ASSESSING STATE STRATEGIES FOR HEALTH COVERAGE EXPANSION: SUMMARY OF CASE STUDIES OF OREGON, RHODE ISLAND, NEW JERSEY, AND GEORGIA

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FIELD REPORT

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About the Economic and Social Research Institute

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

About the Center for State Health Policy

Rutgers Center for State Health Policy (CSHP) informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation. CSHP provides impartial policy analysis, research, training, facilitation, and consultation on important state health policy issues. Established in 1999, the Center is the newest research unit within the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, New Brunswick, New Jersey.

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OVERVIEW

The Economic and Social Research Institute (ESRI) and the Center for State Health Policy (CSHP) at Rutgers University examined the experiences of four states—Oregon, Rhode Island, New Jersey, and Georgia—that have made significant progress in health coverage expansion. The main goal of the project was to determine the key factors that appear essential for success. ESRI and CSHP researchers sought to assess the political, economic, and other "ingredients" that facilitated coverage expansion efforts in each of the states, as well as the barriers and mistakes that hampered those efforts.[1] The underlying question was whether common themes and lessons would emerge from a review of the experiences of these states, despite their different circumstances and strategies.

The research did reveal common themes across all or some of the sites studied, as well as lessons that emerge from individual state experiences. These are highlighted below. The overviews of the case studies that follow provide additional information for policymakers and program administrators. The full case studies, providing details and important insights, can be found at www.cmwf.org. The experiences of these states may provide guidance for other states as they consider how to address a growing uninsured population with limited resources, and how to prepare for more ambitious initiatives under better economic conditions.

The fiscal crises experienced by states in 2001–02 have led many states to consider cutting back Medicaid, State Children's Health Insurance Programs (CHIP), and other health coverage programs, as well as to postpone or cancel plans for further coverage expansions. These temporary setbacks should not obscure the fact that some states have made significant progress in access expansion over the past decade—overcoming myriad obstacles along the way—and remain committed to ensuring that people have access to health coverage.

States have pursued multiple strategies to reduce the number of uninsured. These strategies include increasing enrollment of those already eligible for public programs, initiating CHIP for low-income children, expanding eligibility for public programs to include populations that were previously ineligible (e.g., parents of Medicaid or CHIP-eligible children, adults without dependent children), and shoring up employer-sponsored coverage. Frequently, these state initiatives have been implemented in a piecemeal or incremental fashion, without being integrated into a comprehensive strategy. Several

[1] A subsequent, companion report will present a cross-cutting analysis of access expansion efforts in six additional states and summarize lessons emerging from the HRSA State Planning Grant initiative.

states, however, have tried to develop comprehensive approaches that integrate or at least coordinate multiple strategies in an effort to reach diverse uninsured populations.

This report presents summaries of case studies of four states that have made significant efforts to expand health coverage: Oregon, Rhode Island, New Jersey, and Georgia. For each state, site visits and interviews were conducted with program administrators, policymakers, and representatives from the consumer, business, and health plan/provider communities. The research team identified individuals from both the public and private sectors who have been instrumental in designing and/or implementing their state's coverage strategy, or who have been directly affected by that strategy.

UNIQUE STATE EXPERIENCES

The states selected for this study represent diversity in background, strategies, and experiences. The research confirms that each state must adapt a strategy to its unique character and circumstances. Yet other states can draw important lessons from their successes and challenges.

Oregon

Oregon has been a leader in health reform for many years, beginning with the implementation of the Oregon Health Plan (OHP) more than a decade ago. The OHP approach to broadening health coverage is built on the premise that it is better for a larger number of lower-income people to have good health coverage than for a smaller number of people to have the best possible coverage. When Oregon began OHP, this approach of prioritizing benefits was unique—and looked at with skepticism by many policymakers across the country. Now, however, other states may look to Oregon as they evaluate the trade-off between providing less generous coverage for more people and having a more generous benefit package for a smaller group. Specifically, states may explore the possibility of applying new federal flexibility rules (primarily under the new Health Insurance Flexibility and Accountability Act regulations) to similar types of coverage initiatives.

In addition to OHP, Oregon has developed a public–private partnership, the Family Health Insurance Assistance Program (FHIAP), which allows people to use state subsidies to purchase employer-sponsored coverage or individual insurance (either through the non-group market or through the state high-risk pool). These coverage programs in Oregon, which address different segments of the uninsured population and include both public and private initiatives, have contributed to a substantial reduction in the number of uninsured, from 16.4 percent of the population in 1990 to 12.3 percent in 2000.

Rhode Island

As a small state, Rhode Island chose an approach involving incremental expansion of one major public program, RIte Care, through central planning and coordination. While this strategy may not be ideal for states with larger or more diverse low-income populations, it was quite successful in reducing Rhode Island's uninsured rate to one of the lowest in the U.S.: 5.9 percent among all residents in 2000, and 2.4 percent among children. A unique feature of the program is the commitment to quality improvement through performance standards, collection and use of data, and a comprehensive approach to health care with a strong emphasis on prevention. This commitment has resulted in improved outcomes and long-term efficiencies. The state also outsourced many administrative tasks, helping to ensure that adequate resources and expertise were devoted to RIte Care.

When faced with budget constraints along with pressure by participating health plans to raise reimbursement rates, RIte Care created stop-loss provisions that reduced health plans' risk for certain high-cost services and took responsibility for paying providers directly for other high-cost services. Other states can consider these tactics when facing similar budget pressures. Rhode Island had difficulty convincing small employers to participate in its new premium subsidy program, RIte Share, and subsequently modified the program to allow the state to bypass employers and subsidize employee health insurance directly. States planning similar initiatives might consider building in a direct subsidy to individual workers. Also, the state made RIte Share mandatory for RIte Care applicants and beneficiaries with access to employer-sponsored coverage. Rhode Island's experiences underscore the need for states to be flexible, to continually monitor their programs in light of changing circumstances, and to make adjustments along the way.

New Jersey

New Jersey was one of the first states to introduce comprehensive reforms in the individual and small-group markets to address issues of health insurance affordability and access in the private sector. By initiating market reforms before expanding public coverage, the state stabilized a faltering market, thereby averting an increase in the number of the state's uninsured and positioning itself for subsequent coverage expansions. In particular, the standardization of small-group benefit packages implemented through these reforms helped to simplify the assessment of cost-effectiveness for the state's employer buy-in program. Maintaining stability in these markets while protecting access to affordable private insurance for high-risk individuals continues to be a challenge. But New Jersey's steadfast commitment to regulating these markets, with input from the business and insurance communities, is instructive for other states.

In the latter half of the 1990s, New Jersey concentrated its efforts on expanding state-subsidized coverage for low-income persons. The state first attempted to cover low-income adults and their families through the individual direct purchase market and later focused on a more comprehensive coverage program, targeted primarily at children, which built on the Medicaid/CHIP platform. Through its experimental foray into subsidized coverage through the individual market, the state learned that existing state platforms offer a more cost-effective approach to public subsidies, providing greater administrative efficiencies, lower per unit costs, and federal matching funds. In expanding coverage to children, New Jersey has found enrollment in general to be lower than expected, particularly in the highest cost-sharing plan, suggesting that other states may want to consider lower cost-sharing requirements to encourage more parents to purchase coverage for their children. In sharp contrast, enrollment by adults has far exceeded expectations and budgetary limits, suggesting a significant pent-up demand for affordable health insurance for adults. New Jersey's experience suggests that other states may wish to take a more gradual approach in order to assess the unmet demand for affordable insurance among the low-income adult population and the capacity of budgetary resources to meet this demand.

