HRSA STATE PLANNING GRANT UPDATE: A REVIEW OF COVERAGE STRATEGIES AND PILOT PLANNING ACTIVITIES

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ABSTRACT: To help states examine options and craft policies to cover uninsured populations, the federal Health Resources and Services Administration (HRSA) is providing two types of grants: State Planning Grants and, more recently, Pilot Project Planning Grants. This report finds that most states awarded Pilot Project Planning Grants are exploring strategies that build on employment-based coverage, generally through publicly funded premium assistance. Some states uncovered support among employers and providers for tax credits to subsidize the employer and/or employee share of the premium. Others are exploring premium assistance through Medicaid and the State Children's Health Insurance Program (SCHIP). In addition to employment-based strategies, states are improving outreach and enrollment for people eligible for but not enrolled in existing programs; using federal waivers to extend Medicaid/SCHIP coverage to parents and other adults; establishing health savings accounts; reinsuring private coverage; imposing a full employer mandate; and assessing single-payer and multipayer universal coverage models.

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Overview

To help states examine options and craft policies that address the lack of health insurance among millions of Americans, the federal government is providing two types of grants: State Planning Grants and, more recently, Pilot Project Planning Grants.

Since fiscal year 2000, the Health Resources and Services Administration (HRSA)[1] has been awarding **State Planning Grants (SPGs)** to states to study potential ways to expand health insurance. The goal of the program is to support states as they analyze their uninsured populations and health care marketplaces in order to develop solutions to ensure health coverage for all state residents. With an initial Congressional appropriation of $15 million in its first year, the SPG program has in the last four years awarded 46 states, four U.S. territories, and the District of Columbia initial grants averaging about $1 million (Tables 1 and 2). Additional "continuation" grants as well as no-cost extensions have allowed many states to continue their SPG work. [2]

In September 2004, the Department of Health and Human Services (HHS) announced awards for a new type of grant for states that have previously received SPG program funds. The **Pilot Project Planning Grants** provide funds to support the design and planning of a pilot project to expand coverage to a significant uninsured population within the state. These grants are intended to support states that have developed consensus on a coverage option and would like to test that model, perhaps on a county or multiple-community level. Eight states and one territory have each received a grant of up to $400,000 for the 12-month, September 2004–August 2005 period (Table 3).

Facilitated by these grants, most states have completed or will soon complete the process of studying their own data, identifying the greatest problems and obstacles, attaining a common understanding of the policy solutions, and assessing what reforms their state could support. Of course, given the less-than-robust economy that most states are still facing, moving forward on policy options that require new funding may be difficult. Yet health coverage expansion is likely to be focused on the states in the near future, and many states are indeed moving ahead. For the others, the analyses, relationship building, and policy development already conducted will be invaluable for building support for options that might be implemented when a window of opportunity opens.

By collecting and synthesizing the states' experiences, this report advances a key goal of the SPG program: for grantee states to use their findings to inform other states, stakeholders, and federal policymakers. The SPG program has become more than just a funding stream for state research and planning activities; it is a mechanism for health policy stakeholders at all levels to understand the issue of uninsurance and possible solutions on a more sophisticated level. Sharing of information about data analysis and policy development, along with the kinds of experiments being developed under the pilot planning grants, are vital for creating successful models that can be expanded and replicated throughout the nation.

Activities Funded through the Grants

SPG grantees have used the funds primarily to conduct the following activities:

- Collect and analyze data on uninsured individuals, businesses, and the marketplace;
- Engage and build consensus among stakeholders;

[1] HRSA is part of the federal government's Department of Health and Human Services (HHS).

[2] In 2004, HHS was awarded Continuation Limited Competition Grants, averaging $150,000, to help states complete and/or enhance existing SPG work.

- Study and assess options for expanding coverage, such as building upon private employer-sponsored insurance, Medicaid, and the State Children's Health Insurance Program (SCHIP); or state employee benefits programs through state, federal, and private partnerships.

The Pilot Project Planning Grants may be used for a variety of pre-implementation activities including but not limited to the following:

- Continuing data collection and analysis on the uninsured populations of the state;
- Modeling various policy options and determining which strategy best addresses coverage expansion for the targeted uninsured population;
- Developing premium and benefits structures, administrative and marketing strategies, and financing mechanisms;
- Identifying legislative and regulatory requirements, and pursuing satisfaction of those requirements;
- Educating key stakeholders and the public on the pilot being considered;
- Creating a process to evaluate and measure the impact of the demonstration.

It is expected that at the end of the pilot planning process, states will have a blueprint to implement the pilot.

Summary of SPG Activities and Results

The breadth of the State Planning Grant program is reflected in both the number of states and territories that have received SPG support, and in the range of activities conducted and policy options considered. The in-depth research being conducted by the grantees offers a window into state-specific circumstances, challenges, and approaches. At the same time, a review of the states' activities illustrates a number of commonalities across the states in terms of factors contributing to uninsurance, effective methods of consensus building, and potential models for addressing the problem. An examination of the strategies being pursued (as well as policy options that have been rejected or postponed) reflect the difficult economic times and states' inability to devote significant public funds toward comprehensive expansion strategies.

Data Collection and Analysis

In conducting data collection and analyses, most grantees fielded employer and/or household surveys to gain a greater understanding of coverage, access, and the makeup of their uninsured population. Some conducted analyses to determine the costs incurred by the health care safety net in serving the uninsured, and potential savings or "offsets" from expanding coverage. Many states also conducted analyses using existing Medical Expenditure Panel (MEPS) and Current Population Survey (CPS) data specific to their state. Focus groups with employers, individuals, and providers were commonly used to dig deeper into several key questions, such as why some employers do not offer coverage, or why employees do not take up coverage that is offered, and what it would take to change their decisions.

Policy Development and Consensus Building

Policy development and consensus-building activities, though described separately in the following profiles, are inherently linked. The activities themselves varied widely across grantee sites, but most involved stakeholder representatives coming together through special committees and task forces in order to:

- Identify target subpopulations of uninsured based on data analyses;
- Identify potential strategies for addressing the problem;
- Commission econometric modeling to estimate the cost and impact of selected strategies;
- Conduct a communications campaign to educate stakeholders and build support;
- When possible, convert the strategies into legislation and action.

Because grants were awarded at different times, and because political and financial circumstances varied across the nation, each state is at a different stage in the process of policy development. The profiles taken as a whole illustrate the evolution of this type of activity. Some states are still focusing on collecting data, identifying potential expansion strategies, and building coalitions, while a few have passed legislation on specific reforms and have begun the implementation process. Some states admit the need to place more aggressive reforms on the "back burner" until the economy improves.

In general, the state SPG activity summaries indicate an acknowledgement that an overwhelming majority of uninsured are either full-time or part-time workers, so policies designed to reduce the uninsurance rate must address the problem from that context. That is, most states are actively exploring strategies that build on employment-based coverage, generally through some type of publicly funded premium assistance. Some states uncovered support among employers and providers for the use of tax credits to subsidize the employer and/or employee share of the premium. Others are exploring premium assistance through Medicaid and SCHIP. This trend is illustrated in one state's finding that a majority of employers surveyed thought improving access to insurance should be a higher priority for the government than expanding access through the safety net.

In addition to employment-based strategies, other policy options being explored include:

- Improving outreach and enrollment for people eligible but not enrolled in existing programs;
- Using federal waivers to extend Medicaid/SCHIP coverage to parents and other adults;
- Establishing health savings accounts;
- Using reinsurance to make private coverage more affordable;
- Imposing a full employer mandate;
- Assessing single-payer and multipayer universal coverage models.

Also, some states are pursuing efficiencies to be better able to maintain or expand coverage, through such strategies as enhancing primary care services for indigent populations, or designing case and pharmacy management programs for safety net health centers. Thus, despite limited state budgets, a number of states are using the SPG process to create new strategies or combine approaches in new and innovative ways.

Pilot Planning

Although the range of strategies studied under the original SPG process was quite wide and spanned the public-to-private and incremental-to-comprehensive spectra, it is interesting to note that virtually all of the proposed pilots involve incremental reforms that build on employer-sponsored insurance (ESI). Most target uninsured, low-income workers and small businesses, and involve some type of premium-assistance strategy. Three of the states specifically refer to developing the "three-share" model, which involves a third funding source that supplements employer and worker premium contributions toward employer-based coverage. The pilot planning process will help these states identify and develop financing strategies for that third share, with two of the states stressing the importance of community-specific plan designs and funding sources.

Two states plan to assess *reinsurance* mechanisms to help make coverage more affordable to uninsured workers and their employers. And at least two Pilot Planning grantees will pursue small-group purchasing pools (one specifically through association health plans) to help make insurance more accessible and affordable to employers. Other premium assistance mechanisms that will be examined include public–private funded vouchers, employer tax credits, and high-risk pools.

In the current fiscal and political climate, it is not surprising that the Pilot Planning grantees are pursuing policy options that build on ESI. First, state-specific data analyses have confirmed that many uninsured residents are in families with full-time workers. Second, under ongoing budgetary pressures and escalating Medicaid costs, states are choosing options that leverage their scarce public dollars with employer and worker contributions. [3] Perhaps acknowledging that past premium assistance models have had mixed results, these states plan to design models that fit their specific needs and circumstances. The three-share and employer-subsidy models also reflect an understanding that employers, as well as low-income workers, need financial assistance and incentives to purchase coverage.

Two of the nine Pilot Planning grantees are combining strategies that will build on employer-based coverage with options that target other populations. One will develop a strategic plan to enhance the primary care infrastructure for those utilizing the safety net—through Medicaid or safety net expansions (e.g., federally qualified health centers). Another would address a problem of "underinsurance" by expanding its PPO network and creating a single plan for Medicaid and Medicare enrollees. For a summary of states' policy strategies, see Table 4.

Following this introduction is a set of concise summaries of SPG activity, as reported in the grantees' most recent reports submitted to HRSA.[4] Each state summary includes the following attributes:

- data collection and analysis;
- consensus-building and policy development activities;
- findings;

[3] For additional examples of state initiatives that leverage private and/or federal dollars, see *Stretching State Health Care Dollars during Difficult Economic Times* (Silow-Carroll and Alteras, The Commonwealth Fund, October 2004, http://www.cmwf.org/publications/publications_show.htm?doc_id=243623).

[4] These include the majority of interim and final reports and addenda submitted from September through November 2004.

- policy options;
- next steps;
- contact information.[5]

Also included are summaries of the pilot planning projects awarded to a subset of states and territories, based on the states' grant applications and a review by HRSA officials.

[5] Readers will notice that some profiles include "Preliminary Findings," while others include "Findings and Recommendations" and "Lessons Learned." The former generally indicates a state that is still within its grant period and has submitted an interim report, while the latter generally indicates a state that submitted a final report and has completed its SPG tasks.

Table 1. State Planning Grant Program Grantees

FY 2004 (9)	FY 2003 (10)	FY 2002 (12)	FY 2001 (9)	FY 2000 (11)
American Samoa	District of Columbia	Alabama	Arizona	Arkansas
Guam	Florida	Georgia	California	Delaware
Kentucky	Mississippi	Hawaii	Colorado	Illinois
Louisiana	Missouri	Indiana	Connecticut	Iowa
Michigan	Nebraska	Maine	Idaho	Kansas
North Carolina	New Mexico	Maryland	South Dakota	Massachusetts
Pennsylvania	North Dakota	Montana	Texas	Minnesota
Puerto Rico	Oklahoma	New Jersey	Utah	New Hampshire
Tennessee	Rhode Island	South Carolina	Washington	Oregon
	Virginia	Virgin Islands		Vermont
		West Virginia		Wisconsin
		Wyoming		

Note: States and territories that have not received a State Planning Grant are Alaska, Nevada, New York, Ohio, and Northern Mariana Islands.

Source: Health Resources and Services Administration.

