

# THE FLOOD TIDE FORUM III

Building a Pathway to Universal Coverage  
*How Do We Get From Here to There?*

Neva Kaye  
Mimi Marchev  
Trish Riley

*November 2002*

*Supported in part by The Commonwealth Fund*

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*There is a tide...which taken at the flood, leads on to fortune;  
...on such a full sea are we now afloat  
and we must take the current when it serves or lose our ventures.  
--William Shakespeare*

# Building a Pathway to Universal Coverage

## *How Do We Get From Here to There?*

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## FOREWORD

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NASHP's Flood Tide Forums are designed to provide high ranking legislative leaders and executive branch officials with the rare opportunity to meet in small, informal seminars on topics of key concern to them.

Each Forum is designed to be off-the-record and to offer participants the chance to assess the successes and shortcomings of past initiatives, to learn from their colleagues of promising new policies and programs, and to craft new ideas for future action in state health policy.

At the first Flood Tide Forum, held in December of 1999, the National Academy for State Health Policy convened policy makers from twelve states that had been active in the health policy reform movement. Participants reviewed and examined twenty-five years of state-based efforts aimed at reducing the number of uninsured Americans, brainstormed about possible models for future expansion, and reached consensus on lessons learned from their experiences.<sup>1</sup>

Since the 1999 Forum, the ability of states to continue their initiatives to expand access to the uninsured has been hampered by the slide from economic boom to recession, the erosion of employer-based coverage due to the rising costs of insurance premiums, the erosion of the federal surplus, and the redirection of funds to national security after the attacks of September 11, 2001. The commitment to expanding access to health insurance remains strong, but the attainment of this goal has again become an enormous challenge in the face of growing state budget deficits and rising health care costs. In the current atmosphere, states are struggling to maintain whatever gains they were able to achieve in recent years.

That being said, it is also true that states have a history of creative innovation during times of budget woes. Most of the advances in access for the uninsured developed on the heels of state recessions.<sup>2</sup> Thus, the time seemed right in the fall of 2002 to convene the third Flood Tide Forum,<sup>3</sup> to bring together key policy leaders and thinkers for a discussion aimed at developing additional innovative strategies to improve access for the uninsured.

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<sup>1</sup>See Appendix I for a summary of these lessons.

<sup>2</sup>Trish Riley, Plenary Address, *Necessity is the Mother of Invention: State Health Policy Meeting the Budget Challenge*, Philadelphia, PA, August 5, 2002.

<sup>3</sup>The third Flood Tide Forum was held in Boston, MA, on September 9-10, 2002. The second Flood Tide Forum was held in June 2000 and addressed the problem of medical errors. See: Trish Riley, *Improving Patient Safety: What States Can Do About Medical Errors* (Portland, ME: National Academy for State Health Policy, 2000).

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## INTRODUCTION

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Where do states go from here? For the past thirty years, states have tried a wide variety of initiatives designed to increase insurance coverage for the uninsured. Despite many successes, 41 million Americans remain uninsured,<sup>4</sup> and that number is increasing as the country faces an economic downturn and rapidly rising health care costs. Most of the uninsured are from families where one or more people are employed.<sup>5</sup> As costs rise, in part because the cost to providers of treating the uninsured is shifted to the insured, employers can no longer afford to offer comprehensive coverage and are in turn shifting more of the high cost of premiums to employees, or offering only bare-bones or catastrophic plans. Facing budget deficits, states are forced to cut back public health insurance coverage and postpone new initiatives.

With this as background, the participants of the Flood Tide Forum gathered to address the question of how to achieve universal health insurance coverage in the United States.

Discussion at the Forum was lively and reflected the off-the-record nature of the conversation. The purpose of this broad discussion was to examine state experience with expansion efforts and to explore new and innovative ways to achieve universal coverage, the strengths and weaknesses of various approaches, the barriers that attempts to reach universal coverage might encounter, and some ideas for how those challenges might be addressed. This paper provides an update of what states have done since *Access for the Uninsured: Lessons from 25 Years of State Initiatives*<sup>6</sup> was published in January 2000 and a summary of the discussion at the Flood Tide Forum III. It is not intended to be an exhaustive review of the literature, an all-inclusive description of every state initiative, nor a consensus blueprint of the best means of achieving universal coverage.

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<sup>4</sup>U.S. Census Bureau, Public Information Office, [www.census.gov](http://www.census.gov), downloaded November 19, 2002 (last revised: September 30, 2002)

<sup>5</sup>U.S. Census Bureau.

<sup>6</sup>Trish Riley and Barbara Yondorf, *Access for the Uninsured: Lessons from 25 Years of State Initiatives* (Portland, ME: National Academy for State Health Policy, 2000).

## FLOOD TIDE FORUM 1999: A SUMMARY OF LESSONS LEARNED

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The first Flood Tide forum was held in December 1999 and looked back over the previous twenty-five years during which states had experimented with a wide variety of initiatives to expand access to health care for the uninsured. In their roles as regulators, purchasers, and providers, states had:

- created state-funded programs,
- expanded and restructured Medicaid,
- experimented with individual and small business subsidies,
- reformed the individual and small group insurance markets,
- created medical savings accounts,
- established purchasing alliances, high-risk pools, and indigent care programs, and
- crafted children's health coverage.

At the first Flood Tide Forum the National Academy for State Health Policy convened policy makers from twelve states that had been active in the reform movement. Participants reflected on their experiences, brainstormed about possible models for future expansion, and reached consensus on lessons learned from their experiences.<sup>7</sup> The following is a summary of their conclusions.

- States had laid the groundwork for a number of federal programs that ensured access to increased numbers of the uninsured, and they demonstrated the successes and shortcomings of numerous reform efforts. The Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) and State Children's Health Insurance Program (SCHIP) only after many states had demonstrated the success of those initiatives.
- State demonstrations had shown that, in order to provide coverage to significant numbers of the uninsured in a voluntary market, benefits must be comprehensive and affordable, carefully marketed, and offered through a simplified and accessible eligibility and enrollment process. They had clearly demonstrated that the cost of coverage poses a significant barrier to accessing coverage.
- To achieve affordability, plans must be offered at a substantially reduced cost to low-income families. As of the year 2000, it appeared that small group insurance reforms, purchasing cooperatives, bare-bones policies, Medical Savings Accounts, and state tax incentives, while important demonstrations, had not proved effective as strategies to reduce the number of uninsured.

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<sup>7</sup>See Appendix A for the full text of the lessons learned.

- There was also considerable evidence to show that strategies targeting sub-populations of the uninsured (pregnant women, children) succeed in achieving political consensus.
- SCHIP demonstrates that the greater the flexibility states have in tailoring their programs to meet local needs and to factor in budget constraints, the more likely they are to respond to federal incentives to expand coverage. The SCHIP program is viewed as a political success as it has legislative and popular support. SCHIP could be a base for future reform, particularly if the federal government allows states to streamline eligibility, allow buy-ins, and establish family coverage.
- Participants in the first Flood Tide Forum noted repeatedly that what is needed is a public commitment, a clearly articulated social contract, to guarantee health coverage for all Americans. Absent that, future reforms will continue to fall short of the mark.

## WHERE ARE WE NOW?: A SUMMARY OF STATE INITIATIVES

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In the nearly three years since the first Flood Tide Forum, states have continued to search for ways to provide health insurance to their uninsured residents. While a few states are again discussing single-payer coverage, most have taken an incremental approach and are using a variety of strategies, either alone or in combination, to increase available funds and expand access to health insurance. It is notable that, despite the economic boom that lasted into 2001, recent initiatives to reduce the rate of the uninsured have been led by public sector expansions. Indeed, between 2000 and 2001, the percent of people insured under publically financed programs rose from 24.7 to 25.3 percent, while private-sponsored coverage fell from 71.9 to 70.9 percent.<sup>8</sup> (Note: This section describes the types of efforts states have made in the past three years to expand coverage and uses specific examples of state initiatives to illustrate the general approach. It is not a complete catalogue of state initiatives. See Appendix B for more complete information about state initiatives.)

### The State Children's Health Insurance Program

With the enactment of the **State Children's Health Insurance Program** (SCHIP) as part of the Balanced Budget Act of 1997, states were provided with \$40 billion in federal funding over a ten-year period to cover uninsured children from families earning up to 200 percent of the federal poverty level (FPL). States may cover children in SCHIP by expanding the Medicaid program, establishing a separate SCHIP program, or both. Since the first Flood Tide Forum, SCHIP has been implemented in *all 50 states and the District of Columbia* and the number of children ever enrolled in SCHIP has reached 4.6 million.<sup>9</sup> States receive a higher level of federal matching funds for SCHIP program expenditures than for Medicaid expenditures.

### Medicaid/SCHIP Expansions

States have considerable leeway to establish eligibility in their regular Medicaid programs and they have used it. For example, before its Section 1115 waiver was modified for parent coverage under SCHIP,

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<sup>8</sup>Robert J. Mills, *Health Insurance Coverage: 2001*. (The US Census Bureau, September 2002).

<sup>9</sup>Vernon K. Smith and David M. Rousseau, *SCHIP Program Enrollment: December 2001 Update* (The Kaiser Commission on Medicaid and the Uninsured, 2002); *The State Children's Health Insurance Program Quarterly Report, Second Quarter FY 2002* (CMS, July 2002). The number of children ever enrolled is the unduplicated count of children enrolled during a period of time but does not take into account children leaving the program.

**Rhode Island** covered parents of Medicaid/SCHIP eligible children under Section 1931.<sup>10</sup> Also, **New Jersey's** SCHIP program disregards all income between 200 and 350 percent FPL, which in effect, increases the family income limit for eligibility from 200 percent to 350 percent FPL.<sup>11</sup> If a state expands a program under standard eligibility rules all standard Medicaid and SCHIP requirements apply to people covered under this type of expansion. In the Medicaid program, for example, this means that states cannot cap enrollment, are required to offer the same benefit package to all participants, and can only implement limited cost-sharing provisions.

There are, however, several avenues open to states for expanding their Medicaid/SCHIP programs that allow them to access, or draw down, federal matching funds and also offer some flexibility beyond the standard Medicaid/SCHIP parameters.

### **Section 1115 Research and Demonstration Waivers**

The federal government may approve state applications for §1115 research and demonstration waivers that allow states to waive specified Medicaid requirements in order to test innovative policy initiatives, but federal funding under the waiver is limited to the amount the federal government would have spent absent the waiver, i.e., the initiative must be budget neutral. Under a standard §1115 waiver, states may waive most provisions of Title XIX (Medicaid), including those regarding cost-sharing limits, benefit packages, and income eligibility limits.

A recent example is **Utah** where a standard §1115 waiver was granted that allows the state to reduce the benefit package provided to some categorically eligible Medicaid beneficiaries and use this savings to expand Medicaid/SCHIP eligibility for a limited benefit package (primary and preventive care-only) to up to 25,000 uninsured adults age 19 and older with incomes under 150 percent FPL.<sup>12</sup>

In another example, **Maryland** received approval in July 2002 of a §1115 waiver to create a pharmacy discount program. This waiver allows the state to receive federal Medicaid matching funds for (1) a previously state-only funded program for low-income people (those earning below about 116 percent FPL), and (2) Medicare beneficiaries who do not belong to the first group but have annual

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<sup>10</sup>Section 1931 of the Social Security Act requires states to cover everyone they would have covered under Medicaid before the implementation of the TANF (Temporary Assistance for Needy Families) program. It also allows states to expand eligibility beyond those limits.

<sup>11</sup>Neva Kaye, Cynthia Pernice, and Kirsten Wyses, *SCHIP Family Coverage in Three States: A Report on the Early Experiences of New Jersey, Rhode Island, and Wisconsin*, (Portland, ME: NASHP, forthcoming).

<sup>12</sup>CMS, *Utah Coverage of Uninsured Demonstration Fact Sheet*, (CMS, Updated 8/20/02). <http://cms.hhs.gov/medicaid/1115/utpnfcs.pdf>

incomes of no more than 175 percent FPL. Members of the first group receive all Medicaid covered drugs for a \$5 co-pay, while those in the second group can purchase Medicaid covered drugs at 65 percent of the cost of the drug to the Medicaid program (plus \$1 processing fee paid to the pharmacist).<sup>13</sup>

## Health Insurance Flexibility and Accountability Initiative (HIFA)

In partial response to state concerns that the 1115 waiver application process is unwieldy and time-consuming, the federal Centers for Medicare and Medicaid Services (CMS) launched the Health Insurance Flexibility and Accountability Initiative (HIFA). HIFA facilitates state applications for 1115 waivers that expand Medicaid eligibility by allowing them to use a streamlined application to apply for an 1115 waiver if their proposed waiver meets certain additional specifications in addition to those that all 1115 waivers must meet. These waivers may be funded by (1) offering a reduced benefit package to optional populations that are less costly than those offered to mandatory Medicaid populations, (2) participant premium payments, or (3) unspent SCHIP funds.<sup>14</sup> Three examples of recent HIFA waivers follow.