Georgia

A national innovator in CHIP enrollment, Georgia established a high CHIP income limit (235% of the federal poverty level) and conducted a vigorous initiative to enroll over 200,000 children in its PeachCare for Kids program. Georgia developed a streamlined application process to facilitate enrollment in both PeachCare for Kids and Medicaid. The state's passive re-determination system, which automatically re-enrolls children unless administrators are informed of changed circumstances, has supported program retention and may serve as a model for other states seeking continuity of care.

Georgia was the first state to redirect part of the disproportionate share hospital (DSH) funds to primary care, fostering prevention and early intervention. The governor's decision to bring several agencies with responsibility for health care under one administrative umbrella has improved program management. Georgia has also opened its state employee benefits program to allow medical staff in critical access hospitals in rural areas to purchase affordable coverage and used its purchasing leverage to assure that providers contracting with the state employee benefit plan also participate in Medicaid.

COMMON THEMES

Despite the fact that these four states started from different places, pursued different strategies, and enjoyed different levels of progress, some common themes emerge that may provide guidance to other states.

Importance of Political Leadership and a Clearly Defined Mission

It appears critical to have a strong leader, preferably the governor, adopt coverage expansion as a major priority and "sell" it to the public, legislators, and stakeholders. Each of the states studied had a strong program champion, at least at the initial stages. Similarly, establishment and acceptance of specific goals regarding health promotion or coverage expansion to certain populations greatly enhances legislators' ability to enact necessary reforms. Georgia, Rhode Island, and New Jersey had a strong commitment to expanding coverage for children; the latter two states opted to expand coverage to parents as well in order to promote coverage for the entire family. Oregon embraced the concept of prioritizing benefits to allow coverage for more people.

Public Promotion of Employer-Sponsored Insurance an Uphill Battle

States examined in this study have been searching for ways to promote employer-sponsored insurance through public subsidies. The goal is to leverage state dollars to help sustain employer contributions and prevent erosion of private coverage. This has been an unexpectedly difficult task, however, and the number of people enrolled in these programs is still relatively small, particularly when compared with Medicaid programs (e.g., OHP and RIte Care) that rely on group coverage outside the employer context. This may reveal a discrepancy between what policymakers in Washington see as the potential for public–private partnerships and what the states are actually experiencing when they try to form such partnerships as a vehicle for coverage expansion.

One reason for low enrollment numbers is that businesses have been less-willing partners than initially anticipated by policymakers, leading some programs to provide subsidies directly to employees instead. Rhode Island faced employer resistance to participating in the state's new premium subsidy program because of timing issues, financial difficulties among small firms, misunderstandings about program requirements, fear of administrative burdens, and the perception that different workers would be treated differently. Oregon's state-only FHIAP pays employees their share of the premium directly and does not involve employers. Its limited enrollment is related to lack of sufficient and stable financing.

After consulting with the business community, New Jersey also opted to offer direct subsidies to employees in its Premium Support Program (PSP). However, the state attributes low enrollment to a number of other factors, including delayed program start-up and challenges in meeting the federal waiver cost-effectiveness requirement whereby employers in New Jersey must contribute at least half of the premium to be eligible to participate in the state's PSP. Since the state's small-group reforms only require a

minimum 10 percent employer contribution to purchase a small-group plan in the state, many businesses do not qualify for this program. However, for those that do qualify, New Jersey's required standardization of small-group benefit packages has assisted the state in conducting a complex benefit-for-benefit cost-effectiveness analysis for small employers, a task that has proved onerous for many other states.

Georgia was unable to get the primary components of its *Business Plan for Health* off the ground due to an inability to design an affordable plan for subsidizing private coverage and diminished interest from the state's top-level leaders.

The findings do not suggest that these types of public–private partnerships cannot work, but rather that states have to pay particular attention to design features and learn from one another about key barriers and successful program elements. As other states learn from the experiences of the case study states, they may benefit from new federal flexibility on expanding employer-based insurance through Medicaid and/or CHIP. They may be well served, however, by not setting their expectations for promoting employer-based coverage too high, or putting all of their coverage "eggs" in the employer-based "basket."

Fostering Dialogue and Input from Stakeholders

While tensions among various interest groups are natural and unavoidable, efforts to reduce the adversarial quality of these relationships greatly enhance coverage programs' viability. Programs that require private plan participation, for example, benefited when states sought feedback from and were responsive to the needs of health plans. Including patient advocacy groups in discussions about the development and implementation of health reform proved to be essential for ensuring adequate consumer protections, developing a program that functions well for participants, and providing critical "buy-in," or participation, among the programs' constituencies. Public forums were a key part of Oregon's process when developing the Oregon Health Plan; consumer advocates in Rhode Island began as adversaries to the state but became partners in promoting RIte Care. Finally, the involvement of a neutral third party to convene meetings among various groups was very helpful in promoting consensus and support for reforms.

Struggle to Avoid Crowd-Out While Promoting Equity

Expansion of eligibility for public programs, without simultaneous promotion of private insurance, risks substitution of public for private coverage. It is therefore necessary to anticipate this possibility and establish rules to minimize crowd-out, in which employers drop health insurance coverage because public coverage is available. Yet anti–crowd-out rules (e.g., "look-back" periods) can result in having individuals in the same income

category with different levels and types of coverage and subsidies. In New Jersey, much of the early planning decisions focused on the need to treat families in similar economic situations fairly without giving currently covered individuals or employers incentives to drop private coverage. This concern drove the state's decisions to offer somewhat higher-income enrollees a benefit package comparable to those found in the private sector as well as to propose a state-subsidized premium support program for low-income families currently insured by their employers. In Rhode Island, expansion of RIte Care eligibility months before a premium subsidy program was implemented led to initial crowd-out that was very difficult to reverse.

Benefits of Building Coverage Under One Umbrella

The states studied for this report anticipated the benefits of expanding coverage under one "umbrella" program. Rhode Island and Georgia found it helpful to focus their efforts on establishing and then expanding a single program, providing "seamless" coverage across different eligibility groups. Similarly, New Jersey's decision to build on the state's Medicaid managed care platform, after a brief experiment with subsidizing coverage in the much more expensive individual market, facilitated a rapid response to CHIP requirements and simplified program administration. Oregon's major reform of the early 1990s, though made up of various components, was presented under one "Oregon Health Plan" banner.

This approach appears to be beneficial for garnering public and legislative support, minimizing administrative complexity, and allowing families to be covered together (thereby encouraging more appropriate use of the health care system). New Jersey and Rhode Island, for example, attributed success in part to developing strategies for children and parents to be covered together under one program. Based on focus groups conducted in conjunction with New Jersey KidCare, New Jersey discovered that whole-family coverage was preferred to child-only plans, which led the state to develop the FamilyCare model. Oregon accomplished whole-family coverage by allowing individuals eligible for Medicaid or CHIP to be covered under FHIAP.

