



STATE AND LOCAL INITIATIVES TO ENHANCE HEALTH COVERAGE FOR THE WORKING UNINSURED

Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer
Economic and Social Research Institute

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INTRODUCTION

This report presents brief descriptions of state and local initiatives to expand health insurance coverage for uninsured working people and their families. These sketches illustrate the many different ways that states and local communities can make coverage more affordable and accessible to this vulnerable population. Our primary focus is on initiatives that promote employment-based health insurance, but we include examples of coverage initiatives not targeted solely to employers or employees but that enroll many working uninsured individuals.

This report is not intended to include every state and local effort to improve access to health insurance for the uninsured. It focuses primarily on programs that target employers and employees directly, but also includes a sample of programs that target a broader population of uninsured, which include many workers and their families. It does not, however, include programs that primarily target children or that include adults only if they have children or are pregnant.

Most of the programs included in this report involve direct subsidies to employees and/or employers to help them purchase private insurance through the workplace. A few initiatives involve state efforts to make private insurance plans more accessible to very small firms and individuals without subsidizing the premiums. Others involve states reinsuring private health plans, helping indirectly to reduce the premiums charged to employers and employees. Finally, the report includes a few examples of managed care and Medicaid expansion programs that make publicly-sponsored coverage available to low- and moderate-income people—a group that includes many uninsured workers and their families.

This compilation of state and local initiatives is intended to help policymakers and others understand the range of efforts being undertaken around the country. It is hoped that learning about the variety of design features and experiences will lead to greater efforts to find workable solutions to the problem of uninsured workers and their families.

Background

Workers and their families who do not have access to affordable, employer-based health insurance make up the majority of the 42.6 million uninsured people in the United States.¹ They are highly vulnerable Americans who can be financially ruined by any type of serious illness, disease, or accident. These are people who are fulfilling their end of the social contract by working, but remain unprotected against the costs of illness and disability.

¹ More than four of five people without health coverage live in the household of someone who works.

Some 34 million people work for an employer who offers no health coverage, and about 14 million of them lack coverage from any source. Another 3.7 million people are uninsured because they are ineligible for their employer's health coverage, while some 2.5 million are uninsured because they turn down an employer's offer.² Most of these people believe that they cannot afford their share of the premium.

Indeed, a majority of the working uninsured have incomes that place them in the poor or near-poor category. They tend to have low wages and often work part-time. Some have two or more jobs, and many change jobs frequently. Many work for small companies. In fact, only 55 percent of firms with three to ten employees offered health coverage in 1999, compared with more than nine of ten firms with 50 or more workers.³

Small companies face higher premiums in the private insurance market than do larger firms. Many small firms operate on a thin profit margin, and cannot afford to purchase coverage for their workers. Some small businesses are reluctant to offer coverage to workers who may leave after a few months.

Finding Ways to Insure Workers

A number of states and counties have been experimenting with ways to make health insurance more affordable and accessible to employers and workers. Many states use the flexibility afforded them under the federally matched Medicaid and State Children's Health Insurance Programs (S-CHIP), for example, to expand eligibility to low- and moderate-income working families. Health Insurance Premium Payment (HIPPP) programs, authorized under §1906 of the Social Security Act, allow states to subsidize employer-sponsored coverage for workers with Medicaid-eligible family members. Some states use revenues from tobacco and alcohol taxes, hospital services, or other sources to create insurance options for people who contribute to premiums on a sliding scale based on income and family size. One state offers tax credits to employers newly offering coverage to their workers. A few states are combining the various funding sources in new ways to promote private, employment-based coverage.

Some counties and local communities are also involved in initiatives to expand health coverage to uninsured working people. Some target small businesses, and subsidize premiums that also are shared by employers and employees. Other local initiatives involve creating managed care programs and enrolling low- to moderate-income individuals and families who do not have access to public or employer-sponsored insurance.

² Thorpe, Kenneth E. and Curtis S. Florence. "Why Are Workers Uninsured? Employer-Sponsored Health Insurance in 1997." *Health Affairs* 18 (March/April 1999): 213-18.

³ Kaiser Family Foundation/Health Research and Educational Trust. *1999 Annual Employer Health Benefits Survey* (Washington, DC: October 1999).

Tables 1 and 2 summarize the state and local initiatives, respectively (a few proposed or planned state programs are summarized as well). Following these summary tables are sketches of the initiatives. Each sketch includes a brief overview of the program, target population, number of participants, eligibility criteria, type and amount of subsidy, and other information. Also provided is a contact person at each program who can provide additional information and answer specific questions about the program.

SUMMARY TABLE 1
STATE INITIATIVES TO IMPROVE ACCESS
TO THE WORKING UNINSURED

Summary Table 1: State Initiatives to Improve Access to the Working Uninsured

State	Name of Program	Program Description	Target Population	Eligibility	Enrollment	Financing
Arizona	Healthcare Group of Arizona	Reinsures participating health plans against high losses, making coverage accessible to small businesses and self-employed people, particularly to high-risk individuals priced out of private market.	Small firms and their workers/dependents, self-employed people	Business with 1–50 employees; firms with 1–5 workers must have 100% participation, firms with 6–50 workers must have at least 80% participation	11,559 people in 3,610 small businesses (6/00)	\$8 million annual state funds toward reinsurance; employer and/or employee pay the full premium
Arizona	Premium Sharing Program (PSP)	3-year, 4-county pilot program provides subsidized HMO coverage to uninsured low-income people who contribute up to 4% of income (family) or 2.5% of income (single).	Low-income uninsured ineligible for Medicaid	Income up to 200% of FPL; uninsured (except Medicaid) over prior 6 months	6,276 people in 4,393 households (6/00)	\$20 million annual state allocation funded by tobacco tax
Iowa	Health Insurance Premium Payment (HIPP) Program	State Medicaid program subsidizes employer-sponsored private insurance for Medicaid-eligible people and, if necessary, their families when such coverage is available and when it is cost-effective.	Medicaid-eligible people and their family members with access to private, employer-sponsored coverage	Meet Medicaid income guidelines; have access to employer-sponsored plan; and meet cost-effectiveness test	Approximately 8,500 people, including 3,000 non-Medicaid-eligible family members (4/00)	State and federal Medicaid funds
Kansas	Small Employer Tax Credit	Refundable tax credits to small employers newly offering coverage. In years 1 and 2, credit is \$35 per month per employee or 50% of total annual premium, whichever is less. The tax credits phase out over 5 years.	Small firms not providing insurance	Firms with 2–50 workers not offering coverage over prior 2 years	62 firms (5/00)	State funds
Massachusetts	Insurance Partnership	Subsidizes employer share of work-based coverage: \$400 (individual), \$800 (couple or adult plus child), \$1,000 (family) per year per employee with income up to 200% of FPL.	Small firms with low-income workers, and self-employed	Firms with 1–50 workers in which employer contributes at least 50% of premium	Approximately 800 firms enrolled; approximately 1,500 people subsidized (5/00)	Medicaid 1115 waiver, S-CHIP, state funds

State	Name of Program	Program Description	Target Population	Eligibility	Enrollment	Financing
Massachusetts	Premium Assistance Program	<p>Subsidizes employee share of work-based coverage.</p> <p>For families 100%–200% of FPL with children, employee contributes \$10/child/month up to \$30/family. For families 100%–200% of FPL without children, employee contributes \$25/adult, \$50/couple.</p> <p>For families under 100% of FPL, subsidy covers full employee share plus wraparound services.</p>	Low-income workers in small businesses and low-income workers with children	Income up to 200% of FPL; work for small firm OR have children; employer pays at least 50% of the cost of work-based insurance	Approximately 10,000 people (including the 1,500 Insurance Partnership participants) (5/00)	Medicaid 1115 waiver, S-CHIP, state funds
Minnesota	MinnesotaCare	Managed care program for working uninsured residents and their families with incomes up to 275% of FPL; single adults and couples without children up to 175% of FPL.	Low- to moderate-income uninsured residents of Minnesota	Uninsured resident of Minnesota without insurance for 4 months; no access to employer-based insurance where employer pays 50% or more of premium for 18 months; meet income guidelines (families with children up to 275% of FPL; adults without children up to 175% of FPL)	116,472 enrollees, including over 39,000 adults with children and over 18,000 adults without children (4/00)	Enrollee premiums (sliding scale based on family size and income); 1.5% provider tax; state and federal Medicaid funds for waiver expansion population
New Mexico	New Mexico Health Insurance Alliance	Makes HMO and indemnity plans accessible to small businesses, self-employed people, and individuals who lose their group coverage, with guaranteed issue and modified community rating.	Small businesses, self-employed people, and individuals who lose their coverage	Businesses with 2–50 employees in which at least 50% of workers enroll in the Alliance; self-employed and purchasing insurance for self and at least one family member; individuals who lost group coverage and exhausted COBRA and continuation plan over prior 2 months.	Approximately 7,800 people, through 2,400 small business accounts and 600 individual policyholder accounts (8/00)	Premiums cover insurance; assessment on all insurers in state finances administrative costs

State	Name of Program	Program Description	Target Population	Eligibility	Enrollment	Financing
New York	Healthy New York	Requires HMOs to offer scaled-down health plans (exempt from certain state-mandated benefits) and provides stop-loss protection to health plans, thereby making lower-cost plans available.	Small firms with low/moderate-income workers not providing insurance, and uninsured low/moderate-income workers and sole proprietors	Firms: without coverage during prior 12 months; with 50 or fewer workers; at least 30% of workforce has income at or below \$30,000; at least half of workforce participates; contribute at least 50% of premium. Individuals: no access to work-based insurance and uninsured over prior 12 months; income up to 250% of FPL	Enrollment begins 1/1/2001	State funding
New York	New York State Health Insurance Partnership Program (NYSHIP)	Subsidizes private insurance up to 45% of premium, with employee contributions limited to no more than 10%. The program is being phased out by mid-2003.	Small firms not providing insurance, and uninsured, low/moderate-income self-employed	Firms with 1–50 workers OR self-employed with income below 222% of FPL; no coverage over past 12 months	Approximately 1,100 firms (12/99)	State-financed through provider/health care service assessments
Oregon	Family Health Insurance Assistance Program (FHIAP)	Sliding-scale subsidy toward purchase of private coverage through FHIAP participating plan. Subsidy is 95% of premium if income is below 125% of FPL; 90% if income is 125%–150% of FPL; and 70% if income is 150%–170% of FPL. If employer offers and contributes toward coverage, the subsidy is applied toward the employee's share of the premium for employer plan.	Uninsured low-income workers and their families	Income up to 170% of FPL; investments/savings less than \$10,000; uninsured (except Medicaid) over prior 6 months	4,131 people (6/00); 768 through employer health plan Due to capped enrollment, approximately 23,400 individuals are on waiting list for applications	State tobacco tax

State	Name of Program	Program Description	Target Population	Eligibility	Enrollment	Financing
Vermont	The Vermont Health Access Plan	Medicaid expansion offering comprehensive coverage through a Primary Care Case Management Plan.	Low-income uninsured adults	Income up to 150% of FPL; adult; uninsured for previous year	Approximately 18,500 people (5/00)	Medicaid 1115 waiver State tobacco tax
Washington	The Basic Health Plan	Sliding-scale subsidy toward purchase of coverage from among 9 participating private health plans. Available to individuals and through employer, provider, other group sponsors.	Low-income working families	Income up to 200% of FPL (can be above 200% of FPL in one county)	130,000 “regular subsidized;” 1,214 through employer-sponsored (5/00)	State taxes on hospitals, alcohol, tobacco products
Wisconsin	BadgerCare	Subsidizes coverage through Medicaid HMO; families >150% of FPL contribute 3% of income.	Low-income uninsured families	Income up to 185% of FPL; uninsured	64,620 people (4/00)	Adults: Medicaid 1115 waiver Children: S-CHIP Enrollee premiums
Wisconsin	BadgerCare’s Health Insurance Premium Payment (HIPP) Program	Pays employee’s share of employer-based insurance for family coverage, cost-sharing, and wraparound services; families >150% of FPL contribute 3% of income.	Low-income uninsured families with access to employer-based coverage	Income up to 185% of FPL; uninsured with access to employer plan; and employer pays 60%–80% of premium; must be cost-effective to state	3 families (6/00)	Adults: Medicaid 1115 waiver Children: S-CHIP Enrollee premiums

