program to ensure its continued financial viability and continued coverage of current

¹⁴New Mexico revised HIFA waiver application, page 4.

Medicaid enrollees. There has been no consensus thus far and it is against this backdrop that some of the most serious concerns have been raised about the HIFA waiver.

Politics Surrounding the HIFA Waiver Application

On its face, the HIFA waiver looks like a win-win situation: the state draws down allocated but unspent CHIP funds that otherwise it will lose; adults who currently do not have access to any health coverage receive some benefits; and current Medicaid beneficiaries are not affected. In fact, one of the reasons that the state was eager to submit the HIFA waiver quickly was because it did not affect any current beneficiaries and state policymakers did not want to hold the coverage expansion hostage to the politics surrounding Medicaid. Given the controversy just described coupled with escalating Medicaid costs, however, many in New Mexico are worried that allowing any modifications in the benefit package, even for new populations that currently do not have any coverage, will set a precedent and could be used to change the benefits for current Medicaid enrollees in the future. The concern is that if the governor and the legislature cannot find a way to resolve the Medicaid crisis, the coverage program outlined in the HIFA waiver will have opened the door and provided policymakers with an option to modify the benefit package (certain MCOs will already have an existing contract with the state to offer this modified package) for non-mandatory but currently eligible Medicaid populations. Despite strong support for the SCI program from most of New Mexico's congressional delegation, one of the state's U.S. senators was particularly vocal about his concerns. He has written open letters to the Secretary of the U.S. Department of Health and Human Services and the New Mexico Superintendent of Insurance that voice his apprehensions about the proposed waiver program as it was initially submitted. As noted above, these concerns were echoed by a variety of stakeholders.

Lessons for Other States

Because other states are considering HIFA waivers, or are engaged in a planning process focused on coverage expansion, there is much to be learned from New Mexico's experience. On the positive side, New Mexico has managed to propose a coverage expansion by taking advantage of unspent CHIP funds when many states are considering cutbacks. This desire to expand coverage in a state that has historically not put a high priority on health insurance expansion for adults is very promising, as is the state's ability to capitalize on available grant funding. In addition, the state took great care to include many voices in the planning process as a way of hearing and addressing concerns in the early stages. New Mexico's experience also underscores the importance of handling discussions on benefits with great care because those can generate intense debate.

In the planning process, the state also was helped by certain characteristics of the state health care market, such as a relatively stable managed care environment. In addition, the state made sure to consider the needs of providers and employers, both of whom will be critical as this public/private coverage expansion is implemented. A final lesson from New Mexico is that even in a publicly funded program expansion or a public/private partnership, depending on the stakeholders involved and the politics of the state, it may be important to market the program as a private program to obtain critical buy-in from stakeholders and consumers.

Although New Mexico has the third-lowest per capita income in the country and wages well below the national average, it is not facing a budget crisis of the same magnitude as some other states during the recent economic downturn. As a result, New Mexico has continued to explore coverage expansions, at least for some populations, while other states have had a tough time merely holding on to gains made to date. That said, the state does not have an easy road ahead. Although its waiver was recently approved by the federal government, the Medicaid Reform Committee will need to complete its work on the existing Medicaid program. Much of the committee's work may depend on New Mexico's fiscal situation. Pending recommendations from the committee, some advocates have raised concerns about the fate of current Medicaid beneficiaries. Either way, the state has a difficult battle ahead as it tries to work within a very limited budget, implement its innovative expansion program, and balance the needs of current beneficiaries against the needs of the uninsured.

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NEW YORK

Overview and Summary

With a history of progressive social welfare policies, a large and diverse immigrant population, and one of the most populous urban centers in the country, New York State has been at the forefront of enacting health coverage expansion initiatives. It has the largest Medicaid program in the nation, which provides a very generous benefit package and spends far more than other states per enrollee. Its coverage program for children, Child Health Plus (CHP), preceded and became a model for the nationwide State Children's Health Insurance Program (CHIP). It has been the site for numerous public/private partnership demonstration projects, far-reaching insurance market reforms, and a substantial bad debt and charity care pool. New York recently has implemented two major initiatives legislated by the Health Care Reform Act (HCRA) of 2000: Family Health Plus (FHP), a Medicaid managed care program for low-income adults; and Healthy New York, a reinsurance program geared toward making private coverage affordable to small businesses and individuals. In addition, the September 11 tragedy led to the rapid establishment of temporary Disaster Relief Medicaid (DRM), which enrolled nearly 350,000 people in fewer than four months. Given the goals and limited scope of the current study, this profile focuses primarily on the largest and newest coverage programs: Child Health Plus, Family Health Plus, and Healthy New York (Table 9.)

New York has been criticized for failing to pull together its various initiatives into an integrated, seamless system. Critics point out major fragmentation and lack of communication among the programs, with resulting difficulties and frustrations for eligible populations, enrollment workers, and administrators. Others, however, reject this criticism, accusing detractors of making the “perfect the enemy of the good,” and argue that New York's accomplishments in access expansion far outweigh the difficulties.

New York's complex patchwork of public and private coverage programs appears to result from a number of historical, political, and economic factors. Interestingly, some of the same forces that drove a high level of activity in access expansion also contributed to fragmentation among those programs. For example, New York State, reflecting a long-standing commitment to aiding the needy, enjoys an unusual level of bipartisan interest in improving access to health care. A “split” state government, with a heavily Democratic state assembly and a Republican state senate and governor, has the potential to cause political “logjam” but instead has resulted in the passage of a multitude of coverage programs representing a range of ideologies.

Some policymakers look at this type of compromise as allowing more choice and experimentation. Others, however, view the disconnected programs as inefficient and confusing, discouraging eligible persons from participating in the system. The latter group points to the difficulties in making transitions among programs as enrollees' circumstances change and the negative consequences of family members being enrolled in different health care systems. Despite its breadth of coverage activities and high level of spending, New York has an uninsurance rate that remains slightly higher than the national average, with 17 percent or nearly 2.8 million people without coverage in 1999–2000 (Table 8).

Many factors contributed to fragmentation. At a political level, when developing Child Health Plus there was a need to create a program for children that did not carry the “baggage” of Medicaid and its association with welfare, resulting in a completely separate program. At an administrative level, there was a desire to create a children's program with streamlined enrollment procedures, something that could not be done easily in Medicaid because of a financial arrangement in which counties contribute half of the state's share of primary and acute care Medicaid costs. This county–state fiscal arrangement has created an incentive for counties to resist expanding eligibility and streamlining the application process. Ideological differences about public support for children versus adults and about expanding public coverage versus promoting private health insurance further contributed to the enactment of multiple programs with inconsistent rules.

Despite its many difficulties and ongoing challenges, New York has been extremely active in health coverage expansion efforts, apparently attributable to another set of factors. A state constitutional commitment to caring for the needy reflects a culture of progressive policies. A sharp increase in the number of uninsured, resulting from erosion in the small-group and individual insurance markets in the mid-1990s, was documented by reputable researchers and then highly publicized by the media. This helped to bring key stakeholders together to develop and discuss options for reform. An unlikely alliance between the hospital industry and a major health workers union, which reached out to a broader group of consumer advocates under a common concern and shared goal, led to the development of broad-based support for what became Family Health Plus. The state's desire to work with the business community and promote access to more affordable private insurance led to the formulation of a reinsurance program, Healthy New York. In the end, political compromise in the form of HCRA 2000 resulted in the enactment of two major new access programs geared to low-income adults.

More recently, there have been efforts to simplify and to some degree integrate the programs, including allowing Medicaid and Child Health Plus application through

“facilitated enrollers,” renaming children’s Medicaid and the original Child Health Plus as Child Health Plus A and B, respectively, and developing a single application for adult Medicaid, CHP-A, CHP-B, FHP, and other public programs. These and other modifications expected in 2002–2003 (such as elimination of face-to-face interviews for Medicaid recertification) are likely to reduce, but not eliminate, the complexity and fragmentation of health coverage programs in the state.¹⁵

Table 8. New York State Profile and Overview, 1999–2000

	New York	United States
Total Population	18,439,110	275,740,020
Population Under 65	16,124,510	242,761,980
Percentage Under 200% of FPL	37%	34%
Percentage Under 100% of FPL	19%	15%
Portion of Children that Are Uninsured	11%	12%
Portion of Nonelderly Adults that Are Uninsured	20%	18%
<i>Insurance Distribution Among Nonelderly</i>		
Employer-Sponsored Insurance	64%	69%
Individual	4%	5%
Medicaid	15%	10%
Uninsured	17%	16%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2000 and 2001 Current Population Surveys.

¹⁵ Additional streamlining and other changes are delineated in New York’s Health Care Workforce Recruitment and Retention Act, signed in January 2002. This Act, funded through the Health Care Reform Act, earmarks \$1.85 billion to health care facilities statewide to address health care worker shortages.

Table 9. New York's Major Coverage Programs

	Medicaid	Child Health Plus A	Child Health Plus B	Family Health Plus	Healthy New York
Program Type	Medicaid for adults ^a	Medicaid for children	CHIP	Medicaid expansion for low-income working adults	Reinsurance/stop-loss fund for private HMOs
Waivers/ Legislation Required		Section 1115 waiver	Began as state-only program in 1991, expanded through Health Care Reform Act of 1996 and federal CHIP legislation	1115 waiver, Section 1931, Health Care Reform Act (HCRA) 2000	Health Care Reform Act (HCRA) 2000
Time Frame			Began 1991	Enrollment began fall 2001 in upstate, 2/02 in New York City	Enrollment began 2/1/01
Enrollment	Approximately 1.9 million (as of 6/02) ^b	Approximately 1.4 million (as of 6/02)	526,000 (as of 6/02)	140,000(as of 12/02)	14,700 total (as of 10/02): 55% individuals 25% sole proprietors 20% small businesses
Eligibility Criteria	Childless adults, up to about 50% of FPL (varies by county); Adults with dependent children, up to 87% of FPL, pregnant women up to 200% of FPL	Infants to age 1 up to 200% of FPL, Children ages 1–18, up to 133% of FPL	Infants to age 1, 200–250% of FPL Children ages 1–18, 133–250% of FPL, undocumented children Full premium buy-in if income >250% of FPL	Adults with dependent children, 85–150% of FPL Childless adults, 50–100% of FPL ^d	<i>Small employers:</i> up to 50 eligible employees and at least half participate; 30% or more eligible employees earn less than \$30k/yr and at least one participates; no coverage over prior year (employer didn't offer); employer pays at least 50% single premium. <i>Individuals and Self-employed:</i> employed or sole proprietor; Household incomes up to 250% FPL; uninsured prior year, ^c no access to employer coverage over prior year.

