STATE-SUBSIDIZED HEALTH INSURANCE PROGRAMS FOR LOW INCOME RESIDENTS: PROGRAM STRUCTURE, ADMINISTRATION, AND COSTS

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THE IMPROVING HEALTH CARE COVERAGE AND AFFORDABILITY SERIES

Since the demise of debates on how to achieve universal health insurance coverage, Congress and the states have turned to a strategy of expanding health insurance incrementally. These efforts have included market reforms to make coverage more accessible as well as expansions of federal public subsidies for children's health insurance and, in some states, subsidies for working families.

Expanding coverage incrementally raises a host of issues and choices for public policy, with likely differential impacts on the extent to which efforts succeed in reducing either the number or proportion of uninsured. Different approaches are likely to be more or less successful depending on the extent to which they reduce financial barriers to coverage and reach out to those who are currently uninsured.

To explore a range of issues related to incremental expansion, The Commonwealth Fund has commissioned a series of papers to be published sequentially. The first paper in the series, *The Financial Burden of Self-Paid Health Insurance on the Poor and Near-Poor*, by Jon Gabel, Kelly Hunt, and Jean Kim of KPMG Peat Marwick, LLP, examined the issue of affordability and the need for subsidies for the uninsured living on poverty or near-poor incomes.

In this second paper in the series, *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs,* Laura Summer of the National Academy on an Aging Society looks at early insights from state efforts to extend public insurance coverage for uninsured families and children. The paper conveys the results of interviews and reviews of experiences in 12 states, with a focus on states' administrative structures, use of premium and benefit cost-sharing, eligibility rules, and enrollment processes. Summer finds that states are confronting complex issues of how to target the uninsured and remove barriers to enrollment while living within program budgets.

A primary concern, for example, was whether to charge sliding scale premiums for different income groups and the impact of premiums on enrollment and outreach efforts. Administrators found that premiums may discourage people from enrolling or staying in programs, citing "nonpayment of premiums" or "loss of eligibility" as common reasons for disenrollment. At the same time, state policymakers were reluctant to discard premiums, as they generate program revenues and may discourage otherwise insured families from turning to state-subsidized coverage. Summer shares several overarching lessons gleaned from her interviews with program officials, including recommendations by study states based on their program experiences.

Future papers in the Improving Health Care Coverage and Affordability Series will explore different impacts of expansion policies focusing on short-term versus long-term uninsured populations, as well as coverage issues raised by recent expansions in subsidized insurance for children.

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EXECUTIVE SUMMARY

Over the past several years, state and federal policymakers have sought to broaden the availability of health insurance for Americans who lack coverage. The states have been especially active in designing and implementing programs to provide coverage for low income individuals and families who traditionally have not qualified for assistance through government-sponsored programs but do not receive coverage through their employers and cannot afford to purchase insurance on their own. Examining the experiences of several of these established programs may be helpful to states as they seek to improve current programs or design new ones, and particularly as they plan to use new federal funds to expand health insurance coverage for children.

This report summarizes the results of a study of twelve state programs that subsidize the cost of health insurance coverage for particular groups of low income residents. Six of the twelve programs—in Delaware, Hawaii, Minnesota, Oregon, Tennessee, and Vermont—are funded in part through the Medicaid program under Section 1115 waivers. The other six—in Florida, Massachusetts, New Jersey, New York, Pennsylvania, and Washington—are funded entirely by the states. Information about each program's administrative structure, day-to-day operations, premiums, and costs was gathered through interviews with program officials.

Although the programs share the goal of providing health care coverage, they vary considerably in design. This report highlights common and unique features of the programs, including aspects of their administrative structures, use of managed care, eligibility standards, application and enrollment procedures, premiums, and budgets. Finally, the report offers a set of strategic lessons for comparable programs.

Administrative Structure

The primary difference between the expanded Medicaid programs and the state-funded programs is that those in the first group maintain ties to a federally funded program and so are subject to an established set of rules, while those in the second group operate more independently. In practice, however, these distinctions blur. Section 1115 waivers have given Medicaid programs considerable flexibility, and some states have taken steps to coordinate operations between their Medicaid-funded and state-funded programs.

Among the expanded Medicaid programs, most day-to-day operations are concentrated in state agencies. State government tends to play a smaller operational role in the six state-funded programs; in fact, three of those programs contract with third-party administrators for virtually all day-to-day operations. The location of these operational responsibilities appears to have some bearing on the availability of management information. Administrators who oversee most operations in-house report that their direct involvement allows them to identify aspects of the programs that are working well, are cost-effective, or need improvement.

Many administrators point to differences between their programs and the traditional Medicaid program. They note that their work demands business sense and a commercial awareness of enrollees as customers. For example, to attract new participants—and particularly to appeal to groups not accustomed to dealing with state programs—some administrators suggest working with marketing professionals.

The Use of Managed Care Systems

A common feature of the programs is their reliance on managed care organizations, even among programs with indemnity arrangements still in place. Program staff frequently cite the value of experience in the insurance industry, and particularly in managed care organizations, in their current jobs. That experience is particularly useful at the start of a new program, when state administrators need to understand the workings of managed care operations, including their substantial start-up costs and their need for adequate time and resources to establish systems for enrollment counseling, premium collection, quality assurance, and management information.

Workable guidelines for negotiating with managed care organizations—similar to those used in the commercial sector—are very important to the successful administration of programs. This view is shared by administrators who have considerable latitude to engage in frank discussions with potential contractors and by those who feel constrained by state policies that allow for little communication with bidding organizations. The administrators also urge the importance of specificity in contracts, for example by ensuring that a managed care organization has enough providers to serve participants in the service area in a timely manner or by detailing the plan's responsibility for data collection.

Significantly, some state-funded programs have structured the contracting process to foster coordination with the Medicaid program. For example, New York's Child Health Plus gives preference to managed care organizations that also contract with the Medicaid program. This practice has several administrative advantages, including efficiencies in managing contracts and monitoring performance. Enrollees benefit, as well, when they are able to move between programs while still receiving care from the same managed care organization. As large purchasers, some states have also leveraged their influence by requiring managed care organizations to guarantee the availability of health care providers in traditionally underserved areas.

Program Eligibility

Eligibility factors—including residency, age, income, and Medicaid and health insurance status—vary among the twelve programs. There are also differences in eligibility and enrollment procedures.

Of the expanded Medicaid programs, three enroll adults and children, while three offer expanded coverage for uninsured adults. Three state-sponsored programs provide

coverage for people of all ages; the other three target children. The range of income limits is lower for the Medicaid programs than for the state-sponsored programs. Also, three of the Medicaid programs require applicants to furnish information about assets.

Health Insurance Status

Eleven programs require that individuals be uninsured at the time they apply for coverage. In five programs, applicants do not qualify for coverage if they have held other health insurance during a specified previous period of time. Some states specify particular types of prior coverage that disqualify residents. States impose such requirements to discourage employers or individuals from dropping coverage in order to qualify for state-sponsored subsidies. At the same time, the rules can be written to allow some residents with basic coverage to apply for more comprehensive coverage.

Each of the state-sponsored programs requires that participants not be enrolled in the Medicaid program at the time they apply. In addition to checking on Medicaid enrollment, some programs also screen for Medicaid eligibility. Yet one program, Florida's Healthy Kids, ran an experiment to determine if children who initially appear eligible actually meet Medicaid criteria. After screening approximately 2,000 children and finding that fewer than a dozen were eligible for Medicaid, the program dropped this labor-intensive procedure.

Although some states have systems to screen for dual participation in programs, little attention has been paid to assuring smooth transitions from one program to another. This is an area where more information is needed, especially as states plan to broaden health insurance for children.

All participants are required to report changes in their financial circumstances that might have an impact on their basic eligibility or the level of financial assistance they receive. The majority of programs certify participants for one year, but state-sponsored programs in Florida, Massachusetts, and Washington offer even longer eligibility.

The practice of certifying individuals for a year or longer differs from the approach used in the traditional Medicaid program, where recertification is required at frequent intervals. Longer eligibility promotes continuous care and encourages the provision of primary and preventive care, while also allowing enrollees more freedom to change jobs or to take jobs that do not include coverage but lead to jobs that do. In addition, longer eligibility reduces administrative burdens on program staff.

The Application and Enrollment Process

When program administrators were asked what advice they would give to the designers of future programs, most described some aspect of the application and enrollment process that either worked well or had not worked initially but was improved.

Most administrators recommend phasing in operations over several months to allow staff adequate time to identify problems and correct them. In several states, program staff were overwhelmed by the number of applications they received at the start of the program. Several suggested that programs enroll a distinct population first—such as a county, a region, a category of participants, or participants below a certain income level—to enable staff to identify trouble spots that are not apparent until the program is operational. Some administrators stressed, however, that although an option to phase in operations may be prudent, the state must be committed to full implementation. In other words, administrators were not recommending that states start with pilot programs.

Administrators also recommend that the application and enrollment process be as simple as possible, both to allow applicants to receive benefits quickly and to keep down administrative costs. Some programs have a "one-step" application process; others separate certain application and enrollment steps. TennCare, for example, recently initiated a more complex application process involving staff at local health departments.

Program Revenues and Costs

It is difficult to make comparisons among state program budgets, since differences in budgets tend to reflect differences in program structure. By examining costs for similar tasks and services performed by similar programs, however, it is possible to draw some conclusions about factors that influence costs.

Five of the twelve states use state general revenue to finance the state's portion of program funding. The others rely on dedicated funding sources, such as alcohol and tobacco taxes, assessments of health care providers and services, and taxes levied on employers. The Florida Healthy Kids program also requires that localities contribute to the program.

Ten of the twelve programs require premium payments from some enrollees. Enrollees with incomes below the poverty level pay no premiums in six states and premiums ranging from $2 to $11 per month in the other six states. At higher incomes, the range is broader, especially between payments for children and for adults.

There is some concern that premium payments may discourage people from enrolling in programs. For example, a survey conducted by the Washington Hospital Society found that premium payments for the Basic Health Plan were affordable for people at the low end of the income scale but were not affordable for others. Subsequently the Basic Health Plan changed their premium structure. A number of administrators say it would be helpful to have information on the affordability of premiums for different income groups.

Some policymakers regard premiums as an important feature, not only because they generate revenue but also because paying premiums is thought to encourage enrollees to take more responsibility for their care and be more committed to the program. Small premium payments may not be cost effective, however, since administering a collection system adds

complexity to the program.

Comparing administrative expenditures among programs is complicated by the fact that administrative costs for comparable tasks may be reported in state budgets as line items if performed by state staff and as contracts if performed by outside organizations. Some managed care organizations also perform administrative tasks, such as determining eligibility, enrolling participants, or conducting outreach activities, which may be included in capitation rates or recorded as medical costs.

