



**STATE STRATEGIES TO EXPAND HEALTH INSURANCE
COVERAGE: TRENDS AND LESSONS FOR POLICYMAKERS**

Alice Burton, Isabel Friedenjohn, and Enrique Martinez-Vidal
State Coverage Initiatives
AcademyHealth

January 2007

*Prepared for The Commonwealth Fund/Alliance for Health Reform
2007 Bipartisan Congressional Health Policy Conference*

ABSTRACT: The latest round of state-level reforms, most of them enacted or proposed in 2006, has presented a variety of approaches to covering the uninsured, including new mechanisms to subsidize coverage for low-income families, new variations on employer and personal responsibility for health insurance coverage, and new strategies to facilitate the purchase of insurance for small businesses and for individuals without access to employer-sponsored insurance. The boldest state-level efforts aim at comprehensive (near-universal) coverage, while others focus on incremental approaches such as providing coverage for children or public-private partnerships to insure low-income workers. National solutions are unlikely to emerge in the foreseeable future, but the concept of federally supported state experimentation is being seen as a promising way to make progress.

This paper is a summary of *State of the States 2007: Building Hope, Raising Expectations*, the annual report of the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program. The full report was released in January 2007 and is, along with other SCI publications, available online at www.statecoverage.net.

Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff, or of The Commonwealth Fund Commission on a High Performance Health System or its members. This and other Fund publications are available online at www.cmwf.org. To learn more about new publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#). Commonwealth Fund pub. no. 987.

CONTENTS

About the Authors	iv
Executive Summary	v
Introduction: Drivers of State Health Insurance Initiatives.....	1
State Initiatives to Expand Coverage	3
Comprehensive Reforms: Massachusetts, Vermont, and Maine	4
New Comprehensive Reform Proposals.....	9
Covering All Children	11
Employer-Based Efforts (New Mexico, Oklahoma, and Arkansas).....	13
Observations on State Initiatives	16
Federal Proposals to Support State Innovations.....	20
Recent Federal Initiatives.....	21
Helpful Resources	24
Notes.....	25

LIST OF FIGURES AND TABLES

Figure 1	Percent of Adults Ages 18–64 Uninsured by State.....	2
Figure 2	Half of Middle- and Lower-Income Adults Experienced Serious Problems Paying for Medical Bills or Insurance in Past Two Years.....	2
Table 1	Key Features of State Reforms.....	3
Table 2	Federal Legislative Proposals of the 109th Congress to Encourage State Reforms.....	22

ABOUT THE AUTHORS

Alice Burton, M.H.S., is vice president at AcademyHealth, where she leads the Robert Wood Johnson Foundation's State Coverage Initiatives program and AcademyHealth's work with states. She works with state policy leaders to develop strategies to improve insurance coverage and has participated in numerous task forces on the uninsured, both as a member and advisor. Previously, Ms. Burton was the director of the planning administration at the Maryland Department of Health and Mental Hygiene, where she was responsible for developing policy initiatives for the Maryland Medicaid program, the Maryland Children's Health Insurance Program, and other health care financing programs. She developed and oversaw the HealthChoice Evaluation, the state's first comprehensive evaluation of its Medicaid managed care program, and worked to implement that report's recommendations. Ms. Burton is a graduate of the University of Maryland, College Park, and holds a master's degree in health policy from the Johns Hopkins University Bloomberg School of Public Health.

Isabel Friedenzohn, M.P.H., is senior associate at AcademyHealth, where she works primarily on the State Coverage Initiatives program. Her responsibilities include providing technical assistance to state policymakers on health policy reform, specifically expanding and maintaining health insurance coverage; disseminating state models of expansion through the program's written products; convening workshops and small group consultations for policymakers; and assisting in the development of technical assistance documents. For the past two years, she has been the lead editor for the program's *State of the States* publication. Ms. Friedenzohn received her master's degree in public health from the University of Michigan School of Public Health.

Enrique Martinez-Vidal, M.P.P., is deputy director of AcademyHealth's State Coverage Initiatives program, which works with state policy leaders to develop strategies to improve insurance coverage. He also is project director for a contract with the federal Agency for Healthcare Research and Quality (AHRQ) to conduct an environmental scan of state-level quality initiatives and to help AHRQ develop a strategy to partner with states in quality improvement. Previously, Mr. Martinez-Vidal was deputy director for performance and benefits at the Maryland Health Care Commission, an independent state agency; while there, he was responsible, among other things, for the oversight of Maryland's small group insurance market reforms and the annual evaluation of Maryland's mandated health insurance benefits. He also served as co-director of Maryland's Health Resources and Services Administration State Planning Grant on the uninsured and was a policy analyst with the Maryland Department of Legislative Services. He has a B.A. in political science and international studies from Dickinson College and a master's degree in public policy from Georgetown University.

EXECUTIVE SUMMARY

Our employer-based health insurance system is crumbling—with the result that there are more uninsured people with less access to needed health services. In 2005, the number of uninsured climbed to 47 million, the result of a steady increase since 2000. Even more disturbing are the present trends that show the number of uninsured could reach 56 million by 2013.

Many state policy leaders, frustrated by the lack of federal action on the problem of the uninsured, have taken matters into their own hands, and the result is a trend toward health care reform at the state level. The latest round of state reforms, most of them enacted or proposed in 2006, presents a variety of approaches to covering the uninsured, including new mechanisms to subsidize coverage for low-income families, new variations on employer and personal responsibility for insurance coverage, and new strategies to facilitate the purchase of health insurance for small businesses and for individuals without access to employer-sponsored insurance.

Several state efforts are characterized as comprehensive because they attempt to reach near-universal coverage, accomplishing the task through broad system reforms that include quality initiatives, cost-containment efforts, and strategies to reduce the underlying cost of health care through chronic care management. Other states are moving ahead with incremental approaches such as providing universal coverage for children or public-private partnerships to insure low-income workers.

The boldest reform proposals, demonstrating the capacity for breaking ground in a bipartisan manner, have come from the Northeast. The comprehensive reforms in Massachusetts, Vermont, and Maine go further toward helping low-income families purchase health insurance than in any other states. One of the key elements shared by all three reforms is that they subsidize coverage for families with annual incomes up to approximately \$53,000 (300% of the federal poverty level [FPL] for a family of four). Each of these states uses Medicaid to partly fund its subsidized product, demonstrating the importance of Medicaid as a financing source. However, they each couple the products with other reforms that reflect distinct local priorities.

Meanwhile, a growing number of other states are pursuing less-than-comprehensive but still significant approaches. For example, some states are moving toward coverage of all their children. Illinois has passed the Covering All Kids Health Insurance Act, making insurance coverage available to all uninsured children. As of January 2007, All Kids will be available to any child uninsured for 12 months or more,

with the cost to the family determined on a sliding-scale basis. Pennsylvania has announced the development of the Cover All Kids program, Tennessee has passed the Cover Kids Act, and other states—notably Oregon, Wisconsin, Washington, and New Mexico—are considering proposals in a similar vein.

In aiming to address children and adults alike, several states have developed partnerships with private employers and insurers to cover low-income workers. These collaborations have taken a variety of different approaches, reflecting the different regulatory and market environments of each state as well as the specific compromises that state policy leaders have been able to craft. The majority of state efforts to expand coverage rely on private insurers to deliver services, including those that use Medicaid funds.

This is not the first time that state policy leaders have taken the lead in attempting to improve insurance coverage in their states. The recent reforms build on at least a decade of state experiments, most of them of limited impact, that ranged from comprehensive attempts to numerous incremental approaches.