Additional Proposed or Planned State Initiatives

State	Name of Program	Program Description	Target Population	Eligibility	Financing	Status
Kansas	Kansas Business Health Partnership	Nonprofit partnership would offer at least 2 low-cost health plans (exempt from some state-mandated benefits) to small businesses, and subsidize premiums for low/modest income employees.	Small employers and their low-income workers	Income less than 200% of FPL; work for small firm that has never offered insurance OR majority of employees have income up to 200% of FPL; and at least 70% of workers participate	Combines federal and state subsidies with employer and employee contributions	Bill signed by governor May 15, 2000; effective July 1, 2000; could issue RFP in Fall 2000
New Jersey	FamilyCare	Program will provide free and low-cost health insurance to uninsured adults through a combination of Medicaid expansion, state-only managed care, and employer subsidy programs. Will subsidize premiums in employer-based health plan if applicant has access to work-based coverage where employer contributes at least 50% of the premium.	Low-income uninsured working parents and single adults	Uninsured parents with income up to 200% of FPL (Medicaid expansion for those up to 133% of FPL, state managed care plan for those from 133% to 200% of FPL, employer-based plan when accessible); uninsured childless adults with income up to 100% of FPL	State tobacco settlement funds (\$100 million per year), and expected federal matching funds (\$48 million), state funds (\$29 million), and employer (\$24 million) and employee (\$5 million) contributions; enrollment for non-Medicaid expansion will be capped to keep within appropriated amounts	Signed by governor July 13, 2000
Virginia	Health Insurance Demonstration Project	Program would provide about 30% premium subsidy toward HMO plan under contract with the state; the employer contributes at least 50% of cost of employee-only coverage, and employee pays remainder.	Low-income uninsured workers in small businesses	Full-time worker of small firm (up to 50 employees); income less than 200% of FPL; no access to work-based coverage over prior 12 months; employer agrees to pay at least 50% toward employee coverage	Will rely on private funding sources combined with employer and employee contributions	Fell through in Fall 1999 because unable to obtain HCFA waiver and one major hospital pulled out; if new funding is assured, program will be implemented

SUMMARY TABLE 2
LOCAL INITIATIVES TO IMPROVE ACCESS
TO THE WORKING UNINSURED

Summary Table 2: Local Initiatives to Improve Access to the Working Uninsured

Location	Name of Program	Program Description	Target Population	Eligibility	Enrollment	Financing
Boston, Massachusetts	Boston HealthNet Pilot Plan	Managed care program for the uninsured up to 200% of FPL; eligible individuals receive free care.	Uninsured residents of Boston with incomes at or below 200% of FPL	Patients qualifying under the income guidelines of the state's uncompensated care pool	68,565 (5/00)	Amount to cover receipt of care drawn from state uncompensated (free) care pool; amount varies according to demand for services; annual budget in 1999 = \$94 million
Denver, Colorado	Denver Health - Small Business Premium Subsidy Program	Premium subsidy program for employers with 2–50 employees. Employers purchase a small business HMO benefit product through the Denver Health Medical Plan. Subsidy is worth 20%–50% of the premium for both the employer and employee.	Employers and employees of small, low-income businesses without health coverage	Firms with 2–50 workers not offering coverage in prior 90 days; Net income at or less than \$50,000 the previous year	19 businesses (5/00) receive the subsidy (73 businesses purchase the Small Business HMO product)	5-year, \$5 million grant from The Colorado Trust and W.K. Kellogg Foundation funds subsidy; employer and employee pay remaining premium
Lansing, Michigan	Ingham Health Plan	Health coverage program for uninsured residents of Ingham County up to 250% of FPL; exploring small business subsidy program for 1,000–3,000 low-income workers.	Uninsured residents of Ingham County with incomes up to 250% of FPL; and former enrollees in the State Medical Plan program	Uninsured county residents up to 250% of FPL	10,000 enrollees including roughly 1,400 former SMP enrollees—roughly one-third of the uninsured in the county (6/00); projected to be 14,000 by 10/00	Local government health care funds for indigent; state funds from SMP; federal Medicaid matching funds combine into special “DSH” payment to the local participating hospital that contracts with county to provide direct services/ conduct enrollment; copayments from enrollees

Location	Name of Program	Program Description	Target Population	Eligibility	Enrollment	Financing
Marion County, Indiana (Indianapolis)	Wishard Advantage	Managed care program for uninsured residents of Marion County up to 200% of FPL.	Uninsured residents of Marion County with incomes up to 200% of FPL	Marion County residents up to 200% of FPL not on any other assistance program	22,000 (6/00)	Capitalized with \$20 million in federal DSH match; the program currently is financed through city and county property taxes totaling \$76 million; enrollees from 150% to 200% of FPL contribute to the cost of care based on income level
Muskegon, Michigan	Access Health	Health coverage product for the working uninsured targeted to small and medium-size businesses (up to 150 eligible employees).	Full- or part-time working uninsured individuals in small and medium-sized businesses in Muskegon County	Small and medium-sized businesses in Muskegon County with up to 150 “eligible” employees (not seasonal, temporary or otherwise insured); not providing insurance for 12 months; median wage of eligible employees of \$10 per hour or less	155 small to medium-size businesses (6/00)	Three-way shared buy-in among employer (30%), employee (30%), and community match (40%), comprised of federal DSH funds and local government, community and foundation funds
New York, New York	Small Business Health Insurance	Comprehensive, low-cost health insurance product for small businesses in select sections of Manhattan, Kings, and Bronx Counties.	Small businesses with 2–50 employees	Small businesses with 2–50 employees; select zip codes in East Harlem, South Bronx, and Northern Brooklyn	234 individuals in 25 small businesses; average size of business is 4.5 employees (6/00)	Low-cost premiums (less than half the cost of competitors in the area) through 4-tier premium structure split between employer and employee (split varies by employer)

Location	Name of Program	Program Description	Target Population	Eligibility	Enrollment	Financing
San Diego, California	FOCUS (Financially Obtainable Coverage for Uninsured San Diegans)	Premium assistance program for small employers (less than 50 employees) and low- to moderate-income employees (roughly 300% of FPL). The program is a partnership between Sharp Health Plan and Alliance Healthcare Foundation.	Small businesses (50 or fewer employees) and full-time employees up to 300% of FPL	Small businesses not providing coverage for 12 months; full-time employees with incomes up to 300% of FPL previously uninsured; all eligible dependents must also enroll	1,699 employees and 216 businesses (6/00)	\$1.2 million grant from Alliance Health Foundation; \$400,000 grant from California Endowment; fixed employer contributions; sliding scale for employees
Wayne County, Michigan	HealthChoice	Subsidized managed care program for businesses with three or more employees.	Employers and employees of Wayne County businesses with three or more workers	Wayne County businesses with 3+ workers with average wage of \$10 or less that have not offered insurance in past 12 months; employees must work more than 20 hours a week for over 5 months and be ineligible for other coverage	19,019 employees and 1,977 small businesses (6/00)	Premium split one-third among employer, employee, and HealthChoice (from hospital indigent care pool financed by state Medicaid, federal Medicaid matching, and county general funds).

STATE SKETCHES

Arizona

Healthcare Group of Arizona

Overview

The Healthcare Group of Arizona (HCG) was established by the state legislature to make health insurance more accessible to the small business community. It offers prepaid medical coverage from three HMOs (that also have AHCCCS contracts) to businesses with 1 to 50 employees.⁴ There are no income requirements, and no requirements that the employer did not previously offer coverage or that the enrollees were previously uninsured.

Whereas most insurers market only to groups with more than five employees, HCG is available to very small firms as well. Participating health plans are required to accept all full-time workers in small firms, regardless of health status, and to charge a modified community rate. As a result, the program evolved into a high-risk pool, with many employers enrolling healthy workers in commercial plans and high-risk workers in HCG. The participating health plans were experiencing losses and threatening to leave the program. The state legislature responded by providing funds to reinsure the health plans against high losses, and changing some rules to improve the viability of the program. After declining enrollment for many years, HCG is now stable at about 11,500 members.

Location

Statewide in Arizona.

Target Beneficiaries Number of Participants

Small businesses, their workers and families, and self-employed individuals.

As of June 3, 2000, the program enrolled 11,559 people from 3,610 small business groups. Among enrollees were 2,513 dependent children.

Time Frame

The program was implemented in 1988.

Eligibility

Businesses are eligible to purchase HCG coverage if they:

- Have been located within the state for the past 60 days or more.
- Have 1–50 employees or are self-employed individuals.
- Achieve 100% participation of eligible employees if firm size is 1–5 employees.⁵
- Achieve at least 80% participation of eligible employees if firm size is six or more employees.

Amount of Subsidy

The state subsidizes coverage indirectly by reinsuring the participating health plans to keep them viable. The state does not directly subsidize premiums, which are fully

⁴ It is also available to political subdivisions (employees of the State, counties, cities, towns, school districts and agricultural districts); however, only 219 people are enrolled through this source.

⁵ Employees with proof of group coverage through another family member or a public health care program may be excluded from participation calculation.

paid by employers and/or employees (there is no requirement regarding the premium share contributed by employer and employee). Premiums are determined by the level of copayments, deductibles, and cost-sharing selected by the employer, the age of each enrollee, and the tier selected (employee-only, employee plus one dependent, and employee plus at least two dependents).

Due to modified community rating, the cost of HCG coverage for high-risk individuals is lower than (medically underwritten) market rates, but for healthy individuals HCG premiums are higher than market rates.

A number of program features aim to keep the cost down. New rules have been implemented to reduce adverse selection in the program, including higher participation rate requirements and a more stringent definition of “full-time” employee. HCG coverage is more “bare-bones” than many commercial plans and thus is more affordable to many small businesses. HCG does not require that the employer contribute to the premium, thereby reaching small businesses in which the owner cannot afford premium contributions. Further, administrative costs are kept low.

Coverage

Three health plans cover inpatient hospital services, outpatient services, physician visits, prescription drugs, lab/radiology/imaging, and emergency services.

Outreach and Marketing

There is little active marketing of the program due to conditional funding for the future.

Financing

When the state authorized the program, it did not provide funds. Start-up costs were financed through a \$700,000 grant from the Robert Wood Johnson Foundation. Participating health plans were charged \$4 per member per month to cover administrative costs, and employers and employees paid the full cost of coverage. With health plans losing money and threatening to cease participation, the state appropriated \$8 million to the health plans in 1998, and made additional changes to help stabilize the program. The state contributes \$8 million per year to reinsure the health plans for catastrophic claims (\$100,000 and above) and to allow the plans to earn up to 2% profit. Premiums continue to be paid by subscriber premiums without direct state subsidies.

Contact for More Information

Leigh Cheatham, Executive Director, Premium Sharing Program and Healthcare Group of Arizona, (602) 417-6700, e-mail: lacheatham@ahcccs.state.az.us.

Sources: *Healthcare Group Information Sheet; HCG Monthly Report*, June 3, 2000; *Health Policy for Low-Income People in Arizona*, The Urban Institute, November 1999; Personal communications with Leigh Cheatham, Executive Director, Premium Sharing Program and Healthcare Group of Arizona, Arizona Health Care Cost Containment System (AHCCCS), June 2000.