	Medicaid	Child Health Plus A	Child Health Plus B	Family Health Plus	Healthy New York
Benefits/ Subsidies	Rich, comprehensive benefit package; no premiums or cost-sharing	Rich, comprehensive benefit package; no premiums or cost-sharing	Less rich but comprehensive benefit package Some cost-sharing (sliding scale)	Less rich but comprehensive benefit package No cost-sharing	Streamlined benefits with copays and deductibles, in-network providers Indirect subsidy through stop-loss fund for claims between \$30k–100k per member/year
Financing	State and federal Medicaid funds	State and federal Medicaid funds	State and federal CHIP funds State funds for nonfederally qualified enrollees Enrollee cost-sharing	State and federal Medicaid funds	State funds (\$220 million dedicated through 6/03) through tobacco tax revenues Individual premiums and cost sharing, employer contributions

^a Includes elderly, blind and disabled, very low-income adults, pregnant women, temporary Disaster Relief Medicaid enrollees; excludes Family Health Plus enrollees.

^b This number includes Disaster Relief Medicaid enrollees.

^c Or had prior coverage terminated because of loss of employment, death of subscriber, change in residence, other state-determined factors.

^d Includes 19–20 year olds living with their parents up to 150% FPL.

Sources: Enrollment Data from United Hospital Fund analysis of New York State Department of Health enrollment reports; 12/10/02 presentations by Kathryn Kuhmerker, deputy commissioner of New York State Department of Health, Office of Medicaid Management and James Tallon, President, United Hospital Fund.

Elements that Facilitated Health Reform

Culture of Health Policy Activity

Historically, New York State has been progressive in the social welfare arena. Taking care of the needy is an explicit article in the state constitution, and legislators seem to take this provision seriously.¹⁶ New York has enjoyed an unusually high level of bipartisan engagement in health coverage issues with strong agreement that people should have access to health care, although the preferred method for achieving that goal varies. Governor George E. Pataki and the largely Republican state senate have generally preferred an incremental approach and the private insurance model. Assembly Democrats have traditionally preferred expansions in public coverage programs.¹⁷ Yet both sides have generally been willing to work together and strong leaders in the legislature from each party have achieved compromise within their own ranks and agreements with each other.

The nature of such compromise has varied. In coverage expansion for children, the two parties came together in the development, implementation, and incremental expansion of what is now called Child Health Plus B.¹⁸ When it came to expanding access to adults, however, ideological differences about expanding public versus private coverage resulted in the passage of two very different and distinct programs whose target populations overlap.

Research and Publicity on the Growing Number of Uninsured

Credible documentation of the sharp increase in the number of uninsured in the 1990s by reputable researchers attracted press coverage and sparked debate.¹⁹ Erosion in the small-group and individual markets in the early 1990s and the manner in which Medicaid and welfare were de-linked (in the federal Welfare Reform Act of 1996) had contributed to the rise in the number of uninsured.²⁰ Another major factor was the enactment of the

¹⁶ Article XVII, Section 1, states: “The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine.” (Adopted by Constitutional Convention of 1938 and approved by vote of the people November 8, 1938.)

¹⁷ Similarly, there have been long-standing tensions between New York City—with large immigrant and low-income populations—and primarily rural upstate New York.

¹⁸ New York’s Child Health Insurance Program was initially much more limited; it expanded in both eligibility and benefits incrementally, particularly with the passage of and federal support for CHIP.

¹⁹ The AIDS epidemic, small-group and individual market reforms in 1993, and deregulation of New York’s all-payer hospital rate setting in 1997 (through the Health Care Reform Act of 1996) contributed to or resulted from turmoil in the health care market that had severe implications for health coverage and the safety net. See Holohan et al., *Health Policy for Low-Income People in New York*, Urban Institute, Washington, D.C., March 1998; and Jocelyn Guyer and Cindy Mann, *A New Opportunity to Provide Health Care Coverage for New York’s Low-Income Families*, The Commonwealth Fund, July 1999.

²⁰ In New York, the computer system was designed so that persons leaving welfare would have their computer file closed; they would have to *reapply* for transitional Medicaid rather than be automatically enrolled, contributing to the rise in uninsured rates.

federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), whereby the federal government withdrew its contribution to Medicaid for many legal immigrants who entered the United States after August 22, 1996, except for the treatment of emergency medical conditions. Some of these legal immigrants would become eligible for federal Medicaid after residing in this country for five years; many others would remain ineligible even after that period.²¹ More than 167,000 legal immigrants in New York have incomes that would qualify them for Medicaid or FHP if not for their immigrant status.²²

At the same time, New York City's financial support for public hospitals declined (related to changes in hospital reimbursement).²³ The impending crisis drew additional attention to the issue, leading major stakeholders to take action.

Later, after a proposal for Family Health Plus was developed in the late 1990s, a major publicity campaign arranged and financed jointly by the health care workers union and a hospital association was instrumental in pushing the issue to the forefront of state politics (see "Establishing Unlikely Alliances," below).

Bringing Together Stakeholders

A key factor in access reform for adults was bringing together key stakeholders, including state policymakers, industry, labor, and community advocates, along with a process of analysis and discussion. A "neutral" organization, the United Hospital Fund of New York, convened a series of meetings in which experts formulated a range of policy options.²⁴ Key players discussed and debated these and other options, eventually leading to the development of a Family Health Plus proposal for Medicaid expansion.

Establishing Unlikely Alliances

Perhaps the most important ingredient in the passage of Family Health Plus was the unusual alliance of the GNYHA and a very powerful health care workers union (1199/SEIU).²⁵ These two groups, traditionally at odds during contract negotiations, were

²¹ Many legal immigrants would remain ineligible after five years because PRWORA states that the income of the immigrant's sponsor would be considered available to him or her; also, a subset of legal immigrants considered Persons Residing Under Color of Law (PRUCOLs) remain ineligible regardless of their residency duration.

²² Bachrach, Deborah et al., "Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State," The Commonwealth Fund, New York, March 2001.

²³ See Holohan et al.

²⁴ The United Hospital Fund is a health services research and philanthropic organization that addresses critical issues affecting hospital and health care.

²⁵ GNYHA, a trade association comprising nearly 200 not-for-profit hospitals and continuing care facilities (both voluntary and public) in the metropolitan New York area, was the principal hospital group

able to come together under the common goal of expanding access to health coverage. Lack of insurance was experienced firsthand by family members and friends of many health care workers and was threatening the ability of city hospitals to continue providing adequate care. A broader coalition that included GNYHA, 1199/SEIU, and a number of consumer and public health advocacy organizations was also instrumental in garnering widespread support for reform, although this coalition was at times very difficult to hold together.

GNYHA's design work in formulating the Family Health Plus proposal and intense lobbying by industry, union, and consumer advocates helped push the legislation through as part of HCRA 2000.

Political Compromise

The successful passage of both Family Health Plus and Healthy New York as part of HCRA 2000 was a clear example of political compromise.²⁷ Initially, the state assembly and Democratic leaders favored expanding public coverage with FHP. The governor's office and Republican policymakers generally favored promotion of affordable private insurance to address the dearth of moderately priced insurance options for small businesses, resulting in the Healthy New York model. Each side was willing to accept the other as long as their preferred plan also was passed. This could not have occurred, however, without a clear interest on both sides in reducing the number of uninsured. The difference was an ideological one concerning the best method—public versus private—to achieve the goal. One possible disadvantage of this type of deal-making, however, was the establishment of two completely separate programs with different benefit packages and delivery systems that are not integrated and may even compete with each other for certain low-income people.

Factors Behind Fragmentation

The road of health care reform in New York has had many bumps. There were serious problems with establishing managed care under Medicaid, for example, related to enrollment procedures (there were reported abuses by managed care plans), primary care physician shortages in New York City, and low provider participation. This experience and others have been documented elsewhere and provide helpful lessons.²⁸

involved in this alliance.

²⁷ See Cohen, Rima. "From Strategy to Reality: The Enactment of New York's Family Health Plus Program," *Journal of Health Politics, Policy and Law*, 26:6, December 2001.

²⁸ See, for example, Holohan et al.

The focus of this section, however, is on the elements contributing to fragmentation among the major coverage programs in New York, which appear to be a consequence of political, administrative, fiscal, and ideological factors. This fragmentation—in the form of separate programs with different rules, requirements, and delivery systems—is considered by many to be an almost inevitable outcome of political realities. Most representatives interviewed, however, viewed fragmentation as detrimental to the populations meant to be served and are working toward greater integration among the programs.

Political Level: Dissociation from Welfare

On a political level, it has been recognized that coverage expansion in New York is much more likely to attract broad-based support if it does not appear to be tied to Medicaid, with its historical connection to welfare. This contributed to CHP-B’s design as a completely separate program that looks more like private coverage. Even FHP, which *is* in fact a Medicaid program administered by Medicaid personnel, was designed and presented to the public not as “Medicaid” but as a CHP-like plan whereby private insurers offer publicly subsidized coverage. Even Medicaid for children was renamed Child Health Plus A, in part to disassociate it from the former welfare-based program.

The dissociation of CHP-B from Medicaid, however, contributed to problems in coordination and communication, which in turn has made enrolling entire families more difficult and transferring between programs more cumbersome. Later, in response to these problems, the state deputized community-based organizations as official “facilitated enrollers” for all three programs, CHP-A, CHP-B, and FHP.

Administrative Level: Desire to Streamline

The decision to design a coverage program for children (which evolved into Child Health Plus B) as a private-type health insurance plan rather than in the traditional Medicaid mold contributed to both its success and the current fragmentation. Designers sought to avoid the bureaucratic and what some describe as “overly burdensome” Medicaid application and recertification processes, as well as the stigma attached to the Medicaid program. Instead, the state designed a program that became very popular and desirable, offering streamlined enrollment conducted by participating health plans, that was completely separate from the welfare system.