These newest reforms are more promising than their predecessors. Although they vary in a number of ways, they all are based on some common, hard-won lessons:

- Comprehensive state reforms take time because they build off prior efforts and in-place financing mechanisms.
- Reforms attempt to stem the erosion of employer-sponsored insurance.
- Successful efforts to enact reforms often expect shared financial responsibility. Some are beginning to recognize the need for mandatory participation.
- Expansions in coverage often rely on private insurers to deliver care.
- Voluntary purchasing pools, as a stand-alone strategy, are not likely to be sufficient to expand coverage.
- Medicaid benefits are being redesigned through new reforms, but to date these efforts have not included expansions in coverage.
- Many state reforms address cost and quality in addition to health insurance coverage.

The past year's state-level efforts to implement health insurance reforms have fueled optimism that states can lead the way in addressing the problem of the uninsured. Certainly, states' efforts can test coverage strategies both politically and practically, which can inform and provide lessons to other state and national leaders. However, the variation

among states is far too great for state-by-state reform to result in a national solution for the country's 47 million uninsured.

Nevertheless, because it appears unlikely that comprehensive national health reform will be considered in the near term—as other issues may continue to dominate the national agenda—health policy experts have promoted the concept of federally supported state experimentation as a promising way to make progress.

During the 109th Congress, several members of Congress offered legislation that would provide grant funds to states to pilot new health reforms. The introduction of these bills clearly bolsters the trend toward developing solutions to the problem of the uninsured at the state level rather than in Washington, D.C. Time will tell whether the new Congress is indeed ready to enact laws that provide the federal resources necessary to encourage state innovation, whether the current bipartisan agreements at the state level are able to encourage even broader federal action, or whether the status quo will remain.

STATE STRATEGIES TO EXPAND HEALTH INSURANCE COVERAGE: TRENDS AND LESSONS FOR POLICYMAKERS

INTRODUCTION: DRIVERS OF STATE HEALTH INSURANCE INITIATIVES

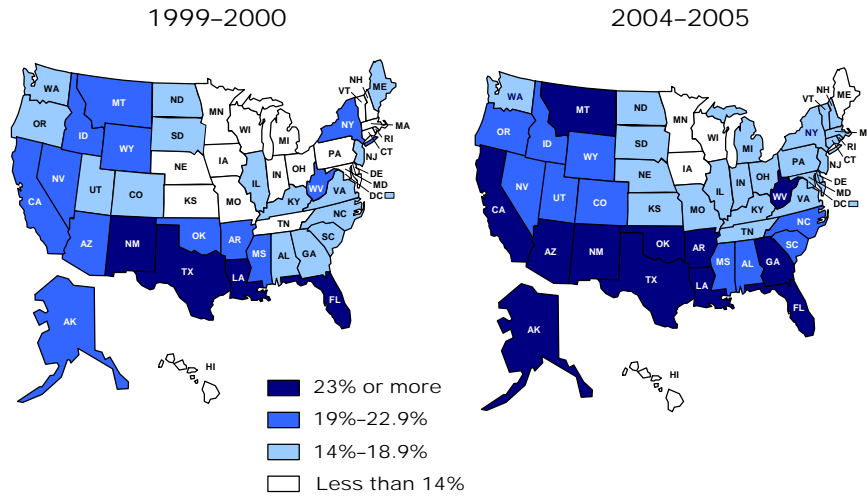
In the last few years, states have been endeavoring to cover the uninsured. Their efforts have been motivated by compelling evidence that our employer-based health insurance is crumbling—with the result that there are more uninsured people with less access to needed health services—and enabled by recovery from what had been a severe fiscal crisis that began in 2001. Covering the uninsured is now a priority issue for state policymakers, whose frustration with the lack of attention placed on finding a national solution is growing. Even national lawmakers are increasingly looking to the states, in hopes that they may serve as practical and political testing grounds for new strategies.

In 2005, the number of uninsured climbed to 47 million, the result of a steady increase since 2000. Even more disturbing are the present trends that show the number of uninsured could reach 56 million by 2013.¹ The proportion of uninsured varies widely among the states; however, few have been immune from the increase in uninsured. Data comparing two-year average rates show a tripling of the number of states with 23 percent or more uninsured adults (Figure 1).²

The increase in uninsured can be explained in large part by the decline in employer-sponsored insurance. In 2000, 68 percent of working-age adults were insured through their employer or through a family member's employer. By 2004, only 63 percent had employer-based insurance, and there were 3.4 million more uninsured.³ Almost three-quarters of the decline in employer-sponsored insurance resulted from fewer employers offering coverage and more employers tightening eligibility requirements for workers and dependents.⁴ While most large firms offer their workers some level of health insurance coverage, only 60 percent of small and mid-sized businesses (those employing from three to 199 employees) did so in 2005—down from 68 percent in 2000.⁵

Consequently, lack of access to affordable health care has become a major concern for many individuals. Half of middle- and lower-income adults report experiencing a problem paying for medical bills or insurance in the past two years.⁶ (See Figure 2.) Moreover, almost half of adults of all incomes report being somewhat worried or very worried about paying medical bills in the event of a serious illness.⁷

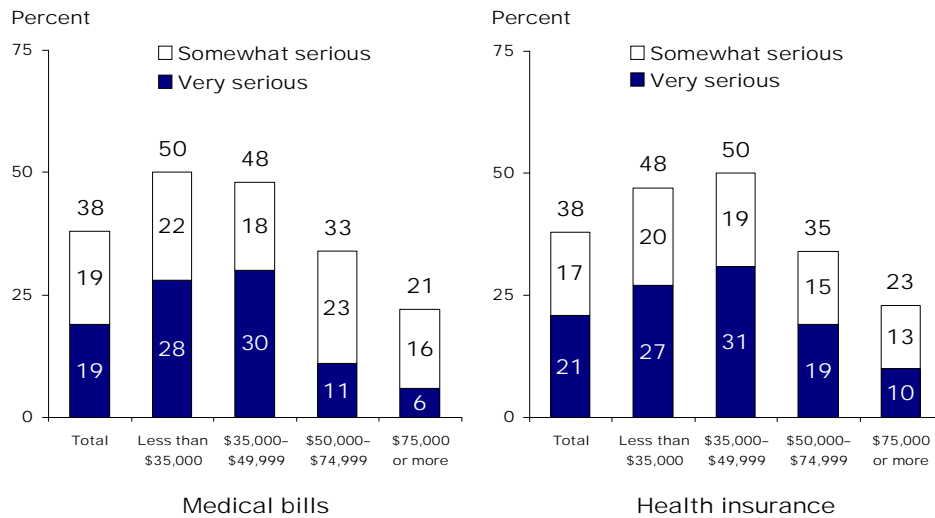
Figure 1. Percent of Adults Ages 18–64 Uninsured by State



Data: Two-year averages 1999–2000 and 2004–2005 from the Census Bureau's March 2000, 2001 and 2005, 2006 Current Population Surveys. Estimates by the Employee Benefit Research Institute.

Source: C. Schoen and S. K. H. How, *National Scorecard on U.S. Health System Performance: Technical Report* (New York: The Commonwealth Fund, Sept. 2006).

Figure 2. Half of Middle- and Lower-Income Adults Experienced Serious Problems Paying for Medical Bills or Insurance in Past Two Years



Source: C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006).