Managed Care Concerns

When designing public coverage expansions that rely on managed care plans, states should pay particular attention to attracting and retaining plan participation. States use managed care as a way to control costs while keeping provider and plan payments sufficient to ensure adequate managed care capacity. One way in which states have assured capacity was to partner with safety net health plans. Although both Oregon and Rhode Island still have commercial plan participation in their programs, Rhode Island's support for a Community Health Center–based safety net health plan paid off when commercial plans

left the market or refused to accept new RIte Care enrollees. Oregon too has developed a relationship with a safety net health plan that has stepped in when commercial plans have backed away from serving OHP enrollees.

Economic Conditions Underscore Need for Flexibility and Creativity

A robust economy and state budget surpluses made major access initiatives possible during the mid- to late-1990s. In looking ahead, however, the principal challenge among all states studied is to sustain past gains through times of budget shortfalls. In order to avoid major cutbacks in coverage or eligibility, Rhode Island has imposed modest premiums and Oregon has proposed a leaner benefit package for non-mandatory Medicaid populations. Georgia will most likely move forward with belt-tightening in Medicaid and hold off planned expansions, but will try to avoid making fundamental changes in eligibility or benefits. To slow program enrollment in its FamilyCare program, New Jersey first curtailed its advertising campaign and eliminated presumptive eligibility, and later closed enrollment to non–general assistance childless adults. More recently, New Jersey has instituted additional measures in order to control escalating costs and keep the program solvent. These include closing enrollment to parents, ending enrollment of general assistance beneficiaries in FamilyCare managed care plans, making the benefit package of all adults similar to the most widely sold commercial HMO coverage in the state, and increasing cost-sharing for higher-income families. New Jersey is still committed to enrolling children and continues to face difficulties in recruiting and retaining children, especially in higher-income categories.

Finally, states remain interested in reaching out to groups, such as low-income adults without dependent children, who frequently fall into gaps between government programs and employer-based coverage. However, given limited state budgets, this has become a long-term goal.

The summaries of the case studies that follow discuss each state's current coverage expansion program or programs, elements that facilitated development of the initiatives, and obstacles that thwarted their efforts. They also describe the primary concerns and challenges each state faces as it confronts major budget constraints and offer lessons for other states interested in expanding health coverage. The full case studies are available as Commonwealth Fund publication **#565,** and on The Commonwealth Fund website, **http://www.cmwf.org.**

SUMMARY OF STATE CASE STUDIES

OREGON

The objective in studying Oregon was to identify the factors that led to the successful implementation of the Oregon Health Plan, a program that uses Medicaid and CHIP funding to cover low-income Oregonians. Other state programs that have contributed to the reduction in the uninsured were examined as well, including the Family Health Insurance Assistance Program (a state-only program providing access to private insurance coverage), the Oregon Medical Insurance Pool (the state high-risk pool), and the Insurance Pool Governing Board (which helps small businesses and the self-employed gain access to coverage). This case study looks at some of the issues that Oregon faced as the state sought to provide a basic level of benefits to a large segment of their low-income population and how they chose to address those issues.

Summary

Oregon has long been a leader in state health reform, as evidenced by the development and implementation of a broad range of public- and private-sector coverage expansion initiatives over the last decade. Oregon's approach to broadening health coverage is built on the premise that it is better for a larger number of lower-income people to have good—though not necessarily the most comprehensive—health coverage than for a smaller number of people to have the best possible coverage. Trimming the benefit package and relying on managed care freed up resources to assist more of the population in need. Oregon was also selected for study because the state has several coverage initiatives that address different segments of the uninsured population, and those efforts include both public and private initiatives. In addition, as a midsize western state, Oregon brought geographic diversity to the case studies. Finally, with new opportunities for federal flexibility around the Medicaid benefit package for optional populations, Oregon's approach to its priority list of services and the development of its basic benefit package offers an interesting option that other states may wish to study and/or pursue (Table 1).

The cornerstone of Oregon's approach has been the Oregon Health Plan (OHP). This plan initially featured an extension of Medicaid to all state residents with incomes below the federal poverty level (FPL), with coverage extended to 133 percent of the FPL for children under the age of six and pregnant women. Pregnant women and their newborns between 133 and 170 percent of the FPL are now also covered. The next piece involved the 1998 implementation of a Medicaid look-alike State Children's Health Insurance Program (CHIP), which used the OHP infrastructure. CHIP was implemented to cover children from birth to six years old between 133 and 170 percent of the FPL and

children from six to 19 years old between 100 and 170 percent of the FPL. The Family Health Insurance Assistance Program (FHIAP) was implemented in 1998 with sliding-scale state-only subsidies to allow people with incomes up to 170 percent of the FPL to gain access to private insurance coverage outside OHP. These programs, along with a strong economy in the late 1990s, have contributed to a substantial reduction in the number of uninsured, from 16.4 percent in 1990 to 12.3 percent in 2000.[2]

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

Oregon	Number
Total population	3,404,950
Nonelderly population (under 65)	3,004,320
Total population under 100% FPL	524,270
Total population under 200% FPL	1,096,000
Insurance status of nonelderly under 100% FPL	
Employer-sponsored coverage	93,294
Medicaid	187,214
Uninsured	169,623
Percent of all uninsured	36%
Insurance status of nonelderly under 200% FPL*	
Employer-sponsored coverage	291,157
Medicaid	281,633
Uninsured	322,916
Percent of all uninsured	69%

* Inclusive of under 100% FPL figures.

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

The underlying philosophy of the Oregon Health Plan is that all Oregonians should have access to a basic level of benefits and there should be an equitable and appropriate utilization of services. To achieve this, the state took a comprehensive view and developed a multi-pronged approach to expanding access to different vulnerable populations. In addition to the Medicaid expansion that covered many poor and near-poor people, Oregon established a high-risk pool (Oregon Medical Insurance Pool) and provided small businesses with access to coverage (Insurance Pool Governing Board).[3] In order to fund the Medicaid expansion, Oregon received a federal Section 1115 waiver to

[2] Oregon Office of Health Plan Policy and Research, *Oregon HRSA State Planning Grant Final Report to the Secretary,* October 2001. These numbers are from the Oregon Population Survey; to see how these numbers compare with the Current Population Survey, see Oregon Office of Health Plan Policy and Research, *Varying Rates of Uninsurance Among Oregonians: A Critical Comparison of Two Household Surveys,* October 2000.

[3] An employer mandate was also passed by the state legislature in 1989 but enabling legislation was not passed in time by the U.S. Congress so the state employer mandate never became law.

extend coverage to the non-categorically eligible groups and enable the state to limit the benefit package and introduce managed care (Table 2).