Table 2. State Planning Grants, FYs 2000–2004

State or Territory	Original Grant Awarded	Continuation and Pilot Project Grant(s)	Pilot Planning Project	Total Grants Awarded	Report Submitted September 2004	Lead Agency
AL	FY 2002	2003		$936,711	Interim	Alabama Department of Public Health
AR	FY 2000	2002/2003		$2,092,749	*	Arkansas Department of Health
AS	FY 2004	No		$868,841	N/A**	American Samoa Office of the Governor
AZ	FY 2001	2002		$1,412,879	Final	Arizona Health Care Cost Containment System
CA	FY 2001	No		$1,197,000	No longer active	California Health and Human Services Agency
CO	FY 2001	2004		$1,490,000	Interim	Colorado Office of the Governor
CT	FY 2001	2002/2003/2004	**X**	$1,322,812	*	Connecticut Office of Health Care Access
DC	FY 2003	2004		$1,121,872	Interim	D.C. Department of Health
DE	FY 2000	2001/2003/2004	**X**	$1,500,810	Interim	Delaware Health Care Commission
FL	FY 2003	2004		$1,066,872	Interim	Florida Agency for Health Care Administration
GM	FY 2004	No		$373,955	N/A**	Guam Department of Public Health and Social Services
GA	FY 2002	2004	**X**	$1,570,518	Final	Governor's Office of Planning and Budget
HI	FY 2002	2003/2004		$1,491,429	Interim	Hawaii Department of Health
IA	FY 2000	2001/2003		$1,618,654	Final	Iowa Department of Health
ID	FY 2001	2002/2003		$1,404,421	Final	Idaho Department of Commerce
IL	FY 2000	2001/2003/2004	**X**	$1,964,177	Final	Illinois Department of Insurance
IN	FY 2002	2003/2004	**X**	$1,471,598	*	Indiana Family and Social Services Administration
KS	FY 2000	2003/2004	**X**	$1,883,205	*	Kansas Insurance Department
KY	FY 2004	No		$713,619	N/A**	Kentucky State Office of Rural Health, University of Kentucky
LA	FY 2004	No		$801,319	N/A**	Louisiana Department of Health and Hospitals
ME	FY 2002	2003/2004		$1,630,423	*	Maine Governor's Office of Health Policy and Finance
MD	FY 2002	2003		1,417,301	*	Maryland Department of Health and Mental Hygiene

State or Territory	Original Grant Awarded	Continuation and Pilot Project Grant(s)	Pilot Planning Project	Total Grants Awarded	Report Submitted September 2004	Lead Agency
MA	FY 2000	2003		$1,254,195	Interim	Massachusetts Division of Medical Assistance
MI	FY 2004	No		$900,000	N/A **	Michigan Department of Community Health
MN	FY 2000	2001/2003/2004		$2,251,938	Interim	Minnesota Department of Health
MS	FY 2003	2004		$1,295,221	Interim	Mississippi Division of Medicaid Office of the Governor
MO	FY 2003	2004		$1,030,361	Interim	Missouri Department of Health and Senior Services
MT	FY 2002	No		$721,377	Final	Montana Department of Public Health and Human Services
NC	FY 2004	No		$864,598	N/A**	North Carolina Department of Health and Human Services
NJ	FY 2002	2003/2004		$1,305,935	*	New Jersey Department of Human Services
NH	FY 2000	2001		$1,223,095	No longer active	New Hampshire Department of Health and Human Services
ND	FY 2003	2004		$944,085	Interim	North Dakota Department of Health
NE	FY 2003	No		$776,522	Interim	Nebraska Health and Human Services System
NM	FY 2003	No		$905,000	*	New Mexico Human Services Department
OK	FY 2003	2004	**X**	$1,274,360	Interim	Oklahoma Health Care Authority
OR	FY 2000	2001/2003/2004		$1,773,262	Final	Office for Oregon Health Plan Policy and Research
PA	FY 2004	No		$900,000	N/A**	Pennsylvania Governor's Office of Health Care Reform
PR	FY 2004	No		$712,811	N/A**	Puerto Rico Department of Health
RI	FY 2003	No		$961,156	Interim	Rhode Island Department of Human Services
SC	FY 2002	2003		$1,213,560	*	South Carolina Department of Insurance
SD	FY 2001	2002		$1,140,336	*	South Dakota Department of Health
TN	FY 2004	No		$837,274	N/A**	Tennessee Department of Commerce and Insurance
TX	FY 2001	2003		$1,550,121	Interim	Texas Department of Insurance
UT	FY 2001	No		$1,102,000	*	Utah Department of Health

State or Territory	Original Grant Awarded	Continuation and Pilot Project Grant(s)	Pilot Planning Project	Total Grants Awarded	Report Submitted September 2004	Lead Agency
VT	FY 2000	2003		$1,437,125	Final	Vermont Agency of Human Services
VI	FY 2002	2003/2004	**X**	$1,386,274	Interim	Virgin Islands Office of the Governor
VA	FY 2003	2004		$1,101,601	*	Virginia Department of Health
WA	FY 2001	2002/2003/2004		$1,774,151	Interim	Washington Office of Financial Management
WV	FY 2002	2003/2004	**X**	$1,782,065	Interim	West Virginia Health Care Authority
WI	FY 2000	2003/2004		$1,722,346	Interim	Wisconsin Department of Health and Family Services
WY	FY 2002	2003/2004		$1,395,938	Final	Wyoming Department of Health

* Reports from these states were not included in this synthesis/review due to time restrictions for this project.

** New fiscal year 2004 grantees were announced in September 2004, with no reports are due as of November 2004; therefore there is no summary update included in this report.

Note: This table does not include states that have not requested and/or received State Planning Grants (AK, NY, NV, OH). These states have had the opportunity to apply for SPGs in prior years and in 2005.

Table 3. Pilot Planning Limited Competition Grants, Grant Period September 2004–August 2005

State	Grant Amount	Target Population	Strategy	Pilot Site(s)
Connecticut	$394,240	Low-income workers who decline ESI* Employers who don't offer coverage	Premium subsidies to workers and employers	Not yet selected
Delaware	$355,910	Uninsured adults with income 100–200% FPL,** and their employers	Employer-focused coverage expansion using three-share or alternative cost-sharing model	Not yet selected
Georgia	$400,000	Uninsured workers in small businesses, and employers willing to participate	Three-share model with community-specific financing mechanisms	Four pilot sites: Atlanta metro area, another metro area, rural communities in north and south Georgia
Illinois	$400,000	Low-income working uninsured population and their employers	Three-share model with community-specific design features and financing mechanisms such as reinsurance, high-risk pool, purchasing cooperative, others	Two sites not yet selected in addition to existing pilot in St. Clair county
Indiana	$273,800	Uninsured workers	Premium assistance or buy-in program for uninsured low-wage workers and employers	Not yet selected
Kansas	$400,000	Uninsured workers in small businesses that do not offer coverage	Reinsurance mechanisms, possibly combined with employer tax credits and worker subsidies	Not yet selected
Oklahoma	$400,000	Small businesses	Small-business purchasing pool	Not yet selected
		Uninsured workers with income below 200% FPL	Premium assistance vouchers for employers, workers, and their dependents	

State	Grant Amount	Target Population	Strategy	Pilot Site(s)
Virgin Islands	$351,687	Uninsured workers and their employers Underinsured Medicaid and Medicare enrollees	Small-business purchasing pools through Association health plans Expanded PPO for Medicaid and Medicare enrollees	Not selected
West Virginia	$399,991	Uninsured residents aged 50–64	Undetermined coverage expansion model	Two sites, one urban and one rural, not yet selected

* Employer-supplied insurance.

** Federal poverty level.

Note: There is no SPG update summary for pilot grantees CT, IN, and KS because as indicated in Table 2, reports from these states due September 2004 were not available for this synthesis/review as of late November 2004

Table 4. Major Policy Strategies Explored by States

Policy Strategy	States/Territories Exploring and/or Piloting Strategy
Medicaid/ SCHIP expansion (HIFA)	AL, AZ, CT (pilot planning), FL, GA (SPG and pilot planning), ID, IL (pilot planning), IN, KS (pilot planning), OK, VT
Public-Private Partnerships (Premium assistance/3-share models)	AL, AZ, CT (pilot planning), FL, GA (SPG and pilot planning), ID, IL (pilot planning), IN, KS (pilot planning), OK, VT
Tax Credits	MN, MT, KS
State employee health plan buy-in	AL, WV
Reinsurance	IL (pilot planning), KS (pilot planning), RI, WV
Small employer purchasing pool/other strategies targeting small employers	AZ, CO, DC, FL, IL, KS, MT, ND, OK (pilot planning), OR, TX*, VI (pilot planning), WV, WY

Policy Strategy	States/Territories Exploring and/or Piloting Strategy
Establishment of high risk pool/uncompensated care pool	FL, WV, WY
Other	FL: evidence-based medicine HI: full employer mandate and HSAs/MSAs ND: expand coverage for Native Americans; improve outreach and education RI: primary care coverage for uninsured residents VT: financing MSAs for Medicaid and SCHIP enrollees VI: Medicaid PBM; coordination of Medicare and Medicaid WV: small group and individual market product development

* Texas' "Consumer Choice Health Benefit Plan" would be available to small and large employers, as well as individuals.

Note: This table is intended to give a sample of states that have explored or are continuing to pursue specific types of coverage strategies. It is based on SPG reports that were available for review under this project only; the table may include states that studied but later rejected specified strategies; also, states may have explored additional strategies not delineated here.

Alabama — Initial Grant Awarded: FY 2002

Update on SPG-Funded Activities

Data Collection and Analysis

- A household telephone survey, also focus groups with consumers and employers in Year 1.
- Secondary data reviews in Year 1 and Year 2.

Policy Development

- Of 14 coverage expansion options identified during Year 1, a few were selected for economic modeling in Year 2 (see Strategies below).
- A September 2003 referendum on a tax package that would have provided funding to expand current public health insurance programs did not pass.

Consensus Building

- The core decision-making group, composed of high-level staff within key state agencies and several advocacy groups, met on an ad hoc basis and provided direction and input to the project.
- A project Web site was maintained and two publications regarding the uninsured were distributed.

Preliminary Findings

- A significant number of state residents are eligible but not enrolled in current programs: 21 percent of the uninsured are potentially eligible for employer-sponsored insurance; 16 percent are potentially eligible for public programs.
- Data analysis highlighted the magnitude of the uninsurance problem, that is, the high number of people eligible for currently available programs.
- Analysis revealed that no one approach will "fix" the problem of the uninsured.
- There is a need for public education and guidance for businesses with respect to insuring the uninsured.

Lessons Learned and Recommendations

- Periodic funding for data collection, analysis, and education of employers/employees is important for policy development and should be continued.
- Quantitative data has been most helpful in terms of focusing on which coverage options to study further.

Strategies

- The following reform options have been modeled:
  - 1931 Medicaid Expansion—Would raise the Medicaid income eligibility level for nonpregnant adults from its current level of approximately 13 percent of federal poverty level (FPL).
  - HIFA Medicaid Waiver—Would provide coverage to uninsured parents of Medicaid and SCHIP enrollees as well as childless adults.
  - Full Cost Buy-in as with Local Government—Would establish a program modeled after the local government program currently administered by the Alabama State Employees

Insurance Board; following economic modeling, the project no longer considers this to be a viable option.

- HIPP Medicaid Waiver—Would expand Medicaid's current Health Insurance Premium Payment Program.
- Medicaid Buy-In—Would allow a buy-in to Medicaid.
- SCHIP Expansion—Would cover the unborn who would be SCHIP eligible after delivery.

Next Steps

- **The state is not currently in a position to implement any option to expand coverage.**
- The SPG process continues to inform discussion and develop strategies that might be implemented in the future if the situation changes.
- Under a no-cost extension of the State Planning Grant, the state will extrapolate data from the household survey to develop county-level uninsurance data, develop a communications plan to guide state officials with respect to uninsurance issues, and can continue to have meetings of the core workgroup to keep stakeholders abreast of findings.
- Also, the state will develop and distribute materials for employers and individuals aimed at explaining importance of health insurance.

Lead Agency/Contact Person

Alabama Department of Public Health, www.adph.org/idea; Fern M. Shinbaum, project director, Alabama State Planning Grant, (334) 206-5568, fshinbaum@adph.state.al.us

Arizona — Initial Grant Awarded: FY 2001

Update on SPG-Funded Activities

Data Collection and Analysis

- Analyzed CPS and MEPS data, as well as state surveys and state agency data reports.
- Literature reviews were compiled on current policy approaches and best practices.
- Stakeholder interviews with employers and providers.

Policy Development

- Developed two policy options with the help of a technical advisory committee and through input from public testimony provided by key stakeholder groups. Both have been drafted into legislative language for review by the state's legislature:
  - A state-operated insurance plan for small businesses;
  - A public–private premium assistance program for Medicaid and SCHIP families with access to employer-sponsored coverage.

Consensus Building

- Policy options described above were developed in coordination with a task force made up of various constituent groups. These groups included insurance carriers, retirement groups, advocacy agencies, employee unions, the hospital association, health facilities, and county governments.

Findings and Recommendations

- An examination of data on the state's Healthcare Group (HCG), a quasi-coverage pool for small businesses, found that the enrolled population had similar characteristics to that of a high-risk pool, with increasing acuity. This was also reflected by the 17 percent increase in health care costs for the pool over a three-year period, a period during which premiums increased by only 9 percent.
- The federal government should consider funding research similar to that done under the SPG program, but specifically examining the issues of the uninsured elderly who are in need of long-term care services.

Lessons Learned

- Relying on secondary data to develop and potentially pilot policy options is not the most effective strategy. Although using these data is less expensive and can be done more quickly than analyses using primary data, it does not provide the level of detail necessary to make well-informed decisions.
- Working concurrently with two consensus-building constituencies—one legislatively based (the Task Force) and one stakeholder based (the Technical Advisory Committee)—was a very effective way to develop policy options and meet project goals.

Strategies and Next Steps

- Continue to pursue ways to implement the two policy options developed under this project: the state-operated insurance plan for small businesses and a public–private premium

assistance program for Medicaid and SCHIP families with access to employer-sponsored coverage.

- Conduct a series of focus groups to further understand the county-level demographics and characteristics of the working uninsured.

Lead Agency/Contact Person

Arizona Health Care Cost Containment System Administration (AHCCCSA); Anthony Rodger, director, (602) 417-4000.