There were other consequences, however. In the effort to “steer clear” of Medicaid and its complexity, as well as to stay within budgetary constraints, the two

systems differed in benefit packages, enrollment sites, delivery systems, and rules and definitions.²⁹ The two programs were unable to share records and the transition of individuals from one to the other (as their circumstances changed) has been described as extremely confusing and difficult. CHP-B's streamlined process and favorable image also led to the enrollment of many children (an estimated 60% of CHP enrollees) who were actually eligible for Medicaid. Later, these children had to be transferred to Medicaid, an arduous and expensive process. This experience illuminated the extent to which the enrollment process itself affects participation. A similar lesson was learned with the temporary Disaster Relief Medicaid, which relaxed many of the usual Medicaid application requirements in New York City and experienced huge enrollment over a short period of time.³⁰

Despite these consequences, some advocates contend that it was important to establish a new, user-friendly enrollment process for CHP-B rather than duplicate an "overly burdensome and bureaucratic" one. Further, given the political factors discussed above, they are not sure that CHP-B could have been designed differently. They stress the need to recognize, however, that such an approach requires years of difficult, tedious "cleanup" work to reduce the inconsistencies and fragmentation on an issue-by-issue basis. The Children's Defense Fund-New York has been extremely active in this process, which involves labor-intensive interactions with state personnel who may be reluctant to change the status quo.

Financial Disincentives for Counties

New York's system of holding counties responsible for paying half of the state's share of Medicaid costs has hindered efforts to expand Medicaid and to streamline its enrollment process. This financial arrangement establishes incentives for counties, which are often strapped for funds, to limit Medicaid rolls and to establish strict protections against fraudulent enrollment. As a result, there has been resistance by counties to proposals to expand Medicaid eligibility or to simplify and streamline the enrollment and recertification processes. On the one side, there have been strong arguments for the need to combat fraudulent enrollment through stringent documentation requirements, asset tests, face-to-face interviews, etc. On the other side, there have been equally vehement complaints, largely by consumer and child advocates, that such rules are overly burdensome to applicants and keep many eligible people from enrolling in the programs for which

²⁹ See Dutton et al. "Creating a Seamless Health Insurance System for New York's Children," The Commonwealth Fund, New York, February 2001.

³⁰ The simplified enrollment process was implemented after the collapse of the World Trade Center cut the connection between Medicaid officials in Albany and the computer system that processed applications in New York City. This temporary program, including the simplified enrollment process, ceased accepting new applicants as of January 31, 2002, and began transitioning enrollees into the appropriate programs.

they are entitled. Monitoring the incidence of fraudulent Disaster Relief Medicaid enrollment during the current transition from DRM to other programs should shed light on this controversy.

Ideological Differences

Opposition to coverage expansion and/or the integration of coverage programs in New York has typically been based on concerns—both financial and ideological—about creating new entitlements. Some have feared that expanding existing public coverage programs or creating new ones would be too expensive, but most of the opposition appears to have been ideological. Some have resisted streamlining enrollment because they view health coverage funded by a finite amount of tax revenues as a social contract whereby beneficiaries are obligated to provide documentation that they are truly eligible. Some prefer separate, smaller programs to one large public program because the latter resembles a single-payer system. As in many other states, there has been less support for coverage for adults than for children, who are considered more deserving. Similarly, there was a drive for more stringent antifraud protections (e.g., asset tests, documentation requirements) among the adult population than among children.

As mentioned above, the split in state government between a Democratic state assembly and a Republican senate and governor reflected two philosophies concerning access for adults. The Democratic assembly, with support from health care industry and consumer advocates, favored the public FHP model. The governor and the Republican-led state senate worked with the business sector and sought to use public policies to make *private* coverage more affordable by reducing mandated benefits and protecting private HMOs against major losses, creating Healthy New York. The final compromise involved a two-pronged strategy representing two very different approaches to access expansion rather than a melding of preferences into one integrated program.

Looking Ahead: Primary Challenges

New York faces a number of short-term and long-term challenges. Most immediate is the task of transferring people from Disaster Relief Medicaid to the appropriate health coverage programs. The state is making an effort to promote continuity by providing DRM enrollees with a Medicaid card, allowing them to continue to receive coverage until a determination is made regarding which program they may be eligible to join. Making this transition swift while educating enrollees about any changes in rules, and weeding out ineligible persons while minimizing burdensome procedures, are difficult but important challenges.

Another challenge for New York involves gearing up the two new major access programs, FHP and Healthy New York. FHP enrollment began in upstate New York in October 2001 but was delayed in New York City until March 2002 because of the World Trade Center attacks. After its first year, coverage through Healthy New York remained relatively low, with less than 1 percent of those who qualified enrolled. Given how new these programs are and the need to focus on the September 11 tragedy and its aftereffects, it is premature to judge them based on initial enrollment levels. Research by Kathy Swartz revealed that Healthy NY premiums were 30 percent to 50 percent less than premiums typically available in the individual market, and 15 percent to 25 percent less than those in the small group market. However, even these reduced rates may still be unaffordable to many in the target population.³¹ Other factors contributing to slow enrollment of small businesses in Healthy New York include lack of motivation among insurance brokers, a crowd-out provision that requires participants to be uninsured during the prior 12 months, and a requirement that employers cover 50 percent of premiums.³² Nevertheless, a significant increase in Healthy New York enrollment in late 2002 is encouraging to supporters. The state will continue to monitor and assess the program.

A longer-term challenge involves figuring out how to make Healthy New York, FHP, and other health programs (e.g., CHP-A and CHP-B) work together more effectively. There does not seem to be consensus among all players regarding pushing integration or simplification of the access programs. Advocates of integration are working on it but admit it is a painstaking process; they anticipate that moving toward a seamless system will continue but in an incremental manner. Resistance to streamlining the enrollment process by stakeholders worried about fraud or with ideological concerns is likely to continue. Even without consensus on truly integrating the programs into one large system, however, consensus may be achieved for developing a computer system that allows the programs to communicate with each other, to allow smoother transitions for enrollees among the programs. Another issue facing New York, as well as other states, is how to cope with budgetary constraints. New York is scheduled to expand Medicaid coverage for breast and cervical cancer for women with incomes up to 250 percent of the FPL and to create a Medicaid buy-in for disabled workers. Implementing these expansions, as well as maintaining current populations in the various programs with reduced state revenues and, depending on the economy, possibly increases in the number of eligible people, will be a major challenge and will require creativity and hard choices.

³¹ See Katherine Swartz, *Healthy New York: Making Insurance More Affordable for Low-Income Workers*, The Commonwealth Fund, November 2001.

³² See The Lewin Group and Empire Health Advisors, "Report on the Healthy New York Program," December 31, 2001 (preliminary findings).

Given New York's long history of engagement with health policy, the state is not likely to roll back its coverage initiatives. Rather, it is likely to continue to experiment and play an active role in health reform, with its groundbreaking FHP and Healthy New York programs serving as demonstration projects for other states. It will be important to closely monitor these programs to help all states learn what works and what does not work. It is also critical for New York to learn from its own experiences, to see what aspects of its programs need "fixing" and to make modifications along the way.

Lessons for Other States

New York's mixed reputation in health reform provides lessons for other states. It illustrates how a large, diverse state can be progressive and creative despite ideological differences and financial and administrative obstacles. But it also points to the need for a culture of "taking care of the needy," solid research and publicity, coalitions with common goals, and political compromise.

New York's experience also illuminates the trade-offs involved in creating new and "improved" programs that may avoid negative aspects of existing programs but also result in fragmentation. Some states may favor a seamless, integrated system and therefore start their coverage expansion by expanding the existing program, and then slowly try to make improvements. Others, like New York, chose for a variety of reasons to create separate programs, resulting in rules and procedures that are not "in synch" with each other. These separate programs then often necessitate efforts to slowly chip away at the differences, or at least to better coordinate enrollment and benefits. One such effort—which has not yet been accomplished in New York but that other states should consider at the front end—involves developing computer systems in which information among programs is shared and individuals are tracked, fostering easier transitions and reducing the likelihood of people falling between the cracks.

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UTAH

Overview and Summary

Utah was selected to be profiled because it was the first state to receive a federal waiver to reduce the current Medicaid benefit package for certain beneficiaries and, in turn, to use the savings to expand limited coverage to other low-income populations who did not have insurance. Although Utah used a “traditional” Section 1115 demonstration waiver process while many states are pursuing Health Insurance Flexibility and Accountability (HIFA) waivers, Utah’s early experiences can offer important lessons for other states seeking to reallocate Medicaid dollars to expand public coverage by limiting the benefit package for certain enrollees.³³ Utah is also working with the private sector to develop a buy-in for employers.

When Governor Michael Leavitt took office in 1993, one of his first initiatives was HealthPrint, an incremental plan for reducing the uninsurance rate in Utah by specifically targeting select population groups (children, seniors, and the disabled). This laid the foundation for Utah’s low uninsurance rate of 8.67 percent (as of March 2002).³⁴ A large percentage of the remaining uninsured group is low-income working adults. Many of these adults are working two or three part-time jobs and do not qualify for coverage through their employers, hold a full-time job yet cannot afford coverage, or have short-term seasonal employment that does not offer coverage. To expand coverage to these working adults, Utah was approved in early 2002 for a demonstration waiver that enabled it to implement the Primary Care Network (PCN) program.³⁵ Enrollment began in July 2002 (Tables 10 and 11).

The governor’s office did not act alone in shaping the state’s efforts to provide insurance to all Utahans. Active involvement from others, such as the legislature, government agencies, advocacy groups, and small communities, played a major role in shaping Utah’s health policy. One specific factor contributing to Utah’s success in implementing PCN was how the program was presented and marketed to interested parties. From the state’s perspective, PCN is not intended as a “budget-cutting” exercise but rather as a way to provide access to coverage for more people by reallocating existing health care dollars.

³³ The Utah waiver is not a HIFA waiver in large part because the state applied before the HIFA waiver authority was implemented.