Table 2. Oregon Public Program Enrollment

Oregon	Number
Total enrolled in Medicaid/Oregon Health Plan (as of 12/01)	367,069
Total enrolled in CHIP (as of 12/01)	18,070
Total enrolled in Family Health Insurance Assistance Program (as of 3/02)	3,795
Total enrolled in Oregon Medical Insurance Pool (as of 10/01)	7,918

Sources: www.omap.hr.state.or.us for OHP enrollment figures; FHIAP staff for FHIAP enrollment numbers; www.cbs.state.or.us/external/omip for OMIP enrollment figures.

Several factors have contributed to the successful implementation of the Oregon Health Plan. First, publicity surrounding the death of a Medicaid-eligible boy who could not obtain an organ transplant because it was not a covered Medicaid service focused public attention on the provision of Medicaid services. Strong leadership in the state senate and later the governor's office helped garner support for a plan based on clearly defined goals and a clearly articulated philosophy. Stakeholder input contributed to the development of a prioritized list of services, a fundamental component of OHP. Growth of managed care capacity beyond the Portland–Salem metropolitan area helped in the implementation of OHP. Finally, FHIAP was successful because it allowed the whole family to be covered by one insurance plan and it was structured as a public–private partnership supporting the employer-based system and did not carry a public program stigma.

Oregon encountered challenges in implementing OHP. The state has struggled with provider reimbursement, maintenance of its managed care capacity, and retention of support of the business community. FHIAP has a long waiting list for enrollment and has had difficulty attracting enrollees with access to employer-sponsored coverage (Table 3).

Despite these challenges, Oregon is still committed to expanding coverage. Now, however, like many other states, they are facing a fiscal crisis. As of October 2001, Oregon's general fund revenues were down 9 percent compared with the September 2000 forecast, and personal and corporate income tax collections were down sharply compared with budgeted levels.[4] One of the largest components of the Oregon state budget is devoted to OHP, and the state believes that existing cost-containment mechanisms (managed care and benefit package limitations) are less effective than they were when

[4] National Conference of State Legislatures. *State Fiscal Outlook for FY 2002: October Update*. October 2001.

OHP began. Compounding state budget issues are concerns about rapidly rising health care costs, particularly for prescription drugs. As a result, Oregon is being forced to find ways to contain, or even lower, costs within the OHP.

As of winter 2001, state policymakers, at the urging of the governor, had chosen to reduce costs by coupling a coverage expansion with a reduction in benefits for certain populations. The idea was that savings generated from the benefit reduction would allow Oregon to expand coverage to everyone under 185 percent of the FPL. In a sense, this was a step away from Oregon's commitment as embodied in the OHP to cover people solely on the basis of income. Under the new plan, people with similar incomes but different family status would have different benefits. However, the state believed this was the most viable way of ensuring the long-term survival of the OHP. At the end of May 2002, the state submitted a waiver application to amend their current Section 1115 waiver as well as a Health Insurance Flexibility and Accountability (HIFA) waiver application. These waivers would allow Oregon to expand the OHP to cover people with incomes up to 185 percent of the FPL, provide more flexibility in structuring the OHP benefit package, increase enrollment in FHIAP, and use the balance of the state's currently unspent CHIP funds on the expansion. The state hopes to cover an additional 65,000 people when the waivers are fully implemented, with implementation beginning on October 1, 2002. Further details about the waivers are outlined in Table 4.

Table 3. Oregon Current Major Access Programs (OHP, FHIAP)

Program aspect	Medicaid (OHP)	CHIP (OHP)	FHIAP
Waivers/legislation required	Section 1115 waiver	Title XXI state plan	Passed by state legislature July 1997
Time frame	March 1993 waiver approved February 1994 began enrollment	June 1998 CHIP plan approved	July 1998 began enrollment

Enrollment	Total enrolled: 367,069
	Enrolled in fully capitated health plans: 234,939
	(as of December 1, 2001)
		Total enrolled: 18,070
		Enrolled in fully capitated health plans: 12,715
		(as of December 1, 2001)
			• 3,795 enrolled
			  • 2,212 in individual coverage
			  • 985 in OMIP
			  • 598 in employer-sponsored
			• 12 approved for enrollment
			• 26,406 on reservation list
			(as of March 19, 2002)

Eligibility criteria	• Oregonians < 100% FPL • Children birth to 6 < 133% FPL • Pregnant women < 133% FPL • Pregnant women and their newborns between 133% and 170% FPL	• Children birth to 6 between 133% and 170% FPL • Children 6–19 between 100% and 170% FPL	• Oregon resident • U.S. citizen or legal noncitizen • No health insurance for past 6 months (unless coming from OHP) • Income < 170% FPL • Assets/savings < $10,000 • All eligible children must have coverage before adults get subsidy • Not Medicare-eligible
Benefits/subsidies	Comprehensive inpatient and outpatient benefits Sliding-scale premium for adult, nonpregnant "expansion" eligibles	Comprehensive inpatient and outpatient benefit package (same as Medicaid) No enrollee premiums	Sliding-scale subsidy of private insurance premium cost • Income < 126% FPL—95% • 126% to 150% FPL—90% • 151% to 170% FPL—70% Commercially available benefit packages
Financing	Federal share: 59.20% State share: 40.80% Member premiums as noted above	Federal share: 71.44% State share: 28.56%	State-only program

Sources: www.omap.hr.state.or.us for OHP enrollment figures; FHIAP staff for FHIAP enrollment numbers.

Table 4. Proposed Changes to OHP from May 2002 Waiver Applications

Current Eligibility Categories	Current Program/ Benefit Package	Proposed Eligibility Categories	Proposed Benefit Package
Oregonians < 100% FPL	OHP (Medicaid)	"Vulnerable populations" – mandatory federal categories (children, pregnant women, categorically eligible adults)	OHP Plus – entitlement
		"Adult population"—adults who qualify based on income only	OHP Standard—capped
Children birth to 6 < 133% FPL	OHP (Medicaid)	Same	OHP Plus—entitlement
Pregnant women < 170% FPL	OHP (Medicaid)	Same	OHP Plus—entitlement
Children birth to 6 between 133% and 170% FPL*	OHP (CHIP)	Same	OHP Plus—entitlement
Children 6–19 between 100% and 170% FPL	OHP (CHIP)	Same	OHP Plus—entitlement
Pregnant women & their newborns 170%–185% FPL	Not eligible	OHP Plus (1115 Waiver)	OHP Plus—entitlement
Children birth to 19 170%–185% FPL	Not eligible	OHP Plus (HIFA)	OHP Plus—entitlement
Oregonians < 170% FPL	FHIAP	"New eligibles"	OHP Standard—capped** *or* FHIAP (up to 170% FPL)***
Oregonians between 170% and 185% FPL	Not eligible		

* Newborns in this income group are funded through Medicaid.

** OHP standard enrollment will be expanded initially up to 110% of the FPL, then moved up by 15% income bands as budget allows, giving priority to parents of CHIP and poverty-level Medicaid children and current clients moving over the upper-income limit of the OHP standard.

*** FHIAP will expand by about 9,500 in the group insurance market and then will open individual insurance. At that time, enrollment in individual insurance will be restricted to keep it approximately equal, from a State General Fund perspective, with group expansion.