Colorado Initial Grant Awarded: FY 2001

Update on SPG-Funded Activities

Data Collection and Analysis

- Household telephone survey.
- Fourteen focus groups with small-business representatives.

Policy Development

- Development of the idea of a Small Group Enrollment Center, which would serve as a single point of entry (not a purchasing pool) to the health coverage system for all small employers and self-employed individuals. It would require all carriers in the small-group market to participate.
- Introduced legislation to the 2002 general assembly to expand the definition of "dependent" to include 18-to-24-year-olds who are not full-time students. At this point, the legislation has been defeated.
- Analyzed potential options for restructuring Medicaid under a Health Insurance Flexibility and Accountability (HIFA) waiver.

Consensus Building

- Created four workgroups to focus on consumer education, employer-based coverage, the health care marketplace, and uninsured individuals and families.

Preliminary Findings

- Approximately 516,000 Coloradoans (11.7%) were uninsured in 2001.
- In four of the state's regions (Boulder, Denver, Mountain, and Northeast) children have higher uninsurance rates than adults.
- Small-business owners feel a "social responsibility" to provide health insurance to full-time employees, but that does not appear to extend to dependents.
- Small-business owners still see health insurance as an important recruitment and retention tool, but at the same time they do not feel well equipped to make decisions about what coverage to offer, and they do not necessarily trust insurance brokers to offer objective advice.

Strategies and Next Steps

- Pursue HIFA waiver to better coordinate efforts of Medicaid, SCHIP, and the Colorado Indigent Care Program so children and families would have an easier time receiving benefits without being shifted among programs as their family income fluctuates. Streamlining of public programs could allow the state to expand coverage to target populations not currently served.
- Assess SCHIP outreach strategies among the Latino community, in order to develop and implement new models for reaching this population.
- Examine ways to streamline care under SCHIP for children with special needs.

- Explore ways in which low-income children and their parents can maintain coverage when transitioning from publicly funded insurance to private coverage.
- Pursue efforts with the consumer education workgroup to develop an initiative, in collaboration with private-sector business groups, to educate small employers on how to be "smart purchasers" of health coverage for their employees.
- Continue to work with the employer-based-coverage workgroup to explore the development of the Small Group Enrollment Center, described above (see Policy Development).

Lead Agency/Contact Person

Office of the Governor, Office of Policy and Initiatives; David Rivera, senior policy advisor, david.rivera@state.co.us

Connecticut Pilot Planning:

Premium Assistance and Employer Subsidy

Grant Amount: $394,240

Preliminary Activities

Data Collection and Analysis

- Conduct in-depth interviews to follow up on the 2001 household and employer surveys conducted under the original SPG project.
- Re-field those surveys to gather more up-to-date 2004 data.
- Explore, model, and analyze the various policy options associated with the pilot project goals.

Policy Development

- Renew the search, through an already-developed request for proposal, for a private sector entity that would develop and operate a program to use public funds for subsidizing employer-based insurance. In the process, the state will take advantage of the $3.6 million in state funds already designated for subsidies in the FY 2005 budget.
- Build consensus around selected policy options by soliciting and collecting input from stakeholder groups.

Pilot Planning

Strategy/Model

- Premium subsidies for employees who decline employer-sponsored coverage that is offered to them.
- Subsidies for employers who do not currently offer coverage.

Target Population

- Small businesses that do not offer coverage and low-income employees who do not take up offered coverage.

Planning Tasks

- Determine the size and structure of proposed initiatives.
- Tailor the implementation plan to the target populations.
- Develop demonstrations of potentially successful models.

Goal

- To develop a plan to provide adequate and affordable coverage for all the state's residents.

Lead Agency

The Office of Health Care Access (OHCA), in collaboration with the Department of Social Services and the Office of Policy and Management.

Contact Information

Marybeth Bonadies, director of research and planning, Office of Health Care Access;
Marybeth.bonadiesm@po.state.ct.us; (860) 418-7014.

Delaware — Initial Grant Awarded: FY 2000

Update on SPG-Funded Activities

Data Collection and Analysis

- Analysis of existing and potential capacity of safety net providers, and pervasive service delivery issues affecting the uninsured and providers.
- Demographic analysis of total uninsured population, based on integration of three data sets, and including a qualitative assessment of uninsured consumers' perception of the quality of their health care.
- Analysis of total cost of health care, comparing state and national trends.
- Research on health disparities of the uninsured.
- Analysis of enrollment impact and cost of options for expanding coverage.

Policy Development

- Pursued and analyzed two general categories of policy options: single payer and building blocks (see Strategies below).

Consensus Building

- Delaware Health Care Commission (DHCC), comprised of five government officials and six private citizens, holds public meetings providing a forum for discussion with key stakeholders.
- DHCC formed Health Care Access Improvement Coalition as public–private partnership of about 50 members, to develop and monitor delivery and safety net initiatives.
- Created Small Business Task Force to study coverage options.
- Use of "assembly method" consensus-building model: key stakeholders convene to frame issues at onset, and later to provide input on findings; core group oversees research and formulates strategy based on stakeholder input.

Lessons Learned and Recommendations

- Process requires significant allocation of time and commitment of key stakeholders.
- Focus group and qualitative information gathering are unexpectedly difficult; must carefully plan recruitment strategies.
- Must assess and incorporate into planning process the safety net's capacity, financial viability, and willingness to participate in systematic state-level change.
- Financial resources from federal government are necessary for coverage expansion.
- Federal government should view states as partners and work collaboratively to find solutions to such problems as the "disconnect" between the purchase and consumption of heath care.

Strategies

- Produced with state Chamber of Commerce an informational Web site that assists small businesses in coverage decisions (www.healthinsurancechecklist.com).
- Designed "single-payer" model:
  - All nonelderly legal residents are automatically eligible and enrolled in single state health plan;

    - People pay premiums, with income-related subsidies up to median income; subsidies are financed through general revenues;
    - Single state entity responsible for administration, cost control, and rate reimbursement negotiation with providers.
- Designed "multiple-payer" model:
    - All nonelderly legal residents automatically eligible and enrolled in one of several private insurance plans offering coverage through a state pool;
    - Financed by an 8 percent payroll tax on employers and 2 percent tax on employees (similar tax on nonworkers);
    - Single state entity responsible for administration, cost control, and negotiation with insurers.
- Designed "building blocks" model:
    - Medicaid and SCHIP combined into a single program that covers everyone up to 200 percent of FPL;
    - State purchasing pool for small employers and individuals that offers multiple insurers, and that negotiates on behalf of enrolled population;
    - Tax credits, graduated by income, to subsidize coverage for high-risk people and those between 200 and 300 percent of FPL; subsidies financed through general revenues.

Next Steps

- During FY 2005, will conduct econometric modeling to update cost and enrollment impact estimates for single and multipayer systems.
- Conduct activities under SPG Pilot Planning Grant including advanced planning on (see accompanying Pilot Planning project summary):
    - Use of existing infrastructural elements that offer platform for a unique coverage expansion model;
    - Employer-focused coverage expansion models.
- Policy conference in early 2005 that reunites stakeholders and assimilates their activities into an integrated plan.

Lead Agency/Contact Person

Delaware Health Care Commission; Paula Roy, Executive Director, Delaware Health Care Commission, paula.roy@state.de.us

Delaware Pilot Planning:

Employer-Focused Coverage Expansion for Low-Income Adults

Grant Amount: $355,910

Preliminary Activities

Data Collection and Analysis

- Use outcomes of disparities research to assess needs of populations at risk for poor health outcomes.
- Study Small-Business Health Insurance Committee's vendor reports regarding impact of 1992 small-business reforms and opportunities for pooling.
- Evaluate costs of employer/employee premiums compared with direct services costs.
- Study Single-Payer Committee's vendor reports regarding opportunities for single-payer financing.

Policy Development

- Design large-scale coverage expansion strategy, using existing processes and infrastructure of the Delaware Community Healthcare Access Program (CHAP), a statewide screening and referral system for uninsured patients.[6]
- Explore various strategy options and potential for blending among three-share model, small-group or high-risk pooling, single payer financing, health savings accounts, employer buy-in, SCHIP expansion.

Pilot Planning

Strategy/Model

- Employer-focused coverage expansion for low-income adults, possibly using three-share or alternative cost-sharing model; specific strategy not yet determined.

Target Population

- Uninsured adults with income between 100 and 200 percent of FPL, who represent 19 percent of the total uninsured population and have the lowest income for which public coverage is not available, and employers of this population.

Planning Tasks

- Develop a health insurance benefits package with focus on prevention and disease management; include primary and preventive services, hospitalization, subspecialty services, ancillary laboratory and radiology services, mental/behavioral health, prescription drugs.
- As an initial step toward disease management, identify how to use Delaware Health Information Network to provide clinical decision-making support and access to shared patient data.
- Create a statewide provider network and proposed fee schedule and/or patient cost-sharing arrangement, working with the CHAP network and state medical society.

[6] Created under the federal HRSA Community Access Program, CHAP is a centralized statewide outreach, information, eligibility, and referral system to screen patients for eligibility in public health insurance, link patients to medical homes and social services, and identify uninsured patients.

- Evaluate methods for use of systems and eligibility staff for coverage program enrollment.
- Determine initial marketing strategy and partnership opportunities with employer community
- Identify legislative, regulatory, and financing requirements for implementation, and seek necessary support.
- Using results of committee reports (above), consider incorporating small-group pooling, creation of high-risk pools, single-payer financing, health savings accounts, other lessons/developments into strategy targeting employer participation.
- Obtain public input on coverage expansion options.

Goals

- By September 2005, produce a report that describes accomplishments of pilot-planning process and serves as a blueprint for implementation.
- Ultimate anticipated outcome: a detailed report on all aspects of a coverage program design, cost, implementation, financing, and sustainability including administration, outreach, cost-sharing, cost-containment, and other features.

Florida — Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Data Collection

- Household telephone survey.
- Seven focus groups with the uninsured; additional focus groups with insurers.
- Key informant interviews with employers.
- Review of recent insurance-related legislation.

Policy Development

- Building on issues explored by the 2003 Governor's Task force on Access to Affordable Health Care for Floridians, including the need to address cost drivers, and options for strengthening the safety net. Specific options include:
  - Establishing small-employer purchasing pools;
  - Premium assistance for employer-sponsored coverage;
  - Creation of a new risk pool/residual market in health coverage;
  - Restructure Medicaid using a HIFA waiver;
  - Promote evidence-based medicine and healthy lifestyles;
  - Encourage development of local health care programs for the uninsured.

Consensus Building

- Efforts at consensus building began with the 2003 Task Force meetings.
- Additional efforts included the formation of a Policy and Technical Advisory Council, which will hold three meetings between October 2004 and June 2005. Council comprises representatives of key state stakeholder groups.

Preliminary Findings

- Findings from the various data collection activities will be available in late 2004.

Strategies and Next Steps

- Finalize data analysis tasks to produce preliminary findings on employers', households', and insurers' perspectives on the health care system.
- Continue to develop the options described above. As of now, some of these options, such as the small-employers purchasing pool (the Small-Employer Access Program), premium assistance (Health Flex Program), and a Medicaid HIFA waiver have already received legislative attention and are in the process of being developed more comprehensively.

Lead Agency/Contact Person

Agency for Health Care Administration; Mel Chang, AHCA Administrator, changm@fdhc.state.fl.us

Georgia Initial Grant Awarded: FY 2002

Update on SPG-Funded Activities

Data Collection

- Employer and household surveys.
- Focus groups with individuals and small-business owners.
- Expert interviews with 22 state stakeholders (ranging from consumers, state executive branch employees, insurers, legislators, and providers) to assess attitudes regarding health insurance, the uninsured, and access to care.
- Assessment of low-cost primary care services available to the uninsured, in order to identify accessibility of affordable primary care.

Policy Development

- The Georgia general assembly created the House Task Force on Health Insurance Options for Small Businesses and the Working Uninsured. The task force worked with the Georgia Association of Health Underwriters while modeling coverage expansion options.
- In April 2004, Georgia Rural Development Council's Health Care Subcommittee asked by the governor to make recommendations on issues related to rural communities: tort reform, the working uninsured, rural hospitals, and the role of communities in rural health care.
- In May 2004, the state planning grant team worked with business leaders to discuss business support for a public–private approach to covering the uninsured, as well as other strategies that would attract large employers.

Consensus Building

- Between August and December, 2003, worked with a variety of groups, including the National Association of Counties, the National Council of State Legislators, the Georgia Health Policy Center, and the Atlanta Regional Health Forum, via conferences and smaller meetings to discuss issues related to coverage and the uninsured.

Preliminary Findings

- Approximately 400,000 private sector employees are not offered any health insurance by their employer.
- Approximately 500,000 private sector employees work for an employer who offers benefits, but they are ineligible because of part-time or temporary status, or because of an exclusionary period.
- Forty percent of workers who are offered but do not take coverage through an employer are covered as a dependent by another member in the household, whereas those whose employers do not offer coverage often go uninsured.
- The insured are frustrated by limits on coverage imposed by their managed care plans, lack of access to specialists, and the cost of premiums, copayments, and deductibles.