- In December 2001, **Arizona** obtained approval to expand coverage to two populations: 1) adults over 18 without dependent children and with income at or below 100 percent FPL and 2) parents of children enrolled in Medicaid or SCHIP, who are not themselves eligible for either program, with incomes above 100 percent and below 200 percent FPL<sup>15</sup>.
- In August 2002, **New Mexico** obtained approval for a waiver to cover two populations; 1) parents with children enrolled in either Medicaid or SCHIP whose family income is at or below 200 percent FPL, and 2) childless adults ages 19-64 with family incomes at or below 200 percent FPL. Under this waiver New Mexico anticipates that the employer and employee will share in the cost of covering the enrollee under HMO contracts that the state plans to negotiate with HMOs; the enrollee will be eligible for services provided under the HMO

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<sup>13</sup>Maryland Department of Health and Mental Hygiene, *Fact Sheet - Maryland Pharmacy Waiver Program*. (Baltimore, MD: MD DHMH, 2002).

<sup>14</sup>HIFA waivers, in addition to meeting all the requirements for obtaining regular 1115 waivers, must be a statewide expansion which coordinates public and private coverage. (Barriers to effective coordination are discussed on page 8.) The waiver may not have an effect on rules that govern populations that states are mandated to cover. HIFA requirements and the benefits to states of applying under this initiative are discussed in *Guidelines for States Interested in Applying for a HIFA Demonstration*, which is available at <http://cms.hhs.gov/hifa/hifagde.asp>

<sup>15</sup>CMS, *Arizona HIFA Amendment Fact Sheet*, (CMS, last modified on July 15, 2002). (<http://cms.hhs.gov/hifa/fact1211.asp>)

contract, not for all Medicaid services. Finally, employers, as well as participants will contribute to the premium cost.<sup>16</sup>

- In September 2002, **Maine** received a Section 1115 waiver through the HIFA initiative to expand MaineCare (Medicaid/ SCHIP) coverage to about 11,500 low-income, childless adults with annual incomes up to 100 percent FPL.<sup>17</sup>

## Work Incentives

The federal **Balanced Budget Act** (BBA) of 1997 and the **Ticket to Work and Work Incentive Improvement Act** (TWWIIA) of 1999 allow states to provide Medicaid coverage to working individuals with disabilities who could not otherwise qualify for Medicaid because of their earnings. Programs established under these provisions are often referred to as “work incentives” or “Medicaid buy-in programs for people with disabilities.” These provisions allow states leeway in determining eligibility rules.<sup>18</sup> They may also establish cost-sharing requirements, such as premiums, greater than allowed under standard Medicaid. Finally, states are not limited by budget neutrality requirements. They may draw down federal matching funds at the standard Medicaid rate for all state funds spent to cover the cost of the expansion. As of July 2002, 21 states had implemented a work incentives eligibility group under BBA or TWWIIA.<sup>19</sup>

## Expanding Medicaid Without Federal Funding

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<sup>16</sup> Sources: (1) CMS, *New Mexico Health Insurance Flexibility and Accountability (HIFA) Initiative Fact Sheet*, (CMS, last modified on October 10, 2002). <http://cms.hhs.gov/hifa/nmfs.pdf> (2) New Mexico Department of Human Services, *Application Template for Health Insurance Flexibility and Accountability (HIFA) §1115 Demonstration Proposal*, (Sante Fe, NM: 2002). <http://cms.hhs.gov/hifa/nmapp.pdf>

<sup>17</sup>HHS. *HHS Approves Maine Plan to Expand Health Insurance Coverage to 11,500 Residents*, Press Release. HHS September 13, 2002. <http://www.hhs.gov/news/press/2002pres/20020913a.html>

<sup>18</sup>For example, states have the option to offer coverage to employed individuals who had previously qualified for work incentive coverage due to a disability and subsequently improved as a result of treatment. As long as these individuals with a “medically improved disability” continue to receive treatment, they may be eligible for Medicaid under this provision. Source: CMS, *Work Incentives Eligibility Groups*, (CMS, last modified May, 2002). [www.cms.gov/twwiia/eligible.asp](http://www.cms.gov/twwiia/eligible.asp)

<sup>19</sup>CMS, *Work Incentive Eligibility Groups State Activity Map*, (CMS, last updated July, 2002). <http://cms.hhs.gov/twwiia/statemap.asp>

Some states use their Medicaid programs as a platform to expand eligibility without federal funding. Medicaid offers a ready-made vehicle for expansion since the administrative systems and outreach programs are already established. If states do not use federal funding they are not bound by any of the Medicaid and SCHIP requirements, such as enrollment caps, limitations on benefit packages, or cost-sharing requirements. They do, however, lose the benefit of federal funding. *Rhode Island*, for example, uses state-only funds to cover qualified home-based childcare providers and their dependents with the package of benefits that MCOs contract to cover under RItCare (Medicaid/SCHIP). These employees do not pay a premium.<sup>20</sup> Because states now have greater flexibility under the HIFA initiative, some states, such as Arizona,<sup>21</sup> are in the process of converting state-only funded Medicaid expansions into HIFA initiatives.

## Coordinating With Employer-Sponsored Insurance

States may subsidize employees' premiums for private coverage through their employer's group health insurance. They can do this within their Medicaid and/or SCHIP programs (with or without a waiver of some federal requirements) or through other programs that are not federally funded.

## Employer-sponsored insurance in Medicaid and SCHIP

Under their Medicaid programs and in those SCHIP programs that are expansions of Medicaid, states may, if cost-effective, pay beneficiaries' premiums, deductibles, coinsurance, and other cost-sharing obligations for participation in an employer's group health plan and receive federal matching funds for those payments.<sup>22</sup> Participants in the employer plan continue to receive services covered by Medicaid that are not covered by the employer's plan. Some states, including **Maryland** and **Massachusetts**, have also established "Employer Buy-In Programs" under the separate SCHIP programs.<sup>23</sup> These states receive federal matching funds at the SCHIP rate for paying participants' premiums in their employer-sponsored plan. Several forum participants, however, reported that these programs are

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<sup>20</sup>Rhode Island Department of Human Services. *RItCare Health Insurance for Family Child-Care Providers, Fact Sheet*. (Cranston, RI: RI DHS, Downloaded September, 2002). <http://www.dhs.state.ri.us/dhs/heacre/drchiccf.htm>

<sup>21</sup>AHCCCS, *Premium Sharing Program Semiannual Report*, (Phoenix, AZ: AHCCCS, October 2002). <http://www.ahcccs.state.az.us/publications/PremiumSharing/PSPSemi1001.pdf>

<sup>22</sup>Social Security Administration, §1906

<sup>23</sup>Debbie Chang, *Integrating Employer Sponsored Insurance with Medicaid & SCHIP Programs*, presented on October 9, 2002, at the National Association of State Medicaid Directors Conference.

administratively burdensome for states due to federal requirements that include the need to ensure—on a case-by-case basis—that the purchasing of private coverage is cost effective and to offer wrap-around services that fill any gaps between the employer’s and the Medicaid benefit packages. Recently granted waivers provide more flexibility. **Rhode Island**, for example, received approval for a §1115 waiver, that among other things, allows them to pre-approve most plans for cost-effectiveness instead of determining it on a case-by-case basis.<sup>24</sup>

States that use Medicaid and SCHIP funds to subsidize participants’ purchase of employer-sponsored insurance (ESI) report that ERISA may act as a barrier to effective coordination of public and private coverage. For example, some states report that many of the public program participants (Medicaid and SCHIP) found to be eligible for ESI coverage were not allowed by their employer to immediately enroll in the employer’s plan.<sup>25</sup> Instead employers required them to wait for an open enrollment period to join the employer plan, thus preventing the public program from offsetting the public costs with the private coverage. ERISA makes it difficult for states to address this issue because the coverage that self-insured employers offer is not subject to state regulations. (States could, through insurance regulations, require insurers to allow public program participants that the state identifies as having access to ESI to join the employer’s plan immediately.)<sup>26</sup> Since one requirement for obtaining a HIFA waiver is coordination of public and private coverage, this issue has recently become more pertinent.

## **Employer-sponsored insurance in state-only funded programs**

States can also choose to subsidize private coverage without federal Medicaid or SCHIP funding. These programs are not required by federal law to offer benefits in addition to those covered by the employer’s plan or meet any of the other requirements of Medicaid or SCHIP. (Other federal laws such as ERISA and HIPAA continue to apply to these programs.)

An example can be found in **Rhode Island**, which will subsidize the cost of employer-sponsored insurance provided by licensed center based child care programs. If the center chooses to participate in the program, the state will pay 50 percent of each worker’s premium cost up to \$85. The program

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<sup>24</sup>Ibid.

<sup>25</sup>Note: the reasons that employers may be reluctant to participate in publicly funded programs are discussed later in this report. (See page 31.)

<sup>26</sup>At least one state, **Wisconsin**, proposes to address this issue through a statutory language change that would make the Medicaid agency’s identification of a participant’s access to ESI a “qualifying event” that enables employees to immediately enroll in an employer sponsored health plan (s.632.746). Source: Wisconsin Department of Health and Family Services. Biennial Budget Request: 2003-2005. Oct. 11, 2002. <http://www.dhfs.state.wi.us/aboutdhfs/OSF/Budget/03-05BiennialBudget.pdf>

does not specify the insurance product that employers must offer.<sup>27</sup> Finally, **Oregon** operates the Family Health Insurance Assistance Program (FHIAP). This program subsidizes the premiums that families (who have been uninsured for at least six months and that have incomes up to 185 percent FPL) pay for private insurance products that meet certain requirements. Based on the applicant's income, the subsidy amount ranges from 50 to 95 percent of the participant's share of the premium.<sup>28</sup>

## Purchasing Strategies

Purchasing pools and other strategies can be used to maximize buying power. For example, **Delaware** was able to save \$10 million in the costs of insurance for public employees by grouping together the state's four major contracts (health insurance for state employees and elected officials, Medicaid administration, health care for adult inmates in state prisons, and health care for juveniles in detention centers and psychiatric facilities) and requiring bidders to submit proposals on each of them.<sup>29</sup> As a result, the state was able to avoid an increase in the premium amount contributed by employees

Some states are also modifying the structure of the health care benefits they deliver to state employees in order to keep health insurance affordable. **Minnesota**, for example, has recently implemented a three-tiered plan for state employees. All primary care providers in all contracted plans are assigned to one of three tiers. Employees select a primary care provider and the co-payments the individual pays vary according to the "Tier" to which the provider belongs. Those providers that provide the most cost-effective care (price and quality) are placed in Tier 1, and employees who select these providers pay the lowest co-pays.<sup>30</sup> Essentially, as the cost-effectiveness of the provider declines, the co-payment amounts increase. Some insurance carriers are also developing products that offer consumers

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<sup>27</sup>Presentation at NASHP Annual Conference by Jane Hayward on August 5, 2002. Slides available at <http://www.nashp.org/Files/Hayward.PDF>. This program is also discussed in Sharon Silow-Carroll et al., *Assessing State Strategies for Health Coverage Expansion*, Commonwealth Fund publication #565.

<sup>28</sup> Oregon Insurance Pool Governing Board, *Family Health Insurance Assistance Program (FHIAP): Frequently Asked Questions*, (Salem, OR: OR IPGB, February 2002). <http://www.ipgb.state.or.us/Docs/fhiapfaqs.htm> Also, a 1115 waiver recently approved by CMS allows the state to claim federal matching funds for FHIAP expenditures made on behalf of people who also qualify for Medicaid or SCHIP. However, the state continues to pay the subsidies of those who do not qualify for Medicaid or SCHIP with state-only funds.