It appears that administrative costs may be higher in programs that pay third-party administrators. The Massachusetts Medical Security Plan and Health Access New Jersey have the highest administrative expenses per enrollee, perhaps because Massachusetts pays insurers both to administer the program and to provide coverage for program participants, while New Jersey pays a third-party administrator to perform all administrative functions related to the program.

Another factor that affects administrative costs is the age of the program. Newer programs may have higher costs because their administrative procedures are not yet firmly established, while older program can generate implementation costs if significant changes are made in the design. For example, when the Oregon Health Plan added an asset test, new application forms had to be designed and printed and staff had to be trained in new procedures.

Administrative costs also reflect the complexity of the program design. For example, if programs require applicants to submit information about both assets and income, more resources will be required to process the applications. If face-to-face interviews are required, the administrative costs will be particularly high. Similarly, the recertification process can be more or less costly, depending on how often recertification is required and what the process involves.

Economies of scale can be achieved when programs work together. In Minnesota, for example, using a single management information system for MinnesotaCare and Medicaid has reduced administrative costs for both programs. Contracting with the same managed care organizations, coordinating activities related to contract negotiation and monitoring for quality assurance, and employing state-sponsored procedures for responding to grievances can also be cost effective.

The composition of the benefit package has a large impact on medical costs. Programs with more generous benefit packages—those that provide a wide array of services and have no copayments or relatively low copayments—are likely to be the most costly. The enrolled population is another major factor: programs primarily serving children tend to have lower medical costs than other programs.

Differences in the cost of medical care may reflect differences in the prevailing rates for medical services in particular geographic regions. Circumstances in the broader health care market may also determine how eager managed care organizations are to participate in the programs and thus to compromise when negotiating rates. At the same time, the ability of programs and managed care organizations to negotiate with health care providers for favorable rates will affect program costs.

Although it is convenient to separate administrative and medical costs for discussion purposes, it is important to note that many features of program design and operation affect both administrative and medical costs. For example, longer eligibility periods save money on recertification procedures while also increasing the likelihood that enrollees will receive preventive and ongoing care, which can result in lower medical costs. Similarly, extensive data collection can increase administrative costs in the short run but save money eventually if the data are used to improve the program's efficiency.

Lessons from State Programs

In addition to specific observations regarding program design and operations, program official in the twelve states offer several overarching lessons:

- **Coordination between the public and private sectors can yield important benefits for participants, programs, and the state.** Ideally, state-subsidized insurance programs should be designed in tandem with efforts to increase employer-sponsored health insurance. Coordination can also help ensure continuity of care for participants and may lead to opportunities to pool administrative tasks.

- **Program operations should be phased in gradually, but it is also important that a state be committed to full implementation.** Testing program operations with a small population gives staff time to identify and solve problems, thus avoiding "bad press" at the outset. Even so, a clear commitment to full implementation has been an important impetus for health maintenance organizations to take steps to qualify for state contracts and expand to underserved areas.

- **Knowledge about the insurance industry and a business orientation are crucial to the success of a program.** Administrators need these qualities to negotiate effectively with managed care organizations and to institute policies to attract participants.

- **Programs that perform most administrative functions in-house have access to information that can be used as a powerful management tool.** Day-to-day experience with program operations helps administrators improve operations, reduce costs, and plan for the future.

- **States should be willing to refine a program on the basis of experience.** Although most of the programs studied are new, many have already been redesigned, limited, or expanded, often with good results. Change may also be needed as a result of shifts in the health care market, federal policies, or other external factors. Designers should remember, however, that retooling or changing direction requires an expenditure of resources.

- **Systematic examination of certain aspects of program design and operational procedures could make the programs more effective.** Administrators in all twelve states agree that they need more information about structuring premiums to make them affordable, outreach to potential participants, eligibility guidelines, enrollment processes, collecting premiums, and continuity of care. They are interested both in studying their own programs and in learning from the experiences of others.

PART 1. INTRODUCTION

Over the past several years, state and federal policymakers have sought to broaden the availability of health insurance for Americans who lack coverage. Many of the uninsured are low income individuals and families who traditionally have not qualified for assistance through government-sponsored programs but who do not receive insurance through their employers and cannot afford to purchase coverage on their own. Interest in the topic has been particularly keen since Congress committed funds to expand health insurance coverage for children, a move that has generated a great deal of discussion in states about how to best accomplish the expansion.[1]

STATE PROGRAMS TO EXPAND HEALTH INSURANCE COVERAGE

To date, the states have been most active in designing and implementing programs to provide health care coverage for uninsured residents. This report describes program operations in twelve states: Delaware, Florida, Hawaii, Massachusetts, Minnesota, New Jersey, New York, Oregon, Pennsylvania, Tennessee, Vermont, and Washington. These states were chosen because their programs have both common elements and important differences. All subsidize the cost of health care coverage, and all have expanded coverage beyond the income and eligibility groups traditionally covered by Medicaid. At the same time, the programs target different groups: children, families, adults, the unemployed. They also differ in how coverage is provided: some are Medicaid expansions, and some are new programs; some offer partial subsidies for coverage, while others provide fully subsidized coverage.

Six of the programs represent expansions of their state Medicaid programs and use a combination of federal and state funds to extend coverage to groups of people who would not otherwise qualify for Medicaid. The other six are funded entirely by the states. Although the programs share the goal of providing health care coverage, they vary considerably in design.

This report, based on interviews with program officials in the twelve states, summarizes how each program is structured, how day-to-day operations are accomplished, what premiums are charged, and what costs are associated with program operations. The purpose of the report is to describe the administrative structure and procedures used by these programs, examine program costs, and draw lessons from emerging state experiences.

The interviews made clear that, although some programs are more firmly established than others, none is static. To a certain extent, program administrators have had to invent programs as they implement them, while also being responsive to changes in federal law, state legislation, and the broader health care system. Throughout this report, recent or pending changes in program design and operation are discussed. Not surprisingly, many of

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[1] The Balanced Budget Act of 1997 includes a child health block grant that provides states with $20.3 billion in new federal funding over the next five years to expand health insurance coverage to uninsured, low income children.

the officials who were interviewed expressed interest in knowing about current policies and procedures in other states, how other programs have evolved, and what aspects of those programs seem to work best.

OVERVIEW OF THE PROGRAMS STUDIED

The twelve programs featured in this report vary in a number of respects. Some are sponsored in conjunction with state Medicaid programs, while others operate more independently. The programs target different age and income groups. They provide subsidies for different income groups. The extent to which the programs rely on managed care organizations differs, as does their administrative structure.

Tables A, B, and C provide a basic profile of the programs, while table D includes a brief description of each. The format used in the tables will be used throughout the report to facilitate comparisons among programs that have similar types of sponsorship and serve similar population groups.

One important distinction among the twelve programs concerns sponsorship. Half are state Medicaid programs that have been awarded waivers under Section 1115 of the Social Security Act to expand Medicaid eligibility to population groups not generally covered under Medicaid and to enroll program participants in managed care plans. They are financed primarily by a combination of state and federal funds. The other six programs were developed independently of Medicaid and rely mostly on state-generated funds to provide access to coverage and subsidized premiums for selected groups of low income residents. Health Access New Jersey provides subsidies to enable individuals to purchase one of six health insurance plans offered in the private market. The Massachusetts Medical Security Plan subsidizes the purchase of coverage in the open market and also contracts with an indemnity plan to provide direct coverage for some enrollees. The other four programs subsidize coverage and make arrangements with certain managed care organizations to provide specific coverage.

Table A
State-Subsidized Health Insurance Programs

State	Program Name	Year Established	Age Group Eligible
Medicaid Section 1115 Waivers			
	Expansions for all ages		
HI	Hawaii QUEST	1994	0-64
MN	MinnesotaCare[2]	1992	0-64
TN	TennCare	1994	0-64
	Expansions primarily for adults		
DE	Diamond State Health Plan	1996	19-64
OR	Oregon Health Plan	1994	19-64
VT	Health Access Plan[3]	1996	18-64
State-Funded Programs			
	Programs for all ages		
MA	Medical Security Plan	1990	0-64
NJ	Health Access New Jersey	1995	0-64
WA	Basic Health Plan[4]	1989	0-64
	Programs for children		
FL	Florida Healthy Kids	1992	1-19
NY	Child Health Plus	1991	0-18
PA	Children's Health Insurance Program	1993	0-17

[2] The MinnesotaCare program was established in 1992, but the Section 1115 waiver was implemented in 1995. Currently, the waiver covers only pregnant women and children; state funds are used to finance coverage for adults. The program expansions for some adults are tied to the expansions for children, since some adults qualify for coverage because they are the parents of minor children covered under the waiver. Because of this close association, the whole program is examined here and is characterized as a Medicaid-sponsored program.

[3] The Vermont Health Access Plan also provides a prescription drug benefit for low income elderly and disabled residents, but that program component is not included in this report.

[4] Most children in Washington are covered under the Medicaid-sponsored program, Basic Health Plus, but children who do not qualify for Basic Health Plus may enroll in the Basic Health Plan. Children account for about 10 percent of Basic Health Plan enrollees.

Table B
Eligibility Criteria for State-Subsidized Health Insurance Programs

State	Program Name	Age Limits	Income Limits (% of the Federal Poverty Line)	Asset Tests
Medicaid Section 1115 Waivers				
	Expansions for all ages			
HI	Hawaii QUEST	0-64	<300%	Y
MN	MinnesotaCare—adults	0-64	<175%[5]	Y
	MinnesotaCare—children		<275%	Y
TN	TennCare	0-64	no limit	N
	Expansions primarily for adults			
DE	Diamond State Health Plan	19-64	<100%	N
OR	Oregon Health Plan	19-64[6]	<100%	Y
VT	Health Access Plan	18-64	<150%	N
State-Funded Programs				
	Programs for all ages			
MA	Medical Security Plan—direct coverage	0-64	<200%	N
	Medical Security Plan—premium assistance		<400%	N
NJ	Health Access New Jersey	0-64	<250%	N
WA	Basic Health Plan	0-64[7]	no limit	N
	Programs for children			
FL	Florida Healthy Kids	1-19	no limit	N
NY	Child Health Plus	0-18	no limit	N
PA	Children's Health Insurance	0-17	<235%	N

[5] Income limits for adults increased from 135 percent of the federal poverty line, effective July 1, 1997.

[6] Students under age 23 are not eligible to participate in the program if they are eligible for coverage through their parents or through the schools they attend.

[7] Most children in Washington are covered under the Medicaid-sponsored program, Basic Health Plus, but children who do not qualify for Basic Health Plus may enroll in the Basic Health Plan. Children account for about 10 percent of Basic Health Plan enrollees.