Strategies and Next Steps

- Continue working with business leaders and other stakeholders to develop support for public/private approaches to improving insurance coverage for working individuals.

Lead Agency/Contact Person

Governor’s Office of Planning and Budget; Glenn Landers, Senior Research Associate, Georgia Health Policy Center, glanders@gsu.edu

Georgia Pilot Planning:

Community-Specific Three-Share Premium Assistance

Grant Amount: $400,000

Preliminary Activities

Data Collection and Analysis

- Supplemental employer survey.
- Analysis of the incidence of the burden of care provided to the uninsured.
- Focus groups with business leaders.

Policy Development

- Design and plan community-based pilots of public–private partnerships to expand insurance in four communities.

Pilot Planning

Strategy/Model

- Public–private partnership that leverages the willingness of small employers to contribute something toward coverage.
- Identifies local public funds to supplement employer/employee contributions to create affordable coverage.
- Four pilot sites: Atlanta metro area, another metro area, rural communities in north and south Georgia.

Target Population

- Uninsured workers in small businesses and employers willing to participate.

Planning Tasks

- Disseminate data analysis to facilitate consensus building among employers, providers, potential public partners, and maintaining engagement of community and state-level stakeholders.
- Finalize pilot-site selection, conduct additional focus groups with local employers and uninsured workers, design plan and benefits, price the coverage product, identify sources and levels of public funds for the public share provision, establish provider reimbursement methods and rates, develop enrollment and marketing strategies with appropriate risk management, project utilization—tailored to unique dynamics of the four communities.

Goals

- Have four distinct community processes for planning and designing public–private partnerships to expand health insurance coverage among workers.
- Identification of the commonalities and key distinctiveness of each community collaborative, which may be helpful to future initiatives in Georgia and other states.
- An estimated 160,000 currently uninsured individuals potentially eligible for the proposed pilot plans.

Hawaii Initial Grant Awarded: FY 2002

Update on SPG-Funded Activities

Data Collection

- Uninsurance estimates derived from the CPS, the Hawaii Health Survey (1997–2002) and the Behavioral Risk Factor Surveillance System (1994–2002).
- Workforce survey of 300 self-employed individuals, 203 part-time employees, and 93 other employees not covered by the Prepaid Health Care Act (PHCA), a partial employer mandate for full-time workers.
- Interviews with 188 uninsured individuals and 21 providers.
- General public survey of 602 residents.

Policy Development

- Options for complementing the PHCA were discussed, including a program for covering all employees on a sliding scale based on hours worked, a full employer mandate, and health and medical savings account.

Consensus Building

- Leadership group formed, including providers, insurers, labor unions, small and large businesses, academia, nonprofit and community organizations, government officials, and consumers, to provide guidance and support to the SPG Task Force.
- A number of public forums and governor's office briefings were held to present findings and discuss potential policy options.
- Task force disseminated information via a community newsletter, technical workshops, and a Web site.

Preliminary Findings

- The application process for enrolling or recertifying in public programs is considered beyond many applicants' ability.
- Many individuals are confused by the terms of available health coverage, mainly regarding what benefits are covered.
- Uninsured individuals tend to delay care until faced with a medical crisis. Those who do enter the health care system feel embarrassed, and report that they are not treated equally by providers.
- Services such as dental care, transportation to care, and pharmaceutical coverage are in serious need. Many individuals also need help with maintaining coverage (e.g., renewing coverage in a timely manner) and with bill paying.
- Providers are frustrated by their lessened ability to diagnose and control care protocols for uninsured patients.
- Patients transitioning between QUEST and Social Security Disability Insurance (SSDI) often experience problems.
- Fifty percent of uninsured workers rated dental coverage as the most important specialty benefit, while 37 percent chose pharmaceutical coverage.
- Sixty percent of uninsured self-employed surveyed said they were extremely or somewhat interested in a government tax credit that would partially pay for insurance costs up front.

- Over half of the respondents to the workforce survey were in favor of a tax increase to expand coverage, particularly children's coverage.

Strategies and Next Steps

- Developing private coverage options for working adults will be the highest priority for research and policy in the state in 2004 and 2005.
- The task force will continue to hold technical workshops and receive feedback from community leaders, stakeholders, government officials, and policymakers.
- All stakeholders agree that any changes made to the PHCA, which dominates the state's coverage picture and health care marketplace, must be done carefully and with the full support of employers and employees.
- The Hawaii Uninsured Project will develop position papers on the subjects of complete enrollment, expansion of the safety net, uncovered workers, and the PHCA by the end of 2004.

Lead Agency/Contact Person

Department of Health; Laurel Johnston, Executive Director, Hawaii Uninsured Project, ljohnson@hipaonline.com

Idaho Initial Grant Awarded: FY 2001

Update on SPG-Funded Activities

Data Collection

- Developed a profile of the uninsured and examined state of insurance markets during early grant period.

Policy Development

- Further development of earlier SPG policy recommendations to:
  - Enroll all children eligible (up to 150% of FPL) in SCHIP and then expand SCHIP to 200 percent FPL;
  - Cover adults to 200 percent of FPL through a public–private partnership of SCHIP expansion to parents.
- Developed premium assistance model called *Idaho Health Insurance Access Card*; enabling legislation was passed and signed April 2003 (see Strategies below).
- Held series of meetings between Medicaid and commercial insurers to plan implementation of access card.
- Hosted meetings with Idaho Association of Counties to develop program to cover low-income adults in expanded and optional Medicaid categories, called *Medicaid County Carve-out* (see Strategies below).

Consensus Building

- Community workgroups discussed options and made policy recommendations.
- ISPG Steering Committee expanded with three additional representatives of low-income community, before its "sunset" August 2004.
- Hosted meeting following implementation of access card with multiple stakeholders to discuss early experience and potential improvements.
- Held meetings of stakeholders to plan Medicaid county carve-out.
- Education and outreach included advertisements for access card/SCHIP expansion, presentations to community groups, open forum on coverage, other educational events.

Strategies and Next Steps

Access Card

- Implemented child component to access card program with SCHIP expansion July 2004:
  - Uninsured children with family income up to 200 percent of FPL could enroll for premium assistance or direct SCHIP coverage;
  - About 2,600 children from 1,400 families applied during initial enrollment period, though many applicants ineligible because already insured;
  - About 27 percent initial enrollments requested premium assistance.
- Plan to implement adult component of access card program, which would provide premium assistance to uninsured adults up to 200 percent of FPL, in July 2005 at pilot level of 1,000 enrollees.
- Ongoing strategy meetings to find options to sustain funding for adult component will take place through ad hoc meetings between public and private sponsors and stakeholders.

Medicaid County Carve-out

- State proposes to use existing county indigent program as foundation for a primary/preventive care Medicaid program for adults up to 185 percent of FPL.
- Program would be optional to counties, which must fund the primary care coverage with an integrated behavioral health care component.
- Six pilot counties have been identified and draft county plans are completed.
- Stakeholders will continue to meet to pursue an 1115 waiver.

Lead Agency/Contact Person

Idaho Department of Commerce; Jay Engstrom, Administrator, e-mail: Jengsto@IDOC.state.id.us

Illinois — Initial Grant Awarded: FY 2000

Update on SPG-Funded Activities

Data Collection and Analysis

- Focus groups.
- Key informant interviews.
- Household survey of the uninsured and newly insured.
- Analysis of public programs in over 20 states.

Policy Development

- Developed three coverage options:
  - Family Care—Extend health benefits to parents of children covered through the state's KidCare program.
  - Incentives for Small Employers—Partnering with CAP grantees to develop affordable coverage plans for small employers.
  - Education and Marketing—Improving education and marketing of KidCare and other public programs to eligible individuals.

Consensus Building

- Collected input on policy issues and options from the Illinois Assembly on the Uninsured, which represents employers, labor unions, social service advocates, commercial insurers, insurance agents, health care providers, and other stakeholders. Results of data analyses were presented to the assembly, which was charged with the task of building consensus on various options.

Findings and Recommendations

- The household survey and BRFSS analysis indicate that 9.7 percent of the state's residents are uninsured, which is lower than the 14.4 percent figure indicated by the most recent CPS.
- Sixty-four percent of the uninsured are employed, and almost half of the working uninsured do not have access to employer-sponsored coverage.
- A significant number of individuals and families are not aware of the public programs that may be available to them. Others are aware of the programs, but perceive them as "taking charity," or "poor quality."
- Household survey findings indicate that the average amount an individual would be willing to pay for insurance was $93 a month; families were willing to pay an average of $131 a month.

Lessons Learned

- Incremental change will be the most readily accepted strategy when it comes to decreasing the number of uninsured.
- While no minimum benefit package has gained consensus in the state, there is general agreement that it should include catastrophic care coverage, hospitalization, preventive medical care, mental health treatment, and prescription drugs. There was no consensus when it came to rehabilitation services, vision care, and dental care.

- Being “underinsured” may be defined as having a high deductible, lacking preventive care, having no basic coverage *or* no catastrophic coverage, having gaps or caps in coverage, or having a specialty policy (such as cancer coverage) without primary care coverage.

Strategies and Next Steps

- The state recently received a pilot planning grant from HRSA to further develop some of the policy options conceived through the original SPG process (see Pilot Planning project summary).

Lead Agency/Contact Person

Illinois Department of Insurance; Tim Olmstead, M.A., Project Coordinator, Department of Financial and Professional Regulation, (217) 557-9248; Tim_Olmstead@ins.state.il.us

Illinois Pilot Planning:

Community-Specific Three-Share Premium Assistance for Low-Income Workers

Grant Amount: $400,000

Preliminary Activities

Data Collection and Analysis

- Complete planning, implement, and monitor upcoming three-share program in St. Clair County, created under existing SPG grants.
- Continue research on alternative financing mechanisms, including projections of cost, impact, and necessary legislative changes.
- For each pilot site, gather and analyze data on the uninsured.

Policy Development

- Process-based, community-based planning approach: recognizes each community has unique characteristics and harnesses local stakeholder input to develop viable program.
- Development of small-group reinsurance pool model, high-risk pool, purchasing cooperative, and alternative financing strategies that could support a three-share model.

Pilot Planning

Strategy/Model

- Three-share coverage model, a subsidized employer insurance model that divides the cost of coverage between the employer and the employee and a subsidy.
- Community input and evaluation will determine specific features in terms of financing, coverage mechanism, care and coverage coordination, and access improvement.

Target Population

- Low-income working uninsured population and their employers.

Planning Tasks

- Identify several potential pilot sites, and select two based on geography, demographics, community support, access, health-status data, and other factors.
- Engage local strategic partners through committee(s) representing local business leaders, providers, health systems and/or community health centers, insurers and brokers, political and religious leaders, and community agencies, with public input.
- Gather and analyze data on the uninsured at the pilot sites, and conduct focus groups and interviews with stakeholders to test reactions to potential coverage models.
- Use consensus-building process to select a single model for each site.
- For each site, develop:
    - Work plan that includes program characteristics and benefit design;
    - Preliminary financing plan and necessary agreements/RFPs/documents;
    - Implementation plan.

Goals

- By August 2005, produce detailed implementation plans to guide development of administrative structure and take pilots up to the point of launch.
- Test and refine community-based three-share model in communities with widely varying characteristics.
- Through careful documentation of process (e.g., steps of process, what decisions were made and why), and barriers (e.g., legal, regulatory), provide framework for future replication.
- Through careful documentation of actual pilot programs (coverage model, financing, etc.), provide template for specific strategies to expand coverage.

Indiana Pilot Planning: Premium Assistance

Grant Amount: $273,800

Preliminary Activities

Data Collection and Analysis

- Using hospital discharge data and data from Medicare, Medicaid, and the Departments of Labor and Commerce, the state will examine the following questions:
  - The cost of the uninsured to the Indiana economy;
  - The economic impact of the uninsured on cost-shifting, productivity, employer competition, business expansion, and other measures;
  - Potential savings that could result from reducing the number of uninsured;
  - How reducing the number of uninsured would potentially improve health status and health care cost avoidance.

Policy Development

- Draft options for implementing a premium assistance for employees and/or buy-in program for employers.

Pilot Planning

Strategy/Model

- Premium assistance that would supplement employee and employer contributions to employer-sponsored insurance, and/or a pooling strategy such as a buy-in into the state health insurance plan.

Target Population

- Buy-in and other pooling strategies would target small businesses, and employers not offering health insurance.
- Premium assistance would target employers currently offering benefits and low-wage workers, to improve take-up rates and maintain current offering of coverage.

Planning Tasks

- Utilize toolkit developed by State Coverage Initiatives and technical assistance.
- Convene a planning committee of internal state staff , representatives from commercial insurers and providers to guide planning effort.
- Conduct planning and research around the following issues:
  - State legislative requirements;
  - Financing (e.g., employer/employee contributions, soda pop tax, hospital user fee, managed care tax) and collection processes;
  - Cost effectiveness of premium assistance versus employee/employee buy in;
  - Assuring small businesses and employers of low-wage workers participation through effective outreach strategies, options for partnering with private insurers to offer a state-sponsored plan;
  - State administration requirements (e.g., exploring mechanisms and implementation methods, obtaining employer/employee contributions);

- Options for cost sharing and cost-sharing limits;
- Determination of premiums and rate setting;
- Enrollment caps or other limitations;
- Minimum requirements for benefit packages;
- Waiver vehicles such as 1115, HIFA and waiver requirements if necessary;
- Adverse selection and risk;
- Interaction with state's high-risk pool and other programs.