³⁴ Utah State Planning Grant Updated Interim Report, March 2002. Note: The 8.67 percent uninsurance rate reflects more recent data than the uninsurance rates displayed in Table 10. Also, it reflects the rate for the entire resident population including the elderly, which has a lower uninsurance rate than the nonelderly population.

³⁵ The waiver also seeks to exempt certain pregnant women from the current asset spend-down.

The Primary Care Network (PCN) Waiver Initiative

The Primary Care Network

The PCN program is unique in a number of ways. It was the first time the federal government allowed a state to offer a limited benefit plan that did not include hospitalization and specialty care and to reduce some benefits to current Medicaid beneficiaries. Although the general philosophy is similar to a HIFA waiver in that benefits are reduced for some beneficiaries to expand coverage to more people, Utah's waiver is not technically a HIFA waiver because of three distinct characteristics: (1) benefits are reduced for some *mandatory* and optional Medicaid populations (under HIFA, states can streamline benefits only for optional and expansion populations);³⁶ (2) Utah's state-funded Medical Assistance Program (UMAP), which covers low-income individuals with serious medical conditions who do not qualify for Medicaid or Medicare and who receive donated hospital care and which is one of the most prominent high-risk-pool programs, was replaced by the Medicaid PCN program (under HIFA, other state-funded programs cannot be modified); and (3) there are no mechanisms to encourage employer-based initiatives (a requirement under HIFA). (House Bill 122, encouraging private-sector coverage, was added after the waiver was approved.) Ultimately, the PCN program affects three populations: a small percentage of current Medicaid beneficiaries, the high-risk population currently enrolled in UMAP, and residents who do not currently have any insurance. PCN's impact on these three distinct populations is discussed below.

Benefit Reductions to Current Medicaid Beneficiaries

Approximately 12 percent of the 145,000 current Medicaid beneficiaries are remaining in Medicaid, but their coverage is affected by the PCN. This includes transitional Medicaid beneficiaries, parents of children on Medicaid, adults who are receiving both Medicaid and Temporary Aid to Needy Families (TANF) (Section 1931 adults), and medically needy adults. Vision, physical therapy, chiropractic, and mental health services still will be covered for optional Medicaid enrollees but with limitations, including slightly higher copayments. Nonemergency transportation is the only service that no longer will be covered for this population. For the mandatory Medicaid population, the benefit cuts include reductions in mental health services and also limited transportation. Children, people with physical disabilities, people with chronic or mental illness, people 65 and older, pregnant women, and women with breast or cervical cancer *will not* have their services affected.

³⁶ Those receiving reduced benefits in the mandatory population are transitional Medicaid adults, "Section 1931" adults (low-income parents who are mandatory Medicaid beneficiaries), and adults who are receiving both TANF and Medicaid benefits. Optional enrollees include medically needy adults who are not aged, blind, or disabled.

Insuring a New Population of People

As noted above, the Primary Care Network is targeted to uninsured, low-income workers. Residents 19 to 64 years of age are eligible if they have not had health care coverage for at least six months, their employer pays less than 50 percent of their health care benefit (when employer coverage is offered), and their annual income is less than 150 percent of the federal poverty level (FPL). Also, all current UMAP patients (approximately 6,000) are being given the opportunity to shift into PCN. Implemented as a demonstration project, PCN enrollment is capped at 25,000, which includes UMAP enrollees. The enrollees will receive a new benefit package that includes primary care, preventive services, some dental care, and prescription drugs. It also will provide care for the management of chronic diseases. The intent is to provide basic primary and preventive care to reduce the need for emergency care and expensive, “avoidable” inpatient services. PCN has an enrollment fee of \$50 per year, with copayments of \$5 for office visits and prescriptions (generic and brand-name drugs on an approved list). Hospital, mental health, substance abuse, podiatry, and nonemergency transportation services are not included in the PCN plan. All hospitals have agreed, however, to provide up to \$10 million in care to PCN patients per year, and specialty physicians are forming a network to which patients can be referred.

So far, feedback on the new PCN program and the Medicaid benefit reductions that have helped finance PCN has been mixed. Support in Utah generally has been strong with Governor Leavitt maintaining an extremely supportive role. The legislature initially had some concerns surrounding income levels and crowd out, but these were addressed by implementing a waiting period before enrollment. On the national level, feedback from the Bush administration has been positive because the PCN program is part of the national initiative to give states more flexibility in programs to insure their residents. A number of patient and advocacy groups have been concerned, however, about the limited PCN benefit package and the potentially dangerous precedent of cutting Medicaid benefits and its impact on access to care for those losing services or facing greater cost-sharing (discussed further below).

House Bill 122

Signed by the governor in February 2002, House Bill 122 changes state law so that private insurers can offer employers the same limited benefit plan that PCN offers to similar populations. The state plans to partner with insurers and employers so that employers may purchase limited coverage for their employees through the private market. This model was chosen over expanding enrollment into public programs or offering vouchers to buy into the current insurance offered by insurers. The state would pay for primary care, with

employers covering wraparound services such as pharmacy, hospitalization, catastrophic coverage, and mental health. Although there is some concern that health plans are not on board, the bill represents a concerted effort to involve employers. Employers, insurance agents, state officials, and insurers serving the small-group market are working together to form a viable action plan.

CHIP

Utah's CHIP program was implemented in July 1998 as a separate program for children under age 19 with family incomes less than 200 percent of the FPL. CHIP was developed as a program separate from Medicaid because of the stigma that often surrounds Medicaid and the desire for more flexibility in benefit design. This separation from Medicaid helped build support for CHIP. Children whose families have incomes at or below 150 percent of the FPL are enrolled in CHIP A; children whose families have incomes between 151 percent and 200 percent of the FPL are enrolled in CHIP B. The only difference is that CHIP A has lower premiums and copayments than CHIP B. In January 2002, enrollment in CHIP was temporarily suspended, primarily because of anticipated budget constraints. The state did, however, hold an open enrollment period between June 3 and June 14, 2002 (deemed very successful), and a second open enrollment period in late October 2002 was under consideration.

Although appearing to the enrollee to be separate programs, behind the scenes Utah's traditional Medicaid program and CHIP are fairly integrated. They do have separate applications because of the state's desire to keep the CHIP application short, but if CHIP enrollees qualify financially for Medicaid, they are asked to fill out an addendum to the application and enroll in Medicaid. The same eligibility staff enrolls people for both programs and children are easily transferred between the programs through electronic input from a shared database management system. Also, two of the three CHIP plans contract with the same health plan and providers as Medicaid.

Table 10. Utah State Profile and Overview, 1999–2000

	Utah	United States
Total Population	2,173,280	275,740,020
Population Under 65	2,006,030	242,761,980
Percentage Under 200% of FPL	34%	34%
Percentage Under 100% of FPL	11%	15%
Portion of Children that Are Uninsured	10%	12%
Portion of Nonelderly Adults that Are Uninsured	17%	18%
<i>Insurance Distribution Among Nonelderly</i>		
Employer-Sponsored Insurance	74%	69%
Individual	5%	5%
Medicaid	7%	10%
Uninsured	14%	16%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2000 and 2001 Current Population Surveys (see www.statehealthfacts.kff.org).

Table 11. Utah's Major Coverage Programs

	Medicaid	Children's Health Insurance Plan (CHIP)	Primary Care Network (PCN)
Program Type	Medicaid	CHIP	Medicaid
Waivers/ Legislation Required		Title XXI Separate CHIP program	Medicaid Section 1115 demonstration waiver approved 2/02 HB 122, which allows private insurers to offer employers the same limited benefit plan that the waiver creates
Time Frame		Approved in July 1998	Waiver approved February 9, 2002; Enrollment began July 2002
Enrollment	145,000 (as of 2002)	26,788 (as of 2000); enrollment temporarily suspended since 1/02	Projected to reach 25,000 (capped enrollment)
Eligibility Criteria	Pregnant women to 133% of FPL Children under age 6 to 133% of FPL Children ages 6–18 to 100% of FPL Aged and disabled to 100% of FPL Adult parents and medically needy to 53.4% of FPL	CHIP A: Children to age 19 with incomes to 150% of FPL CHIP B: Children to age 19 with incomes between 151–200% of FPL	Adults between 19–64 Annual incomes less than 150% of FPL Not qualified for Medicaid No health insurance for at least six months Incorporates current UMAP patients
Benefits and/or Subsidies	Children, elderly, pregnant, and disabled receive comprehensive Medicaid benefits As of July 2002, medically needy adults not aged, blind, or disabled will face limitations on vision, physical therapy, chiropractic, dental, and mental health services; higher copayments; and cessation of nonemergency transportation	Benefit package similar to the Utah State Employees Health Plan	Primary care and preventive services including: office visits, flu immunizations, urgent care, emergency room visits, labs, x-rays, emergency transportation, medical equipment and supplies, basic dental care, hearing, vision screening, and prescription drugs
Financing	Medicaid federal (79%) and state (21%) matching funds	Two-tiered system copayments. For families with incomes less than 150% of FPL, there are reduced copayments for most services and no copayments for labs, X-rays, and hospital visits. For families with incomes greater than 150% of FPL, there are slightly higher copays and up to a 20% payment rate for X-rays, labs, hospital visits, and medical supplies. Federal and state CHIP matching funds	Medicaid dollars \$50 enrollment fee \$1,000 annual out-of-pocket maximum Existing Medicaid funds will be redistributed and additional federal funds will be required. \$5 copayment for office visits, vision screenings, prescription drugs on preferred list \$30 copayment for emergencies Other copayments vary from 5% to 10%

Sources: Centers for Medicare & Medicaid Services. "Utah Coverage of Uninsured Demonstration Fact Sheet"; State of Utah Department of Health website. <http://health.utah.gov>; Updated Interim Report. Utah HRSA State Planning Grant. March 28, 2002.

Other Programs and Initiatives

Primary Care Grants Program (PCGP)

The Primary Care Grants Program (PCGP) is a state-funded grant program that was established in 1996 to finance care for low-income, “medically underserved” families who are without health insurance or have health insurance that does not cover primary health care services and who do not qualify for Medicare, Medicaid, or CHIP. The program provides a primary care medical home to this population and increases the capacity and capabilities of the grantees (primarily community-based health centers) so that they are better able to serve eligible residents. The money to fund this program was established by the legislature in an ongoing general fund appropriation.