<sup>29</sup>Mary Allen, "Bid Process Cuts State Health-Care Costs," *Delaware News Journal*, June 10, 2002. (<http://www.delawareonline.com>)

<sup>30</sup>Minnesota Department of Employee Relations. *Highlights: Minnesota Advantage Health Plan*. (MN DER, 2002). <http://www.doer.state.mn.us/site3/bargaining/Healthplan2.asp>

more choice within the same health plan. Minnesota HealthPartners, for example, has created a “consumer choice” plan that offers each enrollee a choice of one of three networks and one of three benefit plans.<sup>31</sup>

## Pharmacy Benefits for the Uninsured

As of July 2002, at least thirty states have established programs to help some people pay for prescription drugs. Among these, twenty-six states operate programs that subsidize participants’ drug costs, and eight operate discount programs.<sup>32</sup> *California*, for example, operates a discount program that requires all pharmacists that participate in the Medicaid program to limit the cost of drugs purchased by Medicare beneficiaries to the Medicaid price, even if the Medicare beneficiary is not also eligible for Medicaid. Many state regulated drug discount programs have met with heavy resistance from the pharmaceutical industry lobbying group PhRMA. *Vermont’s* program, which offered discounts to seniors not eligible for Medicaid, was successfully challenged in court by PhRMA. *Maine’s* drug discount program was also challenged by PhRMA and upheld at the appellate level. PhRMA successfully petitioned the U.S. Supreme Court, and the Department of Justice has filed a brief on the side of PhRMA, opposing the Maine program.<sup>33</sup> Finally, other states are making use of 1115 waivers to bring in federal funding enabling them to extend their state dollars to provide prescription drug coverage to more of the uninsured (See the previously described Maryland program.)

## State-Only Funded Initiatives

States may also establish programs that are not based on their Medicaid programs. As discussed earlier, by not using federal Medicaid money, states have the flexibility to expand coverage without regard to Medicaid requirements and restrictions. (Other federal laws such as ERISA and HIPAA continue to apply.) On the other hand, these programs may require the development of a new infrastructure at the state level and do not offer the advantage of federal funding to help cover either the

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<sup>31</sup>Jon R. Gabel, Anthony T. Lo Sasso, and T. Rice, “Consumer Driven Health Plans: Are They More Than Talk Now?,” *Health Affairs*, web exclusive, Nov/Dec 2002.

<sup>32</sup>Neva Kaye. *Affording Prescription Drugs: State Initiatives to Contain Costs and Improve Access*. (Portland, ME: National Academy for State Health Policy, 2002)  
[http://www.nashp.org/\\_docdisp\\_page.cfm?LID=666CB5DC-7948-11D6-BD1700A0CC76FF4C](http://www.nashp.org/_docdisp_page.cfm?LID=666CB5DC-7948-11D6-BD1700A0CC76FF4C)  
Another report that examines prescription drug coverage is: Kimberly Fox, Thomas Trail, and Steven Crystal, *State Pharmacy Assistance Programs*, The Commonwealth Fund (pub #530).

<sup>33</sup>Amy Goldstein, "Court Hears Objections to Maine Drug Plan", *Washington Post*, September 22, 2002.

administrative or service costs. An example is the *Pennsylvania* program *adultBasic*. This program is administered by the state's insurance department and is funded with \$76 million from the tobacco settlement. The program was implemented July 1, 2002, and provides basic health coverage to adults aged 19 to 64 with incomes up to 200 percent FPL. Participants pay a \$30 monthly premium with co-payments and receive physician, hospital, and accident and emergency coverage from private health plans.<sup>34</sup> *Oregon* implemented a state-only funded program with a more narrow focus. The state allows foster parents to enroll into its state employee benefits plan<sup>35</sup> even though this group has a 300 to 400 percent loss ratio (i.e., costs three to four times more to serve than state employees).<sup>36</sup>

## Private Insurance Market

Strategies involving the private insurance market have been attempted, such as offering tax credits to purchase private insurance, establishing high risk pools for people who are uninsurable, and allowing, through state insurance regulation, catastrophic and reduced benefit packages with higher co-payments, or other strategies aimed at controlling the costs of employer-based insurance. As the costs of health insurance continue to rise dramatically, individuals are being forced to rely more and more on catastrophic plans with very high deductibles, and employers are requiring employees to pick up an increasing amount of insurance costs and are looking for other ways to control costs. "Defined contribution" plans are also being promoted; in such a plan, employers generally provide a catastrophic plan to employees and contribute an amount of money into a medical savings account which the employee can use toward the high deductible.<sup>37</sup> *Arkansas* is one state planning to implement private sector initiatives such as creating health insurance purchasing pools and giving private insurance carriers the flexibility to offer products without state-mandated benefits.

## The state as reinsurer

Insurance premiums may be significantly reduced by removing the highest cost claims from the insurance risk pool and instead having the state assume responsibility for these claims by acting as the

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<sup>34</sup>Pennsylvania Insurance Department, *Facts about adultBasic: Working Toward a Healthier Pennsylvania*, (Philadelphia, PA: The Department, last updated October 2002). <http://www.insurance.state.pa.us/html/adultbasic.html>.

<sup>35</sup>Oregon Revised Statutes §243.140

<sup>36</sup>Fiscal impact statement for HB3042-1, rev. Prepared by Mylia Wray, Oregon Public Employees Benefit Board, June 8, 2001.

<sup>37</sup>Anne Gauthier and Kathryn Martin, *Shifting Responsibilities: Models of Defined Contribution* (Washington, D.C.: Academy for Health Services Research and Health Policy, 2002)

reinsurer for the pool. By acting as reinsurer, a state may be able to increase access to health insurance by holding down premium costs. *New York*, for example, as part of its *Healthy New York* program for small businesses, acts as the reinsurer for up to 90 percent of the cost of serving enrollees who have annual claims totaling between \$30,000 and \$100,000. One study found that, “in the first year, the reinsurance strategy led to fairly large reductions (30 to 50 percent and, in some instances, 70 percent) in premiums for individuals who do not have access to group insurance..... Since the small group market does not have standardized policies and many require high cost-sharing, comparisons are difficult, but it appears that Healthy New York premiums are at least 15 to 30 percent below the small group rates.”<sup>38</sup>

## Federal Initiatives to Support State Innovation

In addition to CMS’s efforts to ease the application process for obtaining a §1115 waiver, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services has established the State Planning Grants Program. This program provides one-year grants to states to develop plans for providing access to affordable health insurance coverage to all their citizens. States are designing approaches that provide health insurance benefits similar in scope to the Federal Employees Health Benefit Plan, Medicaid, coverage offered to State employees, or other similar quality benchmarks. Under these grants, states have explored options beyond expansion of public programs and considered strategies that build on employer-based coverage, public-private partnerships, and single-payer alternatives.

State policy recommendations made by HRSA grantee states included strategies to expand public coverage, public-private initiatives including various state subsidies to individuals or employers to expand employer-based coverage of low-income workers, tax credits for the purchase of private insurance, purchasing pools, and pay-or-play requirements for employers. Several states are exploring the possibility of single-payer coverage in their grants. California, for example, recommended the creation of a single, publically financed program for all residents, financed thru the folding in of existing programs, tobacco tax, expanded payroll, and income tax.<sup>39</sup> Several states have indicated that budget problems have delayed or sidelined implementation of the HRSA grant recommendations.

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<sup>38</sup>Katherine Swartz, *Healthy New York: Making Insurance More Affordable for Low-income Workers*, (New York, NY: The Commonwealth Fund, 2001).  
<http://www.ins.state.ny.us/acrobat/hnystudy.pdf>

<sup>39</sup>Heather Sacks, Todd Kutyla and Sharon Silow-Carroll, *Summaries of HRSA State Planning Grant Reports, Prepared for The Commonwealth Fund* (The Economic and Social Research Institute, June 2002)

## WHERE ARE WE GOING?: UNIVERSAL COVERAGE

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Forum participants agreed that the first step toward achieving universal coverage was to define a vision of what the goal, once arrived at, would look like. The group quickly developed consensus about the broad elements that a system of universal coverage should include and went on to identify potential barriers to

developing and implementing a universal coverage program, the information they and other stakeholders would need to address those barriers, and potential strategies and tools they would need to implement the model.

*“If you do not know where you are going, any road will take you there.”*

–Chinese proverb

Based on their experience and knowledge, forum participants agreed on the elements that a successful plan for universal coverage would have. These are:

- a comprehensive core benefit package with a wrap-around package for individuals with special needs;
- a straightforward and uncomplicated system of benefits and administration;
- a plan developed in partnership with key stakeholders (consumers, providers, payers, and insurers) and in which all participants in the system are invested and involved;
- a system that relies on evidence-based medical decisions when possible and appropriate, and that supports the continued development of evidence-based medicine; and
- a system with incentives for stakeholders to use the health care system efficiently and effectively, promote the quality of care and access, and contain health care costs

### **A Comprehensive and Affordable Core Benefit Package for All with a Wrap-Around for Special Needs**

Forum participants agreed that universal coverage should provide all people with access to a comprehensive core benefit package. There was some discussion about how extensive the core package needed to be to remain affordable. All agreed that it needed to include preventive care, but

there was less agreement about whether and to what extent services such as behavioral health and dental care could and should be included. These were held to be important services, but some felt they might belong in a wrap-around and not a core package. Some participants also felt that core benefits should be relatively rich and wrap-around packages available for special services needed by those with chronic illness or special needs. It was also pointed out that decisions would need to be made about not only which services were covered, but how much of any service would be covered. Arkansas, for example, is considering establishing a program with a “safety net” benefit package that includes physician visits and in-patient hospital stays, but covers only six physician visits and seven in-patient days each year. These numbers were calculated to meet approximately 95 percent of the demand for these services. The Arkansas participant reported that the state has labeled this plan a “safety net plan” to make clear that the plan is distinct and intentionally different from Medicaid, SCHIP, and existing private plans. The term “safety net plan” was chosen to imply no comparability with full-benefit plans. Others expressed concern about such a narrow benefit plan.

It was also noted that one element of access is affordability. For universal coverage to be feasible, it must be within the reach of all participants, payers, providers, and insurers.

## **A Straightforward and Uncomplicated Benefit Package**

Forum participants’ experience has shown them that the plan and benefit package must be straightforward and uncomplicated. Among the lessons they have learned:

- Consumers must be able to easily understand their choices and the consequences of their choices;
- Simplifying administration can save money that can be redirected to patient care; and
- Employers are loathe to participate in bureaucratically complex programs.

All of this points to the need to limit the number of benefit packages and to re-examine existing participant eligibility, enrollment, and claims processing systems to identify ways to simplify them. In order to reduce complexity, the number of different benefit packages that insurers may offer should be limited to a reasonable number with clear articulation of covered benefits. There is precedence for this in Medigap policies; in all but three states insurers are limited to offering ten Medigap benefit packages (Basic plus optional riders A through J).<sup>40</sup>

## **A Plan Developed in Partnership With Stakeholders**

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<sup>40</sup>CMS, *Choosing a Medigap Policy*, (CMS, 2002).  
<http://www.medicare.gov/Publications/Pubs/pdf/guide.pdf>

Participants observed that one reason past access initiatives have failed may be because key stakeholders had not been involved in the early deliberation, development, and/or implementation of the initiatives. If states are going to develop a viable and sustainable plan for universal coverage, a host of

“Stakeholders must feel that the program is ‘theirs’ if they are to support and sustain it.”

stakeholders—consumers, providers, employers, as well as public and private insurers—will have to be involved and invested. Participants also emphasized that stakeholder involvement had to be “real” in the sense that all had to understand that, as one participant put it, “hard choices are going to be made,” and “it isn’t just a matter of cutting waste and fraud.” Since stakeholders will need to live with and support the plan once it is developed, they need to be involved in making the hard decisions that shape the plan. It was felt that this might be a difficult task because as another participant stated, “Our expectations [of the healthcare system] are high. We want everything, for free, and now!”

“The costs of their decisions must be apparent to the consumer and provider; they have to know when their decisions are contributing to increased costs without resulting in better outcomes.”

It was agreed that the mantra of the Arkansas Health Insurance Roundtable, “Everyone needs to have skin in the game,” is prudent advice. Consumers, employers, providers, state government, and the federal government, all need to invest something to reach universal coverage. Based on their experience, forum participants noted that exactly what (and how

much) each stakeholder contributed would vary among states and that money was not the only thing that stakeholders could contribute. For example, one state found that providers were willing to take lower payments in exchange for speedier payment. Decisions about who will contribute how much are particularly important to make in concert with stakeholders. At least two participating states had conducted focus groups with employers and consumers to determine how much they would be willing to contribute.

Also, most believed that consumers need information that allows them to contribute in ways other than by paying premiums or co-payments. An important principle is that, “The costs of their decisions must be apparent to the consumer or provider; they have to know when their decisions are contributing to increased costs without resulting in better outcomes.”

## Using Evidence-Based Decisions

An important element of any universal coverage plan, according to forum participants, is that medical decisions need to be made based on evidence whenever possible and appropriate. If a treatment is not medically effective for treating the patient's condition it shouldn't be paid for under the plan. This does not mean that doctors should practice "cookie cutter medicine."