Goals

- Draft implementation plan for premium assistance and employer buy-in programs, titled "A Blueprint for Change," including legislative requirements, financing, buy-in from small businesses, and options for partnering with private insurers to offer a state-sponsored plan.
- Provide a resource and planning guide for other states.

Lead Agency

Indiana Family and Social Services Administration

Contact Information

Seema Verma, Project Director, State Planning Grant, (317) 809-8536, sverma1@msn.com

Iowa — Initial Grant Awarded: FY 2000

Update on SPG-Funded Activities

Data Collection and Analysis

- Developed baseline information on uninsured Iowans based on CPS data between 2000 and 2003.
- Conducted the 2004 Iowa Business Survey, a telephone survey to examine business decision makers' attitudes toward the current state of employer-sponsored coverage in the state.

Findings and Recommendations

- Seventy-five percent of businesses surveyed said they are absorbing the higher health coverage premiums, rather than passing the cost along to their employees.
  - Based on these findings, the SPG team estimated that a 12 percent increase in premiums would reduce profit margins by 0.74 percent, resulting in a loss in Iowa business tax revenue of $14.9 million per year.
  - The reduced revenue resulting from absorbing higher health care costs could reduce the private gross state product by $50.8 million.
  - The effects of higher health care costs on labor were estimated to cost the state approximately $10.8 million in payroll tax revenue, $322.5 million in spending, and $16.1 million in state sales tax revenue.
- Forty-four percent of employers said they would consider raising the prices of their goods and services to make up for the increased cost of health insurance.
- Fifty-four percent of companies said they are hampered in business planning efforts because of the unpredictable nature of health insurance costs.
- Only 11 percent of companies that do not currently offer insurance are considering doing so in the coming year.
- Fifty-seven percent of businesses surveyed thought they would be better off under a plan proposed by the surveyors, which included an individual mandate for catastrophic care coverage, employer contributions into a MSA for each employee, and government support for low-income citizens.

Lessons Learned

- In a state such as Iowa, where the majority of employers are small, employers are more likely to absorb as much of the cost of health coverage as possible due to the interpersonal relationships employers have with their employees both in and outside of the workplace.
- Employers are more open to considering new ways of offering health insurance because of the dramatic increases in premiums. Some businesses are already exploring the use of health savings accounts, on-site medical professionals, and employee incentives.

Strategies and Next Steps

- The SPG team is seeking funding to complete the tasks outlined under its most recent SPG effort, entitled "Rethinking Health Insurance." These tasks include further analyses of the

Iowa Business Survey, and a documentary on health care access disparities between the insured and the uninsured.

- Conduct further analysis on the economic impact of rising health insurance rates on consumers, including such aspects as job productivity and entrepreneurialism. Using quantitative data, the team will calculate the economic impact of consumer decisions, use economic models to estimate how consumers might react to different policy scenarios, and "virtually" pilot some programs to identify opportunities and challenges associated with them.

Lead Agency/Contact Person

Iowa Department of Public Health; Anne Kinzel, J.D., SPG Project Director, (515) 281-4346, e-mail: Akinzel@IDPH.state.ia.us

Kansas Pilot Planning:

Reinsurance, Small-Business Tax Credits, and Premium Assistance

Grant Amount: $400,000

Preliminary Activities

Data Collection and Analysis

- Modeling of four reinsurance mechanisms to assess the effect of each on premiums and take-up rates.
- Analyze the combined effects of reinsurance, employer tax credits, and employee subsidies on the uninsured rate.

Policy Development

- Conduct consensus building activities to build support for different policy options.

Pilot Planning

Strategy/Model

- Reinsurance for small businesses.
- Further development of the Business Health Partnership, a not-for-profit company that will assist employers in finding affordable, quality health insurance.
- Tax credits for small employers that are substantial enough to provide an incentive for offering coverage.
- Premium subsidies for employees and their dependents.

Target Population

- Uninsured employees working for small businesses that do not offer coverage.

Planning Tasks

- The modeling of four reinsurance mechanisms requires several planning tasks, including:
  - Gathering and analyzing small-employer health insurance databases to develop assumptions;
  - Transform the data for use in the reinsurance assessment modeling software;
  - Examine the impact of the four alternatives on both carriers and small employers;
  - Incrementally add specificity to the options to better understand their effects on target populations.
- Governor is requesting an FY 2005 appropriation that would fund a subsidy for small businesses that employ low-wage workers.

Goals

- Draft policy option or options for submission by the governor's office to the legislature, reflecting the Business Health Partnership, reinsurance, and premium subsidy mechanisms.
- Ultimate goal is to significantly reduce the number of uninsured in the state.

Lead Agency

The Kansas Insurance Department is the lead agency on this project. It will collaborate with the University of Kansas and the Governor's Office of Health Planning and Financing. Modeling will be conducted by a private contractor (Poll Administrators, Inc.).

Contact Information

Sandy Praeger, Insurance Commissioner, spraeger@ksinsurance.org, (785) 296-3701.

Massachusetts Initial Grant Awarded: FY 2000

Update on SPG-Funded Activities

Data Collection and Analysis

- Using Uncompensated Care Pool (UCP) claims data to analyze cost and utilization patterns of the uninsured population.
- Segment population into subgroups to develop appropriate policy solutions for various pool users.
- Interviews with small employers that do not provide coverage about their decision-making process.
- Focus groups of employees (both insured and uninsured).
- Identify data sources and specific variables that can be used to measure crowd-out.
- Integrate updated state-specific data into model to improve predictive capabilities.

Policy Development

- Improve model for assessing the effects of various reform strategies, and use it to conduct analyses of policy options.

Preliminary Findings

- Key characteristics of high-cost UCP users identified: likely to be male, with more than one chronic medical condition.
- One percent of UCP users are responsible for half of UCP inpatient costs (significantly more skewed than insured population).
- Employers without insurance and their employees devise various ways to cover health expenses, are knowledgeable about health insurance issues, and understand they are taking a risk by not having insurance.
- There is not one solution for extending insurance to small-business workers.
- Lack of insurance in the state does not preclude access to care, given the availability of UCP.
- Several low-income workers reported turning down raises or extra hours to continue to qualify for public coverage (MassHealth).

Next Steps

- Conduct additional analysis focusing on mental health and substance abuse diagnoses and actions the state can take to address issue.
- Complete data analyses, propose new measures of crowd-out, and conduct interviews with providers.
- Continue modeling analyses to expand options for affordable coverage.

Lead Agency/Contact Person

Division of Medical Assistance; Maria Schiff, Health Policy Manager, Massachusetts Division of Health Care Finance and Policy, maria.schiff@state.ma.us

Update on SPG-Funded Activities (since March 2002 Interim Report)

Data Collection and Analysis

- In-person household survey of 2,085 residents.
- 2002 employer health insurance survey.
- Focus groups with young adults and with small employers.
- Study of the adequacy of health insurance coverage and benefits.
- Study of provider and health plan network arrangements.
- Research into values and beliefs of residents regarding health care reform and coverage options.

Policy Development

- The economic downturn and budget deficit have led the legislature to make significant changes in 2003 in the structure of the state's public insurance programs, reducing both eligibility and benefit levels for certain subgroups; the focus of health policy reform has shifted to finding ways the state can support private health insurance coverage, through premium subsidies or tax credits.

Consensus Building

- Development and implementation of plan to communicate results of 2001 health access survey to stakeholders and community groups; helped state build relationships with these communities, and provided data that communities can use in their own efforts to reduce disparities in coverage.
- Research conducted on values and beliefs informed the work of the Minnesota Citizens Forum on Health Care Costs, convened by Minnesota governor Tim Pawlenty in the fall of 2003; it helped form a core set of guiding characteristics of the future of Minnesota's health system; these were critical to the Minnesota Citizens Forum on Health Care deliberations, which resulted in recommendations to the governor in late February 2004 on policies to reduce the rate of health expenditure growth.

Findings

- Despite overall low rate of uninsurance, there are wide disparities in coverage between racial and ethnic groups.
- A variety of factors, varying by population group, contribute to the higher uninsurance rates for populations of color and American Indians in the state.
- About half of Minnesota's private employers offer health coverage and over 82 percent of private sector employees worked for an employer that offered coverage; these rates have been stable since 1993, although there has been a decline in the percentage of eligible employees who enroll for coverage.
- Small employers, who employ approximately 60 percent of the uninsured, are struggling to continue to offer or to begin to offer health insurance coverage; they would find it easier to offer coverage if it were less costly, if rate increases were fixed or predictable, and if there were simpler plans that required little paperwork or explanation.

- Small employers were varied in their opinions about three policy options presented as ways to potentially lower health insurance costs: premium sharing or employer/employee subsidies; tax credits; and stop-loss protection. Some were concerned that all of the options would lead to higher taxes and to second-class health care for their employees; most stated that none of the proposed options would address the underlying problem of rapidly rising health care costs.

Lessons Learned and Recommendations

- State-specific data and analysis have been a crucial part of health policy decision making for over a decade, with policymakers and stakeholders relying on state data to make coverage expansion and other health policy decisions; SPG funding has supported states' ability to obtain high-quality, up-to-date information.
- Having in-house staff with the expertise to use the state-specific data collected with SPG funding, and to respond to real-time, ad hoc requests, is critically important for translating data into policy.
- It is important that state-level research be viewed as credible and objective.
- Federal funding for state-specific data collection and policy development through the SPG program has been critically important for expanding and updating knowledge of health coverage and markets, and for developing policy.
- The federal government should continue to provide funding so that states that have received past SPG funding to establish baseline information on their uninsured can update their analyses in order to monitor the effect of changing economic conditions (e.g., economic downturns and budget deficits) and any policy changes implemented.

Strategies

- Exploration of ways the state could support private insurance coverage in a cost-effective way, through direct or indirect premium subsidies or tax credits.

Next Steps

- Completion and analysis of 2004 household survey and other data collection activities.
- Examine and explore implementation of options to support private insurance market.
- Perform economic modeling to quantify impact of various proposals; use results to promote discussion and consensus building around most effective options.

Lead Agency/Contact Person

Minnesota Department of Health; Scott Leitz, Director, Health Economics Program, (651) 282-6361.

Mississippi — Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Data Collection

- Focus on describing the characteristics of the uninsured and understanding issues for employers, insurers, providers, and policymakers regarding access, affordability, and coverage.
- Surveys: households, employers, health providers.
- Focus groups with college groups, ethnic groups, part-time and low-income employees, and SCHIP and Medicaid nonrenewals.
- Personal interviews with key elected health policymakers.

Policy Development

- State has not yet selected policy options to address needs of uninsured.

Consensus Building

- Established Blue Ribbon Task Force on Health Policy through the governor's office representing wide range of stakeholders, responsible for oversight of project, evaluation of outcomes, facilitating consensus building, developing and prioritizing options for reducing number of uninsured.
- Task force met three times during initial year.

Preliminary Findings

- Uninsurance rate about 17 percent, and nearly 10 percent among children (below 19 years old).
- Uninsurance exacerbated by poor health status related to high prevalence of chronic diseases, predominantly rural setting, and unavailability or unaffordability of preventative/maintenance care.
- More than half (56%) of uninsured surveyed were eligible for a public program.
- Employers are supportive of tax credits, subsidies and incentives, or support from state/federal sources.
- Health providers support public subsidies and tax incentives for low-income people, and are concerned about uncompensated care costs.
- Policymakers support current public programs, but are concerned about continued ability to fund at current levels.

Strategies and Next Steps

- Complete all research (surveys, focus groups) and analysis.
- Develop policy options and recommendations for federal and state actions to provide health insurance to the uninsured.

Contact Person

Division of Medicaid, Office of the Governor; Rachel Stiff, Project Director,
chras@medicaid.state.ms.us

Missouri — Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Data Collection

- Household survey.
- Employer and consumer focus groups.
- Key informant interviews.
- Analyses of Multi-State Integrated Database (MSID) data, including CPS and Behavioral Risk Factor Surveillance System (BRFSS), Medical Expenditure Panel Survey—Insurance Component (MEPS-IC).

Policy Development

- Convened the Advisory (Policy) Council on the Accessibility and Affordability of Health Insurance Coverage. The council members divided into three subcommittees (policy, communications, and sustainability) to address policy options and develop communications strategies.
- Conducting analysis of uncompensated care in the state to determine the effect of changes in public program enrollment on hospitals' provision of uncompensated care, to provide the state with information necessary for understanding the impact of state-level program expansions on uncompensated care delivery.

Preliminary Findings

- Data analyses are still underway. Findings should be available in the state's next interim report.

Strategies and Next Steps

- Continue analyses of data collected under the grant.
- Continue working with the advisory council on policy and communications options.