Table C
Enrollment in State-Subsidized Health Insurance Programs

State	Program Name	Program Enrollment (Spring 1997)	Average Monthly Enrollment (SFY 1997)
Medicaid Section 1115 Waivers[8]			
Expansion for all ages			
HI	Hawaii QUEST	N/A	47,476
MN	MinnesotaCare—all	97,357	96,108
	MinnesotaCare—families with children	88,123	85,245
	MinnesotaCare—adults	9,234	7,890
TN	TennCare	346,236	N/A
Expansion primarily for adults			
DE	Diamond State Health Plan	12,071	10,017
OR	Oregon Health Plan	103,936	111,458
VT	Health Access Plan	7,212	7,049
State-Funded Programs			
Program for all ages			
MA	Medical Security Plan	15,863	14,167
NJ	Health Access New Jersey	14,642	17,223
WA	Basic Health Plan	152,892	140,631
Program for children			
FL	Florida Healthy Kids	37,506	26,321
NY	Child Health Plus	130,495	107,236
PA	Children's Health Insurance Program	50,879	53,879

[8] Enrollment figures represent only those participants who are eligible for coverage under the Section 1115 waivers. One exception is MinnesotaCare; enrollment figures are presented for all MinnesotaCare enrollees. Enrollment figures for Vermont do not include the elderly and disabled enrolled in the prescription drug benefit program.

Table D
Program Descriptions of State-Subsidized Health Insurance Programs

State	Program Name	Program Description
Medicaid Section 1115 Waivers		
Expansions for all ages		
HI	Hawaii QUEST	Hawaii QUEST provides health insurance for uninsured individuals with incomes below 300 percent of the federal poverty line who would not otherwise have coverage. A managed care system of service delivery was also implemented under the Section 1115 waiver from Medicaid. The state-sponsored SHIP program for low income residents preceded the QUEST program in Hawaii.
MN	MinnesotaCare	MinnesotaCare provides health insurance for low income uninsured Minnesota adults with incomes below 175 percent of the federal poverty line and children and parents of minor children with family incomes below 275 percent of the federal poverty line who would not otherwise have access to health care insurance. The Minnesota Children's Health Plan, established in 1988, was a forerunner to the 1992 MinnesotaCare program. In 1995, the state received a Section 1115 program waiver. Children and pregnant women are covered under the waiver. State funds are used to finance coverage for adults. Since January 1997, everyone enrolled in MinnesotaCare has been enrolled in a managed care organization.
TN	TennCare	TennCare's Section 1115 waiver program extends health insurance to groups of "uninsured and uninsurable" people who would not otherwise qualify for the Medicaid program. A managed care system is used for the delivery of health care services.
Expansions primarily for adults		
DE	Diamond State Health Plan	The Diamond State Health Plan, a Medicaid Section 1115 waiver program, provides health care services for Medicaid clients through managed care organizations. The expanded program extends this coverage to adults with incomes below the federal poverty line.
OR	Oregon Health Plan	The Oregon Health Plan is a group of initiatives designed to provide access to health care coverage for all residents of the state. One of the major initiatives under the Oregon Health Plan is a Section 1115 waiver program that expands eligibility to make coverage available to all residents with incomes below the federal poverty line. Individuals who would not otherwise qualify for Medicaid are termed "newly eligible" for the Oregon Health Plan. The program uses a state-specific Prioritized List of Health Services to define the benefit package and contracts with managed care organizations to provide care for most enrollees.
VT	Health Access Plan	The Vermont Health Access Plan (VHAP) is a Section 1115 waiver program with three distinct components. First, the program extends health insurance coverage to previously uninsured adults with incomes below 150 percent of the federal poverty line. Second, the state had implemented a managed care delivery system for all Medicaid enrollees. Since the development of managed care systems for Medicaid occurred at the same time enrollment began for the expanded population, new participants were enrolled first in VHAP-Limited, a fee-for-service program, and transferred later to managed care organizations. Third, the program offers a prescription drug benefit for low income elderly and disabled residents. This report examines the first two program components.
State-Funded Programs		
Programs for all ages		

MA	Medical Security Plan	The Massachusetts Medical Security Plan subsidizes insurance for recipients of unemployment compensation. The program has two parts. The Premium Assistance Plan, available to families with incomes below 400 percent of the federal poverty line, partially subsidizes premium payments for health insurance available through COBRA, the federal law allowing individuals to continue health insurance coverage for up to 18 months after losing employment-based coverage. The Direct Coverage Plan, available to people with family incomes below 200 percent of the federal poverty line who do not have the option to continue employment-based coverage, pays for health insurance provided through an indemnity plan.
NJ	Health Access New Jersey	Health Access New Jersey provides financial assistance to families with incomes below 150 percent of the federal poverty line so they can purchase health insurance in the commercial market. Enrollees can choose from one of five managed care organizations or an indemnity plan. Less than 1 percent of enrollees choose indemnity coverage.
WA	Basic Health Plan	Washington's Basic Health Plan provides coverage through managed care organizations for uninsured adults and some children who do not qualify for Basic Health Plus, the state's Medicaid-sponsored program for most children. Some participants received fully subsidized coverage, while others pay full premiums. In addition to individual coverage, group coverage is available through employers and other sponsors who purchase coverage. Group sponsors may pay reduced premiums for members who qualify for subsidies as individuals
Programs for children		
FL	Florida Healthy Kids	The Florida Healthy Kids program is a community-based program that provides health insurance for school children and their siblings. The program enrolls children at schools. Healthy Kids contracts with managed care plans whose provider networks provide care for children in 16 counties in the state.
NY	Child Health Plus	Child Health Plus is a statewide program that was established in 1991 to provide health insurance coverage for primary and preventive care for children in New York state. Recent legislation has expanded the program significantly by adding coverage for inpatient hospitalization, effective in the fall of 1997. The program contracts with managed care organizations for health care services.
PA	Children's Health Insurance	This program provides health insurance for uninsured children. All services are provided through managed care organizations, except children who must be hospitalized are required to apply for Medicaid coverage.

The programs can also be grouped by the age of the population covered. Since health care costs are generally much lower for children than for adults, age is an important factor in program costs. Among the Medicaid programs, three of the expansions allowed under Section 1115 waivers encompass adults and children, while three are designed to assist uninsured adults. In some states, such as Delaware, Oregon, and Vermont, the expansion population contains relatively few children because previous Medicaid expansions extended benefits to children.[9] Three of the state-sponsored programs provide coverage for people of all ages, while the other three target children.

A common feature of the programs is their reliance on managed care organizations. Even programs with indemnity arrangements still in place are moving to managed care. With the exception of the Massachusetts Medical Security Plan, each program contracts with managed care organizations, whose networks of health care providers offer a range of services for enrollees.[10] Although the programs are designed to use managed care networks, some have recently made or are still making the transition from a fee-for-service health care delivery system. Therefore, some of the systems and operations described in this report are very new, even within programs that have been in place for several years. All programs offer a comprehensive package of health care services.[11]

ADMINISTRATIVE STRUCTURE OF THE PROGRAMS

In administrative terms, the primary difference between the expanded Medicaid programs and the state-funded programs is that those in the first group maintain ties to a federally funded program and so are subject to an established set of program rules, while those in the second group operate more independently. In practice, however, those distinctions blur. Section 1115 waivers have given state Medicaid programs considerable flexibility, and some states have taken steps to coordinate operations between their Medicaid-funded and state-funded programs. Brief descriptions of the administrative structures of the twelve programs are provided in table E.

The expanded Medicaid programs contract with outside organizations for program administration on a limited basis only, keeping most day-to-day operations concentrated

[9] Some states also use other methods to expand Medicaid coverage. Currently, states are required to provide Medicaid coverage for pregnant women and children under age six with family incomes less than 133 percent of the federal poverty line and for children born after September 30, 1983, with family incomes below 100 percent of the federal poverty line. Provisions of Section 1902(r)(2) of the Social Security Act (added in 1988), OBRA-89, and OBRA-90 allow states to expand Medicaid coverage to pregnant women and children beyond the federal requirements. Expanded coverage for children in Minnesota has been available since 1988, first through the Minnesota Children's Health Plan and then through the MinnesotaCare Program, established in 1992. In 1995, the state received a Section 1115 Medicaid program waiver to cover children and pregnant women. State funds are used to finance coverage for adults. This report considers the entire MinnesotaCare program.

[10] The Massachusetts Medical Security Plan offers direct coverage through an indemnity plan as well as a premium assistance plan. Health Access New Jersey offers indemnity coverage as an option, but less than one percent of program participants are enrolled in the indemnity plan.

[11] New York's Child Health Plus program added hospitalization coverage in late 1997.

within state agencies. The activities most commonly performed by contractors are those related to monitoring the quality of care provided by managed care organizations. In the six state-funded programs, government agencies play a smaller operational role. In fact, three programs—the Massachusetts Medical Security Plan, Health Access New Jersey, and Pennsylvania's Children's Health Insurance program—contract with third-party administrators for virtually all day-to-day operations. The Child Health Plus program in New York also contracts for many, but not all, program operations. Most operational functions for Washington's Basic Health Plan are performed by state agencies. Florida's Healthy Kids program has the loosest ties to state government; the program is run by a board that remains relatively independent of other state programs.

Table E
Administrative Structure of State-Subsidized Health Insurance Programs

State	Program Name	Program Structure and Administration
Medicaid Section 1115 Waivers		
	Expansions for all ages	
HI	Hawaii QUEST	The MedQuest Division of the Department of Human Services oversees operations for all participants in the Hawaii QUEST program, including both those who qualify on the basis of eligibility for Medicaid and those in the expanded population. MedQuest contracts with six managed care organizations to provide care to program participants.
MN	MinnesotaCare	The Office of Health and Continuing Care Strategies within the state Department of Human Services oversees policies and operations for three health care programs for low income residents: Medical Assistance, General Assistance Medical Care, and MinnesotaCare. Administrative functions for all three programs are divided among various units or “clusters” within the Department of Human Services. The Health Care for Families and Children cluster is charged with MinnesotaCare operations including those related to the eligibility, application, and enrollment processes. The cluster also expects to administer a grant program for outreach activities. The Purchasing and Service Delivery cluster negotiates and contracts with health plans and maintains a customer services office to assist families enrolled in the program. The Performance Measurement and Quality Improvement cluster monitors health plan performance. Another cluster involved with the administration of the program is the Continuing Care for Persons with Disabilities cluster. In addition, the state Medicaid office participates in the administration of the MinnesotaCare program and the MinnesotaCare program uses the Medicaid Management Information System. At present, MinnesotaCare contracts with eight managed care organizations for the delivery of health care services to all enrollees. An outside organization conducts medical record reviews for the program.
TN	TennCare	The Bureau of TennCare in Tennessee’s Department of Health administers the TennCare Program. Local health departments assist with the application and enrollment process for the program. The Bureau contracts with ten managed care organizations for the delivery of health care services and with an outside organization that conducts activities related to quality assurance.