Arizona

Premium Sharing Program (PSP)

Overview	Arizona's Premium Sharing Program (PSP) is a three-year demonstration project passed by the state legislature in 1997. PSP was designed to enable low-income families not eligible for Medicaid to purchase low-cost health insurance. Administered by the Premium Sharing Administration, a subdivision of the Arizona Health Care Cost Containment System (AHCCCS), this pilot program is available in four counties and is scheduled to end October 2001. There is some support, however, to make the program statewide and permanent after the pilot ends.
Location	Cochise, Maricopa, Pima, and Pinal Counties.
Target Beneficiaries	Low-income uninsured individuals ineligible for Medicaid (AHCCCS), particularly parents of children in AHCCCS or KidsCare. The target enrollment is 7,000.
Number of Participants	As of June 1, 2000, there were 6,276 individuals in 4,393 households enrolled in the program. Enrollees are typically working women, including single mothers.
Time Frame	Enrollment began in February 1998; the program is scheduled to end in October 2001, unless it is extended by the legislature.
Eligibility	<p>To be eligible for the program, individuals must:</p> <ul style="list-style-type: none">• Reside in Cochise, Maricopa, Pima, or Pinal County.• Be a U.S. citizen or legal alien.• Have gross annual household income not exceeding 200% of FPL unless the participant is chronically ill; (chronically ill participants with income from 200% to 400% of FPL may be eligible if they have been enrolled in the AHCCCS Medically Needy/Medically Indigent program for 12 of the preceding 15 months; only three enrollees fit this description as of June 2000).• Have been without health coverage (other than AHCCCS) during the past six months.• Not be eligible or receiving benefits under Medicare, SSI for disability or blindness, VA, or AHCCCS. <p>All household members without insurance must participate. Eligibility does not guarantee participation. If expenditures reach the funding level of \$20 million per year, enrollment would close and applicants would be placed on a waiting list.</p>
Amount of Subsidy	The subsidy amount is determined by the household gross annual income, with premium payments by the family not exceeding 4% of income for a family or about 2½% for a single person. (An exception is for chronically ill people above 200% of FPL, who pay the full premium of \$410 per month per family member enrolled). The average enrollee contribution is \$21 per month.

Coverage	A comprehensive benefits package includes inpatient and outpatient hospital services, physician services, prescription drugs, lab/radiology/medical imaging services, emergency services including emergency dental and transportation services, behavioral health, and transplants for chronically ill members.
Process	Applications are mailed in; applicants deemed eligible receive a packet including a list of health plans and primary care providers available in their county. Three HMOs participate, and there is a choice of at least two HMOs in each of the four counties. If the enrollee does not make a selection, the enrollee is assigned a health plan and primary care provider by the program.
Outreach and Marketing	Information is available at community colleges, churches, clinics, community centers, and through referrals from AHCCCS.
Financing	Program costs are financed through an allocation of \$20 million per year for three years, funded by a tobacco tax. Administrative costs are limited to 4% of total program costs.
Contact for More Information	Leigh Cheatham, Executive Director, Premium Sharing Program and Healthcare Group of Arizona, (602) 417-6700, e-mail: lacheatham@ahcccs.state.az.us.

Sources: *Premium Sharing Program Monthly Summary Report*, June 3, 2000; Personal communications with Leigh Cheatham, Executive Director, Premium Sharing Program and Healthcare Group of Arizona, AHCCCS, June 2000.

Iowa

Health Insurance Premium Payment (HIPP) Program

Overview

Iowa operates the oldest and one of the largest Health Insurance Premium Payment (HIPP) programs. Authorized under Section 1906 of the Social Security Act, HIPP programs subsidize enrollment in employer-sponsored private health insurance for Medicaid-eligible people and their families who have access to such coverage and if it is cost-effective to do so (compared with the cost of regular Medicaid coverage). States are authorized to use Medicaid funds on premiums, deductibles, and coinsurance for the job-based coverage, and are required to provide “wraparound” services if the employer’s benefit package is more limited than the normal Medicaid package.

Only three states (Iowa, Texas, and Pennsylvania) are considered to have “aggressive” HIPP programs. Even among these programs, however, HIPP beneficiaries tend to represent less than 1 percent of the total Medicaid population. Small enrollment is attributed to a number of factors: most Medicaid-eligible people do not have access to employment-based coverage; it is difficult for the state to identify Medicaid applicants or enrollees with access to job-based insurance; and it is difficult to obtain needed information from the employer and applicant.

This example of a HIPP program is included because although the program targets Medicaid-eligible people (versus uninsured workers, the focus of these sketches), a significant portion of HIPP beneficiaries (35% in Iowa) comprises non-Medicaid-eligible family members. Many of these family members are working parents of Medicaid-eligible children, who are unable to afford their share of employment-based insurance premiums and would be uninsured without the program. Thus, HIPP programs offer one avenue for states to expand employment-based coverage to low-income workers, while achieving cost savings, receiving federal matching funds, and keeping families together in one insurance plan.

Location

Statewide in Iowa.

Target Beneficiaries

Medicaid-eligible people and their families who have access to employment-based health insurance.

Number of Participants

As of May 1, 2000, approximately 8,800 people were enrolled in HIPP-subsidized employment-based health plans. About 5,700 of these were Medicaid-eligible, and 3,100 were non-Medicaid-eligible family members.

Time Frame

The program started in 1991.

Eligibility	HIPP beneficiaries must:
	<ul style="list-style-type: none"> • Have a family member eligible for Medicaid. • Have access to employer-sponsored coverage. • Meet cost-effective criteria: enrolling the family would save the state at least \$5 per month (special medical conditions that may increase the cost of coverage to the Medicaid program are considered in the evaluation).
Amount of Subsidy	The state pays the employee's share of the premium for family coverage. The state also pays for copayments and deductibles for the Medicaid-eligible enrollees, but not for the other family members.
Coverage	The program reimburses premiums, deductibles, and coinsurance directly to the enrollee. Enrollees must visit providers associated with the private plan and who have contracted with Medicaid. The providers then bill the private plan first, and then Medicaid for deductibles and coinsurance. Medicaid-eligible enrollees may receive wraparound services from Medicaid providers, who are reimbursed directly from the state.
Process	All income-eligible Medicaid applicants are screened to determine whether they have access to employer-sponsored insurance. If so, Medicaid eligibility workers forward the applications to the HIPP office, where workers conduct a cost-benefit evaluation. If it is deemed cost-effective to subsidize the applicant in the private plan, the applicant is required to enroll in the private plan (if the employee must wait for an open-enrollment period, regular Medicaid coverage is provided until enrollment occurs). If family coverage must be purchased for the applicant to obtain coverage, then HIPP subsidizes family coverage that may include non-Medicaid-eligible parents and children. The employer may choose whether to receive HIPP payments for the employee share of the premium directly, or whether payment should be sent directly to the worker. ⁶
Outreach and Marketing	The state does not actively market HIPP to employers or potential enrollees, although HIPP staff gives presentations about the program to community groups. A HIPP brochure is included in Medicaid application packets, and Medicaid eligibility workers are educated about the program.
Financing	State and federal matching Medicaid funds.
Contact for More Information	Kaye Kellis, Policy Specialist & Supervisor, HIPP Unit, Iowa Department of Human Services, (515) 281-9367, e-mail: kkellis@dhs.state.ia.us .

Sources: Sexton, Jennifer. *Overview of the Iowa Health Insurance Premium Payment HIPP Program*. Institute for Health Policy Solutions, February 4, 2000; *Medicaid: Three States' Experiences in Buying Employer-Based Health Insurance* (Letter Report, 07/25/97, GAO/ HEHS-97-159); Steinberg, Dan. *Expanding Health Coverage to Working Families: State Options*. National Conference of State Legislatures, June 2000; Personal communications with Kaye Kellis, Policy Specialist & Supervisor HIPP Unit, Iowa Department of Human Services, June 2000.

⁶ A small portion of HIPP beneficiaries receives subsidies toward individual private coverage if the coverage is available and cost-effective.

Kansas

Small Employer Tax Credit

Overview	In 1991, the Kansas legislature passed a tax credit for small employers who newly offer coverage, but the program was not publicized—and therefore not utilized—until after the bill was slightly revised in 1999. One important revision was to make the tax credit <i>refundable</i> to businesses whose credit exceeds the state taxes owed (the original version allowed the credit to be carried over to succeeding years). The subsidy to each employer is designed to phase out over six years so employers do not establish ongoing dependence on the government.
Location	Statewide in Kansas.
Target Beneficiaries	Employers of small firms who do not offer health insurance to employees.
Number of Participants	As of mid-May 2000, 62 companies had been issued certificates to receive the tax credits. It will not be known until after tax filing year 2000 how many companies with certificates have actually purchased coverage and claim the tax credit.
Time Frame	Enrollment began in 1999.
Eligibility	Businesses with 2 to 50 employees that have not contributed to health insurance for employees in the previous two years are eligible. Self-insured firms are not eligible. Eligible employees are those working an average of at least 30 hours per week and who elect to participate in the firm's benefit plan.
Amount of Subsidy	Employers receive a tax credit for a portion of the contributions they make to health insurance for their employees, which is phased out according to the following schedule: <ul style="list-style-type: none">• Years 1 and 2: \$35 tax credit per month per employee or 50% of the total annual premium, whichever is less.• Year 3: 75% of the amount in years 1 and 2.• Year 4: 50% of the amount in years 1 and 2.• Year 5: 25% of the amount in years 1 and 2.• Year 6 and beyond: tax credit no longer available.
Coverage	The health plan sponsored by the employer must include state-mandated benefits for small group coverage.
Process	Eligible businesses applying for the tax credit receive a certificate from the state, which must be submitted when filing income taxes. In addition, the firm's insurance agent must sign a form certifying that the business has provided an employee health benefit plan during the previous year.

Outreach and Marketing

In 1999, the state insurance department began a publicity campaign geared toward small businesses consisting primarily of announcements in newspapers and magazines. Also, the state's Insurance Commissioner informs local Chambers of Commerce about the program in talks and meetings around the state.

Financing

State funds.

Contact for More Information

Craig VanAalst, Kansas Insurance Department, (785) 296-7850.

Sources: Personal communications with Craig VanAalst, Kansas Insurance Department, May 2000; *Access to Affordable Health Insurance for Kansas Small Businesses*, Kansas Insurance Department Publication; Kansas House Bill 2090, Session of 1999.

Massachusetts

MassHealth Family Assistance Program

Overview

Massachusetts' Division of Medical Assistance has developed and implemented the MassHealth Family Assistance Program, aimed to encourage and assist small employers in offering health insurance and to make employment-based coverage affordable to low-income employees and self-employed individuals. The program required a Medicaid §1115 waiver, which was approved in 1997 and runs through 2003. The program has two components:

- The *Insurance Partnership* offers subsidies to low-wage self-employed individuals and to small businesses to help pay for health insurance premiums for low-wage workers (up to 200% of FPL).
- The *Premium Assistance Program* offers subsidies to help low-wage workers pay their share of premiums.

MassHealth Family Assistance represents a creative combination of Medicaid expansion, S-CHIP, and state funds that is complex in its coordination of reimbursement and regulatory requirements, but offers a straightforward, seamless subsidy program to families and employers.

Location

Statewide in Massachusetts.

Financing

Combination of state-only funds, state Medicaid funds, federal Medicaid matching funds, and S-CHIP funds (with federal match at 65%).

Insurance Partnership

Target Beneficiaries Time Frame

Small businesses with low-income employees.

Enrollment began on a limited basis in 1999, but eligibility was expanded and a major enrollment campaign began in late January 2000.

Number of Participants

As of May 2000, about 800 employers have enrolled; Insurance Partnership subsidizes 1,100 policies representing 1,500 individuals (workers and family members).

Eligibility

Businesses are eligible for the subsidy if they:

- Employ 50 or fewer full-time (30 hours per week or more) workers.
- Offer comprehensive health insurance to workers (it is not necessary that it is "new" coverage).
- Contribute at least 50% of the premium.

Eligible firms are paid a subsidy for each “qualified employee”—state resident, ages 19 to 64, with gross family income up to 200% of FPL (see Premium Assistance Program, below).

Amount of Subsidy	The Insurance Partnership will pay \$400 (individual), \$800 (couple or adult plus child), or \$1,000 (family) per year toward the employer’s health insurance costs for each qualified employee.
Process	Each month, a participating employer receives a check or an electronic bank deposit that includes the Insurance Partnership payment and premium assistance payments for qualified employees. Payments are made for the following month’s premiums to avoid cash-flow problems for employers and workers.
Outreach and Marketing	<p>The Insurance Partnership is administered by Employee Benefit Resources Insurance Brokerage, Inc. (EBR). An advertising campaign geared to familiarize businesses, insurers, brokers, and workers about the program commenced in January 2000. It included:</p> <ul style="list-style-type: none"> • Mailings to insurance brokers and insurance companies. • Contacts with local Chambers of Commerce. • Radio announcements. • Television commercials. • Mailings to nonprofit organizations with 50 or fewer employees. • Seven regional representatives calling small businesses. • Telephone “cold calling” followed up with literature mailings to interested employers. • Print media (newspaper advertisements). • Billboard advertisements.
Contact for More Information	EBR, (781) 830-8282, Jack McGraff, ext.102, or Peter Terry, ext. 101.