Lead Agency/Contact Person

Missouri Department of Health and Senior Services; Connie Mihalevich, (573) 751-8998; mihalc@dhss.mo.gov

Montana — Initial Grant Awarded: FY 2002

Update on SPG-Funded Activities

Data Collection

- Household survey.
- Employer survey.
- Focus groups.
- Key informant interviews.

Policy Development and Consensus Building

- A group of public and private leaders were appointed to the SPG steering committee for the purpose of developing, implementing, and identifying policy recommendations. The group represented health care insurers and providers, advocates, Indian Health Service staff, senior citizens, legislators, and employers.
- Policy options developed by the steering committee include:
  - Creation of small-business purchasing pools;
  - Educating the public on the importance of health insurance coverage;
  - Pursuing tax credit options for low-income individuals with incomes under 175 percent of the FPL;
  - Expand the SCHIP program up to 200 percent of the FPL.

Findings and Recommendations

- Young adults between the ages of 19 and 25 were more than twice as likely to be uninsured as the general population.
- The state's American Indian populations experience uninsurance at rates that are two times higher than the statewide average.
- Average medical debt for uninsured persons in 2003 was $2,500 or higher, representing as much as 16 percent of household income.
- Approximately 40 percent of small firms (10 or fewer employees) offer health insurance.
- Less than 30 percent of firms not offering insurance thought they would provide coverage if there was a tax credit policy in place, and more than 40 percent of firms not offering coverage said they would definitely participate in a small-business purchasing pool if available.
- Many uninsured previously had coverage, with 56 percent having ESI, 19 percent having individual coverage, and 9 percent being enrolled in a public program.

Lessons Learned

- Collecting state-specific data is crucial to the development of policy options.
- Using a state-based vendor to conduct the data collection was extremely useful, and probably accounted for the very high response rate that the SPG team received on both the household and employer surveys.

Strategies and Next Steps

- Pursue a HIFA waiver to provide primary care health coverage for individuals using the Mental Health Service Plan, and to add 5,000 children to the SCHIP program.

Lead Agency/Contact Person

Montana Department of Public Health and Human Services; Maggie Bullock, Administrator, Health Policy and Services Division, (406) 444-4141, e-mail: Mbullock@state.mt.us

Nebraska — Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Data Collection

- Household survey.
- Focus group interviews.
- Employer survey, large and small businesses.

Policy Development

- Establishment of the Nebraska Health Insurance Policy Coalition; the governor appointed 28 members representing diverse public and private stakeholder groups.
- Based on data results, the coalition developed guiding principles, including:
  - New programs should build on existing public and private programs;
  - The strategy should have a reasonable cost and be affordable to individuals, employers, and the government.
- The coalition has reviewed various public and private policy options.

Consensus Building

- The policy coalition includes representatives from state agencies, the state legislature, business and industry, the health insurance sector, nonprofit agencies, minority populations, health professional organizations, and the two medical schools.
- The coalition has met six times in Year 1.

Preliminary Findings

- The uninsurance rate among the nonelderly is about 9.9 percent, with regional variation.
- The primary reason cited for uninsurance is cost (65%).
- Many uninsured worry about cost, often delay care, and feel depressed, frustrated, hopeless, and suicidal.
- Forty-nine percent of employers with one to three employees offer coverage.
- Small employers (under 10 employees) have little or no access to group policies.
- About 20 percent of employers are somewhat likely or not likely to continue to offer coverage in the next two years.

Strategies and Next Steps

- Prepare detailed report on employer survey results (October 2004).
- The coalition will set priorities on high-risk groups and develop strategies to expand coverage and/or improve access to heath care services.
- After developing a strategic plan, a series of community forums will be held across the state to obtain feedback.
- Final report will be prepared in spring 2005.

Lead Agency/Contact Person

Department of Health and Human Services; Dave Palm, Administrator, Office of Public Health, david.palm@hhss.state.ne.us

North Dakota Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Policy Development

- Establishment of Health Insurance Advisory Committee with governor-appointed members representing stakeholders.
- Committee reviewed results of state-based research and deliberated about coverage options.
- Committee identified target populations for coverage expansion.

Consensus Building

- Committee includes 12 members representing farming community, business community, advocates for low-income and uninsured, academic community, health care, health insurance industry, and state departments.
- Committee met six times in Year 1 to oversee research and explore initiatives by other states.
- Presentations have been made to several groups and discussions held with key legislative members.

Preliminary Findings

- Despite relatively low state-wide insurance rate (8.2%), nearly 32% uninsurance among state's Native Americans.
- Surprisingly little regional variation in uninsurance rates.

Strategies and Next Steps

- Committee is exploring:
  - Opportunities to leverage federal programs to expand insurance among Native Americans;
  - Ways to improve outreach among parents with children eligible for public program;
  - Options to help small businesses obtain access to insurance pools.
- Will focus on educating legislature and citizens.
- Will hold public forums across state and set up a designated Web site to garner public input.
- Committee will continue to explore options and will develop recommendations.
- Anticipate a private sector demonstration project.

Lead Agency/Contact Person

Department of Health; John R. Baird, M.D., State Medical Officer, jbaird@state.nd.us

Oklahoma — Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Data Collection

- Household survey.
- Focus groups.
- Small-business survey.
- Analysis of additional data sources (e.g., MEPS-IC, CPS).

Policy Development

- Formed workgroups tasked to develop viable, realistic, and effective strategies to expand coverage.
- Passed Senate Bill 1546 authorizing a pilot premium assistance plan (see Strategies below).
- Selected options to expand coverage of low-income working adults, and expand SCHIP eligibility up to 200 percent of FPL.
- Applied for and was awarded (September 2004) SPG grant for pilot planning.

Consensus Building

- Established a "large workgroup" containing legislative members/staff, representatives from various state agencies, provider groups, university, insurers, and Native American interest groups; group met quarterly and provides guidance on SPG process.
- Obtained input from stakeholders through governor's presentations, meetings with health policy experts, meetings with private market constituents, e-mail and mail notices of SPG events, participation in conferences and community events.

Preliminary Findings

- Uninsurance rate is nearly 20 percent.
- Many uninsured neglect health problems until they get worse.
- Focus groups indicate willingness by workers and employers to obtain insurance if subsidized.

Lessons Learned and Recommendations to States

- Importance of in-depth, state-specific data.
- Need to enlist right agency to conduct research for useable, trustworthy information.
- Importance of in-depth study of other states and their SPG development/issues.
- Flexibility in design will bring best results.

Strategies and Next Steps

- Plan for pilot premium assistance program; model under consideration features:
  - Target employees with income up to 200 percent of FPL in small businesses;
  - Premium shared among the state (20%), federal government (49% through Medicaid or SCHIP matches), employers (20%) and employees (11%);
  - Extensive marketing and outreach program.
- November 2004 ballot initiative for tobacco tax to fund state portion of pilot.

- Pursue research of long-term funding sources.
- Develop plan for state sponsored plan as alternative to commercial insurance for workers in firms that do not offer insurance and for self-employed.
- Conduct modeling of program, recruit a fiscal agent, and identify employers interested in participating.
- Apply for HIFA waiver to allow implementation of model.

Lead Agency/Contact Person

Oklahoma Health Care Authority; Matt Lucas, lucasm@ohca.state.ok.us

Oklahoma Pilot Planning:

Small-Business Purchasing Pool and Premium Assistance

Grant Amount: $400,000

Preliminary Activities

Data Collection and Analysis

- Continued analysis of SPG data, including small-employer health insurance marketplace study, small area estimation analysis, and database of business information (Dunn & Bradstreet).

Policy Development

- Continue to build consensus on coverage expansion approaches developed under SPG.

Pilot Planning

Strategy/Model

- Small-business purchasing pools.
- Public–private partnership-funded voucher system for premium assistance.

Target Population

- Small businesses.
- Uninsured workers with income below 200 percent of the FPL.

Planning Tasks

- Continue data analysis.
- Develop educational materials on the pilot project.
- Reach out to business leaders and individuals in target areas to get their buy-in.
- Identify specific areas of need for potential pilot implementation, and conduct feasibility study on participation.

Goals

- Draft a pilot program (and strategies for implementing the pilot) that includes a small-business health insurance purchasing pool and premium assistance vouchers for employers, employees, and their dependents.

Oregon Initial Grant Awarded: FY 2000

Update on SPG-Funded and Related Health Reform Activities

Data Collection and Analysis

- Analysis of Oregon Medical Insurance Pool (OMIP), the state's high-risk pool.
- Examined the rate of uninsurance among children, in preparation of implementing a community-focused Children's Access to Health Care survey.

Policy Development

- The Oregon Health Policy Commission pairs legislators with advocates and stakeholders to develop a vision and roadmap for health reform, focusing on cost, quality, health status, and access.
- House Bill 2537 directs the Insurance Pool Governing Board (IPGB) to provide affordable coverage for small employers.

Consensus Building

- Partnered with two local organizations, the Metropolitan Alliance for Common Good (MACG) and the Foundation for Medical Excellence (TFME) to develop an approach to Health Dialogues focused on universal coverage options.
- The MACG sponsored a gathering on education, tax reform, and health, attracting nearly 5,000 attendees.

Findings

- Up to 80,000 children are uninsured and up to 66,000 may be eligible for Medicaid or SCHIP.
- Fifty-eight percent of Oregon Health Plan (OHP) Standard enrollees at the zero-income level were disenrolled for lack of premium payment after the premium rules changed in March 2003.

Recommendations to the Federal Government

- Continue to allow flexibility and creativity on the use of federal funds, to augment or replace limited state funds.
- Help strengthen the safety net.
- Encourage adoption of data information systems that communicate across delivery systems and states.
- Partner with states in evaluation efforts that use local researchers and state agencies to facilitate conversion of research to policymakers.
- Provide additional research funding to allow states to advise other states on best practices and policies, particularly regarding protecting vulnerable populations.

Strategies

- Economic conditions are limiting further expansions of Medicaid; current focus is on improving the capacity of the state's safety net clinics to provide needed care to the uninsured. The Safety Net Policy Workgroup, representing a diverse group of stakeholders,

policy staff, and legislators, is coordinating activities and will propose data-driven state policy that will strengthen the safety net.
- The Medicaid waiver program that expanded coverage to residents with incomes up to 185 percent of FPL had to close to new enrollment due to severe economic downturn.
- Community leaders formed a collaboration around premium sponsorship for adults covered under OHP Standard, Oregon's "expansion" population, and have successfully reduced disenrollment among those between 0 and 10 percent of FPL due to lack of premium payment.

Next Steps

- Data collection and analysis on the safety net's capacity and capability, to develop indicators and benchmarks reflecting a well-functioning safety net system, and inform stakeholders and decision makers and help them develop data-driven policy options.
- Expand premium sponsorship efforts to work toward development of community models that can expand access to health care coverage throughout the state.
- Analysis of the Health Values Survey and Children's Access Survey to help Health Policy Commission as they develop policy strategies.
- Other health reform activities expected in the near future (not funded through SPG) include:
  - The IPGB plans to roll out an "Alternative Group Plan" and a "Children's Group Plan" targeting small-employer groups in January and February 2005, with enrollments beginning in March 2005;
  - The community leader work group is exploring strategies that can leverage community dollars to help those with access to insurance remain covered;
  - The results of KidCare, a pilot of increased outreach to children in two counties, will be examined to assess feasibility of expanding such outreach efforts statewide.
- SPG and related health reform work places the state in a position to work quickly toward coverage expansion once the economy improves.

Lead Agency/Contact Person

Office for Oregon Health Policy and Research (OHPR), http://www.ohpr.state.or.us/; Jeanene Smith, M.D., M.P.H., Deputy Administrator, (503) 378-2422.

Rhode Island — Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Data Collection and Analysis

- Analysis of Current Population Survey and Behavioral Risk Factor Surveillance Survey data on uninsurance, and Medical Expenditure Panel Survey during Year 1.
- Quantifying the uninsured, coverage, marketplace.
- Synthesizing state-specific reports, performing secondary data analysis, and collecting and analyzing new data.

Policy Development

- During Year 1, worked with the state general assembly in obtaining direction for policy option consideration, including directive to develop plan for pilot primary care program (see Strategies, below).
- Reviewing and assessing current coverage approaches and best practices.
- Determining and assessing policy options most appropriate to the state, and calculating the cost of each option and source of financing.

Consensus Building

- The governor postponed the creation of the Health Care Coverage Purchasers Steering Committee, the coordinator of the SPG project, due to major political events related to the regulation of the largest insurer of the state.[7] As a result, SPG project implementation, including consensus building activities, was delayed.

Preliminary Findings

- State uninsurance rate was 10.2 percent in 2003, the second lowest in the nation.
- After experiencing sustained, declining uninsurance rates during the 1990s, uninsurance began increasing after 2000.
- The decline in coverage in 2002 was due primarily to a decline in employer-based insurance.
- Unemployed and self-employed individuals are most likely to be uninsured.
- As in other states, access to care is adversely affected by lack of insurance.