Choice of Health Care Delivery Program

Authorized under a Section 1915(b) Medicaid Freedom of Choice waiver, this program requires Medicaid beneficiaries living in urban counties to select a managed care organization that provides, through an ongoing patient/physician relationship, primary care services and referral for all necessary specialty services. Medicaid beneficiaries living in rural areas are offered a choice of a primary care provider, managed care organization (available in two rural areas), or traditional fee-for-service Medicaid. Enrollment is voluntary in the rural areas. The waiver was renewed until July 23, 2003.

Utah Nonemergency Transportation Waiver Program

This program, authorized under another Medicaid waiver, provides nonemergency transportation services to all Medicaid beneficiaries who have no personal transportation or who have no access to public transportation or cannot reasonably use public transportation. The program was instituted to help control costs by using a transportation broker who is paid a capitated rate based on the historical cost of the service. Enrollment is mandatory except for residents in a nursing facility, those who have access to and are capable of using public transportation, and limited additional exceptions. This waiver was renewed in September 2002 for an additional two years. Medicaid beneficiaries who no longer have access to nonemergency transportation and PCN beneficiaries are not eligible for this program.

Elements that Facilitated Health Reform

Strong and Invested Leadership

The Health Care Access Steering Committee spearheaded health reform in the state. Created in 1987, this was a large, voluntary, public-private initiative that examined the health care system in Utah over the course of four years. Based on recommendations from this committee, Governor Leavitt made the first significant state executive effort to expand

health care in the form of the previously mentioned HealthPrint. This initiated a seven-year process to expand access to and improve the quality of care for all residents. One of the primary accomplishments of HealthPrint was the formation of the Utah Health Policy Commission (HPC). The HPC (which was composed of the governor, lieutenant governor, six at-large members, and a bipartisan group of three senators and three representatives) developed policy alternatives and recommended legislative reform regarding improved access and quality and lower cost. Overall, the HPC recommended and supported the passage of 34 pieces of legislation before its “sunset.”

Utah considers its CHIP program the largest and most successful recent effort to expand coverage and attributes CHIP’s successful implementation as a separate program to the strong cooperation between the executive branch, legislative branch, HPC, department of health, and private sector decision makers. Thus far, CHIP has successfully enrolled over 26,000 children out of an estimated 30,000 who are eligible.

Ultimately, through the leadership of the governor and the coordinated support of the legislative and executive branches, a sturdy foundation was laid for additional access initiatives such as the Primary Care Network. While generally fiscally conservative, overall the legislature has been supportive of requests for coverage expansion, although over time some of that support has eroded because of a change in composition, backlash over prior mandates, and budget constraints.

Building on Past Safety Net Initiatives

Prior to 1993, most access-related efforts in the state were limited to safety net initiatives. One of these was the UMAP, implemented in 1977. UMAP, described earlier, provided limited medical care for low-income adults between 18 and 65 years of age with serious medical illnesses who did not qualify for Medicaid or any other medical assistance program. With the recent approval of PCN, UMAP was integrated into that program. Other safety net initiatives include: Community Health Centers that serve minorities who are disproportionately represented among the low-income uninsured; Intermountain Health Care Clinics that are school-based family clinics; and the University of Utah Hospital and Clinics that provides uncompensated care to the indigent and uninsured on an inpatient and outpatient basis. Although all states have safety net initiatives, this area is and has been a major component of Utah’s health coverage strategy, and PCN builds on this agenda.

Anticipating Resistance to PCN

From the start, Utah anticipated and addressed some of the concerns about the Primary Care Network, which contributed to its eventual approval. As explained above, one of the

major financing sources for PCN was savings from the reduction of benefits for 17,600 current Medicaid beneficiaries. The state has stressed all along, however, that coverage for these beneficiaries still will be comprehensive, albeit with some limitations and slightly higher copayments. The state argues that it has made a conscientious and concerted effort to select the least vulnerable group for benefit reductions, shift the more needy patients from UMAP (which currently has no benefits other than donated hospital services) into PCN, and find cost savings within the department of health to generate administrative savings. With UMAP's integration into PCN, hospitals that had previously donated care still will continue to do so.

PCN had public and political appeal because it was not intended to be or presented as a way to cut costs but rather as a way to offer some coverage to more people. When the state was marketing this program, it billed it as access to insurance for residents who did not have *any* coverage.

Supportive Organizations and Communities

In addition to strong leadership from the governor, the support of certain agencies and organizations was critical to achieving Utah's low uninsurance rate and to implementing new initiatives to reach uninsured populations. Utah's Department of Health and HPC have each played an active role. Similarly, advocacy groups such as Utah Issues and Health Care for All and community groups and providers within the community who are interested in health care have all made a concerted effort to work with the legislature on the problems of the uninsured.

Utah's culture of close-knit communities also has played a role, and communities generally have approved of the initiatives laid out by the HPC. This included support for participation in the high-risk pool, the increase in age (up to 26) that children could be included under parents' private insurance coverage, and the provision of additional services for the senior disabled population. The community-centered culture also facilitated the "outstationing" of Medicaid enrollment workers away from a central office and into clinics, providing a springboard for CHIP outreach and enrollment later.

Challenges to Expansion

Reduction of Medicaid Benefits and Limited PCN Benefits

Critics maintain that cutting existing Medicaid benefits is unfair to one of the state's neediest populations and that a dangerous precedent will be set by allowing the state to assume control over federally mandated benefits (although the current set of cuts includes many non-mandated Medicaid benefits). There are also concerns that the benefits under

PCN are inadequate. The program does not offer coverage for inpatient and outpatient hospital care, specialty care, anesthesia, mental health and substance abuse services, or home health care. Although the hospitals claim they still will donate free care, this may place an unforeseen burden on the providers as well as the beneficiaries when a patient requires hospital care or other non-covered services. State officials do not, however, view this program as a “slippery slope” but rather as access to basic care for more people and a way to provide up-front services that will avoid more serious, costly care later. Addressing these concerns, the state is conducting research and evaluation to test its hypothesis that primary care for previously uninsured individuals will improve health status and reduce inpatient utilization.

Some people fear that the now-reduced Medicaid benefit package will result in less federal money entering the state because Utah will be spending less per Medicaid enrollee due to the benefit cuts that affect some enrollees. With additional PCN patients to serve, and on top of the “drastically reduced payments” in Medicaid reimbursements that providers have been experiencing over the past five years, there also are concerns that providers will cut back on treating Medicaid patients. In fact, the state’s two largest Medicaid HMOs have capped enrollment or announced a decision to leave the public assistance program.

Budget Shortfalls

The Division of Health Care Financing, which runs Utah’s Medicaid program, needed to make budget reductions in 2002 to meet state allocations. As a result, Medicaid had to explore and implement cost-cutting measures, including reducing benefits. Medicaid began cutting back dental services, podiatry, and speech and audiology services as of June 1, 2002. In addition, it instituted a utilization review process when prescriptions for a Medicaid enrollee exceed seven per month. These budget cuts were unrelated to (and earlier than) the implementation of PCN. (As noted above, the state does not present PCN as a way to generate savings but as a coverage expansion strategy.)

CHIP, financed with tobacco funds and on a separate budget track, also faced financial difficulties when it enrolled more people than its budget could support. In response, the legislature capped enrollment into CHIP as of January 2002. As noted above, an open enrollment period was conducted from June 3–14, 2002, but there are no plans yet to fully open enrollment. Also, CHIP enrollees still will have access to basic dental checkups and emergency care, although other dental services have been eliminated.

A number of individuals and groups in the state are fighting to reinstate all previously offered dental benefits, however. According to the Utah School Nurse Association, dental disease was identified as the biggest health problem among elementary school children. It also has been reported that low-income children have five times the rate of dental disease of children from higher-income families.³⁸

Other Obstacles to Reform

Aside from PCN, Utah has faced other challenges to expansion and reform in the past. In 1995 the state submitted a Medicaid expansion proposal to the Centers for Medicare and Medicaid Services (CMS) for residents with incomes up to 250 percent of the FPL that also eliminated categorical requirements. The waiver was not accepted, however, primarily because there was no agreement on cost neutrality.

Utah also taxes residents at a higher rate than many other states. As a result, residents are particularly sensitive to any public program expansions that may require additional revenues and cause a tax increase. Additionally, the culture in the legislature and in the general public is relatively conservative and often resists any new mandates, such as placing children up to age 26 in the high-risk pool. Another example of resistance that has made the implementation of other mandates more difficult occurred when insurance market reforms were put in place that mandated portability of insurance and other commercial market changes.

Looking Ahead

Utah began enrolling people in PCN on July 1, 2002. Within the first two months, more than 6,000 applications were made, with an approximately 50 percent approval rate. Most of the new enrollees are childless adults and about 30 percent are parents. Enrollment notices have been sent to current UMAP enrollees informing them of their ability to shift into the new program. Parents of children enrolled under CHIP and Medicaid are specifically targeted to be enrolled in PCN and community groups are assisting with outreach. One-page notices and forms are being distributed to this population that seek to determine whether individuals have any source of coverage and whether they might be eligible for the new program. PCN, CHIP, and Medicaid share a centralized computer system and the same enrollment workers handle applications for all three programs. Eligibility sites will be located statewide and workers are partnering with Federally Qualified Health Centers, local health departments, local hospitals, and other community sites for on-site processing of applications.

³⁸ Goodman, Troy. "Dental Disease Plagues Low-Income Kids," *Salt Lake Tribune*, May 28, 2002.

Utah also has a strong foundation of outreach successes with its other public programs, which will be utilized to help enroll residents in PCN. The “Baby your Baby” program, a national public initiative to encourage prenatal care, originated in Utah and had a successful enrollment campaign due to television and radio advertisements.

The PCN is uncharted ground, however, and the state will eventually have to address some foreseeable and unforeseeable challenges, such as what will happen with respect to hospital care for the UMAP and PCN populations. Although hospitals have agreed to provide \$10 million per year for care to PCN patients, it is unclear what will happen when the \$10 million limit is reached. The state will be tracking these costs, and, if necessary, may cut back on non-life-threatening services or impose other limits on PCN patients to remain within the \$10 million allocation. This raises concerns that either PCN patients will be denied nonemergency care, or providers may have to absorb the cost to treat these patients (e.g., creating a cost shift to providers). In addition, what will happen if the beneficiaries simply cannot pay even the copayment for services? Another concern is that patients will not understand the limits on the benefit package and go in expecting to receive services and either get turned away or hit with large bills.