Rather as one participant summarized the issue, "We [all stakeholders] need to recognize that there is a continuum in services. Some, like early initiation of prenatal care, are always

valuable; others, are sometimes valuable; and still others, like more expensive new drugs that are no better than older drugs, are never valuable." Forum participants pointed out that evidence should also be used in the development of the benefit package. Planners need to "identify what's worthless and not offer it as a benefit."

"...there is a continuum in services. Some, like early initiation of prenatal care, are always valuable; others, are sometimes valuable; and still others, like more expensive new drugs that are no better than older drugs, are never valuable."

Again, participants believed that stakeholders had to understand that the "hard issues are always going to be the grey areas; the evidence isn't always right, the evidence sometimes changes, and some benefits are life (not health) enhancing." On the other hand, most felt that stakeholders would understand that under the current system we frequently, "...invest in things that will help a few in the future, not in things we all need." Oregon's experience with creating a prioritized list of covered benefits supports the contention that the public can and will participate in making tough decisions. This state's experience has shown that when the public understands and agrees to the premise that everyone can't have everything, then they will support the program even when it denies coverage for some treatments. This has also been the state's experience in the pharmacy area. Most people understand and agree with the concept behind the Medicaid agency's use of a preferred drug list: "Sometimes there is no evidence that any one drug in a class is better or worse than any other, so choose the less expensive drug." Some were quick to point out, however, that Oregon's prioritized list and preferred drug list only affect the poor. Its experience cannot provide a fully accurate reflection of public sentiment until the restrictions apply to everyone.

## **Incentives for all**

A final element of a plan for universal coverage, as envisioned by forum participants, would be built-in positive incentives for all stakeholders. They felt that it was important that not only insurers be rewarded for producing good performance, but that providers be rewarded for practicing cost-effective, evidence-based medicine, and that patients also be rewarded for making good, cost-effective decisions. Although most people think of financial incentives, forum participants pointed out that other options are available. For example, one participant suggested that instead of a flat, per-service co-payment, patients could pay co-payments that are a percent of the total amount the individual spent on

health care, up to a predetermined ceiling. Also, some states have begun to reward good plan performance by decreasing oversight. Providers might respond to a similar incentive.

## HOW DO WE GET THERE?

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Once the group identified the elements of universal coverage, the discussion turned to the more formidable task of identifying the possible avenues for reaching the goal. While the group discussed both voluntary and mandatory avenues, they felt that two conditions would be very important to reaching universal coverage by any means.

Reaching universal coverage might be a long-term goal, but any plan that reaches that goal will need to produce short-term results.

- Participants again emphasized that the only effective way to get to universal coverage was in a partnership with stakeholders.
- Participants believed that while reaching universal coverage is a long-term goal, any plan to reach that goal will need to produce short-term results in order to build and maintain the momentum necessary to achieve the ultimate goal.

### Voluntary Avenues to Universal Coverage

Voluntary avenues to universal coverage all have one feature in common; there is no government mandate requiring anyone to join or pay into the initiative. The individual consumer decides whether he or she wishes to enroll in a publicly funded program or purchase commercial insurance; employers decide whether they will offer insurance to employees and how much they will contribute to its cost; insurers (sometimes within specific limits) decide what, if any, packages they will offer to different purchasers, how they will administer their plan, and how much they will charge. Voluntary avenues available to the states include many of the measures discussed in the previous section of this paper (“Where are We Now?”). Following are two specific examples of voluntary avenues that states are currently using:

Voluntary programs are particularly vulnerable to “gaming,” people making choices that are best for the individual, but not necessarily best for the group as a whole.

- Expansion of Medicaid, SCHIP, and other public programs to make affordable coverage available to more low-income people. Rhode Island, for example, has incrementally expanded

its Medicaid/SCHIP program under a §1115 waiver and now covers children from families earning up to 250 percent FPL and parents from families earning up to 185 percent FPL.<sup>41</sup>

- Subsidies to enable individuals to purchase commercial insurance, such as Oregon does in its FHIAP program.

Finally, some have suggested the use of medical savings accounts and refundable tax credits for purchase of coverage as two more examples of voluntary avenues to coverage (as long as no requirement exists for an individual to use them).

Unfortunately, voluntary programs can be particularly vulnerable to “gaming,” people making choices that are best for themselves, but not necessarily best for the group as a whole. This may, for instance, become a problem in states that use health insurance rate banding or pure and adjusted community rating.<sup>42</sup> Because ERISA exempts self-insured employers from the state requirement for community rating but does not exempt insurers from the federal requirement of guaranteed issue, it creates a situation where it is in the best interest of an individual employer to self-insure if his or her employees are relatively healthy (and therefore cost less than the average person in the community). However, the guaranteed issue provisions mean that if something happens (such as an employee needing expensive cancer treatment or the hiring of a less healthy individual), the employer can switch to a regular commercial coverage and take advantage of the community rating to keep its premiums low. As a result, the average cost of the people taking up commercial insurance, over time, becomes more expensive than average as the healthy groups migrate out of commercial coverage and return only when the cost to care for them increases. This is harmful to the commercial insurance market in the state.

## Mandatory Avenues to Universal Coverage

Three mandatory avenues to universal coverage were discussed at the forum.

1. ***Play or Pay***: This term has been used to include various approaches to require, or at least not discourage, employer-sponsored health coverage. Because ERISA prohibits states from mandating private employers to cover workers, states have considered taxing employers to

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<sup>41</sup> CMS, *Rhode Island Statewide Health Reform Demonstration Fact Sheet*, Revised August 5, 2002. <http://cms.hhs.gov/medicaid/1115/rircfact.pdf>

<sup>42</sup>In community rating, an insurer is required to base premiums on the cost of serving the entire community, not just those in the employer’s (or other) coverage group.

fund a public health coverage program but providing a credit if they do cover their workers. States choosing this approach would need to address this issue, as well as others.<sup>43</sup>

2. **Single payer:** This is when one entity covers all the health care that a defined population needs, either directly or through contracts with existing insurers. For example, in the November 2002 elections, Oregon voters voted down a referendum to establish the Oregon Comprehensive Health Care Finance Plan which would have ensured insurance coverage to all Oregonians. The plan proposed to finance coverage with existing government expenditures on health care, a progressive payroll tax, and a progressive personal income tax.<sup>44</sup> Also, one forum participant suggested creating single payer systems at the local level based on existing delivery areas as opposed to local government jurisdictions. The local entity would receive all funds that purchasers are currently putting into healthcare, be governed by a board that represents payers, and be responsible for paying for the care provided to all residents.
3. **Individual coverage mandate:** This is when all individuals are required to have coverage, similar to the requirement in many states for car owners to have car insurance. This could bypass ERISA issues by placing the requirement on the individual, not the employer.

## **Making the Insurance Market Work: Risk Pools and Re-Insurance**

Throughout the discussion of voluntary versus mandatory, forum participants frequently mentioned state-operated high risk pools as a way to make the insurance market work better by removing from the commercial risk pool those individuals who have the most costly care.

In 2001, twenty-nine states operated formal high risk pools that offered coverage to state residents who cannot afford to obtain insurance because of their illness and cost of care. One study, however, found that existing high-risk pools have had “limited impact in making insurance available and affordable for otherwise uninsurable individuals.”<sup>45</sup> This may be due to the low number of enrollees the report found

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<sup>43</sup>A more complete description of the complications ERISA introduces is contained in *Revisiting Pay or Play: How States Could Expand Employer-Based Coverage Within ERISA Constraints* by Patricia Butler, National Academy for State Health Policy, Portland, ME, May 2002.. This issue brief is available online at [http://www.nashp.org/Files/ERISA\\_pay\\_or\\_play.PDF](http://www.nashp.org/Files/ERISA_pay_or_play.PDF)

<sup>44</sup>Health Care for All Oregon Website <http://www.healthcareforalloregon.org/summary.htm>, accessed September 25, 2002. This proposal did not pass but would have arguably by-passed ERISA issues because ERISA exempts from state insurance requirements the coverage provided by self-insured employers, not employers from taxes.

<sup>45</sup>Lori Achman and Deborah Chollet. *Insuring the Uninsurable: An Overview of State High-Risk Pools*. (The Commonwealth Fund: New York, NY). August 2001.

in most pools; in 1999 only 105,000 people were served by the risk pools in all twenty-nine states combined. The low enrollment may, in turn, stem from the high premiums and cost-sharing, limited benefit package, pre-existing condition exclusions, and other policies designed to limit the state's risk in insuring this population. It is also important to note that the study did not examine the effect of high-risk pools on the cost and availability of commercial insurance to other state residents, the key role that forum participants saw for these pools. Another study did examine this role for reinsurance. It found that taking one percent of those with the highest costs out of the insurance pool would create a 14 percent reduction in the premiums paid by those who remained in the pool.<sup>46</sup>

Forum participants noted that the Medicaid program functions, in part, as a high risk pool by removing many of the elderly and those with chronic illness from the commercial risk pool. Potential may now exist to coordinate high-risk pools and Medicaid. Congress provided new funding under the Trade Adjustment Assistance Act of 2002 (P.L. 107-210) for seed grants of up to \$1 million for states that do not operate a qualified high-risk pool and for covering up to 50 percent of the losses states incur for operating a qualified pool.

The Medicaid program functions, in part, as a high risk pool by removing many of the elderly and those with chronic illness from the commercial risk pool.

Finally, forum participants were interested in innovative ways to increase their power in the insurance marketplace by combining risk pools. Some participants felt that combining Medicaid beneficiaries and state employees into a single pool for purchasing health care would be a good start at containing costs. There is some precedent for this; California<sup>47</sup> and Wisconsin<sup>48</sup> already include local government employees in their state employee risk pool.

## Combining Avenues

The initiatives discussed in the first part of this paper clearly show that states do not generally use these methods in isolation, nor are they used on an “all or nothing” basis. For example

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<sup>46</sup>Sherry A. Glied, *Challenges and Options for Increasing The Number of Americans with Health Insurance*, (New York, NY: The Commonwealth Fund, December 2000).

<sup>47</sup>CalPERS. Facts at a Glance: Health. (Sacramento, CA: CalPERS, 2002). <http://www.calpers.ca.gov/about/factglan/health/health.pdf>

<sup>48</sup>Wisconsin Department of Employee Trust Funds. State of Wisconsin Group Health Insurance Fact Sheet 2002. (Madison, WI: WI DER, 2002). <http://etf.wi.gov/>

- **Arkansas** is exploring the possibility of using a HIFA waiver to expand its Medicaid program. Under the new program, small businesses that have not offered health insurance for a year and who enter the program get public funding to help pay the premiums of employees who earn less than 200 percent of the federal poverty level (FPL). This model combines the voluntary avenue of expanding an existing publicly funded program (Medicaid) with strong incentives for employers to cover non-publicly subsidized workers. Those who choose the program must provide the same coverage to all employees and their families whether or not the employee qualifies for the publicly funded program. Finally, since the state plans to use existing health insurance carriers to provide coverage, it believes that the program will also help stabilize the existing health insurance marketplace.
- The **Maine** legislature passed the Maine Small Business Health Coverage Plan, a voluntary health plan for small businesses and self-employed persons which will be overseen by a publically appointed board. The plan intends to bring in federal dollars to cross subsidize employer and employee contributions by including employees in the plan who are categorically eligible for MaineCare (Medicaid and SCHIP) and maximizing eligibility for MaineCare by increasing the amount of income that can be disregarded in the eligibility calculation. This program will combine the suggested avenue of increasing the size of the risk pool to lower premiums with two of the voluntary methods discussed in the first section of this paper: expanding the Medicaid/SCHIP program and joint purchasing.

## WHAT'S IN THE WAY?

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Forum participants identified several significant barriers to achieving universal coverage:

- The current health care system, as frustrating as it seems to be, has not engendered sufficient dissatisfaction to provoke the public to make the hard choices needed to reach universal coverage. Part of the lack of public will stems from a lack of knowledge about the real costs of the uninsured to the populace at large.
- Paying for universal coverage and keeping it affordable for all is a daunting challenge.
- Evidence-based medicine—a key element in decision-making about benefit packages, individual patient treatments, and relative cost—is not yet developed enough to fully support these efforts.
- It may be difficult to obtain the participation of employers, who are major funders of coverage in the current system. Labor may not be willing to give up the current system that has developed to their benefit through negotiation with employers.
- Federal laws that impede state flexibility and innovation in their efforts to reach universal coverage need to be changed.
- Perhaps the structure of our current model of providing health care coverage needs to be re-examined. It may be that the primarily employer-sponsored, commercial health insurance structure is not the most effective model for delivering coverage to everyone.