Sources: Oregon HIFA application submitted May 31, 2002 and Oregon Section 1115 Waiver Amendment Application submitted May 31, 2002.

RHODE ISLAND

The objective in studying Rhode Island was to determine the underlying forces that led to the development and successful multi-phase expansion of RIte Care, a joint Medicaid and CHIP managed care program for low-income children, parents, and pregnant women. A specific goal was to examine the state's relatively new premium assistance program, RIte Share, to inform others about the impetus behind the program, its struggles, and how the state is addressing the difficulties of promoting private employer-based health coverage.

Summary

Rhode Island has achieved one of the lowest uninsurance rates in the U.S.: 5.9 percent in 2000 among all residents and 2.4 percent among children (Table 5, Figure 1). This is due primarily to the development and expansion of RIte Care, a combined Medicaid/CHIP managed care program that began in 1994 and has expanded incrementally to reach an enrollment that now exceeds 100,000 people. When the program was instituted in 1994, Rhode Island's rate of uninsurance was 7.8 percent for children and 11.5 percent statewide (Table 6). Rhode Island was also selected because it is a small, New England state, contributing to geographic diversity among case studies, and a prime example of a state that has pursued access expansion within one major public program with central planning and coordination. Although this is certainly not the only path to success, it provides other states with a blueprint for a centralized approach.

The case study's main findings involved the identification of certain essential elements that contributed to RIte Care's significant progress. Other states should seriously consider these elements as basic requirements, regardless of the precise model of access expansion they pursue. Among the key "ingredients" are a series of policy initiatives that were built around a clear mission: to improve the health of the population through major public policy reform. Political leadership from the top, backed by a staff with considerable expertise, helped translate the mission into workable programs. The use of outside experts strengthened the effort, while the inclusion of consumers, health plans, and other stakeholders in the design and implementation of the new programs helped to build consensus and support.

Another key to Rhode Island's access expansion strategy was the state's dedication not merely to reducing the number of uninsured but also to improving health. This approach was exemplified in the state's setting performance standards for health plans serving RIte Care enrollees, collecting and using data through evaluation studies, and taking an interdisciplinary, comprehensive view of health care.

Maintaining a non-adversarial relationship with participating health plans has been a top priority for state officials. State support for a Community Health Center–based safety net health plan paid off when commercial plans left the market or refused to accept new RIte Care enrollees. Also, a willingness to make mid-course corrections helped the state government overcome obstacles and address new challenges. Finally, a strong economy in the late 1990s provided a favorable climate for coverage expansion.

The state did face a number of obstacles and unintended consequences, including early opposition by consumer advocates and health care providers, deterioration of the small-group insurance market, and a budget crisis resulting from soaring RIte Care enrollment. The ways that state officials addressed these issues—by creating a structure for input by various interest groups, implementing insurance market reforms, creating a stop-loss feature in contract arrangements with health plans, and instituting modest premiums—provide important lessons for other states.

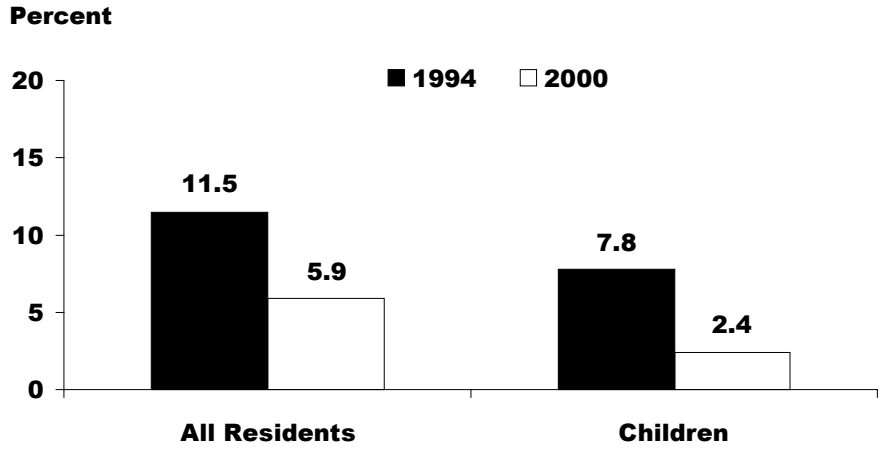
But the greatest challenge lies ahead, with severe budget constraints threatening the state's ability not only to expand access further, but also to maintain the gains achieved to date. An important part of this challenge involves shoring up employment-based coverage through the RIte Share premium assistance program. RIte Share pays all or part of the employees' share of the premium under employer-sponsored health coverage. Overcoming administrative difficulties and addressing employer concerns (particularly during a recession) have already led to adjustments in design, including a provision to bypass the employer entirely and another making RIte Share participation mandatory for eligible persons. These changes have helped the state meet its goal of enrolling 2,000 residents by June 30, 2002. Nevertheless, officials acknowledge that this program remains a "work in progress."

Table 5. Rhode Island State Profile and Overview, 1999–2000

Rhode Island	
Total Population	958,440
Nonelderly Population (Under 65)	813,690
Total Population under 200% FPL	288,030
Uninsured Nonelderly under 200% FPL	42,472
Percent of uninsured	74%

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

Figure 1. Rhode Island Uninsurance Rates, 1994 and 2000



Source: Rhode Island Department of Human Services.

Table 6. Rhode Island Current Access Programs

	RIte Care	RIte Share
Program type	Managed care Medicaid and CHIP combination	Premium assistance program for Medicaid and CHIP-eligible individuals and families with access to employer-sponsored health insurance; mandatory enrollment
Waivers, legislation required	State legislation and amendments Medicaid 1115 Demonstration approved in 11/93, extension approved 9/98 Medicaid Section 1931 State Plan Amendment in 1998 Title XXI CHIP 1115 waiver 1/01	State legislation: Health Reform Rhode Island 2000 1906 Medicaid State Plan Amendment
Time frame	Began enrollment in 1994; federal waiver expires in 7/02, but program is expected to continue	Began 5/01, expected to continue
Enrollment (as of 8/31/02)	116,778 enrollees (including 1,989 substitute/foster care children)	2,148 enrollees
Eligibility Criteria	Uninsured parents with children under age 19 up to 185% FPL Uninsured pregnant women and children under 19 from families with incomes up to 250% FPL Licensed family child care providers who care for children enrolled in DHS's subsidized child care program, and their children under age 19	Meets RIte Care income criteria (parents to 185% FPL, children and pregnant women to 250% FPL) and has access to employer-sponsored health insurance
Benefits and/or Subsidies	Comprehensive medical and mental health coverage plus enhanced services such as home visits, nutrition counseling, and smoking cessation classes Services in prior FFS Medicaid plan that are not included in the prepaid RIte Care plan (e.g., long-term care, dental care) are provided and reimbursed on a FFS basis Window replacement to reduce exposure to lead is provided on an out-of-plan basis for lead-poisoned children	State pays the employee's share of family coverage, copays, and wrap-around coverage for Medicaid benefits not in employer's health plan
Financing	Federal Medicaid and CHIP funds, state Medicaid and CHIP contributions, state-only funds (for undocumented children and others who do not meet federal criteria) 1/02 began charging premiums to members above 150% FPL	Federal Medicaid & CHIP funds, state Medicaid & CHIP contributions 1/02 began charging premiums to members above 150% FPL

NEW JERSEY

The objective in studying New Jersey was to explore the factors and challenges related to the state's active involvement in health coverage initiatives. New Jersey has been at the forefront of insurance market reform, public subsidies for private insurance, and expansion of public coverage for children and adults. Some initiatives were more successful than others, but all provide valuable lessons to other states.