STATE INITIATIVES TO EXPAND COVERAGE

Many state policy leaders, frustrated by the lack of federal action on the problem of the uninsured, have taken matters into their own hands, and the result is a trend toward health care reform at the state level. The latest round of state reforms, most of them enacted or proposed in 2006, presents a variety of new approaches to covering the uninsured, including new mechanisms to subsidize coverage for low-income families, new variations on employer and personal responsibility for insurance coverage, and new strategies to facilitate the purchase of health insurance for small businesses and for individuals without access to employer-sponsored insurance (Table 1).

Several state efforts are characterized as comprehensive because they attempt to reach near-universal coverage, accomplishing the task through broad system reforms that include quality initiatives, cost-containment efforts, and strategies to reduce the underlying cost of health care through chronic care management. Other states are moving ahead with incremental approaches such as providing universal coverage for children or public-private partnerships to insure low-income workers.

Table 1. Key Features of State Reforms

State	Initiative	Key Features
Comprehensive Reforms		
Massachusetts	Commonwealth Care	<ul style="list-style-type: none"> ▪ Individual mandate ▪ Employer Fair Share assessment ▪ Free Rider surcharge ▪ Health Insurance Connector ▪ Insurance market reforms ▪ Commonwealth Care*
Maine (2003)	Dirigo Health	<ul style="list-style-type: none"> ▪ DirigoChoice* ▪ Cost-containment reforms ▪ Maine Quality Forum
Vermont	Catamount Health	<ul style="list-style-type: none"> ▪ Employer assessment ▪ Premium assistance for low-income workers ▪ Catamount Health Plan* ▪ Chronic care initiatives
Covering All Kids		
Illinois	All Kids	<ul style="list-style-type: none"> ▪ Universal coverage for children ▪ Sliding-scale premiums based on family income
Pennsylvania	Cover All Kids	<ul style="list-style-type: none"> ▪ Universal coverage for children ▪ Sliding-scale premiums based on family income
Tennessee	CoverKids	<ul style="list-style-type: none"> ▪ Separate stand-alone State Children's Health Insurance Program (SCHIP) for children in families with incomes up to 250% of federal poverty level (FPL) ▪ Buy-in for children in families above 250% FPL

State	Initiative	Key Features
Public–Private Partnerships		
Arkansas	ARHealthNet	<ul style="list-style-type: none"> ▪ Safety Net benefit package ▪ Provided through private insurers ▪ Open to businesses with 2–500 employees that have not offered insurance within last 12 months ▪ Subsidy provided for workers with incomes below 200% FPL
Montana	Insure Montana	<ul style="list-style-type: none"> ▪ Purchasing pool with a subsidy available to previously uninsured firms (2–9 employees) that have not offered insurance for 24 months ▪ Employer and employee premium subsidies ▪ Tax credit available for currently insured small firms (2–9 employees)
New Mexico	State Coverage Insurance	<ul style="list-style-type: none"> ▪ New subsidized insurance product delivered by Medicaid managed care organizations ▪ Available to low-income, uninsured, working adults with family income below 200% FPL ▪ Individuals may enroll through their employer or as self-employed persons ▪ Premium paid by employer/employee contributions and state/federal funds
Oklahoma	Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)	<ul style="list-style-type: none"> ▪ Premium assistance voucher available for small firms (2–50 employees) that offer a qualified plan and income-eligible employees with incomes below 185% FPL ▪ Individual plan available to uninsured workers whose firms do not offer insurance and to self-employed (who earn less than 185% FPL)
Rhode Island	WellCare	<ul style="list-style-type: none"> ▪ New health plan expected to be 25% below market rates ▪ Assisting Low-Income Small Businesses save an additional 10% through reinsurance pool (legislation passed, but no funding approved) ▪ Making health care cost and quality data more transparent ▪ High risk pool ▪ Certificate-of-need reform
Tennessee	CoverTN	<ul style="list-style-type: none"> ▪ New affordable health insurance product for working uninsured and small firms that do not offer coverage ▪ At least two statewide private plans ▪ Cost limited to \$150/month, split by employer, employee, and state ▪ High Risk Pool
Utah	Utah Premium Partnership for Health Insurance (UPP)	<ul style="list-style-type: none"> ▪ New premium assistance program under the Primary Care Network ▪ \$150 subsidies for low-income workers enrolled in employer-sponsored insurance ▪ Subsidies up to \$100 for employee’s children

* Includes subsidies for low-income workers.

For more information on all these initiatives as well as others, please go to <http://statecoverage.net/matrix/index.htm>.

Comprehensive Reforms: Massachusetts, Vermont, and Maine

The boldest reform proposals passed in 2006, demonstrating the capacity for breaking ground in a bipartisan manner, came from the Northeast. Massachusetts and Vermont passed

comprehensive reforms that have ambitious goals for covering the uninsured. And Maine, which was one of the few to take on comprehensive reform in 2003 when most states were dealing with severe deficits, continued to move toward its goal of universal coverage by 2009. When building their current reforms, all three states had relatively low rates of uninsured compared to the nation—partially from a history of trying to reduce the number of uninsured, including the establishment of relatively generous Medicaid eligibility levels.

The comprehensive reforms in these three states go further toward helping low-income families purchase health insurance than in any other states. One of the key elements shared by all three reforms is that they subsidize coverage for families with annual incomes up to approximately \$53,000 (300% of the federal poverty level [FPL] for a family of four). Each of these states uses Medicaid to partly fund its subsidized product, demonstrating the importance of Medicaid as a financing source. However, they each couple the products with other reforms that reflect distinct local priorities.

Massachusetts: Commonwealth Care

Massachusetts's reform legislation, which is aimed at covering 95 percent of residents within three years, represents the culmination of over a year of negotiations between lawmakers and Governor Mitt Romney (R). The need to find compromises and act on comprehensive reform was made more urgent by the potential loss of \$385 million in federal matching funds that had been previously used to fund care for the uninsured.

Massachusetts broke new ground with its requirement that individuals purchase health insurance. Those who can afford insurance are required to obtain it by July 1, 2007, or risk the loss of their personal exemption for 2007 income taxes. In subsequent tax years, the penalty will include a fine equaling 50 percent of the monthly cost of health insurance for each month without insurance.

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

The Connector will be the sole place where uninsured, low-income populations can enroll in the Commonwealth Care Health Insurance Program, which will provide sliding-scale subsidies to individuals with incomes below 300 percent FPL. No premiums will be imposed on those individuals with incomes below \$9,800 (100% FPL). In October, the state announced that the average monthly premiums for products offered through the Connector will range from \$276 and \$391 before the subsidies are applied.

Prior to reforms, Massachusetts had a high level of employer-sponsored insurance relative to the rest of the nation. Building on this foundation, the state added several provisions to share responsibility with employers. Those with 11 or more employees that do not make a “fair and reasonable” contribution toward their employees’ health insurance coverage will be required to make a per-worker contribution, now estimated at approximately \$295 annually. Employers will pass the “fair and reasonable” test if at least 25 percent of full-time employees are enrolled in the company’s group plan and the employer contributes toward their premiums. Should employers not meet these criteria, they can still pass if they can demonstrate that they pay at least 33 percent of employee’s health insurance premium. Another provision related to employers requires that, by January 1, 2007, all those with 11 or more workers must adopt a Section 125 “cafeteria plan,” as defined by federal law, that permits workers to purchase health care with pre-tax dollars (thereby saving about 25% on the cost of premiums). If these employers do not “offer to contribute toward or arrange for the purchase of health insurance,” they may be assessed a “free rider” surcharge if their employees access free care.