As noted earlier, a research evaluation component is in place that includes an ongoing assessment of PCN throughout its five-year implementation. Researchers will evaluate whether there is an increase in the health status of the PCN group as a result of their coverage for primary care, whether there is a reduction in uncompensated inpatient care, and whether PCN is used as a bridge to an employer-sponsored plan.

In 2001, Utah received a \$1,102,000 Health Resources and Services Administration (HRSA) state planning grant to conduct a large-scale health status survey of the state’s population and to recommend policy options at the state and federal levels. Some of the state policy recommendations to insure the remainder of the population included: continued support for PCN and outreach initiatives through community health centers; investigation of cost-sharing through employer and employee contributions; the possibility of using community funds to provide additional funding for PCN; and expanding the CHIP program to cover parents. Although these options have been explored by the state, it is currently unable to pursue any options that require new funds because of the current budget shortfall.

If the economy gets worse, sustaining current programs in Utah is going to become more and more difficult. One concern is to ensure that the programs do not erode too far. And, even though the governor and legislature are supportive of Medicaid

programs, they remain cautious of expanding to new populations. Generally, there is little political support for far-reaching expansion programs, in part because of continued concerns about crowd out. Consumer advocate groups that oppose cutting existing Medicaid services are continually offering alternative ideas for financing PCN, such as issuing bonds for road construction and using cigarette tax revenues, and they pledge to continue to search for alternative ways to restore benefits.

Recommendations to Other States

In a time of severe budget constraints, each state must consider whether providing some insurance to a large group of people is more important than providing more comprehensive insurance to a smaller, yet arguably more needy, group of people. Utah chose the former route, and it made this public coverage “expansion” possible by reducing some benefits to the “least needy” portion of its Medicaid population. This initiative was possible only because of strong and coordinated support from the governor, the legislature, health agencies, and interest groups; PCN was not the work of just one person or one office.

In states that are similar to Utah, with an already low rate of uninsurance and a high percentage of younger residents (Utah’s population is the youngest in the country, with an average age of 26.7), programs to target a working, typically healthy, uninsured group become extremely important. A program such as PCN provides the basic services and can potentially help this group access needed health care. Yet the program is controversial, and states should anticipate resistance and take steps to minimize the potential negative impact on current Medicaid beneficiaries.

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VERMONT

Overview and Summary

Over the past 10 years, Vermont has successfully worked to decrease its uninsurance rate from 17 percent of the population to its current rate of 8.4 percent—one of the lowest in the country. This is primarily attributable to state-funded coverage programs and the expansion of Vermont’s Medicaid and State Children’s Health Insurance (CHIP) programs to additional populations. The public health programs in Vermont extend higher up the income scale for children and adults (parents and childless adults) than most other states (Tables 12 and 13).

In 1989, the Dr. Dynasaur program was created as a state-funded comprehensive health assistance program for children through age 6 living in families with incomes up to 225 percent of the federal poverty level (FPL) and for uninsured pregnant women not eligible for Medicaid with incomes up to 200 percent of the FPL. Dr. Dynasaur carried less stigma than Medicaid, and from the start consumers thought of it as a separate program with its own separate identity. In 1992, Dr. Dynasaur was expanded to cover children through age 17 and integrated into Medicaid, although the program retained its separate name and identity. With the introduction of the federal CHIP initiative, Dr. Dynasaur was able to expand its income eligibility level in 1998 to children living in families with incomes between 225 percent and 300 percent of the FPL under a Medicaid look-alike CHIP program.

The Vermont Health Access Plan (VHAP) is the state’s major initiative for expanding coverage to adults. Implemented through a Section 1115 waiver in 1995, VHAP expanded health insurance to low-income, uninsured adults and provided pharmacy assistance to low-income, elderly, and disabled state residents without pharmacy coverage. After multiple amendments to the waiver, VHAP coverage now is available to custodial parents and caregiver relatives with incomes up to 185 percent of the FPL, and noncustodial parents and other uninsured adults with incomes up to 150 percent of the FPL. Various populations are eligible for a range of pharmacy benefits (described further below).³⁹ The adult expansion populations with incomes between 50 percent and 185 percent of the FPL receive comprehensive benefits similar to a commercial insurance policy and pay a program fee every six months and copayments for specific services. A fee-

³⁹ Vermont’s pharmacy programs under VHAP and other state programs cover aged and disabled adults with incomes up to 400 percent of the FPL and the general public with incomes up to 300 percent of the FPL.

for-service plan called VHAP-Limited ensures basic coverage from the time adults are deemed eligible for VHAP until they are enrolled in the managed care component.

Administered by the Office of Vermont Health Access (OVHA), VHAP became the “umbrella” coverage program under which Medicaid for adults (both traditional and expansion populations), Dr. Dynasaur for children, pharmacy-related programs, and other access initiatives were placed.⁴⁰ Although the CHIP component of Dr. Dynasaur is technically not part of the Section 1115 VHAP waiver, CHIP is administered along with the other health care programs.

VHAP coverage for adults and Dr. Dynasaur (both the Medicaid and CHIP components) are completely integrated for all practical purposes. Applicants seeking health insurance alone fill out one application that is processed through a centralized unit. Those seeking other benefits as well (e.g., food stamps, Temporary Assistance to Needy Families, fuel assistance, or General Assistance) fill out a different application that is handled by a district office. Through an integrated computer system that serves both the centralized unit and district offices, the staff is able to determine the specific health plan and funding stream for which the applicant qualifies. Enrollees, however, are not aware of which funding stream finances their health care and they may stay with the same set of providers if there is a transition from one health program to another. If an enrollee does lose coverage, it is because he or she no longer qualifies for any of the publicly funded health programs in the state. If it is determined that insurance eligibility status has changed, the state will transfer the individual to the appropriate program without a new application form.

The incremental expansion of coverage in Vermont is attributable in large part to a culture and history of progressive politics and a very active physician-governor in office since 1991. Despite being among the most rural states, Vermont achieved high participation in its health programs through the use of mail-in applications (face-to-face interviews are not required), a centralized, integrated computer system, and effective outreach through partnerships with schools and community organizations. Vermont has faced some difficult challenges, including a disproportionately large number of very small businesses, lack of competition and few choices in the small-group insurance market, and a dearth of managed care organizations. Escalating health care costs have hindered private insurance coverage and are forcing the state to “freeze” certain benefits in its public programs. Looking ahead, the state is considering increasing cost-sharing and cutting some

⁴⁰ A division of the Department of Prevention, Assistance, Transition, and Health Access (PATH).

services to adults, both of which are deemed preferable to reducing eligibility for coverage.

Table 12. Vermont State Profile and Overview, 1999–2000

	Vermont	United States
Total Population	617,770	275,740,020
Population Under 65	553,870	242,761,980
Percentage Under 200% of FPL	34%	34%
Percentage Under 100% of FPL	14%	15%
Portion of Children that Are Uninsured	8%	12%
Portion of Nonelderly Adults that Are Uninsured	14%	18%
<i>Insurance Distribution Among Nonelderly</i>		
Employer-Sponsored Insurance	63%	69%
Individual	5%	5%
Medicaid	20%	10%
Uninsured	12%	16%

Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2000 and 2001 Current Population Surveys.

Table 13. Major Coverage Programs Under the Vermont Health Access Plan (VHAP)^a

	VHAP for Adults	Dr. Dynasaur—Medicaid	Dr. Dynasaur—CHIP
Program Type	Medicaid—traditional and expansion adults	Medicaid—traditional and expansion children and pregnant women	“Medicaid look-alike” CHIP
Waivers/ Legislation Required	Section 1115(a) Medicaid Research and Demonstration waiver. Approved in 1995; recently granted a three-year extension until 2003 Act 14 established the Vermont Health Access Plan (VHAP) in 1995 Medicaid Section 1931 waiver	1902(r)(2) provision (1992) Section 1115(a) demonstration waiver	Title XXI CHIP plan (12/98)
Time Frame	The VHAP waiver was approved in July 1995 Enrollment in managed care organizations began by October 1996 A primary care case management program called PC Plus began in October 1999; by May 2000, all prior managed care enrollees were transferred	Created as a state-funded program in 1989 serving children through age 6 and uninsured pregnant women not eligible for Medicaid In 1992, the program was integrated into Medicaid and coverage was expanded to children through age 17 In 1995, became part of the VHAP waiver at the time of the waiver’s implementation In 1998, expanded eligibility to underinsured to 300% of FPL	In 1998, CMS approved a CHIP waiver that expanded eligibility to uninsured children up to 300% of FPL
Current Enrollment (FY 2002)	Traditional Medicaid managed care: 38,000 VHAP expansion: 20,200 plus 2,700 custodial parents and caretaker relatives not eligible for traditional Medicaid	55,800	2,900 enrolled in CHIP
Eligibility Criteria	Traditional populations of blind, disabled, elderly, and families (parents of welfare enrollees or below the “protected income level”) Expansion populations: Custodial parents and caretaker relatives up to 185% of FPL Non-custodial parents and other adults up to 150% of FPL Adults must be uninsured for at least 12 months to qualify (exceptions for people who involuntarily lose their coverage)	200% of FPL for pregnant women Up to 225% of FPL for children through age 17 Up to 300% of FPL for underinsured children through age 17	Children through age 17 with family incomes between 225% and 300% of FPL

	VHAP for Adults	Dr. Dynasaur—Medicaid	Dr. Dynasaur—CHIP
Benefits and/or Subsidies	Comprehensive benefits for traditional populations Expansion populations receive benefits similar to a comprehensive commercial plan (full Medicaid minus long-term care, home- and community-based services, and transportation); those at or above 50% of FPL pay program fees every six months and copays up to \$50	Full Medicaid package, no cost-sharing except program fees for families above 185% of FPL	Full Medicaid package (same primary care case management delivery system and providers), but with cost-sharing up to \$50 per month per family
Financing	Federal Medicaid funds State Medicaid funds using cigarette tax and earmarked state revenues Enrolling existing Medicaid population into PC Plus and applying any “savings” generated to cover uninsured adults not previously eligible for Medicaid	Federal and state Medicaid funds, with standard Medicaid matching rate Federal share (FY 02): 63.06% State share (FY 02): 36.94% Program fees between \$20 and \$50 per month per family for children above 185% of FPL	Federal and state CHIP funds, with enhanced federal matching rate Federal share (FY 02): 74.14% State share (FY 02): 25.86% Program fees between \$20 and \$50 per month per family for children above 225% of FPL

^a VHAP is an umbrella for virtually all Vermont’s public coverage programs; the pharmacy-related programs are described in the following section.