Summary

Over more than a decade, New Jersey has sought to expand health insurance affordability and accessibility, first through regulatory reforms in the private market and later through expansions in public coverage and subsidies to low-income families (Table 7). In the early 1990s, New Jersey was one of the first states to introduce comprehensive reforms in the small-group and individual purchase insurance markets to promote access to affordable coverage regardless of health risk and to encourage price competition among carriers. Since the mid 1990s, the state has also been a leader in expanding publicly subsidized coverage. New Jersey's State Children's Health Insurance Programs (CHIP), including NJ KidCare, was initiated in 1998 and NJ FamilyCare was initiated in 2001. These programs have among the most generous eligibility criteria in the country, with more than 238,000 adults and children enrolled in 2001.[5] As a result of these programs, as well as a strong private coverage market, the uninsured rate among the nonelderly in the state declined to 14.4 percent in 2001 from a high of 19.1 percent in 1996.

Table 7. New Jersey State Profile and Overview, 1999–2000

New Jersey	
Total population	8,186,500
Nonelderly population	7,117,310
Total population under 200% FPL	2,218,490
Insurance status of nonelderly	
Employer	5,295,890
Individual	267,430
Medicaid	562,480
Uninsured	991,520
Insurance status of nonelderly under 200% FPL	
Employer	639,874
Medicaid	106,958
Uninsured	586,190
Percent of All Uninsured	59%

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

[5] As of 12/3/01. Office of Statistical Analysis and Managed Care Reimbursement, Department of Human Services.

In contrast to some other states that have initiated comprehensive health care reform, New Jersey's coverage initiatives have been incremental and developed over time. The key features of New Jersey's health care access expansions include:

- a combined focus on stabilizing coverage in the private sector and expanding state-sponsored coverage;
- flexibility in its public coverage expansion in program design, outreach, and administration to improve enrollment of children, including a willingness to shift focus from solely covering children to covering parents and some childless adults; and
- consideration of the relationship of public programs to private coverage and an emphasis on maximizing private coverage through such efforts as an employer buy-in program.

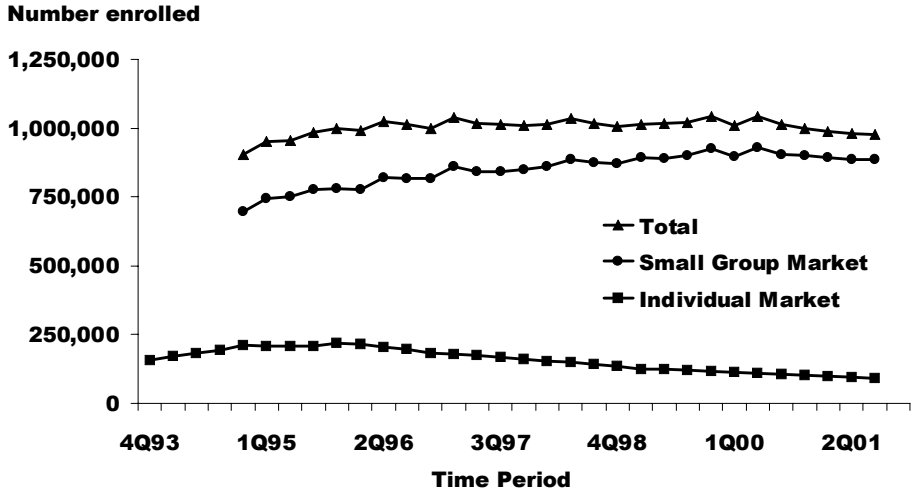
Many factors contributed to the successful enactment of New Jersey's various initiatives. Individual (i.e., non-group) and small-group insurance market reforms were achieved, in large part, as a result of the need to avert collapse of the state's insurer of last resort, Blue Cross Blue Shield. The regulatory culture in the state and its history of engaging stakeholders in shaping policy solutions enabled a broad coalition to reach consensus rapidly on these reforms.

The successful enactment of the NJ KidCare and NJ FamilyCare programs can be attributed to the support of the governor and a favorable fiscal environment, stemming initially from the availability of federal CHIP dollars, a strong economy, and buoyant state tax receipts, and later from tobacco settlement funds. Strong entrepreneurial leadership from the governor's staff and creative state policy officials also contributed greatly to program development and enactment.

New Jersey overcame significant obstacles in creating its policy initiatives that may be instructive for other states considering similar initiatives. The insurance reforms enacted in 1993 and 1994, which were generated in large part by the insurance industry itself, were among the most inclusive in the nation, providing guaranteed issue, renewability, limits on preexisting conditions, standardized benefit packages to simplify price comparisons for purchasers, and pure community rating. (Community rating requires that all purchasers be charged the same premium based on the experience of the entire group; premiums cannot vary by health status, age, gender, or geographic location.) The reforms also included a unique "pay or play" requirement mandating that all health insurance

carriers operating in the state either issue individual coverage or pay an assessment to cover a proportionate share of reimbursable losses of those carriers that do sell in the individual market. Resistance by small business interests to the breadth of these reforms led to significant softening of the rating regulations in the small-group market. While pure community rating in the individual market initially did not have the feared impact of rapid premium increases, over time prices have risen steadily, making direct purchase of insurance unaffordable for many. After small-group market reform, enrollment in small-group plans increased continuously over the next six years, from approximately 690,000 individuals in 1994 to more than 930,000 in the second quarter of 2000 (Figure 2). In contrast, enrollment in non-group plans rose initially but has fallen from a peak of 220,000 in 1996 to near 90,000 in 2002, at a steady decline of 3 percent per quarter.

Figure 2. New Jersey Individual and Small-Group Market Post-Reform Enrollment, 1993–2001



Sources: NJ Department of Banking and Insurance. IHC/SHE Historical Comparison of Covered Individuals 1/2/2002.

The state also learned some important lessons from its initial attempt to subsidize health insurance purchase in the individual market. The insurance reforms included the creation of the ACCESS program, a subsidy program for low-income persons wishing to purchase insurance directly through the individual market, which proved to be administratively complex and a costly mechanism for covering the uninsured. As a result, the ACCESS program was phased out and was eventually replaced by more comprehensive efforts to expand Medicaid and CHIP.

The NJ KidCare program was designed with the philosophy that all children should have health insurance coverage, but that higher-income families should bear some responsibility for the cost of coverage. Program design was premised on the theory that children in the lowest income group should receive the most comprehensive benefits as they are most likely to need services that their families cannot afford. Families with more resources should have benefits that more closely resemble plans available through employers. Thus, the state developed a tiered-benefit approach that provided different levels of benefits to different income groups and imposed cost-sharing for the highest income group (Table 8).