The health care reform bill also includes a number of insurance market reform provisions. Starting in July 2007, the non- and small-group markets will be merged, although a study of this merger must be completed before that date to assist insurers in planning for the transition. The bill also allows HMOs to offer coverage plans that are linked to health savings accounts. In addition, under the bill, young adults may remain on their parents’ policy for two years past the loss of their dependent status, or until they turn 25, whichever occurs first. Carriers will also be designing new products with fewer benefits, as these products are thought to be more attractive to young adults.

The reform will be financed by several significant sources. First, \$385 million in federal matching funds previously used to fund the safety net and uncompensated care will be redirected to cover the subsidies. Additionally, the state will invest \$308 million over three years in general fund revenues and collect individual and employer contributions as well. The ability of the state to leverage Medicaid financing was an essential part of its ability to move forward.

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

Vermont: Catamount Health

Overshadowed to some degree by Massachusetts, Vermont passed a similarly far-reaching health reform plan, called Catamount Health, in May 2006. Vermont policymakers were able to craft a bipartisan compromise on the heels of a year of reform discussions and the passage of the Green Mountain Health plan, which had been vetoed by Governor Jim Douglas (R).

Catamount Health has set a goal of assuring insurance coverage for 96 percent of Vermonters by 2010. The plan provides a new subsidized insurance product, for uninsured families with incomes up to approximately 300 percent FPL, along with a requirement that employers contribute to health care costs. Employers will pay a \$365 per-full-time-employee annual assessment for their uninsured workers. Catamount will offer a premium assistance program to low-income individuals with access to employer-sponsored insurance who have previously been unable to afford insurance.

Vermont's reforms heavily emphasize chronic care management, both in the benefit design of the Catamount Health product as well as in other products offered by the state, such as the State Employees' Health Plan and Medicaid. This coverage expansion is aligned with the Chronic Care Initiative of the State's Blueprint for Health. Managed by the Vermont Department of Health, the Blueprint is a public-private collaborative approach that seeks to improve the health of Vermonters living with chronic diseases and to prevent the complications of chronic disease. It uses the Chronic Care Model⁸ as the framework for system changes.

Funding for the Catamount Health program will come from several sources, including an increased tobacco product tax. Vermont also intends to use federal matching funds that it anticipates will be available through the "Global Commitment to Health" waiver approved by the Centers for Medicare and Medicaid Services (CMS) in 2005. Under this waiver, the state agrees to a cap on Medicaid growth for approximately two-thirds of the population in exchange for the ability to use funds for health care investments such as the Blueprint and expansions of coverage to the uninsured. State projections assume that the cap negotiated with CMS will be sufficient to allow for some of these

health care investments.⁹ Finally, some of the Catamount subsidy will be financed through enrollee premiums and the employer assessment.

Maine: Dirigo Health

The Dirigo Health Reform Act, Maine's comprehensive health reform program, was enacted in 2003 as a priority of the then newly elected Governor John Baldacci (D). Dirigo, the state motto (meaning "I lead" in Latin), includes strategies to control costs, improve quality, and expand coverage. In contrast to the comprehensive reforms of Massachusetts and Vermont, Maine has relied exclusively on voluntary measures to expand insurance coverage. There is no individual mandate nor are there assessments on employers who do not provide coverage for their employees.

The DirigoChoice health insurance product is the centerpiece of the state's efforts to expand coverage to the uninsured. DirigoChoice is available to small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance. DirigoChoice is delivered exclusively through Anthem, by far the largest carrier in Maine. The program offers sliding-scale discounts on monthly premiums, reductions in deductibles, and out-of-pocket maximums to enrollees with incomes below 300 percent FPL.

Maine was ambitious in its goal of expanding coverage to all uninsured Mainers by 2009. The program has drawn criticism for enrolling only 12,000 to date, a number much lower than the state had anticipated.¹⁰ However, considering the small population of Maine, the numbers enrolled in the program are quite impressive. After the first year of operation, most enrollees were low-income individuals who were able to benefit from the subsidies available.¹¹ Still, state officials had hoped for larger enrollment and had not anticipated the continuing resistance from groups that are philosophically opposed to a publicly sponsored program and to the program's financing strategy. Improving outreach and marketing strategies for the DirigoChoice program is now a main focus of Maine's efforts to increase enrollment. In addition, state officials are hoping that some administrative changes effective in early 2007 will help streamline the subsidy process and make it easier for individuals to participate in the program.

Maine also implemented several cost-containment mechanisms, voluntary caps on the cost and operating margins of insurers, hospitals, and practitioners, a global budget for capital improvements, and a one-year moratorium on Certificate of Need activity. The Dirigo reforms also created the Maine Quality Forum, charged with advocating for high-quality health care and helping Maine residents make informed health care choices.

Funding for the Dirigo reform combines employer contributions, individual contributions, state general funds, and federal Medicaid matching funds for those individuals who are eligible. The original reform envisioned that future premium discounts for DirigoChoice would be funded through the “savings offset payment” generated through the recovery of bad debt and charity care, as well as from other voluntary savings targets set by the state.¹²

In its second year of operation, Dirigo faced a lawsuit that challenged the savings offset payment. Although it was designed to recapture savings to the health system from the Dirigo reforms, insurance companies and Dirigo officials disagreed over how much savings this program had generated and whether offset payments are the best way to finance the program. The disagreement prompted a legal challenge, although the court dismissed it. The case is being appealed. Clearly, Maine’s experience underscores how difficult it is to establish consensus on what captured savings actually represent, let alone implement the concept of redistributed savings.

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

New Comprehensive Reform Proposals

The governors of California and Pennsylvania have announced comprehensive reform proposals in their respective states.

California: Governor’s Health Care Proposal

On January 8, Governor Arnold Schwarzenegger (R) announced his new vision for creating “an accessible, efficient, and affordable health care system.” The plan is built on many of the same elements featured in other state reform plans, such as those in Massachusetts and Vermont. The three cornerstones of his plan include:

- prevention, health promotion, and wellness;
- coverage for all Californians; and
- affordability and cost containment

In order to address rising health care costs attributed to preventable disease and disability, Governor Schwarzenegger intends to implement “Healthy Actions Incentives/

Rewards” programs. These programs, accessible in both private and public programs, will provide rewards (e.g., premium reductions, gym memberships, etc.) for individuals to engage in healthy behaviors. Additionally, in order to improve health outcomes and implement long-term cost containment strategies, the governor is also proposing disease management for diabetes, programs to combat obesity and tobacco use, and strategies to improve patient safety.

The governor outlined steps he believes are necessary to achieve universal coverage for the 6.5 million Californians who are currently uninsured:

1. *Individual mandate.* Emphasizing the importance of personal responsibility, all individuals will be required to have a minimum level of coverage—a \$5,000 deductible plan with a maximum out-of-pocket limit of \$7,500 per person. To achieve this goal, children would be eligible for subsidized coverage up to 300 percent of FPL through Medi-Cal, the state’s Medicaid program, Healthy Families (SCHIP), and employer-sponsored coverage. Medi-Cal coverage will also be available at no cost to uninsured legal resident adults below 100 percent FPL. In addition, the state will create a new insurance pool, with subsidies available to uninsured legal resident adults between 100 percent and 250 percent FPL.
2. *Health Care Services Fund.* This new entity will provide funding for the new coverage initiative. The estimated \$12 billion required to fund the reform plan will come from several different sources. First, employers that have 10 or more workers and do not offer health benefits will be assessed an amount equal to 4 percent of payroll for the cost of employees’ health coverage. Hospitals and physicians, meanwhile, will be required to pay back a portion of the “coverage dividend” (totaling \$10 billion–\$15 billion) that providers will receive through increased Medi-Cal provider rates and other programs (4% of gross revenues from hospitals and 2% of gross revenues from physicians). Finally, approximately \$1 billion in medically indigent care funding will be redirected for coverage, while federal financial participation for public programs will also yield approximately \$3.7 billion in new funds.
3. *Cost containment.* Like the Massachusetts reforms, the governor’s plan also envisions putting into place requirements for employers to establish Section 125 plans to provide some tax savings for both employers and their employees. Individuals will also be able to make pre-tax contributions through health savings accounts. The state also intends to work with both providers and insurers to address efficiency and reduce costs, for example, through greater use of health information technology.