### **Access: Does It Need to Get Worse Before It Gets Better?**

Universal coverage, participants agreed, will only be achieved when the public will is sufficient to achieve it. The present situation of rising health care costs, increasing numbers of uninsured, and dissatisfaction with the current system offers an opportunity for building political consensus for universal coverage. Participants believed that raising public awareness of the real costs of the uninsured and the benefits, both economic and social, of universal coverage is extremely important in this regard. The question remains whether the current dissatisfaction with the system is sufficient to create a political consensus for universal coverage. There is some evidence that it may be so. Oregonians, for example, voted down a ballot initiative for universal coverage this November.

State budgets have limited funds and, for most people, including political leaders, health care is only one of a multitude of issues that are important to them.

Although the initiative did not pass, its appearance on the ballot may indicate growing interest in universal coverage. But, a reality for those interested in universal coverage is that state budgets are limited, and for most people, including political leaders, health care is only one of a multitude of issues that are important to them. For many, it is simply not the most important issue. Other pressing issues, such as education and homeland security, may take precedence over health care.

## **Defining the cost of the uninsured**

One reason for the lack of public will is a lack of awareness about the true costs of the uninsured. The costs of treating the uninsured are reflected in the increasingly high premiums paid by employers and individuals. It would be helpful if planners could tell employers: “For every dollar you paid to a hospital, X cents was because of uncompensated care.” But the data is simply not there, especially in a format that can be easily combined. Many entities (multiple federal and state government agencies, local government, providers, foundations, etc.) pay for the uninsured, and they all keep different information in different formats, for different fiscal years, and in different levels of detail. Forum participants suggested that it would be helpful if some states could be funded to develop and test a method for determining the actual cost of the uninsured to all payers and the effect of that cost on premiums paid to health insurers.

## **Financing, Cost, and Affordability**

The discussion at the forum clearly identified financial barriers to universal coverage. At issue is not only how to fund the programs, but also how to contain costs and use finance as an incentive for desired behavior.

### **Funding expansions**

Some have contended that enough “waste” exists in the system to fund universal coverage. However, as one participant expressed it: “There may be enough funding in the current system to cover everyone now, but not if we keep spending it the same way.” All agreed that funding universal coverage would entail hard choices. The group did, however, identify several approaches that were under consideration or in use in various states.

“There may be enough funding in the current system to cover everyone now, but not if we keep spending it the same way.”

Participants noted that some assess insurers to help fund their high-risk pools, and at least two states (Minnesota and West Virginia) tax providers' gross receipts to help fund the delivery of health care.<sup>49</sup> Another suggestion was to make the tax relevant to the population it would benefit. For example, states might implement a "penny-an-hour" tax on wages to fund COBRA subsidies. This may be acceptable because COBRA helps employees who lose their jobs retain coverage until they find a new job. Massachusetts, for example, currently charges employers who have at least six employees a per year an employee tax of about \$16.80, less than a penny an hour for each full-time employee. This revenue is placed into the Medical Security Trust Fund which supports subsidies for COBRA premiums and direct coverage for some unemployed people.<sup>50</sup>

Federal match is another potential source of outside funding for state health coverage. As previously discussed, states receive federal matching funds for the services they provide to Medicaid and a higher matching rate for SCHIP program participants. They also receive matching funds for the state money they spend on administering these programs. Participants have found these matching funds to be a good incentive for states to fund expansions of the Medicaid and SCHIP programs. As one participant noted: "You would think that you can't spend what you don't have, but when legislators see how the federal match can extend state funds for covering the uninsured they find the state funding." Participants, did however, identify two issues regarding the use of Medicaid and SCHIP matching funds.

- The federal government will not contribute any more money to state expansions under a 1115 waiver than it would have contributed to the program without the waiver. Also, as forum participants pointed out, the budget neutrality provisions have limited state efforts to expand these programs to those they can afford to cover without new federal funding.
- States are unable to receive federal matching funds when a SCHIP or Medicaid eligible person chooses another state-funded program.

The second issue may be in the process of resolution. Under its HIFA waiver, Oregon will allow many children and adults who are eligible for the Medicaid/SCHIP program and are informed of their options

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<sup>49</sup> Nellie Hester, *State Options for Financing CCMU's Healthy Colorado Plan*, Yondorf & Associates, a paper prepared for the Colorado Coalition for the Medically Underserved, draft September 2002 (forthcoming, February 2003).

<sup>50</sup>Sources: (1) Massachusetts Division of Employment and Training, *Health Insurance for Unemployment Insurance Claimants, Fact Sheet*, (Boston, MA: MA DET, Downloaded November 2002). [http://www.detma.org/forms/pdf/1022\\_1201.pdf](http://www.detma.org/forms/pdf/1022_1201.pdf) (2) MA DET, *Employer Contributions: Financing the Unemployment Insurance Program*, (Boston, MA: Downloaded November 2002) <http://www.detma.org/revenue/default.htm>

to choose the previously described FHIAP program instead of Medicaid or SCHIP. If someone who chooses FHIAP is Medicaid eligible, the state will get federal matching funds at the Medicaid rate; if the person is SCHIP eligible, the state will get the federal SCHIP match. Oregon's experience without the waiver is that people choose between the two programs based on what is important to them. Each program has strengths and weaknesses.

- Medicaid offers six months of eligibility; FHIAP offers twelve.
- Providers complain about Medicaid payments being too low; FHIAP providers are happier with that program's reimbursement.
- Program participants who choose Medicaid get a Medicaid card; those who choose FHIAP get a commercial insurance card.

Federal matching funds are not only available for Medicaid and SCHIP. For example, one participant mentioned that the federal Trade Adjustment Assistance Act of 2002 offered states potential federal funding for establishing and operating high-risk pools. Participants felt that this potential source of funds could create an incentive for states to establish such pools.

Another suggestion was to increase the percent of federal match provided for Medicaid and SCHIP programs in times of severe state budget shortfalls due to economic downturns. This would enable states to sustain existing expansions in times of recession. Economic downturns create a double whammy for state Medicaid programs in that recession and higher unemployment mean lower state revenues and at the same time lead to an increase in the number of people who are eligible for Medicaid benefits.

Finally, premiums and other cost-sharing such as deductions and co-pays, paid by program participants, can also be used to fund coverage. However, forum participants pointed out that the ability to use these is restricted by federal regulation unless a waiver is obtained, and that even with a waiver states have not been allowed to use the money collected from premiums as their state match for federal funds.

## **Affordability**

Rising health care costs are one of the reasons some employers may no longer provide coverage to employees or move to defined contribution plans. The cost of public programs is also an issue at this time. A recent study found that eight states reduced or restricted eligibility to public programs in fiscal

year 2002 and eighteen plan to do so in 2003.<sup>51</sup> As a result, forum participants identified affordability as a major barrier to universal coverage. They felt that simplifying the system, reducing waste and errors, increasing the size of the risk pool, and containing the costs of individual services (e.g., pharmacy) would help but would likely be insufficient. Participants pointed out that practicing evidence-based medicine would itself offer tools to keep coverage affordable. Several also felt that a return to managed care might offer a way to keep universal coverage affordable.

One strategy some participants believed might keep universal coverage affordable was to keep very narrow the core benefit package discussed in the previous section. This is the approach that Utah is taking under a 1115 waiver and that at least one other state is considering. Generally, the more limited the package, the less it will cost. Other participants expressed concern that this approach could produce a system that offers universal access to insufficient coverage. Some, however, responded that access to enough care to meet the most pressing needs was better than the current situation and foresaw two possible remedies for the other participants' concerns.

1. Private insurance companies might step in and create wrap-around packages that people could purchase to extend their coverage, much like Medigap policies now extend Medicare coverage.
2. As experience with a very narrow universal coverage benefit package grows, states might decide to expand the core package. This occurred in the New York Child Health Plus program; the program's benefit package was expanded after the state had more experience and better information about participant needs and program costs.

Another strategy proposed by some participants was to set a real limit on the amount that could be spent on health care. Several participants pointed out that: "We don't budget for health care. We do for everything else." These participants felt that, "Budgeting is key. Set a bar, stick to it, and give states tools to manage within it." Some felt that this practice should be implemented at the community level, that if the community had access to all the funds currently going to pay for residents' health care that they could come together and develop a plan for universal coverage within those limits. Of course, such an approach would need to first address existing inequalities of funding and resources in the system.

"Budgeting is key. Set a bar, stick to it, and give states tools to manage within it."

Another strategy proposed by participants was to manage the supply side. Some states are already seeing a resurgence of certificate of need (CON) programs, and thirty-five states currently operate

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<sup>51</sup>Vernon Smith, et al. *Medicaid Spending Growth: Results from a 2002 Survey*. (Washington, DC: The Henry J. Kaiser Family Foundation), September 2002.

CON programs.<sup>52</sup> Participants reported that the Maryland Health Care Commission actively uses its authority to decide which facilities can perform heart and lung transplants. Another strategy for controlling the supply side is to look at practice rules. Washington, for example, negotiated with its medical society and instead of implementing a preferred drug list (PDL) to contain drug costs in the Medicaid program changed the pharmacist practice law to allow pharmacists to convert a prescription to the therapeutic equivalent of a prescribed drug. Before this change, pharmacists could substitute a generic drug but could not substitute a lower priced brand-name drug.

Finally, participants emphasized the need to redesign insurance and care delivery systems to emphasize more cost-effective and efficient care, with an emphasis on quality and outcomes. To make the care system more affordable over the longer term and accessible to all in need of care, participants discussed the importance of involving both patients and physicians in more active discussion of evidence-based medicine and the benefits and costs of alternative treatments and care options.

These efforts could include new incentives for physicians as well as for patients to opt for less expensive treatment alternatives and to assess outcomes of care. The challenge is how to incorporate incentives that assure quality and do not just focus on costs. Although patients have a real interest in curbing mis-use or inappropriate care, families and patients are also wary of top-down approaches that appear to pit insurer interests against patients' health and well-being or to give physicians a financial incentive to withhold needed care. One participant proposed establishing "health care green stamps." Those consumers that obtained appropriate preventive care, such as immunizations, would receive "green stamps" that could be exchanged for something of value to the participant.

The discussion emphasized the need for stability of coverage as well as delivery systems in the search for cost-effective care. To the extent that patients move in and out of health plans or endure periods of being uninsured, or physicians move in and out of networks or group practices, this instability is likely to undermine efforts to incorporate incentives or other initiatives to improve return on the national investment in health care.

## **Evidence-based Medicine Is Still in Development**

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<sup>52</sup>Community Catalyst Website. [www.communitycat.org](http://www.communitycat.org), November 20, 2002.

Participants strongly emphasized the need to use evidenced-based decision-making, not just in making individual treatment decisions, but also in developing the benefit package and cost-sharing requirements. They also recognized that evidence-based medicine is still in development. As one participant summarized the situation: “We talk about evidence based

“We talk about evidence based medicine like we have it, but we don't.”

medicine like we have it, but we don't.” Nonetheless, as another participant stated: “If we don't set the bar, it shouldn't surprise us that no one gets over it.” As long as the evidence bar is low for covering treatments, companies will continue to invest in advertising over research as a means for ensuring that their product is used. Participants reported that even some widely used treatments did not have extensive evidence to support their choice over other treatments. Oregon, for example, excluded Lipitor from the Preferred Drug List (PDL) used in the Medicaid program due to lack of studies showing positive clinical outcome (reduction in death and myocardial infarction) and cost-effectiveness<sup>53</sup>.

Several participants also suggested that states could share evidence more often across state lines. For example: “Why have individual states developed their own preferred drug lists?” These participants pointed out that “evidence is evidence;” it doesn't change across state lines. Costs may change, as well as the strategies used to enforce a preferred drug list, but the evidence of effectiveness and safety will not change. They thought it might be cost effective to have an independent, multi-state body to evaluate evidence for a group of states instead of each state working individually.

Participants pointed out that in an ideal system the practice of evidence-based medicine would not be limited to providers. Consumers, in particular, need easily understood information from a source they trust about best practices for treating their conditions, contributions they can make to their own health, provider and health plan performance, and cost. Such information would help them make decisions about the plans and providers they use, as well as about their own health care. Essentially, consumers need data to help them make decisions, especially in defined contribution situations, where they may be financially liable for their decisions.

## **Current data systems do not adequately support the use of evidence-based medicine**

Another barrier to effective use of evidence-based medicine identified by forum participants was that current data systems do not adequately support its use. As one participant noted: "Every information

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<sup>53</sup>One forum participant reported that Lipitor is effective at lowering cholesterol but that its manufacturer has never published clinical outcomes, something that three of the other companies that produce statins have done.

system I know of is defined by the CFO [Chief Financial Officer]. We need a clinical (not financial) information tool for physicians."