	Expansions primarily for adults	
DE	Diamond State Health Plan	The Medicaid program in the Department of Health and Social Services has responsibility for the Diamond State Health Plan. Medicaid contracts with an outside organization, which acts as the Health Benefits Manager to perform outreach functions, enroll participants in the four managed care organizations, and educate enrollees about the program and the health plans. The Health Benefits Manager also pays the plans. Medicaid contracts with an independent quality review organization to monitor the performance of the managed care organizations. A steering committee composed of clients, advocates, and staff from state agencies meets quarterly to review program operations.
OR	Oregon Health Plan	The Office of the Health Plan Administrator coordinates all activities related to the Oregon Health Plan and formulates health policy for the state. The Medicaid portion of the Oregon Health Plan is administered by the Office of Medical Assistance Programs, or OMAP, located in the state Department of Human Resources. OMAP handles all of the administrative functions for the "newly eligible" participants in the Oregon Health Plan, except premiums are collected by an outside contractor. OMAP contracts with 15 managed care organizations.
VT	Health Access Plan	The Office of Vermont Health Access in the Department of Social Welfare, as the designated Medicaid agency within the Vermont Agency of Human Services, administers the VHAP program. Two managed care organizations have contracts to provide health care services to program participants. The office contracts with an independent organization for member outreach, education, and enrollment services. Independent groups also conduct activities related to quality assurance.
State-Funded Programs		
	Programs for all ages	
MA	Medical Security Plan	Initially, the state Department of Medical Security administered the program. In 1996, responsibility for the program was transferred to the Department of Employment and Training, which administers the Massachusetts Medical Security Trust Fund, the program's financing source. The Department of Employment and training contracts with an insurance company to administer the program and provide coverage under the Direct Coverage Plan.
NJ	Health Access New Jersey	Responsibility for Health Access New Jersey rests with the Health Care Financing Systems Office in the Department of Health and Senior Services. The department contracts with a third-party administrator for all administrative activities. Program participants may purchase coverage from any of five managed care organizations and one indemnity plan with which the program has agreements.
WA	Basic Health Plan	The Washington State Health Care Authority is a state agency that administers the Basic Health Plan as well as benefit programs for public employees. (Basic Health Plus is administered jointly by the Health Care Authority and the Department of Social and Health Services.) The Health Care Authority conducts the administrative functions related to the Basic Health Plan program. The authority contracts with 18 managed health care plans for the delivery of health care services to enrollees across the state. The program also contracts with an outside vendor to manage the group accounts for the program.

	Programs for children	
FL	Florida Healthy Kids	By law, the Healthy Kids Corporation Board has thirteen members, appointed by the governor, the state insurance commissioner, and the state education commissioner. Currently, the board is chaired by the insurance commissioner. Four other board members represent state agencies. In addition, the board includes members of physician organizations, a hospital association, the insurance industry, an academic institute, a school board, and a school administration. The board has responsibility for virtually all decisions related to the administration of the program. The Healthy Kids program contracts with eight managed health care plans; each county is served by one plan. The program contracts with a third-party administrator who makes eligibility determinations, enrolls children, and collects premiums. An outside organization conducts activities related to quality assurance.
NY	Child Health Plus	Legislation establishing the Child Health Plus program specifies that it be administered by the state commissioner of health in consultation with the state commissioner of insurance. The Division of Health Care Financing within the Department of Health has primary responsibility for contracting with health plans, paying the plans, and monitoring performance. The managed care organizations with which the program contracts make eligibility determinations, enroll families in the program, and collect premiums. The plans also perform some outreach activities. The Child Health Plus program contracts with an independent organization for some outreach services.
PA	Children's Health Insurance	Three cabinet officers, the insurance commissioner, the secretary of health, and the secretary of the budget comprise the management team for the Children's Health Insurance program. The management team contracts with five health insurance companies, called grantees, who administer the program. The team contracts with an independent organization to review the performance of health plans and providers.

PART 2. PROGRAM DESIGN AND BUDGET

ELIGIBILITY CRITERIA AND PREMIUMS

Residency, age, income, and health insurance status are all factors in determining eligibility for the programs. Each program requires that participants be state residents, and most have set income requirements to enroll and to receive financial assistance. Most states also have rules requiring that participants not have access to other forms of insurance. Age and income eligibility requirements for each program are summarized in table B.

Age Limits

Each of the six states with Section 1115 waivers now offers coverage to individuals who formerly, by virtue of age, did not meet the categorical requirements for Medicaid. In Delaware, Oregon, and Vermont, the expansion population contains relatively few children because previous Medicaid program expansions extended benefits to children. MinnesotaCare distinguishes between two groups of applicants: families with children, and other adults. Different income limits apply to each group.

Among the six state-funded programs, three target children: the Florida Healthy Kids program, New York's Child Health Plus program, and Pennsylvania's Children's Health Insurance program. Three provide coverage for children and adults under age 65: the Massachusetts Medical Security Plan, Health Access New Jersey, and Washington's Basic Health Plan. Washington's program is designed primarily for adults, but about 10 percent of enrollees are children who do not qualify for the state's Medicaid-sponsored Basic Health Plus program.[12] Age limits may also vary within programs. For example, the Healthy Kids program in Florida is open to children ages 5 to 19 who are enrolled in school, but some counties offer coverage to younger siblings, as well.

States use a variety of tactics to cap enrollment or benefits when funding is limited, some of them based on age.

- In Pennsylvania, the state fully subsidizes the $52 monthly premium for children from birth to age 17 whose families meet the program's income limits. In addition, the state pays half of the $63 monthly premium for a smaller group of children from birth to age 5 with somewhat higher incomes.
- When TennCare lifted an enrollment cap earlier this year, applications were accepted for uninsured children under age 18, but not for most older people.[13]
- No new applications are being taken in New Jersey, but the state legislature has just created a new program, Children First, which began enrolling children under age 18

[12] Some children do not qualify because they do not meet certain categorical requirements. For example, children who are not U.S. citizens or teens who do not reside with their parents cannot participate in the program and so are referred to Washington's Basic Health Plan.

[13] Enrollment in TennCare remains open to children and adults who are Medicaid-eligible or who are

in the fall of 1997.

Income Limits

States use income limits for two purposes: to establish eligibility for participation in the program and to determine the extent to which coverage will be subsidized. In four of the twelve programs—TennCare, the Basic Health Plan in Washington, the Healthy Kids program in Florida, and the Children's Health Insurance program in Pennsylvania—uninsured individuals may participate regardless of income. Once they qualify for the program, however, income criteria are used to determine the extent to which their coverage is subsidized. In the eight other states, the same income limits are used to enroll individuals in programs and to calculate the level of assistance they will receive.

The range of income eligibility limits varies substantially and tends to be lower in the expanded Medicaid programs than in the state-sponsored programs.

- Among the five Section 1115 waiver programs with income limits, the limits range from less than 100 percent to less than 300 percent of the federal poverty line.

- In the three state-sponsored programs with income limits, the limits range from less than 200 percent to less than 400 percent of the federal poverty line.

- The programs targeted to adults have the lowest income eligibility limits and the narrowest range, from less than 100 percent to less than 150 percent of the federal poverty line.

Participants in all programs are required to report changes in their financial circumstances that might have an impact on their eligibility or their level of financial assistance. The majority of programs certify participants for one year, although the Oregon Health Plan certifies participants for six months. In three of the state-sponsored programs—in Florida, Massachusetts, and Washington—program participants are presumed to be eligible until they report a change in circumstances. The practice of certifying individuals for a year or longer differs from the approach used in the traditional Medicaid program, where recertification is required at frequent intervals. Longer eligibility periods promote continuous care for program participants. (Approaches used by different programs to determine eligibility are discussed in greater detail in part 3 of this report.)

Asset Tests

None of the six state-funded programs requires that applicants provide information about assets. Among the six Medicaid programs, three now require such information.

- Responding to a belief among some legislators that people with substantial financial resources were participating in the Oregon Health Plan, the state legislature added an

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uninsurable as determined by an insurance company's denial of health insurance for medical reasons.

asset test to the program in 1995.

- Similar concerns prompted the Minnesota legislature to reinstate an asset test for MinnesotaCare on July 1, 1997.

- Hawaii QUEST was developed with no asset limits. After a legal challenge, however, the program added an asset test to comply with the Americans with Disabilities Act. The eligibility requirements for the QUEST program are now equal to those for the traditional Medicaid program, which serves those with disabilities.[14]

Premium Payments

The income criteria used to determine premium subsidies are presented in table F. For individuals with incomes below the federal poverty line, six of the twelve programs subsidize premium payments in full, while the others provide partial subsidies.[15] Partial subsidies are available in some programs for individuals with incomes as high as 400 percent of poverty. Only Delaware and Hawaii offer no partial subsidies. Five states—Florida, Hawaii, New York, Tennessee, and Washington—allow individuals with incomes above specified levels to purchase unsubsidized health insurance coverage through the program.

[14] Knowing that the asset test would exclude some people from the QUEST program, the state developed a second program called QUEST-Net. The program has higher asset limits and a smaller monthly premium than Hawaii QUEST. It provides a basic benefit package.

[15] Self-employed individuals with incomes below the poverty line must pay 50 percent of the monthly premiums for coverage through Hawaii QUEST.

Table F
Premium Subsidy Structure for State-Subsidized Health Insurance Programs

State	Program Name	Income Limits for Premium Subsidies (Percent of the Federal Poverty Line)		
		Full Subsidy	Partial Subsidy	Eligible, but No Subsidy
Medicaid Section 1115 Waivers				
	Expansions for all ages			
HI	Hawaii QUEST	<100%[16]	--	100%-300%
MN	MinnesotaCare—adults	--	<275%	--
	MinnesotaCare—children	--	<175%	--
TN	TennCare	<100%	<400%	>400%
	Expansions primarily for adults			
DE	Diamond State Health Plan	<100%	--	--
OR	Oregon Health Plan	--	<100%	--
VT	Health Access Plan	<50%	<150%	--
State-Funded Programs				
	Programs for all ages			
MA	Medical Security Plan—direct coverage	<200%	--	--
	Medical Security Plan—premium assistance	--	<400%	--
NJ	Health Access New Jersey	--	<250%	--
WA	Basic Health Plan	--	<200%	>200%
	Programs for children			
FL	Florida Healthy Kids	--	<185%	>185%
NY	Child Health Plus—old	<160%	>160%	--
	Child Health Plus—new	<120%	120%-222%	>222%
PA	Children's Health Insurance Program	<185%	<235%	--

[16] Self-employed individuals with incomes below the poverty line receive a subsidy equal to half the monthly premium.

Ten of the twelve programs require some enrollees to make premium payments.[17] Payments are calculated according to ability to pay and actuarial cost. Some states charge a single amount for all individuals or families in a particular income group. In others, premium payments can be based on factors such as age, family size, health plan chosen, or local differences in the cost of medical care. The full cost of the monthly premiums and approximate monthly premium payments for individuals enrolled in each state's lowest-cost plan are presented by income group in table G.