Should the California legislature decide to move forward with the governor's plan, the state will need to submit to CMS a waiver request for approval prior to implementation of any changes to public programs.

Pennsylvania: Prescription for Pennsylvania

On January 17, 2007, Governor Edward G. Rendell (D) unveiled his "Prescription for Pennsylvania" plan to increase access to affordable health care coverage, improve the quality of care, and bring health care costs under control for employers and employees. Full-time students attending four-year colleges and universities will be required to have health care coverage; there is also the possibility of an individual mandate if the number of uninsured does not significantly decline over the next few years.

To increase coverage for the uninsured, Governor Rendell's proposal calls for the creation of "Cover All Pennsylvanians" (CAP), a new health insurance product delivered through the private market. Businesses may participate in CAP if they have not offered health care to their employees in the past six months, if they have fewer than 50 employees, and if, on average, those employees earn less than the state's average annual wage. Businesses that choose to join the program will pay approximately \$130 per employee per month, and their employees will pay on a sliding scale, ranging from \$10 to \$70, depending on income; the state and federal government will subsidize the remainder.

Uninsured adults who earn less than 300 percent of the federal poverty level and employees of eligible small businesses will get help paying CAP premiums through discounts and subsidies. Uninsured adults who earn more than 300 percent FPL can participate in CAP by paying the full cost of the premium, approximately \$280 per month.

To pay for this coverage expansion, the governor has identified several funding sources, including: a "fair share" assessment levied on all companies that do not insure their employees; new taxes on tobacco products; federal matching funds; and the redirecting of health care dollars that currently fund adultBasic, uncompensated care, and Community Health Reinvestment funds.

Governor Rendell's health reform requires approval from both the state legislature and the federal government. The financial aspects of the plan will be part of the Governor's budget proposal due to the legislature in February 2007.

Covering All Children

A growing number of states are interested in covering children above federal SCHIP levels. Since 1997, many have focused on increasing outreach and enrollment for their

SCHIP programs, though states generally did not emphasize the coverage of children with family incomes above SCHIP levels. Until recently, Connecticut's Husky B was the only SCHIP program in the nation that allowed uninsured children in families above 300 percent FPL the opportunity to buy into the program.¹³

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

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

Illinois' efforts have catalyzed others to move forward on similar programs, with several governors proposing initiatives targeted at covering all children in their states. The impetus behind such initiatives is fairly simple: covering children is a relatively inexpensive investment, and years of experience with simplifying eligibility and conducting outreach for SCHIP programs are a solid foundation for the successful expansion of children's coverage.

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

Tennessee also passed legislation to cover all children, putting in place a new stand-alone SCHIP program (SCHIP had previously been part of TennCare, a now

disbanded larger state health care program). The Cover Kids Act, which became law in Tennessee in 2006, creates a SCHIP program for children in families with incomes up to 250 percent FPL and allows children in higher-income families to buy into the program.

Other states are considering proposals in a similar vein. In late September, Oregon Governor Ted Kulongoski presented his plan to cover uninsured children through an expansion of the Oregon Health Plan and a private purchasing arrangement for higher-income children. Wisconsin Governor Jim Doyle proposed extending the state's Medicaid program, BadgerCare, to all uninsured children by 2007. And Washington Governor Christine Gregoire and New Mexico Governor Bill Richardson proposed the goal of insuring all children but have not yet specified details on how this would be accomplished.

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

Employer-Based Efforts (New Mexico, Oklahoma, and Arkansas)

Several states have developed partnerships with private employers and insurers to cover low-income workers. These collaborations have taken a variety of different approaches, reflecting the different regulatory and market environments of each state as well as the specific compromises that local policy leaders were able to craft. The majority of state efforts to expand coverage rely on private insurers to deliver services, including those that use Medicaid funds. New Mexico, Oklahoma, and Arkansas have all implemented or are working on unique employer-based efforts to cover low-income workers, based on leveraging individual and employer contributions as well as Medicaid funds.

New Mexico: State Coverage Insurance

New Mexico was the first state to receive a Health Insurance Flexibility and Accountability (HIFA) waiver in 2002 to expand coverage to low-income, uninsured working adults with Medicaid funds. Because of operational challenges and difficulty securing state matching funds, New Mexico could not implement its program, State Coverage Insurance, until July 2005.

The program is now available to low-income, uninsured, working adults with family income below 200 percent FPL. Individuals may enroll through their employer or as self-employed persons. The premium is paid through contributions from the employer and employee in combination with state and federal funds; self-employed workers must pay the employer as well as employee portion of the premium. The benefit package is comprehensive, with a benefit maximum of \$100,000. Services are provided through private managed care organizations, and cost-sharing is designed to ensure that low-income participants have access to care. The program opened in July 2005 and close to 4,400 workers are currently enrolled.

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

On September 30, 2005, Oklahoma received approval for its HIFA waiver, the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC). O-EPIC is intended to provide health insurance coverage to 50,000 low-wage adults in Oklahoma, using a premium assistance program and an individual plan. O-EPIC is funded by state general fund revenues generated by a tobacco tax, along with federal matching funds under Title XIX and employer and employee contributions.

The O-EPIC Premium Assistance program, launched in November 2005, helps qualified employees in small businesses of 50 or fewer to purchase health insurance coverage through their employer, who works with an insurance producer (agent or broker) to choose a qualified private plan. The Premium Assistance program pays 60 percent of the health insurance premium for qualified employees with incomes below 185 percent FPL and 85 percent of the premium for the qualified enrollee's spouse. Employers are expected to contribute 25 percent of the employee's premium, and employees are expected to contribute up to 15 percent for themselves and 15 percent for their spouses.

Oklahoma's Individual Plan, to be launched shortly, is designed as a safety-net health plan for qualified individuals with incomes below 185 percent FPL and who are ineligible to participate in O-EPIC Premium Assistance. The Individual Plan includes self-employed individuals not eligible for small-group health coverage, workers at small businesses who are either ineligible to participate in their employer's health plan or whose employer does not offer a qualified health plan, and unemployed individuals who are currently seeking work. The Individual Plan also provides coverage to working individuals with a disability who meet the Ticket-to-Work program requirements¹⁴ and have incomes above the Medicaid eligibility level but below 200 percent FPL. Although the Individual Plan offers coverage through private managed care plans that serve the Medicaid program, the benefit package is less comprehensive than that of Medicaid or most products offered in the commercial market.

Arkansas: ARHealthNet

On March 7, 2006, Arkansas received approval for a HIFA waiver that will allow it to use federal Medicaid funds to provide low-cost health coverage to small businesses. Originally proposed to CMS in 2003, the Arkansas Department of Health and Human Services made some changes to the waiver design; however, the central goal—of providing an affordable health coverage option to businesses that are not currently providing insurance—remained intact. The new program, ARHealthNet, was scheduled to be open for enrollment in late 2006 and to begin offering benefits to enrollees in early 2007. Arkansas is the third state to use a Medicaid HIFA waiver to expand insurance options for businesses and low-wage workers.