Strategies and Next Steps

- Ongoing data collection and analysis.
- Focus groups with employers.
- Development of a plan for a *pilot primary care program for uninsured residents* that may include:
  - Catastrophic or reinsurance coverage provided under state auspice.
  - Enrollee premiums and coinsurance payments that are income based, with premiums and coinsurance subsidized by the state.
  - A variety of service delivery and financing models including capitation payments to private physicians, a buy-in program under RIte Care (Medicaid/SCHIP program), and coverage arrangements purchased from qualified community health centers.

[7] Blue Cross and Blue Shield of Rhode Island.

Lead Agency/Contact Person

Rhode Island Department of Human Services; Tricia Leddy, Director of the Center for Child & Family Health, DHS, e-mail: tricia L@dhs.ri.gov

Texas — Initial Grant Awarded: FY 2001

Update on SPG-Funded Activities

Data Collection

- Telephone survey of uninsured households.
- Survey of insurers and HMOs.
- Focus groups of uninsured unemployed, uninsured employed, and small employers who do and do not offer coverage.
- Small-employer survey.
- College student health insurance survey on the availability of school-sponsored health insurance options.

Policy Development

- At the request of the legislature, conducting a study of the Texas Health Insurance Risk Pool (THIRP), including an actuarial evaluation of various expansion options.
- The state legislature abolished two standard small-employer plans in response to SPG findings indicating support for lower-cost, reduced-benefit health plans that employers could make available to their employees. In place of these standard plans, insurers may now market "Consumer Choice Health Benefit Plans" to small- and large-employer groups and individuals. Employers can tailor the benefits and cost-sharing structure of these plans to meet their needs.

Consensus Building

- May 2004 stakeholder symposium for legislative staff, insurance industry representatives, physicians, hospitals, consumer advocates, public health leaders, employers, and others to discuss coverage expansion, employer-sponsored insurance, the THIRP program, and health care access.

Preliminary Findings

- Cost is the primary reason employers do not offer coverage.
- The majority of employers surveyed believe employers should be responsible for providing coverage, assuming it is affordable.
- Forty-six percent of the surveyed employers who currently offer coverage said that in the next five years they are somewhat or very likely to discontinue that coverage.
- The majority of employers thought improving access to insurance should be a higher priority for the government than improving access to health care.
- The cost to the employee of taking up employer-sponsored coverage is often too high, particularly for low-wage employees.
- Over 50 percent of the state's nonpoor uninsured adult population is under the age of 40.
- Forty-two percent of nonpoor uninsured adults are employed in professional jobs; 13 percent in sales; 12 percent in clerical; 11 percent in service, and 9 percent in skilled blue collar.
- Fifty-nine percent of the nonpoor uninsured are employed in small firms of less than 30 employees.

- Fifty-eight percent of nonpoor uninsured are employed by firms that offer insurance, but 53 percent of these workers are not eligible. The other 47 percent report coverage is too expensive.

Strategies and Next Steps

- Develop and field a survey of insurers who offer student coverage.
- Continue to work with small employers and other stakeholders.
- Developing low-cost coverage alternatives that would not require any new revenue streams, as well as options that would require additional resources for when the state's economy improves.
- Potential proposals include redesigning the two small-employer standard benefit plans to make them more affordable; creating a small-employer purchasing alliance, and publishing a small-employer rate guide.

Lead Agency/Contact Person

Department of Insurance; Dianne Longley, Special Projects Director, Texas Department of Insurance, Dianne.longley@tdi.state.tx.us

Vermont — Initial Grant Awarded: FY 2000

Update on SPG-Funded Activities

Data Collection

- Household survey.
- Focus groups with uninsured, employers, insurers, providers.

Policy Development

- Establishment of Blue Ribbon Commission on Health to explore policy options to ensure access to health care coverage, and later the Steering Committee.
- Market testing of policy options through focus groups, resulting in tentative set of options that were modeled to estimate impact on uninsured and cost of each.
- Selection of three policy options for further study: Buy-in to VHAP (Vermont Health Access Plan, covers over 18,000 previously uninsured adults under a Section 1115a Medicaid waiver), premium assistance, medical savings accounts (MSA).
- Completed VHAP buy-in study.

Consensus Building

- Steering Committee composed of representatives of diverse group of stakeholders including providers, employers, advocacy groups, legislators, state agencies.
- Committee met regularly for planning and advising on research and selection of strategies.

Findings and Recommendations

- Employers prefer to provide coverage but face increasing financial pressures due to escalating premiums; a major barrier is lack of a low-cost insurance product.
- A study of VHAP buy-in strategy allowing small firms and individuals (using various eligibility scenarios) to enroll in VHAP found several potential negative consequences:
  - Reduced reimbursement would result in substantial cost shift to providers, and eventual cost shift to purchasers of commercial insurance;
  - Administrative costs would be similar to those of Blue Cross Blue Shield (14 to 18%);
  - Approximately 30 percent of those enrolled in commercial market (nongroup, association health plans, small-group market) would shift to VHAP buy-in, destabilizing premiums and potentially leading to insurers leaving the market;
  - Capital or higher premiums would be required to cover initial claims reserve and stop-loss reinsurance;
  - Majority of enrollees would migrate from existing coverage, with just a modest reduction of uninsured;
  - Employers previously offering coverage would be at a disadvantage, because competitors gain access to lower-cost insurance.
- Recommend to federal government to expand CPS Annual Demographic Survey to larger sample, greater detail, and state-specific questions to eliminate need for individual state surveys.

Lessons Learned

- Need for states to gather detailed data about insurance coverage.

Strategies and Next Steps

- Three policy strategies are being explored for potential implementation:
  - VHAP buy-in/lower-cost insurance products (findings summarized above);
  - Premium assistance: exploring subsidies for both employee and employer shares of employer-sponsored coverage, with efficient administration;
  - Medical savings account (MSA), focusing on use of MSA within public programs; e.g., public financing of MSAs for people eligible for 1115 waiver, VHAP, and SCHIP; or member's monthly enrollment fees may be used to fund the MSA account, with available MSA funds accessed to pay for noncovered health benefits or cost sharing.
- Studies on premium assistance and MSAs are in process with planned completion August 2005.

Lead Agency/Contact Person

Agency of Human Services; Stephanie Beck, Program Consultant, Vermont Agency of Human Services–Office of Vermont Health Access, stephanb@ahs.state.vt.us

Update on SPG-Funded Activities

Data Collection and Analysis

- Household survey resulting in 2,073 interviews.
- Analysis of data from the Department of Labor, Bureau of Labor Statistics (BLS) concerning 3,243 local, private sector employers.
- Agreement with the Agency for Health Research and Quality (AHRQ) to conduct a special Medical Expenditure Panel Survey Insurance Component (MEPS-IC) on employers in the territory.
- Collection of health service utilization and financial data from numerous institutional sources in the territory to improve understanding of how the differences in eligibility for private/public programs affect access and delivery of those services.
- Collection of data to determine the local government's overall contribution to funding health care in the territory.
- Actuarial work and data analysis to model an employee buy in to the government employee insurance (GEI) plan and a "shadow" employer plan.

Policy Development

- Identified and implemented a pharmacy benefits management (PBM) program within Medicaid effective July 1, 2004 to generate savings that might be redirected to expansion effort.[8]
- Identified broad changes in legislative, regulatory, and administrative requirements for expanding a managed care network for coordinating care of publicly funded health programs within community health centers, the Department of Health, and hospitals. Full membership status for the CHCs has been approved by the preferred provider organization (PPO) board of directors, and discussions are underway with the joint commission to understand operational requirements for accreditation of the expanded network, and with the Division of Banking and Insurance for any regulatory requirements that must be satisfied.

Findings

- More than half of the uninsured are 18 to 24 years old, and more than half have incomes below 100 percent of the FPL.
- Seventeen percent of the uninsured are potentially eligible for public coverage programs.
- In addition to cost, language barriers prevent many employers from offering coverage, particularly for Spanish-speaking firms on St. Croix dealing with English speaking agents (nearly one-third of the island's population is ethnically Hispanic).
- Many employers favor creating purchasing alliances not managed by the government; tax subsidies were the second-favored approach to help small employers purchase insurance.
- Uninsurance has had a significant impact on the local government as reflected in the amount of financial subsidization that is required to keep the hospitals operational; subsidy payment

[8] Initial examination found that "usual and customary" prices were being paid for pharmaceuticals provided at local pharmacies under contract to serve Medicaid clients; PBM program estimates savings of $500,000 to $750,000 in the first year of the program.

rate increases requested by the hospitals has exceeded 10 percent per year for the last three years, and represents $1 in every $3 of their revenue budget.

Strategies

- Expand employer-based coverage with a strategy to pool small firms, such as association plan or buy in to GEI or similar “shadow” plan.
- Develop a private/public partnership to assist with the highest risk levels to lower premium expense for employers.
- Better coordinate public insurance programs to make use of existing funding and reduce unnecessary utilization of resources in order to expand coverage potential.
- Expand managed care network for public program beneficiaries to include CHCs, Department of Health, additional hospitals.

Next Steps

- Further work on financial and utilization data is required to:
  - Develop uniform and automatic reporting systems;
  - Develop more refined and coordinated microlevel reporting;
  - Implement training programs for consistent interpretation of the data by analysts in the various agencies;
  - Develop more robust analysis of relational patterns across the different data sources;
  - Consider a reorganization plan within the executive branch to better perform health policy analysis and health policy development.
- Further analysis to determine the financial impact of substituting a dollar of insured coverage for a dollar of uncompensated care subsidy.
- Confirm accuracy of expenditure data and complete the report on potential savings through program redesign.
- Develop benefits and premium structures that are most appropriate in an employee buy in to GEI and private employer “shadow”; consider how this model would affect premium simulations and administrative logistics for the government, and determine legislative, regulatory, and administrative requirements.
- Set benchmarks for expanding a managed care network to support persons in publicly funded health plans.
- Under an SPG Pilot Project Planning grant, develop implementation plan for an association plan for small businesses.

Lead Agency/Contact Person

Virgin Islands Bureau of Economic Research, Lauritz Mills, Director, (340) 714-1700.

Virgin Islands Pilot Planning: Small-Group Purchasing Pools

Grant Amount: $351,687

Preliminary Activities

Data Collection and Analysis

- Modified version of the Coordinated State Coverage Survey instrument developed by SHADAC to determine demographics, source of coverage, and health status of resident.
- 2003 Virgin Islands Health Care Insurance and Access Survey (VIHCS) of households conducted between October 2002 and January 2003.
- Working with Agency for Health Research and Quality to conduct special MEPS-IC on employers in the Virgin Islands.
- Focus groups with employers.

Policy Development

- A Medicaid pharmacy benefits management (PBM) program implemented on July 1, 2004, as a result of original SPG data collection and analyses.

Pilot Planning

Strategy/Model

- Expand employer-sponsored insurance via the establishment of association health plans.
- Develop an expanded PPO that would include not only the current PPO physician and hospital network, but also health centers, in order to create a single plan for Medicaid and Medicare enrollees.

Target Population

- Uninsured workers and their employers.
- Underinsured Medicaid and Medicare enrollees.

Planning Tasks

- Develop premium/benefits plan, legal/regulatory structures, administrative and marketing strategies, and an outline of legislative, regulatory, and administrative strategies.
- Draft actuarial estimates.

Goals

- By August 2005, develop two fully defined and affordable streams of insurance coverage that would reduce the overall uninsured rate in the Virgin Islands to approximately 11 percent.

Lead Agency

Virgin Islands Office of the Governor and the Bureau of Economic Research.

Contact Information

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Washington Initial Grant Awarded: FY 2001

Update on SPG-Funded Activities

Data Collection and Analyses

- Fielded the Washington State Population Survey (WSPS) in 2002. The WSPS supplements the CPS by adjusting for Medicaid undercounting (a problem that has been corrected in the CPS since 2002), adding a question to verify lack of insurance coverage, capturing more-accurate Medicare recipient information, and recoding variables related to labor force participation and employment. Analysis of WSPS data has been a key element of the SPG activities.
- Participated in the Multi-State Integrated Database (MSID).
- Using WSPS 2002, MEPS 2001, the 2003 Employment Security Department (ESD) survey (see Strategies and Next Steps below), conducted analyses of employer-based coverage, demographics of the uninsured (individuals and families), and the state's health care market.

Policy Development

- Worked with the governor's office to evaluate the effects of premium and cost-sharing changes on low-income individuals and families in Medicaid and the Basic Health Plan.
  - As a result of these analyses, a proposal to require premiums for Medicaid-enrolled children below 200 percent of poverty was delayed, until at least July 2005.
- Examined the amount of uncompensated care provided by community hospitals and community health centers, and the sources of financing of that care in Washington state as compared to nationwide. Based on these analyses, the SPG recommended revisions to the state's charity care law and a full review of tax expenditures and subsidy payments vis à vis performance and accountability expectations.

Consensus Building

- Collaborated with providers, public health officials, policy stakeholders, consumers, brokers, and others on the Community Health Works *(*CHW) project (formerly known as the 100% Access Project, funded by HRSA). The goal of CHW is to pilot a community-based coverage, delivery, and administration model by 2008, the centerpiece of which would be a Community Health Management District, designed to oversee service delivery that reflects local values and needs.
- Provided data and analysis support to the Kids Get Care program, a community-based coverage and service delivery effort aimed at offering evidence-based preventive care with a focus on educating individuals about the importance of insurance.
- Participated in a governor-sponsored private/public task force looking at hospital administrative burdens. Recommendations from the task force were introduced in the legislature and passed in 2004, calling for coordinated hospital inspection efforts by the state and local authorities, as well as the Joint Commission on Accreditation of Health Care Organizations (JCAHCO) where appropriate.