- Perhaps the simplest premium structure is used by the Florida Healthy Kids program. Children's eligibility for free and reduced-price school lunches determines their eligibility for premium subsidies and the amount of payment. Up to 90 percent of the premium is subsidized for children who receive free lunches, and up to 75 percent is subsidized for those who receive reduced-price lunches. Children who pay the full price for lunch pay the full premium, which ranges from $48 to $60 depending on the county in which they reside.[18]

- Washington's Basic Health Plan offers a choice of 18 different plans and has different premiums for four age categories, one for children and three for adults. The cost of the least expensive plan for children is $42. The premium for an adult enrolled in the lowest-cost plan may be $95, $119, or $196, depending on age.

- All MinnesotaCare enrollees pay premiums. A fixed premium of $4 per month is charged to children with family incomes at or below 150 percent of the federal poverty line. A sliding scale premium is charged to all other enrollees and is based on income and household composition. An individual adult in a family with children pays up to $98 per month for coverage.

[17] The Diamond State Health Plan does not charge premiums. Participants in the Massachusetts Medical Security Plan do not make payments to the program, but those in the Premium Assistance Program pay insurers directly and receive assistance with their payments from the program.

[18] Each county determines the subsidy for each of the three income groups, but counties cannot subsidize the full premium payment. All families are required to pay a portion of the premium.

Table G
Monthly Premiums and Premium Payments for State-Subsidized Health Insurance Programs, by Income Group, for Lowest-Cost Health Plan

State	Program Name	Individual Premium Payments			Full Premium
		Approximate Income Range[19] (Percent of Federal Poverty Line)			
		<100%	100%-200%	200%-300%	
Medicaid Section 1115 Waivers					
Expansions for all ages					
HI	Hawaii QUEST	$0	$149	$149	$149
MN	MinnesotaCare-family[20]	$4	$4-$61	$76-$98	$72
TN	TennCare	$0	$14-$33	$74-$81	$190
Expansions primarily for adults					
DE	Diamond State Health Plan	$0	--	--	$127-$207
OR	Oregon Health Plan	$6	--	--	$143-$194
VT	Health Access Plan	$2	$2-$3	--	$143
State-Funded Programs					
Programs for all ages					
MA	Medical Security Plan	--	--	--	N/A
NJ	Health Access New Jersey[21]	$5	$33-$105	$106-$170	$220
WA	Basic Health Plan—adults[22]	$10	$10-$65	$95-$196	$95-196
	Basic Health Plan—children	$0	$0	$42	$42
Programs for children					
FL	Florida Healthy Kids	$5	$13	$48	$48
NY	Child Health Plus—old program	$0	$25	$25	$36
	Child Health Plus—new program	$0	$9-$13	full cost	N/A
PA	Children's Health Insurance	$0	$0	$28	$52

[19] For actual income ranges related to subsidies for premium payments, see Table F.

[20] Premium payment range reflects different rates for different income groups within the income range. Full premium is average capitation rate.

[21] Full premium rate represents differences in capitation rate based on age and gender.

[22] Premium payment range reflects different rates for different age groups.

In six of the states, enrollees with incomes below the poverty level are not required to pay premiums. In the other states, premiums for poor individuals range from $2 to $11 per month. The range widens for enrollees with higher incomes: some whose incomes fall between 100 and 200 percent of the federal poverty line pay no premiums, while others pay as much as $100 per month. At income levels greater than 200 percent of poverty, differences in premium payments for children and adults are most apparent, ranging from $25 to $48 a month for children and from $74 to $196 for families enrolled in the lowest-cost plans.

Eligibility Requirements Related to Private Health Insurance

States have various rules regarding applicants' current health insurance status, their previous access to coverage, and the quality of coverage to which they have access. Eleven programs—all except the Oregon Health Plan—require that individuals be uninsured at the time they apply for coverage, although this rule is relaxed somewhat by state-funded programs for children. For example, Florida's Healthy Kids program and New York's Child Health Plus program require only that applicants not have comparable insurance at the time they apply for coverage.

In five programs, applicants do not qualify if they have had other health insurance coverage during a specified time previous to application. States impose such requirements to discourage employers or individuals from dropping coverage in order to qualify for state-sponsored subsidies. Requirements related to prior insurance are more common among expanded Medicaid programs than among state-funded programs, and the complexity of the requirement varies.

- MinnesotaCare requires that applicants not have been enrolled in a health insurance plan in the four months prior to applying for the program and that they not have had access to employer-provided insurance for which the employer paid at least half the cost in the 18 months prior to applying for MinnesotaCare. Children and pregnant women with incomes below 150 percent of the federal poverty level are exempt from this rule.

- TennCare sets a retrospective date from which applicants cannot have had coverage.

- Delaware requires that individuals be uninsured for four months prior to applying for the Diamond State Health Plan.

- In Vermont, applicants qualify for coverage if they have not had insurance that includes both hospital and physician services for 12 months prior to application. Among the state-funded programs, only New Jersey requires a prior period without coverage. New Jersey applicants cannot have had access to health insurance through a current employer within the last 12 months.

The methods used to document a previous lack of coverage vary. In most states applicants are asked to provide information on the application form. TennCare requires a face-to-face interview and proof—either a standardized form or an official letter from the employer—that that health insurance is not offered through the applicant's employer or a family member's employer. Individuals who apply for TennCare because they are uninsurable must produce a letter from an insurance company stating that coverage has been denied.

There is some debate regarding the utility of requirements that applicants be without health insurance for a prior period of time. The Florida Healthy Kids program dropped such a requirement after determining that it was too difficult to verify information about prior coverage.

Eligibility Requirements Related to Medicaid Coverage

The state-sponsored programs all require that participants not be enrolled in the Medicaid program at the time they apply. This ensures that states will not have to pay twice for coverage and enforces the state's incentive to enroll eligible individuals in the Medicaid program to obtain federal matching payments. In some states, Medicaid records are checked against program records to identify individuals enrolled in both programs.

- After children are enrolled in New York's Child Health Plus program, billing files are matched with Medicaid files on a monthly basis to identify children enrolled in both programs. Children thus identified are disenrolled from Child Health Plus.

- The Florida Healthy Kids program screens for Medicaid enrollment by comparing enrollment records for the two programs.

In addition to checking on Medicaid enrollment, some programs also screen for Medicaid eligibility.

- New York's Child Health Plus program requires participating health plans to screen applicants for Medicaid eligibility and refer children who appear to be eligible to the Medicaid program.

- Pennsylvania's Children's Health Insurance program routinely refers applicants to Medicaid if they appear to be eligible for the Medicaid Healthy Beginnings program.
- Applications for Health Access New Jersey are denied if applicants appear to be eligible for Medicaid. Applicants receive a referral to the local Medicaid office with their denial notice.

While the Healthy Kids program in Florida screens for Medicaid enrollment, applicants are no longer screened for eligibility because an early experiment found that the

process is not cost effective. During a test period of several months, approximately one-quarter of program applicants appeared to qualify for Medicaid at the initial screening, but further investigation showed that fewer than 1 percent were actually eligible. Of the approximately 2,000 children screened, fewer than 12 qualified for Medicaid.

ENROLLMENT

As the enrollment figures in table C show, the programs vary in size from fewer than 15,000 enrollees each in Delaware, New Jersey, and Vermont to more than 100,000 in Oregon, New York, and Washington. Tennessee has the largest program, with an enrollment of almost 350,000. Enrollment figures are neither a reflection of the need for health insurance in the state nor an indicator of a state's commitment to providing coverage for the uninsured. A number of reasons explain differences in the size of the programs. Population is one obvious factor, especially in states with small populations such as Delaware and Vermont. The economic climate can also influence the extent to which people need and seek health insurance coverage.

Another factor that influences program enrollment is the manner in which states define the eligible population. For example, the relatively small program in Massachusetts targets a very specific population: individuals receiving unemployment compensation and their families. As noted earlier, some Medicaid programs that expanded eligibility through Section 1115 waivers had already used provisions in the federal law to expand Medicaid coverage for pregnant women and children. In this report, enrollment figures represent only those participants who are eligible for coverage under the Section 1115 waivers.[23]

The level of premium subsidies can have an impact on how many eligible people actually enroll in the program, as can the enrollment process itself. The simpler the process, the more likely people will be to enroll. For example, the Florida Healthy Kids program uses a simple, one-step process that allows families to enroll through their children's schools. In Washington, where the process is more complicated, the Basic Health Plan took steps to streamline enrollment to attract program participants. Outreach and marketing efforts can also have an impact on enrollment.

Limiting Enrollment

With limited funding to subsidize coverage, some programs have had to contain enrollment. Two expanded Medicaid programs have had to impose enrollment caps.

- Hawaii QUEST adds new enrollees only to replace those leaving the program.

[23] MinnesotaCare enrollment figures are for all enrollees, but federal Medicaid payments are available only for pregnant women and children. It is difficult to separate enrollment for adults and children, however, because enrollment is reported for two categories of adults: the "families with children" category includes adults who qualify as parents of minor children covered under the Section 1115 waiver, and the "adults only" category includes adults who qualify based on a lower income-eligibility limit.

- TennCare enrollment for uninsured applicants was closed from January 1995 until April 1997, when the program again began enrolling uninsured children under age 18. The program also extended enrollment to a new category of people: uninsured workers and the families of workers who have lost their jobs due to plant closings.

- MinnesotaCare has not capped enrollment but has limited growth by expanding eligibility in the "adults only" category more slowly than originally planned.

Three of the state-funded programs also limit enrollment:

- The Health Access New Jersey program has not accepted new applications since January 1996.[24]

- Washington's Basic Health Plan places applicants on a waiting list and enrolls new people when slots become available.[25]

- The Florida Healthy Kids program operates in only 16 of the state's counties and can enroll only a certain number of children each year in those counties.

- The Children's Health Insurance Program in Pennsylvania lifted enrollment caps on July 1, 1997. The program had previously maintained a waiting list.

The obvious disadvantage of imposing enrollment caps is that people in need of health insurance do not receive it, but the caps have other consequences as well. The perception that a program is closed may remain even after waiting lists are no longer needed, thus undermining new outreach efforts.

- In Pennsylvania, the Children's Health Insurance program reduced its statewide advertising when enrollment caps were imposed. In one area of the state where space was available, plans then had difficulty recruiting participants.

Another possible consequence of enrollment caps may be that the program attracts and retains a population that is less healthy than the general population. People who are already enrolled may be reluctant to let coverage lapse if they need care and know they cannot re-enroll. Similarly, the people most likely to make the effort to apply despite a waiting list are those who need care the most. This adverse selection can eventually drive up rates and increase program costs.