Participants agreed that an adequate data system for physicians would provide information about evidence in a form that is easy to use in decision-making and would identify when their practice did not match the evidence. One participant stated: "They [physicians] will self-correct if given information; managed care showed that. Physicians need data and a feedback loop." Although states have made efforts to provide this type of information to physicians, sometimes in the form of paper reports showing physician performance, participants felt that no existing tool was sufficient.

"Every information system I know of is defined by the CFO. We need a clinical information tool for physicians."

As previously discussed, participants were interested in more effective ways to gather information about the cost and effectiveness of treatments and providers. They were also interested in developing better ways to communicate this information to providers, patients, and purchasers so that these groups could use this information in decision making. One specific suggestion that emerged from the forum was for two or three states, perhaps with outside funding, to create a consumer data template that would help consumers in decision making. This template would then be available to all. Some participants suggested doing the same thing for physicians.

## **Attaining Participation of Employers and Higher-Income Workers**

Based on their experience, participants noted that employers who do not offer insurance to their workers seem to fall into one of two groups: those who are not interested in providing insurance coverage under any circumstances and those who would like to provide insurance but do not or cannot for various reasons that typically include cost or the bureaucratic hurdles involved in public plans. Small businesses are often a large part of this second group. In these companies, the human resources director is very often the business owner himself (or herself).

Forum participants felt that it would be much easier to address the issues that prevent some employers from offering coverage than to increase interest among those who do not wish to provide coverage. New Mexico, for example, plans to use insurance agents for outreach and enrollment into their new HIFA program, which requires both participants and employers to contribute to the Medicaid premium. Commercial agents, who now often collect health information for some types of insurance such as life insurance, will collect financial information to determine if the purchaser qualifies for HIFA. If consumers are eligible it will be the agent's responsibility to bring the employer into the program. Another participant remarked that his

"Employers who have had a hand in decision making are more likely to participate..."

state also planned to use insurance agents to sell the package. As he noted: “They want to do it because it gets them in the employer’s door to sell other types of insurance.”

Several participants emphasized the need to keep the employers in the loop when developing the program. Employers who have had a hand in decision-making are more likely to participate, even if that involvement is no more than being kept informed of progress and decisions and given an opportunity to comment. Two states found focus groups to be an effective means of determining what employers were willing to contribute. New Mexico, for example, set the employer premium at \$75 after a series of focus groups with employers helped determine what they would be willing to contribute.

In addition to these efforts to facilitate employer participation, New Mexico has established policies to accommodate employees whose employers refuse to participate in the program. These individuals will still be allowed to join the program if they pay both the employer and employee share or find a different source of payment for the employer share. Some American Indian Tribes, for example, have already committed to paying the employer and employee share for their members. The experience of Washington state, where sponsors may assume the cost of premiums for individuals enrolled in the Basic Health Plan, confirms that not only employers and employees are willing to pay an enrollee’s premium. Washington found that clinics were willing to pay the premiums for their patients, or at least those patients whose services cost more than the premium amount.

### **What are people willing to bring to the table?**

In the opinion of forum participants, the goal of universal coverage becomes more attainable if states form partnerships to achieve it. Other stakeholders need to contribute to the effort, but forum participants lacked specific information about the resources these groups would be willing and able to contribute. Participants were particularly interested in hearing from employers and providers, as well as unions, who have achieved substantial benefits under the current system. Forum participants suggested conducting a series of national focus groups to find out what these groups would want from a system of universal coverage and what they would be willing to contribute. Some participants reminded the group that money was not the only thing that the groups had to bring to the table. One person suggested that doctors, interested in lower malpractice insurance rates, might be willing to play a greater role in providing access in exchange for lower rates.

### **Addressing Federal Barriers**

Two federal barriers to universal coverage were identified several times throughout the forum: ERISA and Medicaid budget neutrality requirements for waivers.

1. ERISA limits state ability to require employers to offer insurance coverage and exempts the coverage offered by self-insured employers from state insurance regulation. It also creates a barrier when public programs attempt to enroll eligible participants—who also qualify for employer-sponsored insurance—into the employer’s plan. (See page 8.)
2. Federal costs under §1115 waivers may not exceed the costs the federal government would have incurred without the waiver. This limits state expansion of Medicaid and SCHIP to the amount that states can afford without any new federal dollars.

Some participants believed that removing the barrier that ERISA poses to the coordination of public and private coverage may not require changes to the law. Since ERISA cannot “impair” other federal laws, and public/private coverage coordination is required in the case of Medicaid and SCHIP, some believed that the issue could be resolved by a clarification from the federal executive branch of the relationship between the two requirements.

## **In What Vehicle Will We Arrive?**

One intriguing question raised at the forum centered on whether the traditional commercial insurance model is the right one for attaining universal coverage. Participants noted insurance companies increasingly appear to avoid risk and increasingly seek to move into an Administrative Services-Only (ASO) contract where they do not have financial risk for the cost of care. These participants also pointed to the growing employer interest in defined contribution plans as an indication that the traditional health insurance model was not working. Even those who believe traditional insurance is the right vehicle agreed that it is time to reexamine its role in the current system. These participants felt that the country needs to rethink what and who should be covered by commercial insurance. A few suggestions for alternate arrangements included:

- Implementing a global budget at the local level and requiring the locality to pay for care for all citizens out of that budget;
- Requiring most individuals to obtain a core package of benefits and giving them a tax credit for doing so (public programs would be designed to help the poor purchase the core package and fund the wrap-around services needed by some groups);
- Having the private market cover most healthy individuals while a public program would provide care for those who are the most expensive to care for, perhaps by establishing a high-risk pool that could be funded in part by insurer or provider assessments.

## **Who should pay for what?**

Participants also felt that it would be worth reexamining who should be responsible (federal, state, or local government, consumers, employers, etc.) for managing and paying for the health care provided to individuals. Under the current system many entities could pay for the care provided to a single individual, particularly if he or she is low income. For example, a poor person who qualifies for both Medicare and Medicaid might be receiving services covered by the federal government (Medicare), the state and federal government (Medicaid), local government (some home-based personal care services), etc. Similarly, a low-income family might be covered by Medicaid or SCHIP (federal and state funding) in addition to employer sponsored coverage. This patchwork of payers, providers, and care managers can impede coordination of an individual's care and create the potential for cost-shifting among programs. Forum participants suggested that there might be a better way to divide the responsibility for providing the various services. For example, states might cover acute/primary care while Medicare covers long-term care.

## Learning from the past

Many of the ideas suggested at the forum have already been tried and have often failed to meet expectations. (See Appendix A: Lessons Learned from 25 Years of State Reforms). The question then becomes: "Why do we think it will work now?" Participants responded that these approaches did not necessarily fail because they

"...these approaches did not necessarily fail because they were wrong, but because they encountered barriers they could not overcome..."

were wrong, but because they encountered barriers they could not overcome, including the political realities of the time. Many initiatives, while not fully achieving their aims, did expand coverage, sometimes significantly. Participants strongly felt that these past attempts should be analyzed to determine what challenges prevented them from reaching their full potential so that these barriers could be avoided in the future. Some felt that successes should be analyzed, such as Massachusetts' CommonHealth program, and that more needed to be known about Hawaii's employer mandate.<sup>54</sup> Others were interested in analyzing past attempts to contain costs, such as managed care, to find out what worked, what didn't work, and why some things worked in some conditions but not others. Finally, participants were interested in examining successes and failures to determine why some reforms were sustained and others were not.

## Showing how universal coverage can work

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<sup>54</sup>While not necessarily replicable, participants also thought it would be of interest to look at nations that had achieved universal coverage in recent times (e.g., Canada, Holland) for information about how to achieve universal coverage.

Many participants felt that a successful demonstration of universal coverage in a community, region, or state would be a necessary step to achieving universal coverage. One participant cited the case of Saskatchewan, the first Canadian province to introduce universal coverage (by covering just hospital services). After initial resistance, the rest of Canada—and a broader benefit—followed. Another participant suggested that a demonstration among a particular population such as children or pregnant women might be successful, as there is generally broader agreement that these populations should have access to health care. Another participant suggested starting with state employees since states fund their health coverage, the administration of their coverage is less strictly governed by federal law than Medicaid or SCHIP, and ERISA does not apply to them (or to any other public employer-sponsored plan). A specific suggestion was made to charge state employees premiums based on income; those that earn more pay more. One final suggestion was to find a state interested in modeling the Medicare approach, i.e., creating one risk-bearing entity to contract with multiple administrative entities.

## CONCLUSION

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Since the first Flood Tide Forum was held in 1999, progress was made in decreasing the numbers of uninsured. According to census data, the proportion of Americans without insurance declined in 1999 and 2000, after rising for a decade. This was in no small part due to concerted state action over the past three years to expand public coverage through SCHIP and Medicaid. But more recent data shows that in 2001, this positive trend reversed, with the number of uninsured Americans rising by 1.4 million to a total of 41.2 million.<sup>55</sup> There are several reasons for the latest increase in the uninsured: many people lost jobs last year (and employers are the primary source of health insurance for most Americans); rising health costs pushed up premiums, making insurance less affordable; and employers passed on more of the costs for health insurance to workers.

The situation would be even more dire if not for an increase in public coverage. The census report confirms that Medicaid in 2001 covered 2.5 million additional individuals. While one million children lost employer-sponsored coverage in 2001, the number of children with government health insurance rose by nearly 1.2 million, to 18.8 million. Of course these increases may be hard to maintain in the face of the budget shortfalls many states are experiencing. In May 2002, the National Association of State Budget Officers reported that forty states were facing shortfalls totaling nearly \$40 billion and anticipated that fiscal problems would continue until at least 2003.<sup>56</sup> As previously discussed, some forum participants suggested that the federal government could increase its share of the Medicaid and SCHIP programs during hard times, allowing states to sustain these programs during economic

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<sup>55</sup>Robert J. Mills, *Health Insurance Coverage: 2001*. (The US Census Bureau, September 2002).

<sup>56</sup> NGA and NASBO. *The Fiscal Survey of States*. (NGA and NASBO, May 2002).  
<http://www.nasbo.org/Publications/fiscsurv/may2002fiscalsurvey.pdf>

downturns, for it is during these periods that these programs become more critical for more people, and state funding to operate them becomes more scarce.

As bleak a picture as this recent census data provides, the Flood Tide Forum participants felt these difficult times may be just what is needed to propel a new wave of reforms and advance the move toward universal coverage. As forum participants noted in 1999 and again in 2002, reforms will fall short of the mark without a strong public commitment to guarantee access to health care to all Americans. The past three years have seen many new initiatives in the states. The toolbox is full of both private and public mechanisms that can be used at the opportune moment. Medicaid waivers, as well as federal and private grant funding, have enabled states to explore new avenues to increased coverage and to better identify the barriers that lie in their way.

Based on the discussions at the Flood Tide Forum, it is clear that states could make great progress toward universal coverage if certain barriers to innovation and flexibility were removed, especially if the state fiscal situation also improves. Participants felt that not only the remaining barriers in Medicaid and SCHIP needed to be addressed but also those created by the interactions of other federal laws, such as ERISA with state programs. States are ready to work with each other, educate both consumers and providers as to the real costs of not having universal coverage, set up demonstration models, and work with the private sector in order to reach the goal of universal coverage.

## APPENDIX A

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### Lessons Learned: 25 Years of State Health Reform<sup>57</sup>

Public attention is turning again to the issue of the uninsured, as their numbers grow despite a booming economy and low unemployment. Just as cost explosions drove reforms in the late seventies and early eighties, now, as health care costs again are on the rise, participants in the Flood Tide Forum agreed that the current environment is ripe for reforms to increase access to the uninsured.

These state leaders also expressed concern about the future of employment-based coverage. While slightly more employers are offering coverage, fewer workers are taking up the offer, suggesting that for more and more employees, the costs of coverage are prohibitive. Many Forum participants view employer initiatives to offer employees more choice and control (voucher-like systems are one common means of doing so) as a sign that business is retreating from its traditional responsibility of plan selection and design and is limiting its role to that of payer. Others wonder if these actions foreshadow a possible retreat from employer based coverage altogether.

And participants stressed that while calls for reform are growing louder by the day, no consensus exists on how to achieve reform and no social contract has been articulated to direct such reform.

In examining and assessing the past 25 years of state reforms, the participants identified the following lessons:

#### A. General Findings and Observations

##### 1. State initiatives expand coverage but success of various strategies differs

Over the past 25 years, states have experimented with numerous strategies to expand coverage. The success of these strategies has varied and some recent reforms cannot yet be fully assessed. Among the most common strategies employed by states:

1. Medicaid expansions and state-funded, subsidized health insurance programs can significantly lower the rates of the uninsured among families with incomes at or below 200 percent of the federal poverty level.