Table 8. New Jersey Publicly Subsidized Coverage Programs

Program Type	NJ FamilyCare for children (previously KidCare)/ Phase I & II	NJ FamilyCare/Premium Support Program for adults (plans A and D only)
Waivers/ legislation required	Children's Health Care Coverage Act. 12/97 (P.L. 1997, c.272)/ 5 amendments 1999–2001 Medicaid 1931 waiver (Plan A) Title XXI State Plan (Plans B,C,D)	FamilyCare Health Coverage Act 7/00 (P.L. 2000, c. 71) 1115 CHIP waiver
Time frame	Enrollment began Feb/March 1998 (Plans A, B, and C) Enrollment for Plan D—July 1999	Family Care Enrollment began October 2000. CHIP 1115 waiver approved 1/2001 Premium Support Enrollment began July 1, 2001/Outreach began in May
Benefits/ subsidies	Benefits: Plan A—Same as Medicaid managed care Plans B & C—Modified commercial benefit package Plan D—Average commercial HMO benefit Subsidies: Plan A—No premium, no copays Plan B—No premium, copays for some services Plan C—$15 premium per month, per family; copays $5–$10 Plan D—Premium based on sliding-scale ranges from $30–$100 per month, copays $5–$35	Family Care Benefits: Plan A—Same as Medicaid managed care Plan D—Average commercial HMO benefit Subsidies: Plan A—No premiums or copayments Plan D—Premium based on sliding-scale ranges from $30–$100 per month for families with children. Parents above 150% FPL pay an additional $25 for one parent or $35 for two parents. Childless adults pay no premiums, copays $5–$35. Premium Assistance Program—wrap around employer benefit to cover all Plan D benefits if deemed cost effective. Premium lower than for FamilyCare.

Program Type	NJ FamilyCare for children (previously KidCare)/ Phase I & II	NJ FamilyCare/Premium Support Program for adults (plans A and D only)
Eligibility Criteria	Children under 19 in families earning less than or equal to 350% FPL: Plan A—133% FPL or less Plan B—134%–150% FPL Plan C—151%–200% FPL Plan D—201%–350% FPL Six-month waiting period for Plans B, C and D. Exceptions allowed for waiting period in some cases.	Plan A: • Parents up to 133% FPL • Pregnant women up to 200% FPL • Single adults/childless couples up to 50% FPL • Individuals on General Assistance (GA) Plan D: • Parents who do not qualify for Medicaid up to 200% FPL • Single adults/childless couples from 51% to 100% FPL Six month waiting period for Plan D Premium Support Program: • FamilyCare eligible whose employer offers health insurance with comparable benefits and pays 50% of the premium.
Enrollment as of 12/01	Plan A—33,855 Plan B—9,868 Plan C—27,741 Plan D—15,008 Total—86,472	Single Adults • GA—24,495 • 0%–50% FPL—11,396 • 51%–100% FPL—6,858 Parents • TANF 0%–133% FPL—77,398 • 134%–150% FPL—13,772 • 151%–200% FPL—12,983 Prior Health Access enrollees—1,306 Other restricted aliens—3,616 TOTAL FamilyCare Adults—151, 824 Premium Support Program—115 enrolled and 108 pending open enrollment.
Financing	Plan A B, C, and D— 65% federal funds, 35% state (CHIP matching rate)	Plan A—50% federal, 50% state funds (Medicaid matching rate) Plan D: • Parents—65% federal, 35% state (CHIP matching rate) • GA, restricted aliens, childless adults—100% state funded

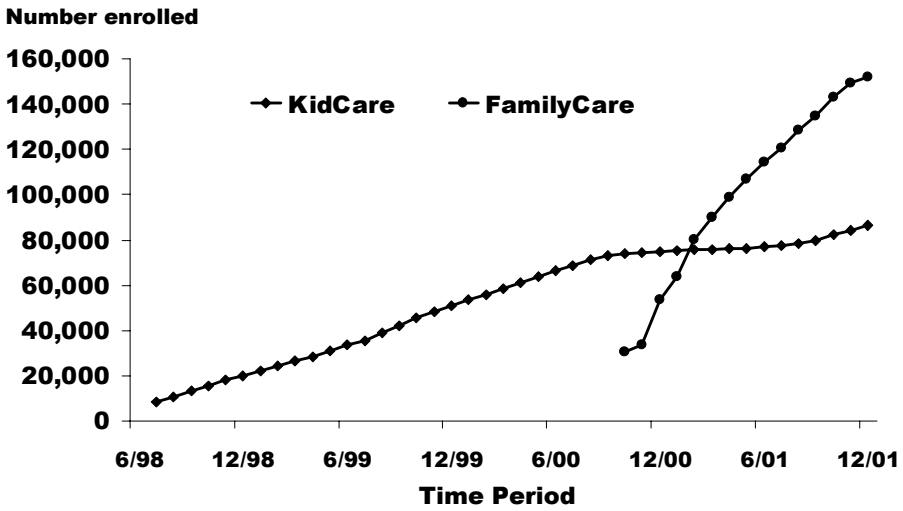
Source: Office of Statistical Analysis and Managed Care Reimbursement, NJ Department of Human Services, Enrollment as of December 2, 2001.

Like CHIP initiatives in most other states, the NJ KidCare program experienced early difficulties reaching enrollment targets. Program managers were quick to respond with aggressive outreach strategies. Enrollment eventually moved closer to expectations,

but only after garnering considerable criticism from state legislators and the media. Even with the expansion of coverage to parents, which was intended to increase the number of children covered, child enrollment overall as of December 2001 is still only about half of the target (53%).[6] However, enrollment varies considerably by type of plan. Plans with no or low cost-sharing had approximately 76 percent enrollment compared with 22 percent in the plan with high cost-sharing requirements. This suggests that, even if premiums and cost-sharing requirements are well below market rates, they may be significant deterrent to enrollment.

The state's enrollment experience in NJ FamilyCare was very different (Figure 3). After opening CHIP to parents and other adults, program enrollment reached its three-year target in just nine months. The extent of the response of adults to NJ FamilyCare has been attributed to widespread awareness of the program resulting from a statewide multimedia campaign and the existing KidCare program, as well as to a significant unmet need for affordable health insurance in the adult population. NJ FamilyCare enrollment was particularly high among parents earning between 134 and 200 percent of FPL, who are required to pay monthly premiums. The low enrollment of children in similar plans suggests that the willingness to pay premiums may differ when coverage is being purchased for adults rather than children. Although New Jersey has experienced high demand for subsidized coverage for adults, it is not yet clear whether higher coverage of eligible children will follow.

Figure 3. NJ KidCare and FamilyCare Enrollment Trends, 1998–2001



Source: Office of Statistical Analysis, Office of Managed Care, NJ Department of Human Services, December 2001.

[6] Office of Statistical Analysis and Managed Care Reimbursement, NJ Department of Human Services, December 3, 2001.