ARHealthNet is open to employers who have not offered health insurance to their employees during the preceding 12 months. The program requires employers who participate to guarantee coverage for all workers, regardless of income. While all employees enroll in the new product, a subsidy is only available to those employees with family incomes below \$40,000 (200% FPL for family of four). Through the Medicaid waiver, the state receives federal matching funds for the subsidy.

The ARHealthNet benefit plan, best described as a safety-net benefit design, offers limited coverage compared to what would typically be available through commercial plans or through the Medicaid program. It will include six clinician visits, seven hospital days, two outpatient procedures or emergency room visits per year, as well as two prescriptions per month. The state has contracted with a commercial third-party administrator to offer ARHealthNet and to develop and implement a marketing plan using the Arkansas's existing network of private carrier health insurance brokers.

Arkansas originally envisioned that private insurance carriers would accept all medical “risk” associated with this plan. However, in acknowledgement that this is a new program with so many unknowns, especially with the possibility that enrollees may have preexisting conditions, the state subsequently elected to initially retain the risk in order to enhance acceptance by the private marketplace.

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

OBSERVATIONS ON STATE INITIATIVES

This is not the first time that state policy leaders have taken the lead in attempting to improve insurance coverage in their states. The recent reforms build on at least a decade of state efforts, ranging from comprehensive attempts to numerous incremental approaches.

When constrained by the fiscal challenges of the past few years, many states attempted to extend coverage to the uninsured by using strategies that did not require additional spending—including the enacting of laws that allowed carriers to sell limited benefit products. For the most part, states found that interest among consumers in purchasing these products was limited as well, most likely because the states were not able to reduce the cost of insurance enough to give the reduced benefits some perceived value.¹⁵ Several states also attempted some of the strategies promoted at the federal level, such as tax credits; however, they had difficulty making these strategies work, as the impact of tax breaks at the state level is much lower than at the federal level.

Although the potentially more successful reforms of the past year vary in a number of ways, they all are based on some common lessons:

Comprehensive state reforms take time because they build off prior efforts and in-place financing mechanisms. The passage of comprehensive reform can require several years of discussions, as the Massachusetts and Vermont experiences can attest. Given the complexity of the health care system, there and elsewhere, it is not surprising that compromise took several years of working with stakeholders and building consensus.

States that are attempting to reach near-universal coverage usually build these reforms on prior efforts. The comprehensive reforms in Massachusetts, Vermont, and Maine are all examples of coverage initiatives for which previous initiatives served as foundation. For instance, Medicaid eligibility levels for adults were expanded over time in these states to levels well above the national average. Likewise, they all had strategies in place to improve access to care or contain costs. In Massachusetts, the safety net historically consumed as much as \$1 billion, much of which is now being shifted to insurance coverage. In Vermont, a Medicaid waiver provided some of the flexibility to use funding for new expansion efforts.

Reforms attempt to stem the erosion of employer-sponsored insurance. Many state efforts to expand coverage are motivated by compelling evidence that increases in the numbers of uninsured are caused in large part by the decline in employer-sponsored insurance. During the past several years, many states have collected and analyzed their own

data about the uninsured. These studies, as well as national reports, show that over 80 percent of all nonelderly uninsured are either workers or living in families with working individuals¹⁶—a finding that has led state leaders to focus on expanding coverage for the working uninsured. These strategies either reach out to small businesses to encourage them to offer insurance or target low-income workers or their dependents without access to employer-sponsored insurance.

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

States look to employers for these coverage strategies for three main reasons: employer contributions to premiums can be leveraged; employers and employees both derive tax advantages; and in many cases, where employers are already offering health insurance, the new programs can take advantage of administrative structures already in place.

What is troubling is that a large number of employers are not offering coverage to their workers; to date, states' voluntary strategies have induced few employers to begin offering insurance. Therefore many of the strategies also assist low-income workers if their employer is not willing to participate. Oklahoma's O-EPIC Individual Plan, New Mexico's State Coverage Insurance, as well as all of the comprehensive proposals, allow uninsured individuals to enroll if they do not have access to employer-sponsored insurance. Even the states that are only expanding coverage for children are reaching working families who no longer have access to employer-sponsored insurance.

Successful efforts to enact reforms often expect shared financial responsibility. Some are beginning to recognize the need for mandatory participation. Even though employer-sponsored insurance has declined, 63 percent of working-age adults still obtain insurance through their employer.¹⁷ Therefore most state reforms include a role for employers; none of the efforts to expand coverage in 2006 were exclusively financed with public funds. They assumed that employers and individuals would

contribute to the cost, with individuals contributing based on their income. Some also included elements of consumer-driven purchasing to encourage consumer involvement.

While many state initiatives see employers as contributing to coverage on a voluntary basis, Massachusetts and Vermont explicitly impose employer assessments—albeit only a modest amount compared to the actual cost of health insurance premiums. Maryland’s Fair Share Act tried to go further by requiring employer responsibility, but the courts struck it down.¹⁸

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

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

Whether states move forward through incremental or comprehensive reforms, there clearly is a significant role for private insurers. Commonwealth Care (Massachusetts), Catamount Health (Vermont), and DirigoChoice (Maine) all use private insurers as a delivery mechanism. Even states that are largely using Medicaid financing for expansion efforts—for example, New Mexico’s State Coverage Insurance and Oklahoma’s O-EPIC—have carefully crafted the delivery of services through private health insurers. Arkansas’s ARHealthNet uses a private carrier to administer claims and provide the services.

While these programs use private plans, whether they are the most efficient platforms for expanding coverage continues to be debatable. In the case of Vermont’s reform, where policymakers questioned whether the expansion of coverage would use private health plans or be administered by the state, a compromise was crafted: the state’s Commission on Health Care Reform can deem that rates offered by carriers are not cost-effective, thereby allowing the state to pursue self-insuring. Maine contracted out DirigoChoice to its largest private carrier (Anthem) but has more recently examined whether the state should consider self-insuring, as well as administering the program on its own, to achieve greater efficiency.¹⁹ Arkansas made the decision to self-insure and privately administer, at least for the first two years, thus avoiding the uncertainty that could lead to higher private insurer premiums.

Voluntary purchasing pools, as a stand-alone strategy, are not likely to be sufficient to expand coverage. The creation of a Connector in Massachusetts sparked renewed policymaker interest in ways to facilitate the purchase of insurance for small businesses and individuals. While some may consider the Connector to be a purchasing pool, Massachusetts's state officials describe it more as a purchasing mechanism. The Connector does not pool risk but instead streamlines the administrative aspects of purchasing insurance. However, states do have a long history of creating pooling arrangements, and the evidence suggests that pooling alone is not sufficient to drive down health costs. In fact, voluntary purchasing pools may attract higher risk enrollees than the rest of the market, contributing to a segmentation of risks.²⁰

Until recently, California operated one of the largest and longest-running purchasing pools—PacAdvantage. Enrollment in PacAdvantage was over 100,000 in August 2006, but evaluations of the initiative demonstrated that it had done little to expand coverage to uninsured individuals.²¹ In 2006, PacAdvantage announced that it would cease operations, saying the “withdrawal of participating health plans has left PacAdvantage unable to continue offering competitive healthcare coverage choices for California’s small business employees.”²² Plans’ withdrawal was caused by numerous factors, including an adversely selected risk pool that led to increasing financial losses for those carriers.