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<sup>57</sup>From Trish Riley and Barbara Yondorf, *The Flood Tide Forum. Access for the Uninsured: Lessons from 25 Years of State Initiatives* (Portland, ME: National Academy for State Health Policy, January 2000), pp. 41-45.

- High-risk pools, operating in 28 states, cover very few people - primarily those with uninsurable medical conditions. Enrollment as a proportion of those eligible is low, largely due to costs.
  - The impact of insurance market reforms remains somewhat unclear, but evaluations to date suggest that: (1) the market reforms of the 1990's have had only a modest positive impact on insurance coverage rates, mainly in the very small group market; (2) the reforms seem popular with business and the public and have been sustained; (3) the primary beneficiaries of reform have been high risk groups.
2. Purchasing cooperatives, authorized in 28 states, have met with limited success, increasing plan choice for employees in small firms but not generally achieving cost savings.
- Standardized health insurance plans have encouraged consumers to assess comparable plans by price but have not sold well when the benefits provided were seen as excessive or inferior.
  - Medical Savings Accounts have not caught on with the public, but opinions vary widely about why.
  - Requiring health insurance coverage can reduce the numbers of uninsured without causing major economic disruptions. States have experience mandating insurance coverage. Hawaii requires employers to offer and contribute to the cost of employee coverage and requires eligible employees to accept the coverage and pay for it through payroll deductions. Massachusetts requires colleges to assure that all full-time students have health coverage. Given the federal prohibition through ERISA that has stifled employer mandates, some believe individual mandates might pose more potential for assuring access.
  - It is not clear that tax incentives have led more people to purchase health insurance, and some states have repealed tax incentive programs. Recent studies suggest that for tax incentives to have a substantial impact on the numbers of people purchasing insurance, they need to be structured as refundable tax credits.
  - Indigent care programs and the Medicaid and Medicare Disproportionate Share Hospital Program (DSH) remain important sources of health coverage for the uninsured. But when those programs are not well coordinated with state insurance initiatives, they may create disincentives for enrollment in insurance-based programs.

## **2. Medicaid has been an important platform for state-based reform and provides critical resources to finance access initiatives.**

- Congressionally mandated and optional expansions of Medicaid eligibility have been used by states to reach more of the uninsured.
- Forum participants noted that changes are needed in the federal/state relationship to ensure that the federal government fully recognizes the shared governance responsibilities of the program. Since states fund nearly one-half the program and are accountable for program management, a new HCFA-state model is needed to reflect the true nature of the partnership. The Medicaid entitlement will continue to challenge the partnership as it makes caseload hard to predict and budget. States struggle to administer Medicaid within state balanced budget requirements and, as Medicaid costs continue to challenge the growth of state expenditures for competing priorities, states seek the capacity to better control expenditures. At the same time, HCFA must enforce the law's open-ended entitlement which increases states' costs in sometimes unpredictable ways.
- While the dual governance of Medicaid poses challenges to the states, it has also played a significant role in reform efforts. HCFA has authorized significant reform through 1115 waivers and can protect those reforms from erosion during changes in state political leadership by requiring that the conditions of those waivers be met. And occasionally HCFA's resistance to a state based reform initiative can unify state stakeholders and galvanize their support to advance an initiative.

## **3. State solutions respond to local needs and capacities**

- Attendees reaffirmed the value of state-based initiatives to achieve access for the uninsured, in **spite** of the challenges posed by enacting and sustaining such reform. As participants noted, health care is delivered locally and local factors (demographic, political, economic) play a significant role in shaping the system. Some states have many large employers and a strong union base; others have only a handful of insurers and an economy comprised primarily of small businesses. States also vary widely in the rate of coverage by Medicaid and by employer. Even the poverty level varies from state to state. State-based solutions can appropriately respond to and reflect local circumstances.
- Health coverage initiatives need to be facile, as they have proven to be at the state level, in order to respond to such environmental differences and to respond to marketplace changes. Today's marketplace of mergers, retrenchment of traditional HMOs, and the creation of more provider-sponsored and public programs is fundamentally different than the marketplace of 10 or 25 years ago, and state reforms have been revised to reflect that change.



## **B. Operational Lessons**

### **1. Implementation is difficult and takes resources to be done properly.**

- Implementation of initiatives to expand access to the uninsured is a complex and difficult undertaking no matter how small or incremental the reform. This leads some to conclude it may be wise to launch comprehensive reform since the effort to implement smaller reforms is nearly as great.
- Subsidized health insurance programs are costly. To achieve enrollment, subsidies must be deep (with premiums not to exceed 1-3 percent of income), the enrollment process simple, and marketing strong.
- Just because you build it does not mean they will come. New programs for the uninsured require a substantial investment in marketing and outreach.

### **2. Enrolling all eligible has historically been a challenge in state-based programs.**

- Varying, complex program eligibility requirements adversely affect enrollment rates. Most Americans who are insured through their workplace need only complete one simple form to secure coverage, but the uninsured must meet a much more stringent test, proving income and other eligibility. Recently, the State Children's Health Insurance Program (CHIP) has highlighted the issue of the uninsured who are eligible for coverage but who remain unenrolled. But as Forum participants noted, this issue is not a new one. States that have implemented access reforms have identified similar problems over the last 25 years. Some believe the problem is one of mixed messages: encouraging the uninsured to enter into complex eligibility determination for insurance, while at the same time offering parallel systems of direct, free care through clinics and hospitals. Others suggest the issue is more complex and that there may always be a segment of the uninsured who will be unable to understand and navigate an insurance model and will need the enhanced supportive services provided through the public health system.
- The influence and cost of intermediaries in the system need to be examined. Insurance brokers, for example, play a critical role in marketing to employers and can influence business willingness to accept or reject reforms. The influence of brokers has been strongest where states started new private insurance programs for the employed and failed to understand the importance of brokers in marketing a new product that competes with existing products. Brokers are often de facto human resources directors in small businesses, and as the health insurance market becomes more volatile, their role is reinforced and their costs to the system may rise. However, as more Internet based solutions develop, the traditional broker role may change significantly. States need to be sensitive to the role of brokers in any reforms they craft.

## **C. Political Lessons**

### **1. Enacting Reforms**

- Outside constituencies are essential to push reform and demand accountability.
- Strong leaders are a critical element of reform. Each state represented at the Forum identified a governor and/or legislative leader as instrumental in building and sustaining reform.

### **2. Sustaining Reforms**

- Sustaining reforms in a political environment and with balanced budget requirements is a challenge. Building sustainable reforms takes time. Securing enough votes to enact a new law is not enough. Building solid consensus for reform is critical to assuring its sustainability. Providing incremental reform in which consumers see immediate results and benefits builds public support.
- Sustaining reform efforts and preventing bad policy are, in fact, victories for state policy makers.
- There is a commonality of interests between public and private purchasers. Working together, public and private purchasers can get better data, promote successful quality initiatives, and improve consumer education.
- States can demonstrate reform, but they can't do it all. Significant reforms usually require a federal partnership, whether in the form of financial support, a waiver of federal rules, or allowing exceptions to ERISA.

## **APPENDIX B**

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### **Examples of State Access Initiatives since 1999**

## Overview: State Access Initiatives since 1999

State	SCHIP parent coverage <sup>58</sup>	Medicaid expansion	Medicaid buy-in	Private insurance premium support	State funded only	Purchasing	Drug discount	Private
Arizona	✓	✓	✓		✓			
Arkansas		✓					✓	purchasing pools; community self-insurance; bare bones products
California	✓ (not implemented)		✓ working disabled		✓		✓ Golden Bear Discounts	local initiative: subsidized insurance product for children
Delaware						✓		
Maine		✓	✓	✓		✓	✓	
Massachusetts		✓	✓ (Common-health for disabled)	✓ (mental health for immigrants)			✓ (elderly and disabled)	Premium support for COBRA
New Mexico		✓		✓				✓
New York				✓ Subsidy is re-insurance	✓			✓
Oregon		✓ reduced benefit pkg for some (not impl.)		✓				
Pennsylvania				✓	✓ tobacco \$			✓

<sup>58</sup>All 50 states and the District have now implemented SCHIP programs.

Rhode Island	✓	✓	✓	✓	✓ child care workers			Local initiative: tax credit; MSA
Utah		✓ reduced benefit pkg						

### Examples of State Access Initiatives since 1999

*Arizona* established the state-funded-only Premium Sharing Program for individuals who did not qualify for the Arizona Health Care Cost Containment System (AHCCCS) Medicaid and who could not afford private coverage (up to 250 percent FPL or up to 400 percent FPL for chronically ill individuals). Participants pay a monthly premium based on income and co-payments which range from \$5 to \$50.<sup>59</sup> State funds pay for the difference between participant cost sharing and the actual cost of providing care. Enrollment in the Premium Sharing Program is limited to ensure that annual premium expenditures do not exceed the annual allowable cost allocations; as a consequence, enrollment has currently reached its limits. (Most program participants will qualify for Arizona’s HIFA waiver, which covers all adults up to 100 percent FPL and parents of SCHIP or Medicaid eligible children up to 200 percent FPL.)

Under its recently granted HIFA waiver, *Arizona* proposes to expand coverage to two populations: 1) adults over 18 without dependent children and with income at or below 100 percent FPL, and 2) parents of children enrolled in Medicaid or SCHIP who are not themselves eligible for either program, with incomes above 100 percent and below 200 percent FPL.<sup>60</sup> *Arizona* expects to ultimately enroll nearly 50,000 adults under the HIFA initiative, including more than 25,000 without health coverage now. Under the plan, the state will fund the expanded coverage by relying primarily on unspent federal funds originally allocated to support *Arizona*'s SCHIP program. All *Arizona* children now eligible for Medicaid and KidsCare will remain eligible.

*Arkansas* will build upon the Strategic Plan developed in the first round of HRSA State Planning Grants with a State Coverage Initiative demonstration grant awarded by the Robert Wood Johnson Foundation<sup>61</sup>. The state will combine multiple efforts to stabilize existing health insurance coverage and expand coverage to uninsured individuals. With this plan as a guide and despite budgetary deficits, the

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<sup>59</sup><http://www.ahcccs.state.az.us/Services/psp/index.htm>

<sup>60</sup>*Arizona* and *California* were granted the first two HIFA waivers: (<http://cms.hhs.gov/hifa/hifaadem.asp>)

<sup>61</sup>The HRSA State Planning Grants Program provides one-year grants to states to develop plans for providing access to affordable health insurance coverage to all their citizens. Under these grants, states have explored options beyond expansion of public programs and considered strategies that build on employer-based coverage, public-private partnerships, and single payer alternatives.

state has used tobacco settlement funds in the public arena to 1) extend coverage for pregnant women from 133 percent to 200 percent FPL (3,000 additional women annually), and 2) extend in-patient hospital benefits for existing Medicaid adult beneficiaries. Additionally, the state has new proposals under review by CMS for 1) coverage targeting adults aged 19 to 64 up to 100 percent FPL (an additional 30,000 individuals), and 2) prescription drug coverage for Medicaid-eligible, non-institutionalized elderly (an additional 10,000 individuals). Private sector initiatives in the state are focusing on community-based purchasing pools targeting those communities and/or counties with taxes levied to support indigent care, small business regulation modifications, and increased flexibility for private insurance carriers to offer products without state-mandated benefits.

In an innovative strategy blending public and private efforts, a small business initiative in Arkansas will, if approved, target employers through a HIFA waiver. By focusing on small businesses that do not offer group health insurance, efforts to expand health insurance and enroll individuals who are Medicaid eligible but not insured (e.g., pregnant women and Medicaid/SCHIP eligible children) will be enhanced. The state will help the 65 percent of small businesses currently not offering health insurance afford this package for all employees by subsidizing the premiums paid for employees earning less than 200 percent of the FPL. Arkansas is applying for a §1115 waiver that will enable it to obtain federal matching funds for services provided to enrollees earning less than 200 percent of the FPL. By requiring 100 percent employee and family insurance coverage as a condition of employer participation, this strategy will expand coverage not only to those eligible for the subsidy, but also for those uninsured individuals above 200 percent of the FPL. As proposed, the program will be an employer/state partnership utilizing existing health insurance carriers to provide coverage, thus promoting both expanded coverage and stabilization of the existing health insurance marketplace.<sup>62</sup>

*California's* approved HIFA waiver allows the state to offer health coverage to the custodial parents, family caregivers, and legal guardians of children eligible for Medicaid or SCHIP, provided those parents do not have health insurance and have family incomes at or below 200 percent of the federal poverty level. Children of these families already qualify for SCHIP in California. Eligible parents will receive a benefits package similar to that offered to children in the SCHIP program. Families generally would pay monthly premiums of \$10 or \$20, depending on their family incomes. An estimated 275,000 parents would be covered under the waiver, and the state also expects to enroll more eligible children as a result of the new coverage for parents.<sup>63</sup>

California also provides an example of an initiative at the county level in the *Children's Health Initiative (CHI) of Santa Clara County*, wherein private funders, local governments, and non-profit

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<sup>62</sup>Arkansas SCI Demonstration Grant Proposal, May 2001. (<http://www.statecoverage.net>).