Preliminary Findings and Lessons Learned

- Employer-sponsored insurance has decreased for the under age 65 population, from 70.9 percent in 1993 to 66.5 percent in 2002.
- Public program changes in 2002 have resulted in an increase in uninsured children. Estimates are in the thousands; a more accurate picture will be available following the analysis of the 2004 Washington State Population Survey.
- There is no "one-size-fits-all" solution. Low-income individuals need substantial subsidies to afford coverage that will provide a reasonable level of health and financial security.

Strategies and Next Steps

- The state hopes to be able to match WSPS 2004 survey data to a survey of employers conducted semi-annually by the Washington Employment Security Department (ESD), which captures labor market information on job vacancies. Earlier attempts at matching up these two data sources, in an effort to estimate premium costs for workers in firms that do not currently offer coverage, were unsuccessful due to weighting and methodology issues.
- Continued analysis of WSPS 2004 and MSID data.

Lead Agency/Contact Person

Washington Governor's Executive Policy Office, Vicki Wilson, Ph.D., SPG Project Director, Vicki.wilson@ofm.wa.gov; (360) 902-0652.

Washington, D.C. Initial Grant Awarded: FY 2003

Update on SPG-Funded Activities

Data Collection

- Conducted analyses using data from the DC Health Access Survey (fielded by the Kaiser Family Foundation in 2003).
- Developing a survey for union representatives to identify health insurance options available to them.
- Household survey of Latinos.
- Analysis of MEPS and CPS data on the costs of being uninsured.

Policy Development

- Advisory panel (see Consensus Building, below) considering various proposals for coverage expansion, including expanding Medicaid through a HIFA waiver, and developing a small-business health insurance purchasing pool similar to the Federal Employees Health Benefits Plan (FEHBP).

Consensus Building

- Developed a community advisory panel of 25 members representing a variety of interests. Goal is to help the Department of Health consider the findings of the data analyses in developing policy positions.
- Launched a website (www.dchealth.dc.gov) to provide information to the advisory panel and other interested stakeholders.

Preliminary Findings

- One in seven District residents does not have insurance coverage.
- The District has an uninsurance rate that is lower than the national average, mainly due to the high rate of public sector employment. At the same time, fewer District residents are covered by employer-sponsored insurance then in neighboring states.
- Latinos are three times as likely to be uninsured as African Americans, and eight times as likely to be uninsured as Caucasians.
- Fifty-two percent of the total population lives in federally designated primary care Health Professional Shortage Areas.
- In 2002, hospitals provided $150 million in uncompensated care to the uninsured.

Strategies and Next Steps

- Continue to hold the remaining four meetings of the advisory panel to discuss the Medicaid expansion and the private small-business purchasing pool strategy.
- Finalize the MEPS/CPS analysis.
- Conduct an insurance market case study and focus groups of employees and small-business owners.

Lead Agency/Contact Person

District of Columbia Department of Health, Angelyn Eastwick, Health Policy Analyst, District of Columbia Department of Health, aestwick@dchealth.com

West Virginia — Initial Grant Awarded: FY 2002

Update on SPG-Funded Activities

Data Collection and Analysis

Building on earlier SPG data collection/analysis, 2003–2004 extension year activities included:

- Telephone household survey;
- Focus groups among uninsured consumers, small employers, and agents and brokers on "affordable" benefit designs;
- Completion and dissemination of final reports on employer survey and focus groups, and completion of safety net paper.

Policy Development

- Subcommittees of the project's Health Advisory Council made policy recommendations, including options for increasing insurance levels over the short term.
- The governor incorporated the SPG recommendations into his agenda, resulting in passage of three bills authorizing:
  - A public/private partnership involving a small employer buy in to the Public Employees Insurance Agency;
  - A high-risk pool for HIPAA eligibles and persons deemed medically uninsurable;
  - A plan for a SCHIP expansion to include children in families with incomes from 200 to 300 percent of FPL.
- Development (with actuarial analysis and focus group testing) of an "affordable" adult basic product for the small-group market (Adult Basic Product) and a streamlined product (Individual Health Access Plan) for the individual market.
- Analysis of direct state subsidies and tax credits to promote coverage; concluded that state is not in financial position to support these options at this time.
- Preparation of report exploring administrative savings associated with simplified public insurance programs.

Consensus Building

- The Health Advisory Council (HAC), comprised of more than 100 leaders from key stakeholder groups, continued to meet and guide the planning process.
- The Health Umbrella Group (HUG), comprised of the executives of all state agencies involved in health care, continued to guide the SPG work.
- Town hall meetings, policy forums, focus groups, and surveys to obtain input from the public and key stakeholders.
- Continuation of communication plan, including production of a video on the uninsured to be used by local community groups.

Preliminary Findings

- Along with deteriorating economic conditions, uninsurance among nonelderly adults increased from 19.9 percent in 2001 to 21.7 percent in 2003.

- Of small and midsize employers surveyed in 2003, 18 to 25 percent indicate they would be willing to pay $100 in monthly premiums for health insurance; uninsured consumer strongly prefer low copays and deductibles.
- Eighty-one percent of uninsured adults are chronically uninsured: they have been uninsured for one year or more or have never had coverage.
- Public programs do not carry a stigma with most uninsured consumers; the main complaints revolve around eligibility rules and difficulty in locating providers.

Lessons Learned and Recommendations

- Timing of SPG recommendations just before legislative session provides momentum for inclusion into governor's agenda and action by legislature.
- Hearing various points of view by stakeholders is necessary.
- Changes in the economy may necessitate additional data analysis, to ensure that deliberations and recommendations are based on up-to-date information.
- Medicaid deficits underscore the importance of identifying solid revenue sources.
- Organizers of national initiatives consider the calendars of the various states when scheduling their initiatives.

Strategies and Next Steps

- Preparation of reports on coverage changes among children, nonelderly adults, and older adults.
- Development of pilot coverage project that targets uninsured residents aged 50 to 64 (see Pilot Summary).
- Continued development of streamlined affordable product, Individual Health Access Plan, for individual market.
- Continued development of health plan for uninsured small businesses; one insurer has expressed interest in offering plan. *The recent legislation takes advantage of the state's purchasing power by using the provider reimbursement rates in effect for the Public Employees Insurance Agency.*
- SPG project views maintaining current coverage levels as a major goal, and anticipates that the private market will be involved in most strategies recommended for coverage expansion.
- Ongoing assessment of various coverage expansion options; additional strategies will be included in the legislative recommendations for 2005 or form part of the project's final recommendations to be issued in mid 2005; options under consideration include:
  - Expanding Medicaid to cover custodial parents to 100 percent of FPL;
  - Individual purchase of limited benefits plan;
  - Reinsurance;
  - Incentives for employers to offer health insurance;
  - Cost containment council to oversee expenditures in each health care sector and react if a sector exceeded its limits.

Lead Agency/ Contact Person

West Virginia Health Care Authority, Sally Richardson, Executive Director, Institute for Health Policy Research at West Virginia University, srichardson@hsc.wvu.edu

West Virginia Pilot Planning:

Coverage for Uninsured Aged 50 to 64

Grant Amount: $399,991

Preliminary Activities

Data Collection and Analysis

- Use 2001 and 2003 surveys to document the uninsured status of residents aged 50 to 64
- Use prior surveys and new data analysis (interviews and focus groups) to document health care and coverage needs and costs of uninsured residents aged 50 to 64.

Policy Development

- Develop affordable option to meet needs of uninsured aged 50 to 64.

Pilot Planning

Strategy/Model

- Model not yet determined.
- Model must be affordable and spread risk equitably across delivery system stakeholders.
- Two pilot sites: one rural, one urban.

Target Population

- Uninsured residents aged 50 to 64.

Planning Tasks

- Develop communications plan that explains the needs of target population and benefits of coverage to build support for pilot demonstration; focal audiences include local community leaders, providers, general public, and Interim Study Committee of the WV legislature.
- Identify resources to fund demonstration in two sites.
- Use analysis to develop and refine insurance options, recommend pilot sites.

Goals

- By August 2005, have final comprehensive plan for pilot to submit to governor.
- Goal of pilot: Demonstrate financial feasibility and sustainability of model in both rural and urban settings.

Evaluation

- Create process to evaluate and measure impact of pilot including beneficiary participation, health status and satisfaction, provider participation experience, reduction of the community's/region's uncompensated care costs, and long-range sustainability.

Wisconsin — Initial Grant Awarded: FY 2000

Update on SPG-Funded Activities

Data Collection

- Profiling employers who would be likely to participate in the state's Health Insurance Premium Payment (HIPP) program to determine what they like about it.
- Review of successful HIPP programs in other states in order to develop a tool to determine program's cost effectiveness.
- Evaluation of the application and enrollment process to determine where individuals are exiting the process.
- Focus groups with insured and uninsured individuals.
- A study of the feasibility and cost of implementing a case management program and pharmaceutical discount program for federally qualified health centers (FQHCs).
- Analysis of MEPS data, with an increased state sample.

Policy Development

- State plans to develop policy options based on the above data collection activities.

Preliminary Findings

- Seventy-five percent of individuals under the age of 65 are covered by employer-sponsored insurance.
- Seven percent of full-time, self-employed working age adults age 18 to 64 were uninsured over the past 12 months, versus 4 percent of adults in the same age category who worked full time for an employer.
- Of the 93 percent of individuals age 65 or older who have Medicare coverage, only 8 percent do not purchase a Medicare supplemental package.

Strategies and Next Steps

- Use the findings from the HIPP-related data activities to develop recommendations for process improvements, policy changes, and expansion plans.
- After feasibility assessment of FQHC case and pharmaceutical management program, make recommendations to Department of Health and Family Services on implementing these programs.

Lead Agency/Contact Person

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Wyoming Initial Grant Awarded: FY 2002

Update on SPG-Funded Activities

Data Collection

- Household survey.
- Focus groups with uninsured individuals, small employers, and health care professionals.
- Key informant interviews with insurance industry leaders, health care provider groups, business representatives, and Department of Health staff.

Policy Development

- Chose seven coverage expansion strategies (out of 32 options) for the state to pursue, including covering parents through the state's SCHIP program, creating a state-funded uncompensated care pool for hospitals, and establishing a purchasing cooperative.
- Working with the Department of Employment to conduct research on labor market and compensation issues, and employer attitudes toward a purchasing pool.

Consensus Building

- Strategic research workgroup formed with representatives from the University of Wyoming, state agency staff, the Wyoming Business Council, provider associations, the Wyoming Insurance Department, and others, to discuss the health care marketplace in the state.
- Established a partnership between the Departments of Health, the Wyoming Healthcare Commission (established by legislative mandate) and the Department of Employment, in order to further pursue the feasibility of a small-employer purchasing alliance (under FY 2003 supplemental grant).

Findings and Recommendations

- Of the state's citizens, 70,000 (14.1%) are uninsured, 17,000 of those being children.
- Of the currently uninsured, almost 73 percent had never had insurance, or had not had it in the last 24 months.
- Of household survey respondents, 23.7 percent reported a member of the household was eligible for coverage but not insured, primarily due to cost.
- Preliminary findings based on the household survey indicate that the annual cost of covering a currently uninsured individual would be $2,500 for adults and $819 for children, significantly lower than the national cost of $4,600.

Lessons Learned

- Partnering with the Department of Employment was invaluable in regard to the amount of information gathered and consensus building accomplished by the task force on business community and its role in providing coverage.
- It would be helpful to less-populated states with large rural areas (like Wyoming) if national household surveys would focus additional efforts on tracking what is happening in these locations. The state recognizes that despite the value of conducting a household survey through the SPG process, it is a costly effort that cannot be conducted on an annual basis, thereby requiring the state to rely on national data that may not be representative of the state's demographics.

- Fully funding the Indian Health Service would allow the state to improve health care and coverage for the Native American population.
- Equalizing the tax treatment of employer-sponsored and individual insurance products by creating a tax credit for the full cost of individual purchases is recommended.
- The state recommends conducting studies to identify solutions for improving the quality, and ultimately reducing the cost, of providing care to those in rural areas. By the same token, the definition of "frontier areas" should be changed in order to automatically qualify those areas for community health center funding.

Strategies and Next Steps

- Based on SPG Task Force recommendations, the Department of Health is exploring ways in which Medicaid and SCHIP waivers can be used to expand coverage, with a particular focus on employer-sponsored insurance.
- A study is currently being conducted that will look at waiver approaches other states have used, and will include an actuarial analysis of the cost estimate for expanding coverage to parents of Medicaid and SCHIP eligible children. The task force expects the results of this study to inform efforts made by the legislature in its 2005 session.
- Continue to examine the cost of uncompensated care to the state to determine whether spending would be affected by an investment in and expansion of public coverage programs.

Lead Agency/Contact Person

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