The rapid enrollment of adults in NJ FamilyCare, higher-than-expected costs (particularly among the general assistance population), and the emergence of a significant state budget shortfall led to the need to control program growth. In response, the state closed enrollment to adults without children (with the exception of general assistance beneficiaries) in September 2001, stopped outreach and marketing, and allocated an additional $25 million in fiscal year 2001 in order to maintain coverage for parents. Because of continued concerns about program solvency, the state instituted in 2002 additional cost-containment strategies, including closing enrollment to parents, no longer enrolling general assistance beneficiaries in FamilyCare managed care plans, making the benefit package of all adults similar to the most widely sold commercial HMO coverage in the state, and increasing cost-sharing for higher-income families. The state has also faced delays in its employer buy-in program under NJ FamilyCare and difficulty in demonstrating cost-effectiveness as defined by the CHIP federal waiver requirements. Enrollment has been slow, with only 150 individuals enrolled and 108 pending enrollment six months after the program began. As a result, it is unlikely to reach its revenue target from this source.

The state faces even greater financial challenges ahead. Unrestrained state spending and tax cuts in recent years positioned New Jersey poorly for the economic shockwaves of September 11 and the national economic downturn. New Jersey faces one of the largest state budget deficits in the country. The slumping economy is likely to increase the number of uninsured in the state, while the capacity of the state to extend or even maintain its current coverage efforts is in doubt.

GEORGIA

The objective in studying Georgia was to identify factors leading to the development of the state's integrated and flexible approach to child health coverage as implemented through the state's Medicaid program and its CHIP program, called PeachCare for Kids. The study explored the state's experience in leveraging public funds to expand coverage for low-income people and in forging partnerships with business leaders, providers, and community representatives to develop Georgia's *Business Plan for Health*. The following summary describes the forces and ingredients leading to the development of these efforts and identifies reasons why certain components were successful while others stalled.

Summary

Georgia made a concerted effort to place all of the state's purchasing—under Medicaid, CHIP, and for its own employees—under one roof. It was successful in developing a streamlined public program enrollment system that substantially reduced the number of

uninsured children (Tables 9–11). Georgia's consolidation and integration of diverse health programs have enabled the state to leverage its purchasing power to foster improvements in coverage and access in a state with rural access barriers, reluctance by some providers to participate in public programs, and few organized systems of care. State officials have also forged partnerships with business leaders, providers, and community representatives to develop Georgia's *Business Plan for Health,* a blueprint for coordinated public- and private-sector initiatives to improve access to health care. This plan brought together diverse stakeholders to develop a sweeping package of public, private, and community-based approaches to the problem of the uninsured. Central to the plan is the idea that public-sector expansions must go hand-in-hand with support for private-sector coverage.

Table 9. Georgia State Profile and Overview, 1999–2000

Georgia	Number
Total population	7,772,210
Total adults 19–64	4,874,480
Total children 18 and under	2,116,080
Total population below 100% FPL	1,229,930
Adults 19–64 under 100% FPL	643,400
Children 18 and under below 100% FPL	471,410

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

Table 10. Georgia Current Access Programs

	Medicaid	PeachCare for Kids
Program type	Medicaid	Medicaid look-alike CHIP program
Waivers, legislation required	None	Legislation passed in 2000 to increase eligibility to 235% the FPL
Time frame		Plan approved in 1998. Eligibility expansion from 200% FPL to 235% FPL in 2001
Enrollment	1,331,110	190,377
Eligibility Criteria	• TANF adults—44% FPL • Pregnant women/ newborns—200% FPL • Infants—185% FPL • Children 1–5—133% FPL • Children 6–19—100% FPL	• Children through age 18 from Medicaid eligibility level up to 235% FPL • Three-month waiting period
Benefits and/or Subsidies	Medicaid benefits	Same benefits as Medicaid excluding non-emergency transport and targeted case management
Financing	Federal match 59.7% State contribution 40.3%	Federal match 71.8% State contribution 28.2% Most recent expansion funded through tobacco settlement monies Sliding-scale premiums

Source: Georgia Department of Community Health, Office of Communications for enrollment numbers.

Table 11. Georgia Public Program Enrollment, 2002*

Georgia	Number
Total enrolled in Medicaid	1,331,110
Adults 19 and over	478,660
Children 18 and under	852,450
Total enrolled in PeachCare for Kids	190,377
Total enrolled in public programs	1,521,487

* 2002 year-to-date numbers; unduplicated numbers as of 5/02.

Source: Georgia Department of Community Health, Office of Communications.

Several factors have contributed to the Georgia's success in developing and expanding public coverage programs for children, leveraging public financing, and developing the state's *Business Plan for Health*. First, by focusing on children—a vulnerable population that generates public support—the state has maximized political support for comprehensively tackling a single task. Georgia has not only implemented effective outreach and enrollment policies to cover children, but has also created workable

strategies to retain coverage for kids. Building on the existing Medicaid infrastructure, CHIP has served as a laboratory for the development of program improvements that are now used in both Medicaid and CHIP. These improvements have contributed to a children's coverage program that is integrated and user-friendly.

Second, by creatively using its leverage as a major purchaser, the state has undertaken a number of initiatives to foster coverage and improve access with relatively small amounts of funds. For example, the state has made a number of small demonstration grants to localities to assist the uninsured. It has also re-directed a portion of Disproportionate Share Hospital (DSH) funds from hospital services to primary care and wielded its purchasing leverage to increase provider participation in Medicaid and CHIP. It has also used the forum of stakeholders organized initially to write the *Business Plan for Health* as a sounding board for ongoing discussions about setting priorities during a period of scarce state resources.

To date, few of the initiatives outlined in the *Business Plan for Health* have been implemented. Progress has been greater in the public arena and in developing community approaches than in developing private-sector strategies. While major new developments in all areas are currently on hold because of the state's shaky fiscal outlook, Georgia seems to have taken a pronounced step back from some of the proposed private-sector strategies, such as tax credits for small employers. State officials attribute this retreat to an independent analysis prepared for the state showing a relatively low impact on health coverage per dollar spent on state tax credits (as currently designed), the centerpiece of the private-sector proposals. But they have not responded by trying to redesign the tax credit or develop another approach to health coverage among uninsured workers.

In addition, given the costs involved and the political climate in the state, Georgia seems unlikely to pursue Medicaid expansions for adults. As a result, it seems unlikely that the state will embark on any substantial coverage initiatives in the near future, especially for adults who are not targeted for coverage under current programs.

Georgia's state leadership is hopeful that even though the environment is not currently ripe for major coverage expansions or other new initiatives, the infrastructure recently built can serve as a foundation for new programs in the future. This infrastructure includes leadership from the governor and in the Department of Community Health, dialogue and partnerships with a wide variety of stakeholders, and experience developing creative approaches for leveraging the state's purchasing clout.

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

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

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

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

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

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

#518 *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health

insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income.

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

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

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

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

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

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

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

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

#484 *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

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

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

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

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

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

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

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

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

#476 *"Second-Generation" Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review,* vol. 22, no. 2. This study of Medicaid managed care programs in seven states finds that the programs require state policymakers to make difficult tradeoffs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at www.cmwf.org.

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

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

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

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

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

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

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

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

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

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