<sup>63</sup>A GAO report released August 6, 2002, questions the validity of the Arizona waiver that allows unspent SCHIP money to be spent on adults and further questions whether the California waiver meets the requirement of "cost effectiveness."

agencies are working together to achieve universal access for children. CHI combines a comprehensive and integrated outreach and enrollment strategy with a new subsidized insurance product marketed to children with family incomes up to 300 percent FPL who do not qualify for Medicaid or SCHIP, regardless of their immigrant status.

**Delaware** grouped together its four major contracts—health insurance for state employees and elected officials, Medicaid administration, health care for adult inmates in state prisons, and health care for juveniles in detention centers and psychiatric facilities—and required bidders to submit proposals on each of them.<sup>64</sup> In doing so, the state was able to save \$10 million in the costs of insurance for public employees and thus avoid an increase in the premium amount contributed by employees.

**Kentucky Access** is a high-risk pool with a state authorized health plan that offers medical coverage to Kentuckians who find it difficult to obtain health insurance in the individual insurance market due to high-cost medical conditions or who have been denied insurance because of high-cost conditions. Spouses and dependent children of eligible enrollees may be included in Kentucky Access coverage.<sup>65</sup> Kentucky Access offers six different benefit/cost sharing options designed to give applicants a variety of choices similar to what is available in the private market. Each benefit plan also offers (at additional cost) a prescription drug rider and a mental health parity rider. Two of the six options do not have lifetime maximums. The other four are each associated with benefits having a \$2,000,000 lifetime maximum.

Kentucky Access is financed with tobacco settlement funds in addition to premium revenue, an assessment on premiums written by stop-loss carriers, and an assessment on premiums written by health insurance carriers offering fully insured plans. Although it is expected Kentucky Access will subsidize program costs to some extent, it is not designed to serve indigent citizens or to completely subsidize program costs.<sup>66</sup> As of July 31, 2002, 1,437 individuals were covered by Kentucky Access.<sup>67</sup>

**Maine:** In its most recent session the Maine legislature passed the *Maine Small Business Health Coverage Plan*, a voluntary health plan for small businesses and self-employed persons which will be

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<sup>64</sup>Mary Allen, “Bid Process Cuts State Health-Care Costs,” *Delaware News Journal*, June 10, 2002. (<http://www.delawareonline.com>)

<sup>65</sup>[www.kentuckyaccess.com](http://www.kentuckyaccess.com)

<sup>66</sup>[www.kentuckyaccess.com](http://www.kentuckyaccess.com). Premium rates vary depending on age, gender, and benefit/deductible chosen. The premium for a 40-year-old woman with a \$400 deductible under the Traditional Access indemnity plan would be \$531.94/month, excluding mental health and pharmacy riders which would cost \$265.97 and \$37.24, respectively.

<sup>67</sup>Kentucky Access, Administrative Services, (502) 513-1026.

overseen by a publically appointed board. The plan intends to bring in federal dollars to cross subsidize employer and employee contributions by including employees in the plan who are categorically eligible for MaineCare (Medicaid and SCHIP) and maximizing eligibility for Maine Care by increasing the amount of income that can be disregarded in the eligibility calculation.<sup>68</sup>

Maine also recently received a Section 1115 waiver to expand health insurance coverage to about 11,500 low-income, childless adults. Under the waiver, Maine residents who do not have children and have annual incomes up to 100 percent of the federal poverty level, or \$8,860 per year for an individual, will be eligible for coverage under Maine Care, the state Medicaid and SCHIP programs.

**Massachusetts:** The Insurance Partnership Program, a program of MassHealth, offers premium assistance towards employer-sponsored health insurance. The employer pays 50 percent of the cost and is able to offer lower wage employees a basic benefit package similar to comprehensive private coverage. As of August 2002 there were over 12,000 enrollees in this program.<sup>69</sup>

Massachusetts also initiated the Medical Security Plan (MSP) which provides COBRA assistance of up to 80 percent of the premium (with caps of \$250 for an individual plan and \$598 for a family plan) to unemployed workers who earned up to 400 percent FPL. The MSP also provides a direct coverage option for people with incomes up to 200 percent FPL who have no ability to continue the coverage with their employer (e.g., there is no COBRA option). Other people can get a hardship waiver. Legislation for the MSP was passed in 1988, and the plan was implemented in 1993. The MSP is supported by a broad-based employer payroll tax; all employers with at least six employees pay \$16.80 per year per employee. This tax is dedicated to the support of the MSP.<sup>70</sup>

Massachusetts also incrementally expanded its programs between 1997 and 2002. During this time it expanded Medicaid, implemented a state-only funded program to deliver limited mental health services to immigrants, implemented a Medicaid buy-in program for the disabled and elderly, and implemented a drug discount program for the disabled and elderly.

**New Mexico** was granted the third and most recent HIFA waiver in August 2002. Under the waiver, the state will use its unexpended SCHIP funds to subsidize health insurance coverage through private insurers. The coverage will be offered to low-income, uninsured workers by their employers. Participants will not receive the full Medicaid package. They will receive a benefit package similar to a basic commercial plan with maximum annual benefits of \$100,000. The coverage will be financed with

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<sup>68</sup>Maine Small Business Health Coverage Plan, 22 MRSA c. 854 (2002).

<sup>69</sup>Amy Lischko, Assistant Commissioner of the Massachusetts Division of Health Care Finance and Policy, August 28, 2002.

<sup>70</sup> Personal communication from Stephanie Anthony, Director, Federal and National Policy Management, Massachusetts Division of Medical Assistance, November 14, 2002.

state and federal funds, employer contributions (\$75 a month per person), and employee premiums ranging from \$20 to \$35 per month, depending on income. Individuals with incomes less than 100 percent FPL will not be required to pay a monthly premium. Individuals not associated with an employer can receive coverage by paying the employer and individual share or by obtaining another sponsor to pay those costs. Under this initiative, New Mexico proposes to insure up to 40,000 additional individuals.<sup>71</sup>

**New York:** *Healthy New York* is a state-sponsored health insurance program for businesses with fifty or fewer employees and for individuals who buy their own coverage. Its intent is to address the high cost of coverage for low-income workers and small employers by creating a standardized product of limited benefits that is offered by all HMOs in New York and subsidized by the state, through the creation of a stop-loss fund which pays for up to 90 percent of the costs of enrollees with annual claims between \$30,000 and \$100,000. The plan also depends on higher cost sharing or co-payments by employees. The benefits package is comprehensive but is exempt from state requirements to cover services such as mental health, home health care, chiropractic care, and outpatient treatment of alcoholism and substance abuse. As of March 15, 2002, there were approximately 6,000 enrollees.<sup>72</sup>

**Oregon** received approval for a §1115 waiver in October 2002 that will expand and restructure the Oregon Health Plan (OHP) by creating a new and reduced benefits package for adults without children (with incomes up to 185 percent FPL) while retaining the current package for categorical Medicaid and general assistance eligibles. While not as comprehensive as the current package, the new benefits would be equivalent to those offered in the private market. The plan will provide insurance to 56,000 additional residents. Oregon also looks to expand its program that subsidizes employment-based coverage.<sup>73</sup> The waiver will allow children and adults to choose to enroll in an employer sponsored plan under FHIAP even if they are eligible for Medicaid or SCHIP.

**Pennsylvania:** The program *adultBasic* was implemented July 1, 2002, and is designed to provide basic health coverage to adults aged 19 to 64 with incomes up to 200 percent FPL. It is funded with \$76 million from the tobacco settlement, and program administrators expect to be able to cover 42,000 to 43,000 people with this money. Participants pay a \$30 monthly premium with co-payments and

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<sup>71</sup>“HHS Approves New Mexico Request to Expand Health Insurance Coverage to 40,000 People,” *HHS News*, August 23, 2002. [Http://www.hhs.gov/news/press/2002pres/20020823a.html](http://www.hhs.gov/news/press/2002pres/20020823a.html).

<sup>72</sup> New York State Insurance Department. *Healthy NY: Health Insurance for the Uninsured Program Website*. (The Department, September, 2002) <http://www.ins.state.ny.us/healthny.htm>. Another report that examines the Healthy New York Program in more detail is: Katherine Swartz, *Healthy New York: Making Insurance More Affordable for Low-Income Workers*, Commonwealth Fund Report 484, November 2001.

<sup>73</sup><http://cms.hhs.gov/hifa/orapp.pdf>

receive physician, hospital, and accident and emergency coverage from private health plans. The program had 29,406 participants as of November 2002.<sup>74</sup>

**Rhode Island's** RIteShare program is an example of a premium assistance approach which builds on employer-based coverage. Rhode Island requires that all individuals and families eligible for RIteCare (Medicaid/SCHIP demonstration program) and with access to employment-based coverage must enroll in RIteShare. RIteShare pays for the employee's share of the premium and the employee's co-pays. It also pays for the difference in benefits between the employer plan and the RIteCare plan.<sup>75</sup>

Rhode Island also built—on the structure of its RIteCare program—an innovative program for child care workers. This program addressed the problems of high turnover rate in the child care workforce and lack of access to affordable health insurance among that workforce. In 1997 Rhode Island allowed qualified certified family child-care providers and their minor children (under 18 years of age) who live with them to be covered by health insurance through the state's RIteCare program if they met the criteria for program eligibility and if they had no other health coverage. In 1999, this coverage was extended to employees of licensed center based child care programs and provided for an employer buy-in to the program. The state program reimburses employees 50 percent of their health care insurance costs, if their employer (the child care center) pays at least 50 percent of the cost of the insurance. (In other words, the center pays at least 50 percent of the cost of the insurance, and the employee and the state split the remaining premium cost.) To be eligible, providers and centers must be certified by the state and serve a certain number of DHS subsidized, low-income children. In fiscal year 2002, the state will contribute \$1.9 million of general revenue to this program, which will insure 1,255 additional individuals.

An additional initiative in Rhode Island consists of legislation enacted at the close of the 2002 session that allows the town of Scituate to establish the first population-based primary care practice in the United States. Under this plan, participants would pay \$200 per year to support a primary care health center that would actively service plan members. In addition, each participant has a medical savings account (MSA) backed up with a high deductible health plan, paid for by the individual or employer. The Scituate plan will start by being offered to municipal employees in 2003. The state legislature has enacted a \$200 tax credit for all participants.<sup>76</sup>

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<sup>74</sup>PA Department of Insurance, *Facts about adultBasic: Working Toward a Healthier Pennsylvania*, (Philadelphia, PA: PA Department of Insurance, last updated October 2002). <http://www.insurance.state.pa.us/html/adultbasic.html>. Enrollment figures updated by Pat Stromberg, Executive Director, *adultBasic*, Pennsylvania Department of Insurance, November 15, 2002.

<sup>75</sup><http://www.dhs.state.ri.us/dhs/drishar.htm>

<sup>76</sup>Rhode Island Department of Human Services. *Subsidy for Health Insurance for Center-Based Child-Care Providers*. (Cranston, RI: RI DHS, Downloaded September, 2002). <http://www.dhs.state.ri.us/dhs/heacre/dinsccf.htm>

*Utah* was granted a §1115 demonstration waiver that allows the state to offer a reduced benefit package to adults aged 19 and over whose annual incomes are under 150 percent of the federal poverty level (FPL). It also allows the state to exercise an option to institute an annual \$50 enrollment fee for these newly eligible enrollees and others who are eligible for Medicaid. Coverage for newly enrolled adults will consist of a package of primary and preventive care services. These include physician visits (excluding specialists), lab, radiology, durable medical equipment, emergency room services, pharmacy, dental, and vision. Enrollees will not be eligible for in-patient hospital or long-term-care services. Hospitals in Utah have agreed to donate \$10 million in hospital services. The state also has commitments for donations of specialty care provided in an in-patient setting. A second demonstration will provide to high-risk pregnant women the full Medicaid benefit package available under the state plan.<sup>77</sup>

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<sup>77</sup><http://cms.hhs.gov/hifa/hifaadem.asp>