Growth in Enrollment

Current enrollment figures fail to convey changes that occur over time, but a comparison of enrollment figures for spring 1997 and average enrollment during state fiscal year 1997

[24] The state began enrolling children in the Children First program in the fall of 1997.

[25] Washington's other program, Basic Health Plus, continues to enroll children. Families with children who apply for the Basic Health Plan are referred to Basic Health Plus.

indicates significant growth in some programs.

- In the Florida Healthy Kids program, enrollment in June 1997 represents a substantial increase from June of the previous year, when about half as many children (18,977) were enrolled. The expansion of the program to seven new counties during 1996 accounts for the higher enrollment. The program now operates in 16 of Florida's 67 counties. About half the state's school-age population lives in those 16 counties.

- In New York, the Child Health Plus program received considerable publicity as federal lawmakers considered methods to expand health care coverage for children. As a result, program enrollment increased. Also, there has been increased interest in the program as families learn that the benefit package has been expanded to include coverage for hospitalization.

- Enrollment has declined in New Jersey's Health Access program because no new applications have been accepted since January 1996. As participants leave the program, they are not replaced.

REVENUES AND COSTS

Although some programs receive the majority of their funding through the federal Medicaid programs, all programs depend on additional funding from other sources, whether from states, localities, or premiums paid by enrollees. Revenue sources for the twelve programs are listed in table H.

Program expenditures, including total expenditures for eight of the twelve programs studied, are presented in table I. Some programs are unable to provide figures for their administrative costs, and three of the six expanded Medicaid programs cannot provide figures pertaining only to the expanded population.

Table H
Revenue Sources for State-Subsidized Health Insurance Programs

State	Program Name	Revenue Source		
		Federal Funds	State Funds	Local Funds
Medicaid Section 1115 Waivers				
Expansions for all ages				
HI	Hawaii QUEST	Medicaid	General Fund	No
MN	MinnesotaCare	Medicaid	Health Care Access Fund: (2% health care services tax)	No
TN	TennCare	Medicaid	General Fund	No
Expansions primarily for adults				
DE	Diamond State Health Plan	Medicaid	General Fund	No

OR	Oregon Health Plan	Medicaid	General Fund, Tobacco Tax ($0.30 per pack)	No
VT	Health Access Plan	Medicaid	Health Security Trust Fund: Tobacco Tax ($0.24 per pack)	No
State-Funded Programs				
Programs for all ages				
MA	Medical Security Plan	No	Health Insurance Trust Fund (employer tax of 0.12% on the first $14,000 of each employee's salary levied on employers with six or more employees	No
NJ	Health Access New Jersey	No	General Fund	No
WA	Basic Health Plan	No	Health Care Subsidy Fund: Tobacco tax, alcohol tax, hospital provider tax	No
Programs for children				
FL	Florida Healthy Kids	No	General Fund	School districts, county commissions, hospital taxing authorities, children's service councils, community donors
NY	Child Health Plus	No	Health Care Initiatives Pool: surcharges on hospital services, laboratory services, and diagnostic and treatment center services	No
PA	Children's Health Insurance Program	No	Tobacco Tax ($0.03 per pack)	No

Table I
Expenditures for State-Subsidized Health Insurance Programs
(State Fiscal Year 1997)

State	Program Name	Average Monthly Enrollment	Expenses (Millions of Dollars)			Expenses per Enrollee (SFY 1997)		
			Total Expenses	Medical Care Expenses[26]	Administrative Expenses	Total Expenses	Medical Care Expenses	Administrative Expenses
Medicaid Section 1115 Waivers[27]								
	Expansions for all ages							
HI	Hawaii QUEST	47,476	$89.6	$87.7	$1.9	$1,887	$1,847	$39
MN	MinnesotaCare[28]	96,108	$108.2	$97.1	$11.1	$1,126	$1,010	$115
TN	TennCare	349,375[29]	$627.1	$604.4	$22.7	$1,795	$1,730	$65
	Expansions primarily for adults							
DE	Diamond State Health Plan	10,017	N/A	$22.9	N/A	N/A	$2,286	N/A
OR	Oregon Health Plan	111,458	N/A	$216.3	N/A	N/A	$1,941	N/A
VT	Health Access Plan	7,049	N/A	$6.4	N/A	N/A	$908	N/A
State-Funded Programs								
	Programs for all ages							
MA	Medical Security Plan	14,167	$18.4	$15.9	$2.5	$1,299	$1,122	$176
NJ	Health Access New Jersey	17,223	$34.8	$32.0	$2.8	$2,020	$1,858	$163
WA	Basic Health Plan	140,631	$177.8	$162.7	$15.1	$1,264	$1,157	$107
	Programs primarily for children							
FL	Florida Healthy Kids	26,321	$25.5	$23.9	$1.6	$969	$908	$61
NY	Child Health Plus[30]							

[26] These figures primarily represent payments to managed care organizations. Therefore, some administrative functions may be included if they are included in the negotiated capitation rates for the managed care organizations. In Vermont, where the change to a managed care system is in progress, about half of medical care expenses are paid on a capitated basis; the other half is paid on a fee-for-service basis.

[27] Expenditures are only for those participants eligible for coverage under the Section 1115 waivers, except expenditures for MinnesotaCare are for all enrollees.

[28] These figures are for state fiscal year 1996.

[29] Enrollment figures are for June 1997.

[30] These figures are for calendar year 1996, except administrative expenses are reported for state fiscal year 1996 (April 1, 1996-March 31, 1997).

Revenues from States and Localities

Five of the twelve states use general revenue to finance the state's portion of program funding: Delaware, Florida, Hawaii, New Jersey, and Tennessee. Other states support their programs through dedicated funding sources. Pennsylvania and Vermont rely only on tobacco taxes, while Oregon uses a combination of general revenue and tobacco taxes. Two states, Minnesota and New York, rely only on assessments of health care providers and services, and Massachusetts finances its program through taxes levied on employers. Washington uses diversified funding sources, including taxes on alcohol and tobacco as well as on health care providers.

As state fiscal circumstances change, some legislatures have changed revenue sources:

- The Children's Health Insurance program of Pennsylvania received some funds generated by an alcohol tax during one year.

- The major revenue source for the New York Child Health Plus program in 1996 was the Statewide Bad Debt and Charity Care Pool, funded by assessments on hospitals and third-party payers. In 1997, the Health Care Initiatives Pool will fund the program through surcharges on hospital, laboratory, and diagnostic and treatment center services.

- The general fund has formerly been used for the Oregon Health Plan, but a new cigarette tax will be a significant funding source for the 1997-99 biennium budget.

- New Jersey began its Health Access program with funds from the state's Unemployment Trust Fund, but general funds are used now to maintain the program. No new participants have enrolled since January 1996.

Only one of the programs examined in this report receives funds from localities.

- Since 1996, Florida's Healthy Kids program has required contributions from localities totaling at least 5 percent of costs for medical services and third-party administration in the first year of the program, increasing to 10 percent in the second year and by 10 percent more each year until 40 percent is reached in year five. Local governments provide some 90 percent of local funds from sources such as school districts, county commissions, hospital taxing authorities, and children's services councils. About 10 percent of local funds are contributed by philanthropic donors in the community.

Premium Payments

The extent to which premium payments cover the cost of care differs among programs, as

indicated in table J. Premiums collected from enrollees paid for as little as 1 percent and as much as 33 percent of payments for medical care expenses. In general, the portion of funding generated by premiums depends on such factors as which participants pay premiums, how many paying participants are enrolled, and how much they pay.

There is some concern that premium payments may discourage people from enrolling in programs. For example, a survey conducted by the Washington Hospital Society found that premium payments for the Basic Health Plan were affordable for people at the low end of the income scale but were not affordable for others. As part of an effort to attract enrollees, the premium payment for the program was reduced.

Some policymakers regard premiums as an important feature of health insurance programs, not only because they generate revenue but also because paying premiums is thought to encourage enrollees to take more responsibility for their care and be more committed to the program. Yet requiring small premium payments may not be cost effective, since administering a collection system adds complexity to the program.

For example, under Oregon Health Plan's premium payment system, established for newly eligible enrollees early in 1996, enrollees are charged between $6 and $28 per month, depending on family size and income. Procedures were instituted for determining the amount of premium payments, billing for and collecting premiums, disqualifying enrollees who do not pay, and granting waivers for several categories of participants. In May and June of 1996, some 1,838 enrollees were disqualified for failure to pay premiums, while more than twice that number—some 4,137 applicants—were granted waivers. Generating the premium payments, monitoring them, and processing waiver requests requires substantial administrative effort, which may not be offset by premium revenues to the program.

Table J
Premium Payments from Enrollees as a Percent of Medical Care Expenses for State-Subsidized Health Insurance Programs

State	Program Name	Medical Care Expenses[31]	Premium Payments from Enrollees	Premiums as % of Medical Care Expenses
		(Millions of Dollars)		
Medicaid Section 1115 Waivers				
	Expansions for all ages			
HI	Hawaii QUEST	$87.7	$3.8	4%
MN	MinnesotaCare	$97.1	$20.3	21%
TN	TennCare	$604.4	$30.0	5%
	Expansions primarily for adults			
DE	Diamond State Health Plan	$22.9	$0	0%
OR	Oregon Health Plan	$216.3	$8.5	4%
VT	Health Access Plan[32]	$6.4	$0.07	1%
State-Funded Programs				
	Programs for all ages			
MA	Medical Security Plan	N/A	N/A	N/A
NJ	Health Access New Jersey	N/A	N/A	N/A
WA	Basic Health Plan (subsidized)	$142	$21.5	15%
	Programs primarily for children			
FL	Florida Healthy Kids	$23.9	$7.9	33%
NY	Child Health Plus	$71.7	$0.7	1%
PA	Children's Health Insurance Program	N/A	N/A	N/A

[31] These figures primarily represent payments to managed care organizations. Therefore, some administrative functions may be included if they are included in the negotiated capitation rates for the managed care organizations.

[32] Premium payments are lower than expected in subsequent years because the collection of premiums for the Vermont Health Plan was suspended for a period in 1997 for administrative reasons.

Administrative Expenditures

Comparing expenditures is complicated by the fact that the programs have very different administrative structures. Some programs perform the majority of administrative functions in-house; others contract with outside organizations. In some instances, the managed care organizations that provide medical care also perform administrative tasks, such as making eligibility determinations or enrolling participants. As a result, administrative costs for the same tasks may be reported in state budgets as line items if performed by state staff and as contracts if performed by outside organizations. Similarly, figures for medical care expenses may include some administrative expenses.

Reporting differences seem to account for the wide range of values in per enrollee administrative expenses, reported in table J. For example, administrative expenses appear to be higher for MinnesotaCare, a program that conducts most administrative functions in-house, than for the two other Section 1115 programs that enroll people of all ages, Hawaii QUEST and TennCare. But total expenditures per enrollee are substantially lower for MinnesotaCare than for the two other programs. This suggests that the cost of some administrative functions for the Hawaii and Tennessee programs may be reported as medical care expenditures. Similarly, administrative expenses for New York's Child Health Plus program appear low because they include only state office expenses. Managed care organizations with which the program contracts make eligibility determinations, enroll children in the program, collect premiums, and conduct some outreach activities.