Premium Assistance Program

Target Beneficiaries	Low-income workers in small businesses, low-income workers with children in any size firm, and low-income self-employed individuals and their families.
Time Frame	Began enrolling low-income workers with children in 1998; program expanded somewhat in 1999, and again in 2000 with the commencement of the Insurance Partnership.
Number of Participants	Approximately 10,000 individuals as of May 2000 (this includes the approximately 1,500 individuals enrolled through Insurance Partnership).
Eligibility	<p>A “qualified” worker must meet all of the following criteria:</p> <ul style="list-style-type: none"> • Live in Massachusetts. • Be age 19 through 64.

- Be self-employed or work full-time or part-time for a qualified business with no more than 50 full-time employees.
- Employees with children can be of any age and can work for any size business.
- Have comprehensive health insurance through one's employer.
- Have an employer who pays at least half the cost of the premium.
- Have gross annual family income that does not exceed the following amounts:⁷

<i>Family size:</i>	1	2	3	4	5
<i>Max. Income</i>	\$16,704	\$22,500	\$28,308	\$34,104	\$39,900

Amount of Subsidy

For workers with gross income from 100% to 200% of FPL, the subsidy covers the full employee contribution toward employer-sponsored health coverage, except the following amount to be paid by the worker:

- Families with children: \$10 per child, up to a maximum of \$30 per family (including parents).
- Families without children: \$25 per adult, \$50 per couple.

If family income is below 100% of FPL, the subsidy covers the entire cost of the premium to the commercial insurance plan and the state provides wraparound Medicaid services, if this arrangement is more cost-effective than straight Medicaid coverage. If it is not more cost-effective, the worker may enroll in Medicaid.

Outreach and Marketing

When the program began in 1998, eligibility and outreach staff from the state's Division of Medical Assistance informed potential applicants of the program and conducted enrollment activities. Outreach also was conducted through Health Access Network Coalitions (groups of advocates for the uninsured including community health centers, legal aid organizations, and public hospitals). In 1999, marketing to small firms was conducted through Billing and Enrollment Intermediaries (BEIs). In 2000, EBR's marketing campaign (described above) targets workers as well as employers.

Contact for More Information

Charles Cook, Director Insurance Partnership, Division of Medical Assistance, (617) 210-5450.

Sources: Personal communications with Jack Hobson (EBR), Peter Terry (EBR), Charles Cook (DMA); Commonwealth of Massachusetts, Division of Medical Assistance, Publications IP-BK-ER/EBR (12/99) and IP-FAF-EE (Revised 3/99).

⁷ Amounts are valid through March 31, 2001, and will be adjusted annually.

Minnesota

MinnesotaCare

Overview

MinnesotaCare is a primarily state-subsidized managed care program for uninsured residents of Minnesota and their families. The program started in 1992 as an expansion of the state's Children's Health Plan and initially included families with children with incomes below 185% of FPL. Today the program includes families with children with incomes below 275% of FPL and single adults and couples without children with incomes below 175% of FPL. The program is financed through enrollee premiums, a state provider tax, and state and federal Medicaid funds. Total program expenditures for 1999 were \$165 million. Projected expenditures for 2000 are \$199 million.

Location

Statewide in Minnesota.

Target Beneficiaries Number of Participants

Uninsured low- and moderate-income individuals and families.

As of April 2000, the program enrolled 116,472 individuals, including over 39,000 adults with children and over 18,000 adults without children.

Time Frame

The program began in October 1992.

Eligibility

- Minnesota residents with a Social Security number.
- Uninsured and without health insurance in the past four months (except low-income children).
- No access to employer-based health insurance in which employer pays 50% or more of the cost of the premium, and employer has not dropped employer-paid insurance in the past 18 months.
- Meet income guidelines of up to 275% of FPL for families with children and up to 175% of FPL for single adults and couples without children: e.g., for adults over 21 without children, monthly income limit is \$1,218 for household of one and \$1,641 for household of two; for families with children, monthly income limit ranges from \$2,579 (family size of two) to \$5,237 (family size of six).

Coverage

Comprehensive coverage includes medical (clinic and hospital), ambulatory, chiropractic, emergency, dental, vision, mental health, substance abuse and prescription drug coverage. For adults (excluding pregnant women), copayments of \$3 per prescription, \$25 per pair of glasses, and 10% of inpatient hospital costs apply. Managed health care plans contract with MinnesotaCare to provide these services for a monthly fixed fee. Enrollees must select a plan at the time of enrollment and receive all covered services from that plan. Enrollee premiums vary by income level, family size, and number of individuals covered. For example, for an individual with monthly income at or below \$1,000, the monthly premium is \$31; for a family of three with monthly income at or below \$3,000, the premium is \$264; and for a family of five or more with monthly income at or below \$4,000, the premium is \$296.

Outreach and Marketing

An Outreach and Education Team in the Minnesota Department of Human Services uses several strategies to identify and educate uninsured individuals. These include training sessions for community agencies and individuals on health care options, presentations at workshops, conferences and health fairs, operation of a resource center with information on health care options, and partnerships with county and state agencies and private and nonprofit organizations to disseminate information on MinnesotaCare. In addition, applications for MinnesotaCare are available in health provider offices, county public health and social service agencies, or from a variety of “outreach grantees,” including legal aid offices and community health centers.

Financing

The program is financed through enrollee premiums (using a sliding scale based on family size, number of individuals covered, and income); a 1.5% tax on hospitals and health care providers; and some state and federal Medicaid funds from expansion waivers. In 1999, federal dollars covered just over 20% of the total program expenditures.

Contact for More Information

MinnesotaCare, Minnesota Department of Human Services, (651) 297-3862.

Sources: Minnesota Department of Human Services website: www.dhs.state.mn.us; Personal communications with staff from the Minnesota Department of Human Services, June 26, 2000.

New Mexico

New Mexico Health Insurance Alliance

Overview	The New Mexico Health Insurance Alliance, mandated by the state legislature in 1994, was created to make health insurance more accessible to small businesses, to self-employed people, and to individuals who lose their group health coverage. Administered by a quasi-public, nonprofit corporation, the Alliance has contracts with 13 insurance companies throughout the state that offer HMO and indemnity plans (HMO plans are not available in some less-populated areas of the state). The program does not offer direct subsidies, but is geared to make insurance available to groups that may be too small to obtain coverage in the private market, and to uninsured individuals who have lost their group coverage. Through guaranteed issue, all eligible groups and individuals may obtain coverage regardless of medical history or risk. Unlike small group plans outside the Alliance, participating health plans cannot charge higher premiums due to the health status of members of a group.
Location	Statewide in New Mexico.
Target Beneficiaries	Small businesses, self-employed people, and individuals who lose their group health coverage.
Number of Participants	There are approximately 7,800 covered people in 3,000 “accounts” insured through the Health Insurance Alliance as of August 2000. These accounts represent about 2,400 small businesses that offer Alliance health plans, and about 600 individual policyholders.
Time Frame	The program was mandated by the state in 1994, and is scheduled to end in June 2002. The state legislature will vote in February 2001 on whether to extend the program.
Eligibility	Employers are eligible to purchase an Alliance health plan if: <ul style="list-style-type: none">• The firm has from 2 to 50 eligible (working at least 20 hours per week) employees or self-employed and purchasing insurance for self and at least one family member.• At least half of eligible workers enroll in an Alliance plan.• The employer does not offer group coverage other than Alliance plans to eligible workers. Individuals are eligible to purchase an Alliance health plan if: <ul style="list-style-type: none">• They have lost group coverage and have exhausted COBRA and a similar state six-month continuation plan (if available) in the prior two months.
Coverage	The health plans include designated benefits including hospital services, physician services, wellness benefits, and limited prescription drug coverage. The indemnity plans offer a choice of deductibles (\$100 to \$2,500), coinsurance (plan pays from

50% to 70%), and out-of-pocket maximums. The plans have a lifetime maximum of \$2 million. Employers may change the plan they offer, and individuals may change the plan they select, on an annual basis.

Outreach and Marketing

Enrollees who leave New Mexico may convert to an Alliance indemnity plan and continue coverage indefinitely. On average, people leaving the state maintain Alliance coverage for about one year.

The New Mexico Health Insurance Alliance educates insurance agents throughout the state about the program. There is occasional newspaper advertising, and there has been some radio and billboard advertising. Also, there is information about the Alliance in the Yellow Pages.

Financing

The Alliance, as third-party administrator, is compensated through an assessment on all health insurance companies in the state.

Contact for More Information

Deborah Righter, Executive Director, New Mexico Health Insurance Alliance, (505) 989-1600.

Sources: Personal communications with Deborah Righter, Executive Director, New Mexico Health Insurance Alliance July 2000; and Georgetown University website <http://data.georgetown.edu/research/ihrp/hipaa>.

New York

Healthy New York

Overview

The Healthy New York program will begin January 1, 2001, under the Health Care Reform Act of 2000 (HCRA).⁸ Healthy New York is designed to promote and provide affordable insurance coverage to 1) small businesses with low-income workers, and 2) low- to moderate-income working uninsured individuals. Both components are based on making coverage more affordable through a streamlined benefits package and state-funded stop-loss protection to health plans.

As of January 1, 2001, all HMOs in the state will be required to offer a “scaled-down” standardized comprehensive benefits package to qualifying employers and eligible individuals. Nonprofit and commercial insurers may participate on a voluntary basis. The health plans will be able to submit claims that fall from \$30,000 to \$100,000 per member for reimbursement from two state stop-loss funds (one for small group coverage and one for individual coverage). The New York State Department of Insurance will administer the program, and is currently writing regulations and preparing for implementation.

Location

Statewide in New York.

Target Beneficiaries

1) Small businesses (with a portion of low- to moderate-income employees) that are not providing insurance, and 2) uninsured, low- to moderate-income working individuals.

Number of Participants

Not yet implemented.

Time Frame

Program will begin January 1, 2001.

Eligibility

Businesses will be eligible to purchase the scaled-down health plans if they:

- Have 50 or fewer eligible (to be defined) employees.
- Have not offered group health insurance during the past 12 months.
- Have a workforce in which at least 30% are receiving annual wages at or below \$30,000 (adjusted annually for inflation).
- Have at least 50% of eligible employees and at least one employee earning \$30,000 or less participate in the health plan.
- Agree to contribute at least 50% of the premium under the program, with employer contributions the same for all covered employees.

⁸ The description here reflects program planning as of June 2000; some aspects may be modified as regulations are developed through year 2000.

In addition, sole proprietors may participate if they have been uninsured for the past 12 months and have a gross household income at or below 250% of FPL (approximately \$41,000 annually for a family of four).

Individuals are eligible to purchase the scaled-down health plans directly if:

- Their employer does not provide and has not provided group health insurance over the past 12 months.
- Their household income is at or below 250% of FPL.
- They are not eligible for Medicare.
- They have not had health insurance during the past 12 months.

Amount of Subsidy

It is expected that the scaled down benefits package and the stop-loss protection to HMOs will result in reduced premium rates. (HMOs will be required to submit rate filings for state review and approval.) It is not yet known, however, to what degree the rates will be lower than existing small group and individual insurance plans. Qualified employers must contribute at least 50% of the premium (employees pay the remainder), and individual workers purchasing coverage directly through the program pay the full cost of coverage.

Health plans will be eligible for reimbursement from two stop-loss funds for 90% of claims that fall from \$30,000 to \$100,000 for each member. The health plans are responsible for all claims below \$30,000 and above \$100,000.

Coverage

The standardized benefit package will include essential coverage for inpatient and outpatient hospital services, physician diagnostic and treatment services, maternity, family preventive and primary care, x-ray and lab services, emergency services, and a prescription drug benefit. The plan is exempt from certain state-mandated benefits, and thereby does not cover home health care, chiropractic care, outpatient alcohol and substance abuse treatment, and mental health coverage. The drug coverage is limited to a \$3,000 maximum.

Outreach and Marketing

Initially, brochures will be sent to small businesses. A full marketing plan involving a variety of media is being developed and will commence in fall 2000.

Financing

State funding under HCRA provides \$219 million over 2½ years (through July 1, 2003).

Contact for More Information

Eileen Hayes, Associate Insurance Attorney, New York State Department of Insurance, (518) 486-7815.