It is important to note that Massachusetts has several financial incentives in place—including access to subsidies available only to those covered through the Connector—to attract enrollees. The experience of the Connector will test whether purchasing arrangements coupled with financial incentives will indeed affect enrollment and build purchasing power.

Medicaid benefits are being redesigned through new reforms, but to date these efforts have not included expansions in coverage. A current focus of Medicaid policymakers is the new flexibility that states have been given under the Deficit Reduction Act to redesign benefits for current populations. In 2006, West Virginia, Kentucky, and Idaho became the first states to propose such changes. Although these reforms are likely to have a significant impact on coverage for low-income individuals and may change their access to care, to date none of these reforms have changed Medicaid beneficiaries’ eligibility level for the program.

Meanwhile, Medicaid continues to be an important source of funding for strategies to cover the uninsured. Several incremental approaches leverage Medicaid financing to expand coverage, as do all of the comprehensive reforms.

Many state reforms address cost and quality in addition to health insurance coverage. As states struggle with reforming their health care systems, the issue of coverage has become more deeply entwined with quality and cost issues than ever before. Access to health care is increasingly becoming a question of affordability; states are trying to determine the level of efficiency and value they would like the health care system to provide.

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

A large part of Vermont's reforms addresses the issue of chronic care management, not only to improve the health of Vermont's population but also to help control one of the main cost drivers in the health care system. Other states have created task forces and commissions to simultaneously address issues of access, cost control, quality, and equitable financing. These bodies include the new Massachusetts Health Care Quality and Cost Council and West Virginia's Interagency Health Council.

Across the country, many states are collecting data on health plan and provider performance, and they are disseminating that information to the public. Medicaid agencies in particular are measuring performance, establishing financial incentives based on those measurements, and encouraging programs to directly improve clinical care for their beneficiaries. The public health agencies in most states are focused on population-based clinical quality improvement. And in some states, the agencies that administer state employee health plans are also working on quality initiatives, oftentimes as part of a larger coalition of local employers.

FEDERAL PROPOSALS TO SUPPORT STATE INNOVATIONS

Recent state efforts to implement health insurance reforms have fueled optimism that states can lead the way in addressing the problem of the uninsured. Certainly, states' efforts can test coverage strategies both politically and practically, which can inform and provide lessons to other state and national leaders. However, the variation among states is far too great for state-by-state reform to result in a national solution for the country's 47 million uninsured.

The most recent data on the uninsured show a threefold variation in the uninsured across states.²³ The states leading the way with comprehensive solutions all have uninsured rates lower than the national average. But a few states have uninsured populations that are

close to a quarter of their population, making it unlikely that they will be able to consider the universal coverage goals of the comprehensive reform states.

Moreover, there are significant differences in the resources and funding streams that states have at their disposal, typically because of variation in income distribution, to address the problem of the uninsured. States often build their current reforms on prior strategies to expand coverage and on public investments in coverage for low-income individuals. States with prior health coverage investments through Medicaid and safety-net funding have already addressed a portion of their uninsured problem. But states that have not made significant prior investments in coverage have to find new funding sources. Without federal financial assistance to help low-income states, they will not be able to act.

Despite the evidence that states cannot completely address the problem of the uninsured on their own, state policy leaders are not waiting patiently for national reform. It appears unlikely that comprehensive national health reform will be considered in the near term because other issues may continue to dominate the national agenda. Instead, it appears as though many are looking toward the states to assist the uninsured. For example, former HHS Secretary Tommy Thompson recently said that in the absence of federal action, he believed that states would very likely take the lead on health care reform.²⁴ Other health policy experts have promoted the concept of federally supported state experimentation as a promising way to make progress.²⁵

Recent Federal Initiatives

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

However, the seeds of many of the state innovations we are witnessing today have roots in the State Planning Grant initiative, which provided state officials with a greater understanding of the uninsured and an increased technical capacity to address the issue. After the SPG was struck from the HHS budget last year, new federal proposals emerged to foster state innovation.

During the 109th Congress, several members of Congress introduced legislation that would provide grant funds to states to pilot new health reforms (see Table 2). Several of these legislative proposals (S. 3776, H.R. 5864, and S. 2772) would set up a process for states to propose and pilot-test reforms. S. 3701, the Catastrophic Health Protection Act, also would allow states to conduct demonstration projects for expanding coverage within a federal framework.

Table 2. Federal Legislative Proposals of the 109th Congress to Encourage State Reforms

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

Among the fundamental issues for fostering state innovation are how new state strategies will be financed and whether states will be required to find savings to finance expansions in coverage. Some of the congressional proposals provide federal funding for implementation, but it is not clear whether this is short-term support during the life of the grant or whether federal financing would continue. The potential for ongoing federal financial support is essential if states are to expand coverage.

Some of the congressional proposals suggest state demonstrations will need to be budget-neutral, requiring states to fund new initiatives by finding savings elsewhere in their programs. States could be faced with difficult choices, such as limiting benefits to currently covered individuals or taking funds from an already underfunded safety net.

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

Beyond federal strategies to encourage state innovation through grant funds, federal flexibility on other issues may be essential to allowing states to consider large-scale reforms. For example, while several states have passed reforms that try to strengthen the role of employers in financially contributing to health care for their workers, the federal Employee Retirement Income Security Act of 1974 (ERISA) complicates state efforts to include employer financing in initiatives to expand insurance coverage.²⁶ Maryland's effort to require large employers to contribute to health care costs, the Fair Share Health Care Act, was in fact derailed because the court found that it was inconsistent with federal ERISA requirements. Other states have crafted approaches to require employers to contribute to health care as part of larger state reform efforts—though some have questioned whether they would survive a legal challenge.

Meanwhile, it is possible that the 109th Congress's H.R. 5864 and S 2772, which propose to fast-track federal legislative changes to accommodate state reforms, may allow state strategies that are currently deemed to be inconsistent with ERISA.

The introduction of these bills clearly bolsters the trend toward developing solutions to the problem of the uninsured at the state level rather than in Washington, D.C. Time will tell whether the new Congress is ready to provide the federal resources necessary to encourage state innovation, whether the current bipartisan agreements at the state level are able to encourage even broader federal action, or whether the status quo will remain. Regardless of the degree of federal action, however, states will most likely continue to feel pressure to increase coverage and experiment with new health care reforms.

Helpful Resources

AcademyHealth	www.academyhealth.org
AFL-CIO	www.aflcio.org
Alliance for Health Reform	www.allhealth.org
America’s Health Insurance Plans	www.ahip.org
Center for Studying Health System Change	www.hschange.org
The Commonwealth Fund	www.cmwf.org
Covering the Uninsured	www.coveringtheuninsured.org
Employee Benefit Research Institute.....	www.ebri.org
Families USA.....	www.familiesusa.org
Health Care Leadership Council	www.hlc.org
Health Research and Educational Trust.....	www.hret.org
Heritage Foundation.....	www.heritage.org
State of Illinois All Kids	www.allkidscovered.com
Institute for Health Policy Solutions.....	www.ihps.org
The Robert Wood Johnson Foundation	www.rwjf.org
Kaiser Commission on Medicaid and the Uninsured	www.kff.org/about/kcmu.cfm
State Coverage Initiatives.....	www.statecoverage.net
State Health Facts	www.statehealthfacts.kff.org
U.S. Census Bureau—Health Insurance Data	www.census.gov/hhes/www/hlthins/hlthins.html
Urban Institute	www.urban.org
Utah Primary Care Network	health.utah.gov/pcn/
Office of Vermont Health Access	www.ovha.state.vt.us/

NOTES

¹ T. Gilmer and R. Kronick, “It’s the Premiums, Stupid: Projections of the Uninsured Through 2013,” *Health Affairs* Web Exclusive (Apr. 5, 2005):w5-143–w5-151.