Reported administrative costs range from 1 to 13.5 percent of total program costs, as shown in table K. It is important to note, however, that the range reflects the manner in which the costs are reported. For example, although total administrative costs for Florida's Healthy Kids program run about 6 percent, data collection required by the state is reported as a medical care expense because health plans conduct the activity. If the $1.3 million annual cost of data gathering were reported as an administrative expense, administrative costs would be 11 percent of total costs. Inconsistent reporting practices therefore make it impossible to compare costs across programs.

Two programs have specific rules about the amount of money spent for administration:

- In Pennsylvania's Children's Health Insurance program, 7.5 percent of program costs are used for administration. Contracting health plans are also required to provide in-kind services for outreach equaling not less than 2.5 percent of the total amount paid in premiums. The program also requires that plans participate in evaluation activities, although the program does not pay the full cost of those activities.

Table K
Administrative Expenditures as a Percent
of Total Program Expenditures
for Selected State-Subsidized Health Insurance Programs
(State Fiscal Year 1997)

State	Program Name	Total Expenses	Administrative Expenses	Administrative Expenses as a Percent of Total Expenses
		(Millions of Dollars)		
Medicaid Section 1115 Waivers[33]				
Expansions for all ages				
HI	Hawaii QUEST	$89.6	$1.9	2.1%
MN	MinnesotaCare[34]	$108.2	$11.1	10.3%
TN	TennCare	$627.1	$22.7	3.6%
Expansions primarily for adults				
DE	Diamond State Health Plan		N/A	
OR	Oregon Health Plan		N/A	
VT	Health Access Plan		N/A	
State-Funded Programs				
Programs for all ages				
MA	Medical Security Plan	$18.4	$2.5	13.5%
NJ	Health Access New Jersey	$34.8	$2.8	8.0%
WA	Basic Health Plan	$177.8	$15.1	8.5%
Programs primarily for children				
FL	Florida Healthy Kids	$25.5	$1.6	6.3%
NY	Child Health Plus[35]	$73.1	$1.4	1.9%
PA	Children's Health Insurance Program		N/A	

[33] Expenditures are only for those participants eligible for coverage under the Section 1115 waivers, except expenditures for MinnesotaCare are for all enrollees.

[34] These figures are for state fiscal year 1996.

[35] These figures are for calendar year 1996, except administrative expenses are reported for state fiscal year 1996 (April 1, 1996-March 31, 1997).

- Under the current contract, the Massachusetts Medical Security Plan pays the health insurance company that administers the program an amount equal to 14.7 percent of claims paid for administrative expenses. (In state fiscal year 1997, this amount was equal to approximately 13.5 percent of total program costs.) Currently, however, the insurance company is negotiating for an increase in administrative fees to 23 percent of claims paid. The company maintains that it cannot cover administrative costs because the cost of claims filed was lower than expected.

Some states report that specific amounts of money are obligated for certain administrative tasks. For example, New York's Child Health Plus program will spend $500,000 on outreach activities in 1997, half for a marketing contractor and half for a mass marketing campaign conducted by the state health department. In the same year, Florida's Healthy Kids program spent $100,000—approximately $10,000 per site—for quality assurance activities and some $90,000 on program evaluation. The program director notes that the money spent on evaluation is a good investment because evaluation results have been used to demonstrate program effectiveness and increase support for the program.

Expenditures for Medical Services

Average medical care expenses per enrollee for state fiscal year 1997 are presented in table J, and average monthly medical expenses per enrollee shown in table L. With the vast majority of program participants enrolled in managed care organizations, capitated premium payments to health plans account for almost all expenditures for medical care.[36] Yet, because capitation rates also reflect administrative services the health plans provide, figures for medical care expenses include some administrative costs. The extent to which administrative expenses are included varies from state to state.

In the three programs for children, monthly medical expenses range from $56 to $76. All the programs are state-funded, and all charge copayments for some services. Rates for the Pennsylvania and New York programs would be higher if they provided full coverage for hospitalization, as the Florida Healthy Kids program does.[37] Also, New York's program does not cover dental care. In New York and Pennsylvania, managed care organizations perform the majority of administrative tasks, which may be included under medical expenses. The variation in medical care expenses for the other programs is greater than that among the children's programs, with average monthly expenses per enrollee ranging from $76 to $190.

[36] The one exception in the Massachusetts Medical Security Program, which makes premium payments to indemnity plans. Because the Delaware and Vermont programs were changing from indemnity to managed care coverage in 1997, they also made substantial payments for provider claims.

[37] New York's Child Health Plus program began to cover hospitalization in the fall of 1997, but rates quoted here apply to the earlier primary and preventive care program. Pennsylvania's Child Health Insurance program requires enrollees who must be hospitalized to apply for Medicaid coverage.

Table L
Average Monthly Medical Care Expenses Per Enrollee
for State-Sponsored Health Insurance Programs
State Fiscal Year 1997

State	Program Name	Medical Care Expenses Per Enrollee
Medicaid Section 1115 Waivers		
Expansions for all ages		
HI	Hawaii QUEST	$153.98
MN	MinnesotaCare-all	$84.16
TN	TennCare	$144.17
Expansions primarily for adults		
DE	Diamond State Health Plan	$190.50
OR	Oregon Health Plan	$161.75
VT	Health Access Plan	$75.66
State-Funded Programs		
Programs for all ages		
MA	Medical Security Plan	$93.50
NJ	Health Access New Jersey	$154.83
WA	Basic Health Plan – all	$96.42
Programs primarily for children		
FL	Florida Healthy Kids	$75.67
NY	Child Health Plus	$55.75
PA	Children’s Health Insurance	$56.75

Reasons for Differences in Program Costs

Limited information on program expenses makes it impossible to determine why costs for individual state programs are lower or higher than others. It is possible, however, to draw conclusions about factors that affect expenses for administrative and medical costs. Each factor is discussed briefly below; part 3 of this report includes more detailed examples.

It appears that administrative costs may be higher in programs that pay third-party administrators. The Massachusetts Medical Security Plan and Health Access New Jersey have the highest administrative expenses per enrolled, perhaps because Massachusetts pays insurers both to administer the program and to provide coverage for program participants, while New Jersey pays a third-party administrator to perform all administrative functions related to the program.

Another factor that affects administrative costs is the age of the program. Staff from the Vermont Health Access Plan note that newer programs may have higher costs because their administrative procedures are not yet firmly established. Similarly, implementation costs will be generated if significant changes are made in the design of an established program. For example, when the Oregon Health Plan added an asset test, new application forms had to be designed and printed and staff had to be trained in new procedures.

Administrative costs also reflect the complexity of the program design. For example, if programs require applicants to submit information about both assets and income, more resources will be required to process the application. If face-to-face interviews are required for eligibility determinations (as they are in TennCare), the administrative costs will be particularly high. Similarly, the recertification process can be more or less costly, depending on how often recertification is required and what the process involves.

Economies of scale can be achieved when programs work together. In Minnesota, for example, using a single management information system for MinnesotaCare and Medicaid has reduced administrative costs for both programs. If two programs contract with the same managed care organizations (as Washington's Basic Health Plan and Medicaid programs have done), some activities related to contract negotiations and monitoring for quality assurance can be conducted jointly. Similarly, the use of established state-sponsored procedures for responding to grievances can be cost effective.

The composition of the benefit package has a large impact on medical costs. Programs with more generous benefit packages—those that provide a wide array of services and have no copayments or relatively low copayments—are likely to be more costly. Delaware's Diamond State Health Plan is the only state-sponsored program that does not charge copayments. This means that the state must pay higher rates for health insurance coverage. By contrast, the rates for Washington's Basic Health Plan may be lower, in part, because the benefit package does not cover dental care and requires higher copayments than

many other programs. Copayments in most state programs range from $1 to $10 for most services; approximately $25 is charged for emergency services.

The composition of the population enrolled in the program also has an impact on medical costs. For example, programs that primarily serve children are likely to have lower medical costs than programs that serve substantial numbers of adults.

Differences in the cost of medical care may reflect differences in the prevailing rates for medical services in particular geographic regions. Circumstances in the broader health care market may also determine how eager managed care organizations are to participate in the programs and thus to compromise when negotiating rates. At the same time, the ability of programs and managed care organizations to negotiate with health care providers for favorable rates will affect program costs.

While it is convenient to separate administrative and medical costs for discussion purposes, it is important to note that many features of program design and operation affect both administrative and medical costs. For example, longer eligibility periods save money on recertification procedures, while also increasing the likelihood that enrollees will receive preventive and ongoing care, which in turn can result in lower medical costs.

Similarly, although administrative costs may be relatively high for programs that collect and analyze a great deal of data, those data can sometimes be used to improve program operations and reduce program costs. For example, information on the use of medical services by enrollees can be used when negotiating capitation rates.

PART 3. ADMINISTRATIVE PROCEDURES

THE APPLICATION AND ENROLLMENT PROCESS

All twelve programs have toll-free numbers that individuals can call to request applications, and all allow applications to be submitted by mail.[38] A number of states also make applications available at community locations, such as health centers, hospitals, WIC clinics, schools, and social service agencies. In ten states, a single application form is used statewide; in New York and Pennsylvania, however, the health plans design and distribute plan-specific application forms that conform to state standards. Other aspects of the application and enrollment process are less uniform across states.

Design of the Application and Enrollment Process

When program administrators are asked what advice they would give to the designers of future programs, most describe some aspect of the application and enrollment process that either worked well or had not worked initially but was improved. Several caution that what may seem like a relatively straightforward set of tasks in the initial design of the program becomes more complex in practice.

All six expanded Medicaid programs make their own eligibility determinations. Hawaii QUEST, MinnesotaCare, and the Oregon Health Plan also handle enrollment procedures, while Delaware's Diamond State Health Plan and Vermont's Health Access Plan use third-party administrators and TennCare works with local health departments.

By contrast, all but one of the state-funded programs, Washington's Basic Health Plan, contract with outside organizations to make eligibility determinations and enroll applicants in health plans. Massachusetts, New York, and Pennsylvania assign those administrative functions to the health plans. Third-party administrators carry out application and enrollment for Health Access New Jersey and enrollment for Florida's Healthy Kids program. Only Washington's Basic Health Plan makes eligibility determinations and administers enrollment in-house. Program administrators for the Basic Health Plan note that, because the program's eligibility criteria are unique and complex, it is more efficient and less costly to use staff who are very familiar with the program rules than to engage an outside group.