Sources: Personal communications with Eileen Hayes, New York State Department of Insurance, June 2000; New York State website: <http://www.ins.state.us/csmhlthy.htm>.

New York

New York State Health Insurance Partnership Program (NYSHIPP)

Overview

The New York State Health Insurance Partnership Program (NYSHIPP) was established by the New York Health Care Reform Act of 1996 to assist eligible employers and self-employed people in purchasing small group health insurance policies for themselves, their employees, and dependents. The program, under the auspices of the New York State Department of Health, subsidizes premiums toward private health insurance in the small group market. The program was not renewed, however, and is being phased out by mid-2003.

Location

Statewide in New York.

Target Beneficiaries

Small businesses that have not been providing insurance to workers, and low-income self-employed individuals.

Number of Participants

NYSHIPP was subsidizing health insurance for about 1,100 small businesses as of the end of 1999. A waiting list began in 1998.

Time Frame

The program became operational in August 1997, but was not renewed under the new state budget for year 2000. As a result, the firms already enrolled in NYSHIPP will continue to receive premium subsidies through mid-2003, but businesses on the waiting list will not enter the program and new enrollment has ceased. New legislation provides for the transition of current participants into the Healthy New York program (see Healthy New York sketch), without regard to the existence of prior coverage or specific eligibility criteria.

Eligibility

Businesses are eligible for the subsidy if they:

- Are located in New York State.
- Have 1 to 50 employees (eligible employees must work at least 20 hours per week) or are a proprietor without employees and have gross household income below 222% of FPL.
- Have not provided group health benefits to any employee during the 12 months prior to application.

Amount of Subsidy

NYSHIPP subsidizes premiums up to 45%. Employees may pay 10% and employers 45%; or employers may pay 55% of premiums (i.e., employee contributions are limited to no more than 10%).

Coverage

The health plans include group health insurance policies or comprehensive health services plans issued on a community-rated, open enrollment basis. The application for the subsidy includes a list of “participating” insurance companies, where participation means only that they offer group health insurance. Special legislation requires that small groups include one-person businesses.

Outreach and Marketing

The state department of health contracted with the firm MDI Associates to administer and publicize the program. The publicity campaign focused on the media—TV, newspaper, and radio—and large mailings to small employers throughout the state.

Financing

The program was supported through assessments on providers and other health care services. By the end of 1998, the program had committed its allotted \$6 million and started a waiting list.

Contact for More Information

Ralph Bielefeldt, Assistant Director, Child Health Plus Program, New York State Department of Health, (518) 473-8822.

Sources: NYSHIP application material, MDI Associates, LLC; New York State website: <http://www.health.state.ny.us/nysdoh>.

Oregon

Family Health Insurance Assistance Program (FHIAP)

Overview

Oregon's Family Health Insurance Assistance Program (FHIAP) provides premium subsidies for low-income uninsured residents to help them purchase coverage through their employer or through the individual market. The program is a component of the Oregon Health Plan, which was designed to ensure health insurance for all residents and includes Medicaid expansion, small group insurance reform, the Oregon Medical Insurance Pool (OMIP), a small employer insurance pool, and other programs.⁹ FHIAP is intended to increase availability and affordability of private insurance, and is administered through the Insurance Pool Governing Board.

Location

Statewide in Oregon.

Target Beneficiaries Number of Participants

Uninsured working low-income individuals and their families.

As of June 19, 2000, there were 4,131 people approved and enrolled, 518 approved to be enrolled, 47 applications under review, 5,236 applications sent out, and 23,369 people on the waiting list for applications (due to capped enrollment). There are 768 members enrolled in group health insurance plans through their employer.

Time Frame

FHIAP was passed in the 1997 legislature and enrollment began in July 1998.

Eligibility

To be eligible for the subsidy, a person must:

- Be an Oregon resident.
- Have gross family income under 170% of FPL.
- Have total investments and savings less than \$10,000 (including cash, checking and savings accounts, stocks, and bonds; IRA, home, and car are not considered investments or savings).
- Have not had insurance other than Medicaid in the past six months.
- Not be eligible for or receiving Medicare.

Eligibility does not, however, guarantee participation. As noted above, the capped enrollment has resulted in a waiting list for applications numbering approximately 24,000. A person wishing to apply must request a space on the reservation list and wait for an opening in the program.

Amount of Subsidy

The amount of the subsidy is determined by income, the number of family members to be insured, and family size. The subsidy is scaled: 95% of the premium is

⁹ OMIP is a high-risk pool funded through member premiums and an assessment on insurance companies. The small employer insurance pool is being phased out due to declining participation attributed to insurance reform and more firms using the regular private market. The state has been helping participating companies find and enroll in new plans in year 2000.

subsidized if income is under 125% of FPL, 90% is subsidized if income is from 125% to 150% of FPL, and 70% is subsidized if income is from 150% to 170% of FPL. If the enrollee obtains coverage through his/her employer, the subsidy applies to the employee's share of the premium.

Coverage

Once approved for a subsidy, participants must obtain health insurance either:

- Through their employers, if it is offered and the employer makes a contribution toward the coverage; or
- Through one of the insurance carriers participating in FHIAP (if the employer does not offer coverage or make a contribution toward coverage).

In order for adults to receive a subsidy, they must obtain coverage for all children in the family under a health insurance plan or the Oregon Health Plan. If one's employer does not offer dependent coverage, the subsidy may be used to purchase such coverage through a participating FHIAP carrier.

Process

Participants in the group health insurance market (i.e., employment-based insurance plan) are eligible to receive prospective payments in order to avoid cash flow problems caused by the withholding of premiums from wages. Employers are blind to which, if any, employees receive a FHIAP subsidy and are not involved in the process, unless the employee asks the employer for help in filling out the Employer Verification form. This form provides FHIAP with information on the employer's health insurance, which is needed to determine the employee's share of the premium.

Participants in the individual market pay their share of the premium directly to FHIAP. FHIAP then forwards the participant's share and the subsidy payment to the insurance carrier. Participants are responsible for copayments or deductibles that are required when health care services are received.

Outreach and Marketing

There is no active outreach and marketing due to the long waiting list for subsidies, although the program anticipates increasing marketing efforts in the fall of 2000. The state certifies agents to assist with enrollment when applications are received.

Financing

The FHIAP subsidy is financed by a state tobacco tax. Limited funding caps enrollment at 5,250 people. The state has applied for S-CHIP funding for an employer-sponsored insurance coverage demonstration project to supplement state sources, which could increase the number of people who could be served by the program.

Contact for More Information

Kelly Harms, FHIAP Marketing and Communications, 625 Marion Street, NE, Suite 2, Salem, Oregon 97301-3749, (503) 373-1692 ext. 232, e-mail: kelly.harms@state.or.us.

Sources: Sparer, Michael S. "Health Policy for Low-Income People in Oregon," Assessing the New Federalism, Occasional Paper #31, Urban Institute, Washington, D.C., Sept. 1999; Personal communications with Kelly Harms, FHIAP Marketing and Communications, State of Oregon, June 2000; Oregon website: www.ipgb.state.or.us/docs.

Vermont

The Vermont Health Access Plan (VHAP)

Overview	The Vermont Health Access Plan (VHAP) is an example of a Medicaid waiver program to expand health coverage to uninsured adults. While it does not target employers or uninsured workers specifically, state representatives confirm that low-income working people without employment-sponsored insurance are among VHAP's 18,500 participants (the exact number of workers is not available). VHAP offers uninsured adults with incomes up to 150% of FPL enrollment in a Primary Care Case Management Program. In addition, a VHAP-Pharmacy program offers prescription drug coverage to low-income elderly and disabled residents.
Location	Statewide in Vermont.
Target Beneficiaries	Low-income uninsured adults.
Number of Participants	Approximately 18,500 individuals as of May 2000. There is much turnover, with 600 to 750 new individuals enrolling each month and nearly the same number of enrollees leaving the program each month.
Time Frame	VHAP was approved as a Medicaid §1115 waiver program in 1995 and began enrollment in January 1996. It was approved through year 2000, and the state has received a three-year extension through calendar year 2003.
Eligibility	To be eligible for VHAP, an individual must: <ul style="list-style-type: none">• Be at least 18 years old.• Be uninsured for at least one year.• Have income no greater than 150% of FPL.
Coverage	Comprehensive inpatient and outpatient services, including dental coverage, and excluding long-term care services. Coverage includes a pharmaceutical benefit with 50% coinsurance up to \$750 per year and full coverage above \$750.
Process	By May 2000, all enrollees were transferred from two managed care plans to a new Primary Care Case Management Program, administered by the Office of Vermont Health Access (OVHA) in the Department of Social Welfare. Each enrollee selects a primary care physician (PCP) from a list of participating providers. PCPs receive a \$5 per member per month fee to "manage" patient care; other covered services are paid by the state on a fee-for-service basis.
Outreach and Marketing	Potential enrollees are referred by social welfare offices and clinics serving the uninsured. There is a toll-free number and a brochure available upon request, and applications are mailed in. Outreach is geared toward individuals as opposed to businesses.

Financing

State and federal Medicaid dollars finance the program. A state tobacco tax finances the state share of VHAP costs as well as other Medicaid programs.

Contact for More Information

Paul Wallace-Brodeur, (802) 241-3985, or Ann Rugg, (802) 241-2766, at the Office of Vermont Health Access, 103 South Main Street, Waterbury, Vermont 05671-1201.

Sources: State of Vermont website: <http://state.vt.us>; Personal communications with staff of the Office of Vermont Health Access, May 2000.

Washington

The Basic Health Plan

Overview

The Basic Health Plan (Basic Health) is Washington's state-sponsored program that provides affordable, private health care coverage to low-income working families. It offers health insurance subsidies to families with income below 200% of FPL who purchase health coverage from one of nine private health plans participating in the program. In addition to individual enrollment, groups such as provider groups and Indian tribes may sponsor eligible people. Also, employers may sponsor eligible workers and contribute toward their premium in the program.

Location

Statewide in Washington.

Target Beneficiaries Number of Participants

Low-income working families.

As of June 2000, a total of 217,046 individuals were enrolled in Basic Health. Among these, approximately 131,250 people were in the "regular subsidized" program, which include individual enrollees (106,227), people sponsored by provider groups (2,943), people sponsored by non-provider groups such as Indian tribes (20,415), people enrolled through employer groups (1,176), foster parents (378), and home care workers (111). Among the regular subsidized members, the majority (56%) has income below 100% of FPL.

The "non-regular subsidized" enrollees are composed primarily of children enrolled in Basic Health Plus (funded through Medicaid, described below). A smaller number (approximately 2,300 people) are individuals with income above 200% of FPL who pay the entire premium. The latter, unsubsidized group has declined rapidly in recent years as insurance carriers have stopped offering this option due to adverse selection; in spring/summer 2000 it is available only in one county.

Limited state funding has capped enrollment in the regular subsidized program at approximately 133,000 people; when this cap is reached, applications will continue to be processed, but enrollment will be delayed to allow new spaces to become available through attrition.

Time Frame

Basic Health began in 1988 as a five-year pilot program in two counties. It expanded to additional counties, and became a statewide, permanent program in 1993.

Eligibility

An individual is eligible for the premium subsidy if he/she:

- Is a Washington State resident.
- Has family income less than 200% of FPL (residents of Clark County with income above 200% of FPL may apply for nonsubsidized coverage).¹⁰

¹⁰ New legislation has authorized expansion of eligibility to people with income up to 250% of FPL, but the funds to implement this expansion have not been approved as of June 2000.

- Is not eligible for Medicare and is not institutionalized at time of enrollment.

If parents qualify for Basic Health, their children may qualify for the Basic Health Plus program at no extra cost. Basic Health Plus, administered by the Department of Social and Health Services and based on Medicaid eligibility criteria, offers a wider range of benefits such as dental and vision care, and physical therapy, with no premiums or copayments. Similarly, pregnant women may be eligible for free maternity coverage through the state's Maternity Benefits Program.