² C. Schoen and S. K. H. How, [*National Scorecard on U.S. Health System Performance: Technical Report*](#) (New York: The Commonwealth Fund, Sept. 2006).

³ Kaiser Commission on Medicaid and the Uninsured, *Changes in Employees’ Health Insurance Coverage, 2001–2005* (Washington, D.C.: Henry J. Kaiser Family Foundation, Oct. 2006).

⁴ Ibid.

⁵ Kaiser Family Foundation/HRET, *Employer Health Benefits 2006 Annual Survey* (Menlo Park, Calif., and Chicago: Henry J. Kaiser Family Foundation/Health Research and Educational Trust, Sept. 2006).

⁶ C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, [*Public Views on Shaping the Future of the U.S. Health System*](#) (New York: The Commonwealth Fund, Aug. 2006).

⁷ Ibid.

⁸ The Chronic Care Model identifies the essential elements of a health care system that encourage high-quality chronic-disease care. These elements are the community, the health system, self-management support, delivery-system design, decision support, and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise. The model can be applied to a variety of chronic illnesses, health care settings, and target populations.

⁹ T. Sachs, J. Walls, and I. Friedenzohn, *Uncharted Territory: Current Trends in Section 1115 Demonstrations*, State Coverage Initiatives Issue Brief, vol. 6, no 2 (Washington, D.C.: AcademyHealth, Mar. 2006).

¹⁰ T. Bragdon, “Eight Challenges for Dirigo Health in 2006,” *Dirigo Watch*, vol. 3, no. 1 (Portland, Maine: Maine Heritage Policy Center, Jan. 30, 2006).

¹¹ T. Bowe, *DirigoChoice Member Survey: A Snapshot of the Program’s Early Adopters* (Portland, Maine: Institute of Health Policy, Muskie School of Public Service, University of Southern Maine, Aug. 12, 2005).

¹² The savings offset payment is based on all savings that are identified from the Dirigo Health reforms—not just the reduction in uncompensated care. It is a function of the savings impact of the moratorium on the Certificate of Need; the implementation of a Capital Investment Fund to limit future Certificate of Needs post-moratorium; the impact of rate regulation in the small-group insurance market; voluntary targets on hospital expenditures; the infusion of new state funds to match Medicaid for increases in physician and hospital payments to reduce cost shifting; and the costs associated with savings in the system resulting from insuring the previously uninsured.

¹³ State Coverage Initiatives Web site, <http://www.statecoverage.net/matrix>.

¹⁴ The Ticket to Work Program was authorized under the Ticket to Work and Work Incentives Improvement Act of 1999, which aims to remove barriers, including concerns about the loss of health coverage, to individuals’ going to work.

¹⁵ I. Friedenzohn, *States’ Experience with Benefit Design*, State Coverage Initiatives Issue Brief, vol. 4, no. 4 (Washington, D.C.: AcademyHealth, Apr. 2003).

¹⁶ Kaiser Commission on Medicaid and the Uninsured, *The Uninsured: A Primer* (Menlo Park, Calif.: Henry J. Kaiser Family Foundation, Oct. 2006).

¹⁷ Kaiser Commission, *Changes in Health Coverage*, 2006.

¹⁸ P. A. Butler, *ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision*, State Coverage Initiatives/National Academy for State Health Policy Issue Brief (Washington, D.C.: AcademyHealth, Nov. 2006).

¹⁹ Maine State Legislature, "LD 1845: An Act to Increase Access to Health Insurance Products," Indefinitely postponed, May 24, 2006.

²⁰ E. K. Wicks, *Purchasing Pools in a System of Universal Coverage: Facilitating Consumer Choice*, Working Paper no. 3 (Washington, D.C.: New America Foundation, Universal Health Insurance Program, May 2004).

²¹ E. K. Wicks, M. A. Hall, and J. A. Meyer, *Barriers to Small-Group Purchasing Cooperatives: Purchasing Health Coverage for Small Employers* (Washington, D.C.: Economic and Social Research Institute, Mar. 2000), accessed Nov. 2005 at <http://www.esresearch.org/Documents/HPC.pdf>.

²² <http://www.pacadvantage.org/brokers/closure.asp>.

²³ Data from Kaiser Family Foundation, "Health Insurance Coverage of the Total Population" (Menlo Park, Calif.: Henry J. Kaiser Family Foundation), accessed Nov. 15, 2006, at <http://www.statehealthfacts.org>.

²⁴ *CQ HealthBeat* (Washington, D.C.: Congressional Quarterly, Inc., Oct. 27, 2006).

²⁵ H. J. Aaron and S. M. Butler, "How Federalism Could Spur Bipartisan Action on the Uninsured," *Health Affairs* Web Exclusive (Mar. 31, 2004):w4-168-w4-178.

²⁶ Butler, *ERISA Implications*, 2006.

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's Web site at www.cmwf.org.

[*States in Action: A Bimonthly Look at Innovations in Health Policy*](#) (January/February 2007).

[*Public Reporting and Transparency*](#) (January 2007). John M. Colmers.

[*Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?*](#) (January 2007). Karen Davis, Cathy Schoen, Stuart Guterman, Tony Shih, Stephen C. Schoenbaum, and Ilana Weinbaum.

[*Enhancing Value in Medicare: Demonstrations and Other Initiatives to Improve the Program*](#) (January 2007). Stuart Guterman and Michelle P. Serber.

[*The State Children's Health Insurance Program: Past, Present, and Future*](#) (January 2007). Jeanne M. Lambrew.

[*A Blueprint for Universal Coverage in New York*](#) (December 2006). Danielle Holahan, Elise Hubert, and Cathy Schoen.

[*Toward More Effective Use of Research in State Policymaking*](#) (December 2006). Jack A. Meyer, Tanya T. Alteras, and Karen Bentz Adams.

[*U.S. Health System Performance: A National Scorecard*](#) (September 20, 2006). Cathy Schoen, Karen Davis, Sabrina K. H. How, and Stephen C. Schoenbaum. *Health Affairs* Web Exclusive (*In the Literature* summary).

[*Why Not the Best? Results from a National Scorecard on U.S. Health System Performance*](#) (September 2006). The Commonwealth Fund Commission on a High Performance Health System.

[*Framework for a High Performance Health System for the United States*](#) (August 2006). The Commonwealth Fund Commission on a High Performance Health System.

[*State Behavioral Health Innovations: Disseminating Promising Practices*](#) (August 2006). Sylvia B. Perlman and Richard H. Dougherty.

[*Public Views on Shaping the Future of the U.S. Health System*](#) (August 2006). Cathy Schoen, Sabrina K. H. How, Ilana Weinbaum, John E. Craig, Jr., and Karen Davis.

[*Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down*](#) (May/June 2006). Jon Gabel, Roland McDevitt, Laura Gandolfo et al., *Health Affairs*, vol. 25, no. 3 (*In the Literature* summary).

[*How States Are Working with Physicians to Improve the Quality of Children's Health Care*](#) (April 2006). Helen Pelletier.

[*Using Clinical Evidence to Manage Pharmacy Benefits: Experiences of Six States*](#) (March 2006). David Bergman, Jack Hoadley, Neva Kaye, Jeffrey Crowley, and Martha Hostetter.

[*Can Medicaid Do More with Less?*](#) (March 2006). Alan Weil.