Sources: State of Vermont. Department of Prevention, Assistance, Transition and Health Access website. <http://www.dpath.state.vt.us>; Personal communication with Jackie Levine of the Department of Prevention, Assistance, Transition, and Health Access; Vermont State Planning Grant Application. July 2000. “Expansion of Health Insurance Coverage to Uninsured Vermonters,” HRSA State Planning Grant Final Report. March 15, 2002; Office of Vermont Health Access Annual Report. December 2000.

Other Programs Under VHAP

Vermont has a number of initiatives in place under VHAP to provide pharmaceutical coverage to state residents.

VHAP-Pharmacy

This program began in January 1996 under the Section 1115 waiver that created VHAP and covers the aged and disabled with incomes up to 150 percent of the FPL. There is no enrollment fee, and the program covers prescription drugs for both short-term and long-term medical problems and costs the enrollee \$3 per generic prescription or \$6 per brand-name prescription. The quarterly out-of-pocket maximum is \$50. In 2002, 8,500 people were enrolled in VHAP-Pharmacy.

VScript and VScript Expanded

In 1989, Vermont created VScript, a state-funded program providing prescription drug coverage for the low-income elderly with incomes up to 175 percent of the FPL. In January 2000, VScript Expanded was implemented to provide more limited coverage for the low-income elderly up to 225 percent of the FPL. These programs cover maintenance drugs for long-term medical problems for this population with incomes over the limit of VHAP-Pharmacy. Under VScript, which is now part of the Section 1115 waiver, prescriptions cost enrollees \$5 or \$10 depending on whether the drug is generic or brand name, with an out-of-pocket maximum cost of \$100 per quarter. Current enrollment is 3,000. Under VScript Expanded, which is state-funded, prescriptions are discounted to 41 percent of the normal cost, and there is a \$275 yearly deductible and a \$2,500 out-of-pocket cap. Current enrollment is 3,200.

VHAP Pharmacy Discount Program

This program began January 1, 2001, under Vermont's Section 1115 waiver, but was discontinued in June 2001 because of a Supreme Court decision stemming from a complaint from the Pharmaceutical Research and Manufacturers of America (PhRMA) that the Health Care Financing Administration (HCFA), now the Centers for Medicare and Medicaid Services (CMS), violated the Medicaid law by approving the waiver. PhRMA argued that although the waiver did not provide medical services to beneficiaries, it did require beneficiaries to pay more than a nominal copay for prescription drugs and manufacturers to pay for the remainder. Individuals with no insurance coverage for prescription drugs with incomes up to 300 percent of the FPL (or covered under Medicare with incomes over 150% of the FPL) received a drug discount equal to 17.5 percent of the state's cost. There was an annual enrollment fee of \$24.

Vermont Health Access Pharmacy Benefit Management Program

In November 2001, the Vermont Health Access Pharmacy Benefit Management Program was implemented. This stemmed from a partnership between Vermont, Maine, and New Hampshire to form a Tri-State Pharmacy Initiative that sought out and hired a pharmacy benefit manager to provide expertise, maintain the quality of care, control pharmaceutical expenditures, and reduce administrative costs in the states. By March 2002, an initial preferred drug list (PDL) was implemented in Vermont to encourage the use of therapeutically equivalent prescriptions at a lower cost. Future anticipated plans for the program include the expansion (in size and scope) of the PDL, prior authorization and clinical detailing, state disease profiling and management, provider profiling, and pharmacy auditing.

Healthy Vermonters Program (HVP)

The Healthy Vermonters Program (HVP) was developed in response to the rising cost of prescription drugs in the state for Vermonters who do not have insurance that covers drugs or who have a commercial insurance plan with a yearly limit. This program was designed to fill the gap in drug coverage left by the now-defunct Pharmacy Discount Program. Residents age 65 or older or disabled and receiving Medicare or Social Security benefits who are below 400 percent of the FPL, or who are of any age and have incomes at or below 300 percent of the FPL, are eligible. VScript and VScript Expanded beneficiaries are automatically enrolled and are able to benefit from HVP for prescriptions not covered under those programs. This program was developed in June 2002 and began implementation on July 1, 2002. Beneficiaries are able to purchase drugs at the Medicaid payment rate. If and when the program is fully implemented (pending approval from CMS as an amendment to the state's Section 1115 demonstration waiver expanding the Pharmacy Program of VHAP), qualified residents will receive an additional pharmaceutical discount based on manufacturers' rebates and the state's contribution of up to 2 percent. There also will be an annual enrollment fee to offset administrative costs.

Elements that Facilitated Health Reform

Political Culture of Health Policy Activity

Governor Howard Dean is a physician with a personal interest in health care. From the time he became governor in 1991, he placed an emphasis on expanding health care coverage to all Vermonters. His interest "drove the train" to place health care coverage high on the state's agenda. His first focus was on expanding coverage to children. Working closely with the legislature, Governor Dean incorporated Dr. Dynasaur into Medicaid and incrementally expanded coverage to adults through VHAP. The latter was facilitated by presenting VHAP as coverage for *working* Vermonters. All the coverage

expansions were made easier because Vermont has a history of acceptance of public programs.

Outreach and Community Involvement

The culture in Vermont bodes well for strong support for and participation in public health programs. Although many other states with large rural populations have had trouble enrolling residents in public programs, Vermont has had success by offering mail-in applications to eligible citizens. Additionally, because the eligibility office is centralized, the state is positioned to deal with any increase in applications due to access expansion initiatives such as CHIP or new pharmacy programs.

Vermont also has increased enrollment through some innovative outreach approaches. For example, Dr. Dynasaur outreach continues to enroll eligible children through its partnership with the state department of education, which allows the program to use school lunch program applications to target eligible children. Additionally, Dr. Dynasaur brochures have recently been revised, and posters will be distributed to all providers and doctor's offices. Through their Covering Kids grant, many outreach initiatives also have been initiated through community partnerships on a local level, benefiting from Vermont's small community-based orientation and widespread commitment to help enroll people. Although outreach for VHAP is significantly less than outreach for Dr. Dynasaur, Vermont has made a special effort to work with transient adults to help them apply for VHAP and with Agencies on Aging to enroll seniors in Medicaid and the pharmacy programs.

Challenges to Expansion

Lack of Employer-Sponsored Initiatives

Over one-third of Vermont's workforce consists of very small employers (under 10 workers), who are least likely to offer insurance to their workers in Vermont and nationally. Whereas small firms in Vermont are more likely to insure their workers than the national average (25% of workers in firms in the state with fewer than 10 employees are uninsured, compared with 32% nationwide), the barriers to small-group coverage are high. The small-group insurance market offers few choices and has little incentive to control costs (described below). Further, there is no strong, organized business "voice" to address the high premiums that small employers face in Vermont. In the 1990s, there was a fairly active Business Coalition whose primary focus was to influence legislative policy, but the coalition dissolved and the business community has yet to establish another organized voice in the political forum.

Because of these and other factors (see “Higher Health Care Costs,” below), small-group premiums have increased considerably. Many small employers have had to stop offering coverage to their employees or require employees to pay a higher share of the premium. Indeed the portion of the nonelderly population with employer-sponsored coverage (63%) is less than the national average (69%). Because the income eligibility levels for VHAP are relatively high, however, many employees have the option to enroll in the public coverage programs after 12 months of uninsurance so that they do not necessarily remain uninsured indefinitely.

Health Insurance Market

Growth in Vermont’s health insurance market has been focused on large employers, associations, and self-insured employer plans. There has been a decline, on the other hand, in the individual market and a gradual decline in the small-group market. Heavy regulation of the small-group market contributed to the departure of all but three small-group carriers. The three HMOs that do operate in the state are making a profit but, as noted above, lack of competition results in less incentive to be “the best” or to negotiate aggressively with providers over costs and reimbursement rates.

There is also a dearth of managed care organizations (MCOs) in the state. Vermont initiated a managed care program under Medicaid, but had to convert to a primary care case management (PCCM) program called Primary Care Plus (PC Plus) because of lack of MCO capacity. PC Plus, although not a fully capitated managed care program, provides a “medical home” for beneficiaries through the coordination of services by a network of primary care providers. Enrollment is mandatory for all VHAP beneficiaries and all traditional Medicaid beneficiaries who are not otherwise exempt.

Higher Health Care Costs

Vermont’s health insurance premiums, like those nationwide, are increasing at a significant rate. In addition to the factors described above, Vermont is playing “catch-up” for previous underpricing in the market; additional factors include increases in utilization, increased cost of technology, increased cost of pharmaceuticals, and new mandated benefits. Further, Vermont’s disproportionately high number of resident baby boomers will be using more health care services as they age.

Meanwhile, high costs and budget constraints have forced Vermont to increase cost-sharing and cut back some benefits in its public programs despite efforts to retain existing benefits. For example, in the 2001 legislative session, adult dental care was dropped from VHAP. Additionally, Vermont has put a freeze on vision benefits and is

exploring freezing enrollment in its pharmacy programs, or even reducing some of the drug benefits to the elderly in the pharmaceutical programs described earlier.

Looking Ahead

To address the problem of uninsured workers in small firms (19 or fewer workers), legislation was introduced in spring 2002 that would give workers with incomes up to 300 percent of the FPL the option to buy in to VHAP. Small employers with 75 percent of their workforce eligible would be required to pay 50 percent of the premium. Even though this initiative came from the governor's office and was intended to be as simple as possible for businesses, it did not quite "catch fire" in the state because it would impose mandates on small firms. Although this bill passed the state senate, it did not pass out of the state house Health and Welfare Committee.