Amount of Subsidy	Premiums are based on family size, income, age, and the health plan selected; there are no deductibles or coinsurance, but copayments are required for most services. State funds pay a portion of the monthly premium, with participants paying as little as \$10 per month per adult for the "benchmark" plan. Participants may be enrolled as individuals or as part of a group.
Coverage	Basic Health coverage is administered through nine private health plans throughout the state. Coverage includes hospitalization, provider visits, emergency services, prescriptions, and other benefits. The sliding scale subsidies are based on the most basic, or "benchmark" plan. If an enrollee selects a more expensive plan from among the Basic Health choices, the enrollee pays the difference in cost in addition to their basic contribution.
Process	<p>Applicants send completed applications and the first month's premium payment to the state. Those who are eligible may join Basic Health as individuals, or through a participating employer, home care agency, or financial sponsor group. Provider groups serving indigent populations, for example, may "sponsor" their uninsured patients, paying (subsidized) premiums, but then receiving reimbursement when medical services are rendered. The largest growth in Basic Health is among immigrants through provider sponsorship.</p> <p>Employers may enroll their eligible employees in Basic Health group coverage. They can choose to pay all or part of their employees' monthly premiums. However, they must pay a minimum of \$45 per month for each full-time employee and \$25 per month for each part-time employee. Since individuals enrolling in Basic Health pay as little as \$10 per month, there is an incentive for employers to encourage uninsured workers to enroll as individuals rather than through the employer. Apparently this "disincentive" is due to the employer-sponsorship provision being put in place when it was believed that an employer mandate would be implemented. The provision remained in place even after the mandate was repealed.</p>
Outreach and Marketing	Outreach for Basic Health is primarily "piggybacking" onto Medicaid outreach, which provides information through day care centers, churches, employers, and community agencies.
Financing	The regular subsidized Basic Health plan is financed through a state Health Services Account, funded through tobacco settlement payments and state taxes on hospital services, alcohol, and tobacco products. Enrollees contribute toward the premium. Basic Health Plus utilizes federal and state Medicaid funds, and nonsubsidized coverage is financed through enrollee premiums.

**Contact for More
Information**

Jill Hanks, Public Information Officer, Washington Health Care Authority,
(360) 923-2645, or e-mail: jhan107@hca.wa.gov.

Sources: Personal communications with Cathy Everly, Washington State Health Care Authority, and JoAnn Volk, Abt Associates, June 2000; Washington State website: <http://www.wa.gov/hca/basichealth.htm>.

Wisconsin

BadgerCare

Overview

Wisconsin's BadgerCare program aims to provide health insurance for low-income uninsured working families with children, filling the gap between employer-sponsored health insurance plans and Medicaid. Implemented in July 1999 as a Medicaid expansion/S-CHIP program (under Titles XIX and XXI of the Social Security Act), it is available to uninsured children and parents with income not exceeding 185% of FPL. Once enrolled, families can remain in BadgerCare until their income exceeds 200% of FPL.

BadgerCare is intended to help families in the workforce receive affordable health insurance until they can obtain insurance from their employment. BadgerCare enrollees generally receive health care services (same as the state's Medicaid benefit package) through a Medicaid HMO or fee-for-service arrangement. Under certain circumstances, coverage is obtained through the worker's employer-sponsored health insurance plan under BadgerCare's Health Insurance Premium Payment (HIPP) program.

Location

Statewide in Wisconsin.

Target Beneficiaries

Uninsured low-income working families.

Number of Participants

As of April 2000, 64,620 people were enrolled in BadgerCare, including 17,195 children, 43,178 adults, and 4,247 teenagers.

Time Frame

The program began in July 1999 through a Medicaid §1115 waiver.

Eligibility

To be eligible for BadgerCare, an individual must:

- Be in a family with at least one child under age 19.
- Have family income not exceeding 185% of FPL.
- Be a United States citizen or a qualified alien residing in Wisconsin (or physically present with the intent to reside).
- Not have Medicaid or be eligible for Medicaid (although a family may have some members that are eligible for Medicaid and some members that are eligible for BadgerCare).
- Not be covered by a health insurance plan that covers at least physician services nor have been covered by a plan in the past three calendar months.
- Not have access now or during the past 18 months to an employer-sponsored family health insurance plan where the employer pays 80% or more of the premium.
- Not have access to a state employee's family health plan.

Eligible people must also cooperate in providing their Social Security number; providing information about other available health insurance; enrolling in the Health

Insurance Premium Payment (HIPP) program if applicable (see below); and, if a non-pregnant adult with a child, locating an absent parent, establishing paternity, and establishing a medical support order.

Amount of Subsidy	Cost of coverage, with families with incomes above 150% of FPL paying a monthly premium of 3% of family income. There are no copayments or deductibles.
Coverage	Comprehensive inpatient and outpatient coverage (same benefits as Medicaid), generally provided through an HMO that contracts with the state. Fee-for-service coverage may be provided until HMO coverage (or HIPP coverage) begins or under special circumstances.
Outreach and Marketing	Brochures, television commercials, outreach meetings, “outstationing” enrollment workers at social services agencies, clinics, etc. in high population areas, work with public health agencies/counties, website, and toll-free hotline.
Financing	Adults are funded through Medicaid and children are funded through S-CHIP funds (state and federal). For the 1999–2001 biennium, the program is budgeted for \$161.2 million. Of this amount, state funding is capped at \$56.6 million; if this cap is reached, the legislature will change the income requirements to curb new enrollment. Financing includes federal matching funds of \$59.0 million (Title XIX) and \$42.8 million (Title XXI), and premium collection is expected to be \$2.9 million.

Health Insurance Premium Payment (HIPP) Program

Target Beneficiaries	BadgerCare enrollees (low-income children and their parents) with access to employer-sponsored plans.
Number of Participants	Only 4 families have enrolled in HIPP as of June 2000; an additional 3 families are expected to be enrolled by mid-July 2000. Small enrollment is attributed to a limited number of enrollees with access to employer-based coverage, and the narrow band of required employer contribution toward premium (60%–80%). (Low enrollment for HIPP programs in general also is attributed to difficulty obtaining information about employer-sponsored coverage from applicants and employers, and lack of aggressive enrollment efforts by states.)
Time Frame	Enrollment began October/November 1999.
Eligibility	Families that are eligible for BadgerCare (see above requirements) are enrolled in the HIPP program if all of the following conditions are met: <ul style="list-style-type: none">• A BadgerCare family member is employed and the family member’s employer offers a Health Insurance Portability and Accountability Act (HIPAA) Standard Plan (i.e., a major medical plan that covers at least physician services) to its employees and their families.• Family members are not currently covered by this health plan or were not covered by any employer-offered HIPAA Standard Plan in the last six months.

- The employer pays from 60% to 80% of the cost of the monthly premium for this health plan.
- The cost to the State of Wisconsin, for coverage of the family, by paying the employee share of the premium plus wraparound costs (coinsurance, deductibles, BadgerCare services not covered by the employer health plan) is less than the cost of Medicaid HMO coverage for the family.

Amount of Subsidy

The State of Wisconsin pays the employee's share of the premium toward family coverage, the coinsurance and deductibles associated with the employer-provided family health insurance plan, and any BadgerCare services not covered by the employer's health plan (through BadgerCare fee-for-service). If the family's income is above 150% of FPL, the employee must contribute toward the premium 3% of family income.

BadgerCare family members are required to pay nominal copayments for services received in BadgerCare fee-for-service unless they are under 18, are receiving pregnancy-related services, or if other exceptions apply.

Options for state payments toward employee share of family coverage include:

- The employer withholds the premium from employee's wages and the state sends the check to employee.
- The employer pays the premium and the state sends the check to the employer.
- The state sends the check directly to the insurance company.

Coverage

Comprehensive coverage, including the employer-sponsored plan benefits plus wraparound benefits.

Process

If an employee is eligible for BadgerCare, his or her employer will be asked to complete an Employer Verification of Insurance Coverage (EVIC) form to verify insurance information. The Department of Health and Family Services verifies access and eligibility for health insurance offered by an employer, and determines whether purchasing the employer insurance plan is cost-effective for the state and meets federal requirements. If so, the employer and the BadgerCare-eligible employee are notified of the intent to purchase the employer health insurance plan for the BadgerCare family members. If it is not cost-effective, the enrollment process for Medicaid HMO coverage begins.

Outreach and Marketing

In addition to the general outreach for BadgerCare (above), the state provided information about HIPP to business associations, which then informed member companies about the program.

Contact for More Information

Angie Bobrowicki, Division of Health Care Financing, Wisconsin Department of Health and Family Services, (608) 266-1935, e-mail: dombra@dhfs.state.wi.us.

Sources: Personal communications with Angie Bobrowicki and Donald Schneider, Wisconsin Department of Health and Family Services, May 2000; Wisconsin website: <http://www.dhfs.state.wi.us/badgercare>.

LOCAL SKETCHES

Boston, Massachusetts

Boston HealthNet Pilot Plan

Overview	<p>Boston HealthNet Pilot Plan is a health coverage program for uninsured individuals at or below 200% of FPL who meet the income guidelines of the state's Uncompensated Care Pool (or Free Care Pool). The program is operated by Boston Medical Center (BMC), Massachusetts' largest safety net hospital system. BMC is authorized by the state to use funds from the pool to subsidize free care for eligible individuals. The program does not use a managed care model (e.g., gatekeeper, authorization/referral system), but enrollees are required to select a PCP from the hospital or one of the clinics and are encouraged to call their PCP before going to a specialist or to the emergency room. In addition, patients receive a Boston HealthNet "insurance" card that lists their PCP and site of care. Patients enroll in the program for one year and then can renew their enrollment based on a redetermination of eligibility. Program administrators are considering using a partial risk-bearing arrangement in the future to reduce the financial strain on the free care pool.</p>
Location	Boston, Massachusetts
Target Beneficiaries	Roughly 100,000 uninsured individuals below 200% of FPL in the Boston area.
Number of Participants	As of May 2000, 68,565 individuals are enrolled in Boston HealthNet Pilot Plan. About half of these individuals are employed.
Time Frame	The program was launched in November 1995.
Eligibility	<ul style="list-style-type: none">• Patients who qualify under the state Uncompensated Care Pool income guidelines at or below 200% of FPL.¹¹
Amount of Subsidy Coverage	<p>Patients with family incomes up to 200% of FPL receive free care.</p> <p>Comprehensive inpatient and outpatient coverage, emergency, and ancillary services. Limited dental, vision, pharmacy (\$100 per prescription per month), and mental health (inpatient). Services currently are reimbursed from the pool on a fee-for-service basis. Patients cannot be billed for services. Services are provided to enrollees at BMC and its clinics and community health centers.</p>
Outreach and Marketing	Initially, mailings were sent to individuals eligible for the free care pool. Outreach workers are trained to approach and assist prospective applicants in the community health centers. The program also maintains a toll-free member services assistance

¹¹ Individuals at or below 200% of FPL qualify for free care under Uncompensated Care Pool guidelines; individuals from 201% to 400% of FPL qualify for partial care (must pay an annual deductible based on income). Only those at or below 200% of FPL are eligible to enroll in Boston HealthNet Pilot Plan.

number. Providers are encouraged to invite their patients to participate in the program. BMC has enrollment workers in all of its inpatient and outpatient units.

Financing

The program is financed using funds from the state's uncompensated care pool. The annual program budget varies according to the demand for services each year. However, the estimated annual budget for 1999 was \$94 million. The pool is financed through hospital assessments (on all hospitals in the state) based on private sector care charges (\$215 million); surcharges on payments made by private sector payers to hospitals and ambulatory surgical centers in Massachusetts (\$100 million); and federal government participation funds to the state (\$30 million).

Contact for More Information

Thomas P. Traylor, Vice President of Federal, State and Local Programs, Boston Medical Center, (617) 638-6730.

Sources: Andrulis, Dennis and Michael Gusmano. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* The New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, August 2000; Personal communications with Thomas Traylor and Trish Melchionda, Boston Medical Center, June 2000.

Denver, Colorado

Denver Health - Small Business Premium Subsidy Program

Overview	In Denver, a special premium subsidy program is available to low-income small businesses that have not offered health coverage in the past. Eligible businesses must purchase one of three small business HMO benefit plans through the Denver Health Medical Plan, a subsidiary of Denver Health, an independent governmental authority administering Denver's public health care system. As part of an effort to test new approaches to improving the health of Denver's medically underserved populations, the impact of the program is being examined under a research study design.
Location	Denver, Colorado
Target Beneficiaries	Employers and employees of small, low-income businesses without health coverage.
Number of Participants	As of May 2000, 19 small businesses received the subsidy. A total of 73 businesses purchase Small Business HMO coverage through the Denver Health Medical Plan.
Time Frame	The subsidy began in 1998 and is funded for 5 years.
Eligibility	Businesses are eligible for the subsidy if they: <ul style="list-style-type: none">• Choose to contract with Denver Health Medical Plan for the Small Business HMO.• Have 2–50 employees (it is not available to self-employed individuals).• Had net income of equal to or less than \$50,000 the previous year.• Did not offer coverage over the past 90 days.
Amount of Subsidy	The subsidy is worth from 20% to 50% of the premium for both the employer and employee, determined by a sliding scale based on the firm's net income the previous year. The subsidy is available during years 1 and 2, and again in years 4 and 5. It is not available in year 3 because the program's designers are trying to determine the extent to which businesses retain coverage without financial assistance. The subsidy ceases after year 5.
Coverage	The Denver Health Medical Plan offers three health plans to small businesses: 1) a basic plan; 2) a standard plan; and 3) premier plan. The benefits of the basic and standard plans are determined by the state's Commissioner of Insurance and include inpatient and outpatient hospital services, physician services, and others.
Outreach and Marketing	An advertising campaign focuses on radio and targeted print ads in business journals and ethnic newspapers. Additional marketing is conducted through direct mail, presentations, brokers and account service representatives, billboards, and bus exteriors.

Financing

The premium subsidy under the current five-year, \$5 million grant is funded by The Colorado Trust and the W.K. Kellogg Foundation. It is hoped that successful results will lead to policy change and ongoing public financing in the future.

Contact for More Information

Elizabeth Whitley, Ph.D., Denver Health and Hospital Authority, (303) 436-4071, e-mail: lwhitley@dhha.org.

Sources: Denver Health Community Voices, *Annual Progress Report July 1, 1998–December 31, 1999*; Personal communications with Elizabeth Whitley, Denver Health and Hospital Authority, June 2000.

Lansing, Michigan

Ingham Health Plan

Overview

Ingham Health Plan is a health coverage program for uninsured residents of Ingham County who are not eligible for any other insurance. The program is managed by the Ingham Health Plan Corporation (Corporation), a nonprofit organization that was created to administer the plan. The program uses managed care principles to link enrollees to a medical home. The Corporation is developing plans to cover an additional 1,000 to 3,000 low-income workers through small businesses in Ingham County that do not offer health coverage. Up to two-thirds of the cost of the new program will be borne by employers and employees, while the final third will be subsidized by the community. Premiums are estimated to be roughly \$120 per month. The new model also will cover inpatient care. The Corporation is negotiating with local HMOs to market and manage the new product.

Location

Lansing, Michigan

Target Beneficiaries

14,000 uninsured residents of Ingham County with incomes up to 250% of FPL and 1,400 former State Medical Plan (SMP) enrollees (a coverage program for low-income individuals who are ineligible for Medicaid).

Number of Participants

As of June 2000, there are over 10,000 enrollees in Ingham Health Plan, including roughly 1,400 former SMP enrollees. This represents roughly one-third of the uninsured population in the county. Enrollment is expected to reach 14,000 by October 2000.

Time Frame

The program was launched on October 1, 1998.

Eligibility

- Uninsured county residents up to 250% of FPL.

Amount of Subsidy

Individuals below 100% of FPL receive free care and those from 100% to 250% of FPL have cost-sharing requirements. The total amount budgeted is about \$40 per person per month. Participating providers are reimbursed \$12 per person per month for primary care. Specialty care, x-ray, and pharmacy claims are paid on a Medicaid fee-for-service basis. Lab rates are capitated.

Coverage

Previously uninsured enrollees receive coverage only for outpatient services, including outpatient primary and specialty, lab and x-ray, and pharmacy services (formulary). For individuals from 100% to 250% of FPL, a copayment of \$5 is required for primary care, lab and x-ray, and generic pharmacy services, and a copayment of \$10 is required for specialty care and brand drugs. These enrollees do not have coverage for emergency, outpatient hospital, inpatient hospital, organ transplant, vision and hearing, dental, mental health, and substance abuse services. Services are provided at the participating hospital, clinics of the local health department, and other area health clinics, pharmacies, and labs. Former SMP

enrollees are covered for outpatient hospital, emergency, and physician services and do not have copayments.

Outreach and Marketing

The first group enrolled was the former SMP-covered population. The program then enrolled uninsured individuals seen at primary care centers operated by the Ingham County Health Department and at Cristo Rey Clinic. Recent outreach is directed to offices operated by Michigan State University and by local hospital systems.

Financing

Local government health care funds (\$2 million/year from county tax revenues), state funds for former SMP enrollees (\$1.2 million/year) and federal Medicaid matching funds (\$3.4 million/year) are combined to create a special “DSH” payment to the local hospital that participates in the program (only one of two local hospitals is participating). The hospital contracts with the Corporation to provide direct services and conduct enrollment.

Contact for More Information

Bruce Miller, Ingham Health Plan Corporation, (517) 887-4311, e-mail: hamiller@ingham.org.

Sources: Personal communications with Doak Bloss, Ingham County Health Department, June 14, 2000, and Bruce Miller, Ingham Health Plan Corporation, June 19, 2000.

Marion County, Indiana (Indianapolis)

Wishard Advantage

Overview	Wishard Advantage is a managed care program for uninsured and underinsured residents of Marion County with incomes up to 200% of FPL. The program was launched in 1997 by Wishard Hospital, Indianapolis' public hospital, which is operated by the Health and Hospital Corporation (HHC) of Marion County. The Indiana University Medical Group-Primary Care, a physician group sponsored by HHC and Indiana University's medical school, provides primary care services, while Wishard Hospital provides ancillary, specialty and inpatient services for members. The program is administered by University Medical Group and HHC. The annual program budget is over \$76 million year.
Location	Marion County, Indiana
Target Beneficiaries	Over 40,000 uninsured or underinsured residents of Marion County with incomes up to 200% of FPL.
Number of Participants	As of June 2000, there were approximately 22,000 members.
Time Frame	The program was launched in March 1997. Members' eligibility is redetermined annually or when circumstances change (e.g., they become eligible for Medicaid or move out of the county).
Eligibility	<ul style="list-style-type: none">• Marion County resident.• Not eligible for any other payer program (can have Medicare as primary payer).• At or below 200% of FPL.
Amount of Subsidy	Individuals/families with incomes up to 150% of FPL receive free care. Individuals/families with incomes from 150% to 200% of FPL contribute to the cost of care according to a five-tier rate structure that varies by the individual's income level. Individuals from 151% to 160% pay 20% of medical care costs incurred; from 161% to 170% pay 30%; from 171% to 180% pay 40%; from 181% to 190% pay 50%; and from 191% to 200% pay 60%. The primary care physician group receives capitated payments of \$15 per member per month. Specialists are paid according to an internally developed rate formula.
Outreach and Marketing	Initially, HHC contacted uninsured patients of the hospital onsite or by mail or phone. Program administrators have expanded their outreach efforts to community-based organizations (e.g., WIC and churches), employers, social service agencies, among others. The program does not have a distinct marketing budget.
Coverage	Comprehensive coverage; benefits are similar to those of Indiana's Medicaid managed care program, which includes outpatient primary and specialty, inpatient,

emergency, lab and x-ray, pharmacy and limited mental health services. Managed care principles apply and some specialty services require authorization and referral.

Financing

The program was capitalized with \$20 million in federal DSH matching funds. The program currently is financed through city and county property taxes totaling roughly \$76 million per year.

Contact for More Information

Susan Jo Thomas, Director, Wishard Advantage, (317) 630-7889 or fax (317) 630-6032.

Sources: Andrulis, Dennis and Michael Gusmano. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* The New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, August 2000; Personal communications with Susan Jo Thomas, Wishard Advantage, June 20, 2000.

Muskegon, Michigan

Access Health

Overview

Access Health is a community-wide coverage initiative of the Muskegon Community Health Project (MCHP). MCHP is a Comprehensive Community Health Models partnership of the W.K. Kellogg Foundation. Access Health provides health coverage to the working uninsured through their employers. Program administrators do not view Access Health as an HMO or as an insurance product, but as a health coverage product to fill in the gap between no insurance and commercial insurance. Annual overall cost of the program is projected to be \$4 million.

Location

Muskegon, Michigan

Target Beneficiaries

Up to 3,000 full- or part-time working uninsured individuals. Dependent coverage is available, although families are encouraged to enroll eligible children in MIChild (Michigan's S-CHIP) or Medicaid. Children from ages 19 to 23 can enroll in Access Health as adults.

Number of Participants

As of June 2000, 155 small to medium-sized businesses were enrolled in the program. On average, one business enrolls per day.

Time Frame

Access Health enrollment began in September 1999 and will continue until the initial goal of 3,000 workers is complete. After that, new enrollment will be based upon program expansion or upon open slots created when member businesses transition to commercial coverage.

Eligibility

- Small to medium-sized businesses in Muskegon County (e.g., currently up to 150 "eligible" full- or part-time employees). Ineligible employees include seasonal and temporary employees and employees covered by other insurance.
- Business must not have been providing insurance to employees for the past 12 months.
- The median wage of eligible employees is \$10 per hour or less.

Amount of Subsidy

The cost of coverage is shared among the employee (30%), the employer (30%), and the community (40%). The employee's share of adult coverage is \$38 per month. The employee's share of dependent coverage is \$22 per month.

Coverage

Access Health covers physician services, inpatient hospital services, outpatient services, emergency services, ambulance services, prescription drugs (formulary), diagnostic lab and x-ray, home health, and hospice care. Individuals are not excluded because of pre-existing conditions. The program does not cover any care received outside of Muskegon County. Copayments are required for most services. For example, PCP office visits require a \$5 copayment and specialist visits require a \$20 copayment. The copayment rates were designed to encourage primary and preventative care.

Outreach and Marketing

During development, Access Health used marketing consultants to conduct consumer research, develop community support, utilize free media, develop a marketing plan, and launch the product. As of June 2000, a sales staff sells the product to eligible businesses.

Financing

The program is financed according to a three-way “shared buy-in” among the employer, employee, and community. The employer pays 30% of the cost of coverage, the employee pays 30% and a community match pays the remainder. The community match comprises federal DSH funds and local government, community, and foundation funds (e.g., \$100 in local funds attaches \$122.80 in DSH funds). In addition, 10% of provider fees are donated back to the program for ongoing administrative costs.

Contact for More Information

Vondie Moore Woodbury, Director, Muskegon Community Health Project, (231) 728-3201, e-mail: vwoodbury@mchp.org.

Sources: Muskegon Community Health Project website: www.mchp.org; Personal communications with Vondie Moore Woodbury, Muskegon Community Health Project, June 13, 2000.

New York, New York

Small Business Health Insurance

Overview	Small Business Health Insurance (SBHI) is a comprehensive low-cost health insurance product for small businesses in select sections of Manhattan, Brooklyn, and the Bronx that was designed to expand health coverage to working uninsured individuals. The product is offered by Group Health Incorporated (GHI), the largest not-for-profit PPO in New York State, in collaboration with the New York City Health and Hospitals Corporation (NYCHHC), which represents the city's public hospitals. The program is a two-year demonstration project that began in January 1999.
Location	Manhattan, Kings, and Bronx Counties, New York
Target Beneficiaries	Roughly 15,000 to 17,000 small businesses (2–50 employees) in select zip codes in East Harlem, the South Bronx, and Northern Brooklyn. Potential enrollment for the first two years of the program is 3,000 individuals.
Number of Participants	As of June 2000, there is a total cumulative enrollment of 234 individuals, with 25 small businesses participating in the program. Average size of participating businesses is 4.5 employees.
Time Frame	SBHI is a demonstration project that was created in January 1999 and is scheduled to continue for two years, after which the program will be evaluated.
Eligibility	<ul style="list-style-type: none">• Small businesses with 2–50 employees (Community Rated Guidelines are followed).• Select zip codes in East Harlem (6 zip codes), South Bronx (9 zip codes), and Northern Brooklyn (19 zip codes).
Coverage	SBHI is a comprehensive insurance product offered by GHI in participation with NYCHHC. Coverage includes inpatient, emergency, preventive, office visits, ambulatory surgery, chiropractic, pharmacy, skilled nursing, and mental health/substance abuse services. Since SBHI is a PPO, enrollees are “encouraged” to select a PCP and are contacted by a case manager upon enrollment. There are some limits on very extended periods of care. Annual well-care visits have no copayment, while some other office visits require a \$15 copayment. A \$5 copayment is required for pharmacy. Enrollees receive services through three NYCHHC networks that include over 750 HHC-affiliated providers. GHI's network complements NYCHHC's provider network when necessary (e.g., chiropractors, home care). SBHI is not an HMO and does not use the PCP/gatekeeper model of managed care.
Outreach and Marketing	SBHI began a marketing campaign in March 1999. Health insurance specialists from NYCHHC act as community liaisons by explaining the program and benefits of health insurance to businesses and individuals in the community, coordinating community activities (e.g., events, door-to-door canvassing) and gauging the interest

of small businesses. GHI-selected brokers who have a community presence and are familiar with the product's catchment areas sell SBHI to small businesses. The program also is advertised through mass mailings and through GHI's general marketing materials.