Much like the rest of the nation, Vermont is facing less-promising economic times than it was a few years ago. To maintain coverage at the current level, avoid drastic cuts in any benefits, and deal with increases in enrollment, the state is considering increasing copayments and cutting some services to adults in VHAP. In March 2002, program fees in Dr. Dynasaur were increased to \$50 for children in families with incomes between 225 percent and 300 percent of the FPL. Proposed cost-sharing mechanisms have been proposed as an alternative to reducing eligibility, but many state legislators are against them. However, if costs are not cut sufficiently, benefits may have to be.

Among the largest state expenses is the cost of pharmaceuticals paid for by Vermont's publicly administered programs, including traditional Medicaid, VHAP, and the multiple pharmacy-related programs. Escalating prescription drug costs affect the total budget, so there is less money for provider reimbursement and increasing (or maintaining) eligibility levels and/or services. Because Vermont has a number of state pharmacy initiatives, as discussed above, controlling these costs while maintaining the benefits has become a top priority in the state. This is where the Pharmacy Benefit Management Program and the preferred drug list play extremely important roles.

Vermont was the recipient of a Health Resources and Services Administration (HRSA) State Planning Grant in FY 2000, whereby the state received nearly \$1.3 million over the course of one year (although Vermont did receive a one-year, no-cost extension) to conduct a targeted, in-depth study of the uninsured population in the state and to develop a plan for providing coverage to that population. One policy recommendation emanating from this grant that has garnered particular attention in the state is the single-

payer model. OVHA has been charged by the legislature to look at the single-payer model more closely to determine its feasibility.

Vermont's experience in carrying out this large-scale population study underscores the need to consider wide disparities in demographics and conditions even within a small state. For example, the Northeast Kingdom portion of Vermont has a large number of small employers and a high rate of uninsurance. The primary problem is that the region has no insurance carrier and very few health care providers. An understanding of these geographic differences is critical when making state policy recommendations.

Recommendations to Other States

Despite being a rural state with a high percentage of very small employers, two characteristics that are found in areas with high uninsurance rates, Vermont has managed to maintain a relatively low level of uninsurance. One of the major lessons emerging from Vermont's experience is the importance of understanding local characteristics when designing or expanding programs, especially given the fact that not all populations have access to the same services.

Another lesson is the importance of understanding the political climate in the state. Because of Vermont's progressive stance on various policies, passing widespread coverage expansions in the past was not as difficult a challenge as it could have been without a supportive administration and legislature. It also is not enough merely to set high-income eligibility limits for public programs. Outreach and enrollment through small, tight-knit communities across the state, a user-friendly application process, and a centralized, integrated computer system have contributed to Vermont's low uninsurance rate.

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RELATED PUBLICATIONS

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#598 *Building Quality into RItE Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations* (January 2003). Sharon Silow-Carroll, Economic and Social Research Institute. RItE Care, Rhode Island's managed care program for Medicaid beneficiaries, Children's Health Insurance Program enrollees, and certain uninsured populations, has made quality improvement a central goal. This report examines the state's initiatives aimed at improving care for pregnant women, children, and others, including efforts focused on preventive and primary care, financial incentives, and research and evaluation.

#596 *Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times* (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

#585 *Small But Significant Steps to Help the Uninsured* (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

#589 *Health Insurance Tax Credits: Will They Work for Women?* (December 2002). Sara R. Collins, Stephanie B. Berkson, and Deirdre A. Downey, The Commonwealth Fund. This analysis of premium and benefit quotes for individual health plans offered in 25 cities finds that tax credits at the level of those in recent proposals would not be enough to make health insurance affordable to women with low incomes.

#586 *Staying Covered: The Importance of Retaining Health Insurance for Low-Income Families* (December 2002). Leighton Ku and Donna Cohen Ross, Center on Budget and Policy Priorities. This report examines why many low-income adults lose their health coverage, what the effects of losing coverage are, and which strategies can help people retain their insurance.

#587 *Assessing State Strategies for Health Coverage Expansion: Summary of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These summaries of case studies look at four states' unique as well as shared experiences and draw lessons for other states. (See pub. **#565** for the full case studies.)

#577 *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (November 2002, Web publication). Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, Economic and Social Research Institute. In 2000, the

DHHS' Health Resources and Services Administration awarded grants to 20 states to create comprehensive coverage plans for all citizens. These summaries report on the progress of states' coverage expansion efforts, detailing the history of reform, data on uninsured populations, actions taken, and goals for future efforts. Available at www.cmwf.org.

#565 *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These case studies provide an in-depth account of four states' efforts to expand health coverage, detailing their relative strengths and weaknesses and highlighting what appear to be the key factors for success.

#574 *Employer Health Coverage in the Empire State: An Uncertain Future* (August 2002). According to this report, the combination of a weak economy, higher unemployment, and rising health care costs is placing pressure on New York State employers to eliminate or scale back health benefits for workers, their dependents, and retirees.

#559 *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (August 2002). Based on a Commonwealth Fund survey of health insurance in the workplace, this report finds that two of five workers experienced increases in their premiums or cost-sharing, or both, during 2001. Although public support for job-based health insurance remains strong, many workers are not confident that employers will continue to offer coverage to them down the road. Workers are even more uncertain about their ability to get good health care in the future.

#509 *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity* (June 2002). Mark Merlis. This report examines trends in out-of-pocket spending, the components of that spending, and the characteristics of families with high out-of-pocket costs.

#557 *Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?* (May/June 2002). David R. Nerenz, Vence L. Bonham, Robbya Green-Weir, Christine Joseph, and Margaret Gunter. *Health Affairs*, vol. 21, no. 3. The absence of data on race and ethnicity in health plan and provider databases is a significant barrier in the creation and use of quality-of-care reports for patients of minority groups. In this article, however, the authors show that health plans are able to collect and analyze quality of care data by race/ethnicity.

#556 *Do Enrollees in 'Look-Alike' Medicaid and SCHIP Programs Really Look Alike?* (May/June 2002). Jennifer N. Edwards, Janet Bronstein, and David B. Rein. *Health Affairs*, vol. 21, no. 3. In their analysis of Georgia's similar-looking Medicaid and SCHIP programs, the authors present three possible explanations for the differences in access to care between the two populations: Medicaid families are less familiar with and supportive of systems requiring use of an assigned primary care physician, the families face more nonprogram barriers to using care, and physicians have different responses to the two programs.

#527 *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make tax credits and the individual insurance market work, including raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

#518 *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income.

#507 *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

#528 *The APHSA Medicaid HEDIS Database Project* (December 2001). Lee Partridge, American Public Human Services Association. This study (available on the Fund's website only) assesses how well managed care plans serve Medicaid beneficiaries, and finds that while these plans often provide good care to young children, their quality scores on most other measures lag behind plans serving the commercially insured.

#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64, some 38 million adults, was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

#513 *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (December 2001). Michelle M. Doty and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, examines the potential as well as limits of COBRA eligibility as a strategy for protecting workforce access to affordable health care benefits.

#514 *Experiences of Working-Age Adults in the Individual Insurance Market* (December 2001). Lisa Duchon and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, describes the difficulties faced by those without access to group health coverage in obtaining adequate, affordable individual health insurance.

#478 *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

#511 *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (November 2001). Jeanne M. Lambrew, George Washington University. This report documents the link between loss of health insurance and unemployment, estimating that 37 percent of unemployed people are uninsured—nearly three times as high as the uninsured rate for all Americans (14%). The jobless uninsured are at great financial risk should they become ill or injured.

#485 *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

#484 *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack

access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

#475 *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

#502 *Gaps in Health Coverage Among Working-Age Americans and the Consequences* (August 2001). Catherine Hoffman, Cathy Schoen, Diane Rowland, and Karen Davis. *Journal of Health Care for the Poor and Underserved*, vol. 12, no. 3. In this article, the authors examine health coverage and access to care among working-age adults using the Kaiser/Commonwealth 1997 National Survey of Health Insurance, and report that having even a temporary gap in health coverage made a significant difference in access to care for working-age adults.

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children’s Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation’s 15 million uninsured women.

#472 *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

#464 *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children’s Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

#445 *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

#439 *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs*, vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

#415 *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series *Strategies to Expand Health Insurance for Working Americans*.

#476 *“Second-Generation” Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review*, vol. 22, no. 2. This study of Medicaid managed care programs in seven states finds that the programs require state

policymakers to make difficult tradeoffs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at www.cmwf.org.

#422 *Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs* (December 2000). Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP. Available online only at www.cmwf.org.

#419 *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs* (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so. Available online only at www.cmwf.org.

#424 *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

#411 *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supersedes state laws that relate to private-sector, employer-sponsored plans.

#392 *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

#385 *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report examines the effect of cost-sharing on participation in the State Child Health Insurance Program (CHIP).

#384 *State Experiences with Access Issues Under Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report explores how the design and administration of state incremental insurance expansions affect access to health insurance coverage and, ultimately, access to all health care services.

#380 *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities* (May 2000). Sue A. Kaplan, Jessica Green, Chris Molnar, Abby Bernstein, and Susan Ghanbarpour. In this report, the authors document the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country.

#366 *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (February 2000). Lee Partridge and Carrie Ingalls Szlyk, American Public Human Services Association. This report summarizes the first year of a project to create national summaries of state Medicaid HEDIS data and national Medicaid quality benchmarks against which each state can measure its program's performance.

#368 *Managed Care in Three States: Experiences of Low-Income African Americans and Hispanics* (Fall 1999). Wilhelmina A. Leigh, Marsha Lillie-Blanton, Rose Marie Martinez, and Karen Scott Collins. *Inquiry*, vol. 36, no. 3. This article examines the experiences of low-income Hispanics, African Americans, and whites enrolled in managed care plans in Florida, Tennessee, and Texas and compares them to their racial/ethnic counterparts enrolled in fee-for-service plans.

#260 *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs* (April 1998) Laura Summer, Alpha Center. In an effort to determine states' success in covering uninsured populations, the author interviewed public insurance officials in 12 states and reviewed their programs' administrative structures, use of managed care, eligibility rules, and application and enrollment processes.