Financing

SBHI uses a four-tier monthly premium structure. The premiums are less than half of the premiums of GHI's competitors in the area. The premiums are as follows: individual, \$99.80/month; employee and child(ren), \$161.29/month; employee and spouse, \$224.00/month; and employee, spouse, and family, \$235.22/month.

Contact for More Information

Lori Metz, GHI, (212) 615-0386, e-mail: lmetz@ghi.com.

Sources: Andrulis, Dennis and Michael Gusmano. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* The New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, August 2000; Personal communications with Lori Metz, Group Health Incorporated, June 14, 2000.

San Diego, California

FOCUS (Financially Obtainable Coverage for Uninsured San Diegans) Sharp Health Plan

Overview	Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) is a premium assistance program for small employers and low- to moderate-income employees in San Diego County developed as a partnership between Sharp Health Plan and Alliance Healthcare Foundation. ¹² FOCUS was developed to increase coverage for workers in San Diego by providing health coverage for small businesses at affordable rates. FOCUS was funded by a \$1.2 million grant from the Alliance Healthcare Foundation, and later expanded by a \$400,000 grant from the California Endowment to cover additional enrollees.
Location	San Diego, California
Target Beneficiaries	Based on program budget, more than 150 businesses with 50 or fewer employees and up to 2,000 full-time employees with incomes below 300% of FPL.
Number of Participants	As of June 2000, 1,699 employees and 216 businesses participated in the program.
Time Frame	FOCUS is a two-year grant program that began in April 1999.
Eligibility	Employers: <ul style="list-style-type: none">• San Diego-based small businesses (e.g., 50 or fewer employees).• Not providing coverage in the past year. Employees: <ul style="list-style-type: none">• Full-time employees with incomes up to roughly 300% of FPL.• Employees must work full-time (as defined by the employer) and be uninsured for the past year.• All eligible uninsured dependents must also enroll.
Amount of Subsidy	Monthly premiums are divided among the employer, employee and Alliance. Employer contributions are fixed and range from \$24.29 per month for employee-only coverage to \$48.70 per month for employee and family. Employees pay according to their income and family size, ranging from \$10 to \$194 per month. Alliance subsidizes the remainder of the cost of the premium, ranging from \$0 to \$175 per month.

¹² Sharp Health Plan is an affiliate of Sharp Healthcare, a local health system. Alliance Healthcare Foundation was created after the sale of the nonprofit Community Care Network to a for-profit entity. The Foundation has assets of about \$100 million.

Coverage	Standard commercial plan design, including physician office visits for a \$5 copayment, 100% hospitalization coverage, outpatient prescription drugs (\$5 generic/\$15 brand name copayments), and limited mental health coverage. The plan is “no frills” (e.g., no chiropractic or infertility coverage).
Outreach and Marketing	Primary marketing successes were attained through: 1) a media relations campaign that used placements regarding FOCUS in local newspapers, business publications, radio talk shows, and television programs on the uninsured to build awareness/sales inquiries; 2) targeting key local business organizations (e.g., chambers of commerce, economic development councils, business improvement districts) for assistance in helping to build awareness through publication in their internal communication vehicles; and 3) enrollee referrals.
Financing	Sharp will spend \$160,000 over two years to administer the program (2/3 of the total administrative cost of the program). Alliance is contributing a \$1.2 million grant to subsidize the insurance premiums. The University of California, San Diego, was awarded a \$250,000 grant from the Oakland-based California Healthcare Foundation to evaluate the economic impact of the program. The California Endowment is contributing a \$400,000 grant to provide coverage for additional enrollees and to study the impact of the program on undocumented children.
Contact for More Information	Jeffrey Lazenby, Sharp Health Plan, (858) 637-6696, e-mail: jeffrey.lazenby@sharp.com.

Sources: *FOCUS Project Overview, Sharp Health Plan*, slide presentation by Kathlyn Mead, President and CEO, Sharp Health Plan, National Conference of State Legislatures, Health Care Conference, November 16, 1999; Personal communications with Jeffrey Lazenby, Sharp Health Plan, June 21, 2000.

Wayne County, Michigan

HealthChoice

Overview

HealthChoice is a managed care program that provides health coverage to businesses with three or more employees in Wayne County, Michigan. The program was created in 1994 and is administered by the Patient Care Management System, a management corporation created by the Wayne County Executive and Wayne County Board of Commissioners. The annual budget, based on premiums for basic health coverage for a projected 20,000 enrollees, is \$16.8 million.

Location

Wayne County, Michigan

Target Beneficiaries Number of Participants

Estimated target of 9,000 businesses and 20,000 employees.

As of June 2000, the program included 19,019 employees in 1,977 businesses. Roughly 80 to 90 new businesses join per month.

Time Frame

The program began on May 1, 1994, and is an ongoing program.

Eligibility

Employers:

- 90% of the business must be in Wayne County.
- At least 3 employees who qualify for coverage.
- 50% or more of all employees and 50% or more of employees qualifying for coverage must average a wage of \$10 per hour or less.
- Not offered health benefits in similar job classifications in the last 12 months.

Employees:

- Anticipated work future of 5 months or more.
- Work at least an average of 20 hours a week.
- Without health coverage and not eligible for any other benefits.

Amount of Subsidy

Premium costs are divided equally (one-third each) among the employee, the employer, and the HealthChoice program. The employee's share of the cost of coverage for single coverage is \$42; for employee and spouse is \$90; for employee and one minor dependent is \$70; for employee and two minor dependents is \$78; and for employee, spouse, and one to three minor dependents is \$120.

Coverage

Enrollees can choose from five health plans that cover a full range of inpatient, outpatient, emergency, diagnostic, and prescription drug services. Enrollees are assigned a PCP/gatekeeper who authorizes access to specialty care. The copayment for physician visits and prescription drugs is \$5. Supplemental riders are available for an additional premium charge. For example, vision and exam coverage is available for an additional 6 cents, dental for \$3.29, and unlimited hospitalization for \$1.86.

Outreach and Marketing

Radio and television advertisements and some direct marketing are funded by the program. Each participating plan employs a sales staff that targets the plan to small and midsize businesses.

Financing

The program is financed through enrollee premiums, employer contributions, and the HealthChoice program. HealthChoice's share of the cost of coverage is funded through a hospital indigent care pool, which is financed by state Medicaid funds, federal Medicaid matching funds, and county general funds.

Contact for More Information

Joyce Brown-Williams, Deputy Director, Patient Care Management System, (313) 833-3430 or fax (313) 833-7175.

Sources: Andrulis, Dennis and Michael Gusmano. *Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us?* The New York Academy of Medicine, Division of Health and Science Policy, Office of Urban Populations, August 2000; Personal communications with Joyce Brown-Williams, Patient Care Management System, June 13, 2000.

Acknowledgements

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About the Economic and Social Research Institute

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

About the Authors

Sharon Silow-Carroll, M.B.A., M.S.W., is a Senior Research Associate at ESRI. Ms. Silow-Carroll's areas of expertise include health care reform strategies and meeting the needs of vulnerable populations. Her recent projects involve assessing the strengths and weaknesses of several proposals to improve access to health coverage, including Congressional proposals for tax credits or deductions for people buying individual health insurance plans. She is author of an ESRI book analyzing the corporate/employer role in providing health care coverage to workers and families from economic, social, and cultural perspectives. She is coauthor of numerous reports and articles analyzing major health care reform plans.

Stephanie E. Anthony, J.D., M.P.H., is a Senior Research Associate at ESRI. Ms. Anthony specializes in research on improving the health of children, families, and vulnerable populations. She is coauthor of numerous reports analyzing the State Children's Health Insurance Program (S-CHIP), new strategies to extend health coverage to the uninsured, Medicaid and Medicare managed care, internal dispute resolution practices in managed care, the health care system in the District of Columbia, state and federal managed care patient protection legislation, hospital and health system governance, and youth violence.

Jack A. Meyer, Ph.D., is the founder and President of ESRI. He is also an Adjunct Associate of the Center for Health Policy at Stanford University. Dr. Meyer is the author of numerous books, monographs, and articles on topics including health care, labor market and demographic trends, and policies to reduce poverty. He has directed a series of studies on the role of employers in the U.S. health care system; innovative private sector cost management initiatives; new strategies to extend health coverage to the uninsured; and financing arrangements for safety net providers. Dr. Meyer is also the founder and President of New Directions for Policy, a health care consulting firm.

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

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

#405 *Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70* (July 2000). Cathy Schoen, Elisabeth Simantov, Lisa Duchon, and Karen Davis. This summary report, based on *The Commonwealth Fund 1999 Health Care Survey of Adults Ages 50 to 70*, reveals that those nearing the age of Medicare eligibility and those who recently enrolled in the program place high value on Medicare. At the same time, many people in this age group are struggling to pay for prescription drugs, which Medicare doesn't cover.

#391 *On Their Own: Young Adults Living Without Health Insurance* (May 2000). Kevin Quinn, Cathy Schoen, and Louisa Buatti. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance and Task Force analysis of the March 1999 Current Population Survey, this report shows that young adults ages 19–29 are twice as likely to be uninsured as children or older adults.

#370 *Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans* (March 2000). Kevin Quinn, Abt Associates, Inc. Using data from the March 1999 Current Population Survey and The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this report examines reasons why nine of the country's 11 million uninsured Hispanics are in working families, and the effect that lack has on the Hispanic community.

#364 *Risks for Midlife Americans: Getting Sick, Becoming Disabled, or Losing a Job and Health Coverage* (January 2000). John Budetti, Cathy Schoen, Elisabeth Simantov, and Janet Shikles. This short report derived from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance highlights the vulnerability of millions of midlife Americans to losing their job-based coverage in the face of heightened risk for chronic disease, disability, or loss of employment.

#363 *A Vote of Confidence: Attitudes Toward Employer-Sponsored Health Insurance* (January 2000). Cathy Schoen, Erin Strumpf, and Karen Davis. This issue brief based on findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance reports that most

Americans believe employers are the best source of health coverage and that they should continue to serve as the primary source in the future. Almost all of those surveyed also favored the government providing assistance to low-income workers and their families to help them pay for insurance.

#362 *Listening to Workers: Findings from The Commonwealth Fund 1999 National Survey of Workers' Health Insurance* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. This full-length analysis of the Fund's survey of more than 5,000 working-age Americans finds that half of all respondents would like employers to continue serving as the main source of coverage for the working population. However, sharp disparities exist in the availability of employer-based coverage: one-third of middle- and low-income adults who work full time are uninsured.

#361 *Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century* (January 2000). Lisa Duchon, Cathy Schoen, Elisabeth Simantov, Karen Davis, and Christina An. Based on The Commonwealth Fund 1999 National Survey of Workers' Health Insurance, this short report shows that although most working Americans with employer-sponsored health insurance are satisfied with their plans, too many middle- and low-income workers cannot afford health coverage or are not offered it.

#262 *Working Families at Risk: Coverage, Access, Costs, and Worries—The Kaiser/Commonwealth 1997 National Survey of Health Insurance* (April 1998). This survey of more than 4,000 adults age 18 and older, conducted by Louis Harris and Associates, Inc., found that affordability was the most frequent reason given for not having health insurance, and that lack of insurance undermined access to health care and exposed families to financial burdens.