For each program, two types of determination must be made: an applicant's eligibility to participate and the level of financial assistance for which the applicant qualifies. Those who are eligible must choose health plans and, in some instances, pay premiums before coverage begins. In most cases, coverage begins in the month following the completion of the application and enrollment process. Processes with many steps generally take longer to complete. Therefore, a cumbersome application and enrollment process can delay the start of

[38] TennCare also requires a face-to-face-interview.

coverage for individuals and families.

Only one expanded Medicaid program and three state-funded programs have "one-step" application and enrollment processes.

- In Delaware, the state Medicaid office makes eligibility determinations for the Diamond State Health Plan and sends the names of eligible applicants to an enrollment broker, who notifies applicants that they are enrolled in particular managed care organizations. Since the program assigns applicants to health plans and no premiums are charged, the application process is quite simple.

- Applicants for the Massachusetts Medical Security Plan are notified about the program when they apply for unemployment benefits. After they apply, a tape-match process is used to verify that they are receiving unemployment benefits. In addition to providing financial information, applicants are asked to indicate whether they are applying for the Premium Assistance Plan or the Direct Coverage Plan. Once the application is submitted and processed, the enrollee receives an identification card from the program and assistance begins. The process is relatively easy because applicants do not have to enroll in a particular health plan and are not required to pay premiums.

- The application for the Florida Healthy Kids program lists the premium payments required for program participation. Children's eligibility for free or reduced price school lunch is used to determine their eligibility for premium subsidies. Applicants are asked to return the completed form with a check for the first premium payment. Thus, an applicant can be enrolled in the program as soon as the application is processed. After an initial eligibility screening at the Healthy Kids office, applications are sent to the program's third-party administrator, where information is entered in a computer system. The electronic record is then matched with records from the National School Lunch Program to verify family income and from the Medicaid program to verify that the child is not already enrolled in Medicaid. Program records are matched with school lunch and Medicaid records each month to verify continued eligibility. The application process can be relatively simple, since applicants know the amount of the premium they must pay when they apply and do not choose a health plan, since each county offers only one plan.

- Washington's Basic Health Plan is a comparatively complex program but has a streamlined application process. Along with the application, potential participants receive a consumer guide that describes the available managed care organizations and provides a "you-pay" table. Applicants indicate their choice of plan on the application and calculate their own premiums for that plan based on monthly family income and the age of each family member. To verify income, the program mails a request for

current information on income to a targeted sample of several hundred enrollees each month. Enrollees who fail to respond are sent bills for the full premium amount rather than the subsidized premium payment in the next month. Since applicants choose a health plan and make a payment with their applications, program enrollment can be accomplished in a single step. The process does require more effort on the part of applicants than some other programs, however.

The application and enrollment process becomes more complex and requires more time when individuals must wait to be billed for premium payments or to choose a managed care organization after they have submitted applications.

- Applications for MinnesotaCare are screened for eligibility using the existing Medicaid Management Information System. Those who are found to be eligible receive a premium notice and information about the health plans available in their area. Coverage begins after they choose a health plan and MinnesotaCare receives their premium payment.

Of the twelve programs, TennCare is unique in requiring a face-to-face interview with program staff at a local health department. The TennCare Bureau conducts initial screenings of written applications. If an applicant appears to be eligible, information from the application is transferred to an on-line computer system. Health care professionals at local health departments retrieve applicants' records and make appointments for face-to-face interviews to complete the application process. Applicants are asked to bring specific items, including proof of income, to the appointment and to be prepared to make a premium payment. Coverage can begin at the conclusion of the appointment if the enrollee chooses a managed care organization and makes the premium payment. The process requires added time and effort, but the on-line eligibility system helps reduce the time it takes for applicants to receive coverage. During the appointments, health department staff also educate applicants about managed care organizations.

TennCare's eligibility and enrollment system is relatively new. It was designed to replace the program's original system, which had several significant problems. For example, under the old system, large numbers of enrollees had their coverage terminated for nonpayment of premiums, although state officials later determined that many of these enrollees were unaware of their obligation to make such payments. The process for verifying income was also burdensome: applicants were enrolled based on self-declared information, which was verified retroactively. This method resulted in a need to reconcile many accounts and a high number of appeals by enrollees. One positive change associated with the new system is greater contact between program participants and managed care organizations and local health departments and increased use of local health department services.

The experience of the twelve programs suggests strongly that the less complicated the

design of the program, the easier the application and enrollment process will be. Obviously, the process is simpler when applicants do not pay premiums or choose their own managed care organization, but those features are not always practical or desirable. When premiums are charged or a choice of plans is offered, a simple payment structure or clear information on the plans available can ease the application process.

Group Enrollment

Washington's Basic Health Plan is unique among the twelve plans in that it is designed to enroll groups as well as individuals. Employers may purchase group coverage from the Basic Health Plan, as can other financial sponsors, such as community groups that work with low income populations. When the groups purchase coverage, they receive subsidies for members who would be eligible for subsidized coverage if they enrolled in the plan on their own. State-sponsored group coverage is also available for home care workers and foster parents.

In practice, about 17 percent of program participants are enrolled through groups. The low proportion does not necessarily represent lack of need or interest. Rather it reflects the fact that interest in the Basic Health Plan was initially so strong among individuals that the program has had little capacity to enroll groups.

Collecting and Verifying Income Information

The manner in which information about applicants is collected and processed is another important aspect of the application process. The period for which information about family income is collected varies among the programs. For example, Health Access New Jersey asks applicants to submit information about the previous four months of income, MinnesotaCare and the Oregon Health Plan ask about the previous three months, and Vermont's Health Access Plan asks about the previous month. Most programs require that applicants submit copies of their 1040 tax forms to verify their income, although some states ask applicants to submit recent pay stubs as well.

Eligibility Period

The length of time for which applicants are certified to participate has an impact on the burden the application process places on program staff. Longer eligibility periods require fewer program resources, allowing the program to handle more enrollees with fewer staff members. Although the Oregon Health Plan certifies participants for six months, the majority of programs certify participants for one year. It is important to note, however, that eligibility periods apply only as long as participants' circumstances do not change. Participants in all programs are required to report changes in their financial circumstances that might have an impact on their eligibility to participate or the level of financial assistance they receive.

In three of the state-sponsored programs, recertification does not occur at a regularly scheduled time:

- Participants remain enrolled in Washington's Basic Health Plan until they report a change in circumstances. The program mails income verification forms to several hundred enrollees each month. Those who do not respond are sent bills for the full premium amount rather than the subsidized payment in the next month. They are not disenrolled, but they must respond if they wish to have the premium subsidy restored. Program staff point out that this system requires fewer resources than would be needed to recertify all program participants.

- Each month, Florida Healthy Kids matches program records with school lunch records and Medicaid enrollment records; as long as children remain eligible, they continue to participate in the program.

- Individuals may participate in the Massachusetts Medical Security Plan as long as they remain eligible for unemployment benefits.

When program participants have continuous coverage, they are more likely to receive continuous, coordinated care and have more opportunities to get primary and preventive care. With longer eligibility periods, the coverage resembles insurance available in the commercial market. Staff from MinnesotaCare note that people who know they can keep their health insurance for a year have more freedom to change jobs or to take jobs that do not provide coverage but may lead to jobs that do.

Disenrollment

Although programs do not routinely collect data on enrollees' reasons for leaving, administrators have some information about why people leave their programs. Staff from a number of states say that the most common reason people leave is "nonpayment of premium," but it is not clear whether people do not pay their premiums because they cannot afford to pay or because they no longer need coverage. In the TennCare program, it appears that some people did not pay premiums initially because they did not understand that they were obligated to pay. A number of people dropped their coverage when they received large bills representing several months of unpaid premiums.

Another common reason people leave programs is that they get other types of coverage. Some receive health insurance through an employer, and some become eligible for Medicaid after a drop in income.

- When the Florida Healthy Kids program surveyed former enrollees, 38 percent said they had left because they got other coverage. Of that group, about half left because they received coverage through employers, and about half had qualified for Medicaid. These figures suggest that the Healthy Kids program serves as a bridge for families whose financial circumstances change.

Participants also leave programs when they are no longer categorically eligible. For example, children leave when they become too old to qualify for benefits, and families leave

when they move away from the geographic area the program serves.

OUTREACH AND MARKETING

Programs' efforts to reach potential applicants vary according to their financial ability to accommodate new enrollees. Programs in five states—Hawaii, Tennessee, New Jersey, Washington, and Pennsylvania—do not actively recruit enrollees because enrollment is limited, although they have conducted outreach activities in the past. To date, the Massachusetts Medical Security Plan has not made an effort to market the program beyond the narrowly defined and easily identified population it serves. Similarly, the Florida Healthy Kids program is a school enrollment-based health insurance program, publicized almost entirely through schools. In other states, a variety of outreach and marketing activities have occurred.

Although the terms "outreach" and "marketing" are often associated with mass media campaigns, states use many different methods to reach potential participants and provide information about the programs, sometimes in languages other than English. Many programs distribute brochures and flyers directly through the mail or through health centers, churches, schools, and other community institutions. At one time, local fast food restaurants featured tray liners with information about the Florida Healthy Kids program. Some programs produce public service announcements for television or radio. Educating and assisting enrollees as they choose managed care organizations are also important aspects of the outreach process.

Media Campaigns

In discussing outreach conducted through the media, administrators tend to emphasize the impact of positive media coverage rather than organized marketing campaigns.

- When New Jersey launched the Health Access program, the governor promoted the program and generated media coverage.
- Enrollment in New York's Child Health Plus program increased substantially after the program received publicity as a model for federal lawmakers' efforts to expand health coverage for children. News about the expansion of the program to cover hospitalization also increased interest. A media campaign is planned to publicize the program and promote enrollment.

- While policymakers were designing the Oregon Health Plan, a nonprofit organization was formed to engage the public in discussion about health insurance options in the state and the role of the new program. Officials in Oregon observe that subsequent advertising for the Oregon Health Plan was well received because early work had generated broad public awareness about health insurance.

Community-Based Outreach

Several program administrators recognize the need to recruit program participants in the communities where they live.

- New York's Child Health Plus program contracts with community-based organizations to publicize the program and recruit children. With the expansion of the program, more aggressive outreach efforts are planned. An outside evaluation found that Hispanic and African-American children and children in the lowest income groups were under-represented in the enrolled population. Therefore, the program plans to focus future outreach efforts on those groups.

- MinnesotaCare will give grants to private and public sector offices to publicize the program in local areas. The goal is to fund organizations with the capacity to reach potentially eligible populations in different areas of the state.

Improving Program Design

Changes in the design and operation of programs have also facilitated enrollment.

- The outreach plan for Washington's Basic Health Plan entailed redesigning the enrollment process. The program contracted with an outside marketing firm to hold focus groups and advise the state about how to promote the plan. In addition to reducing premium levels, the state simplified the premium subsidy structure by reducing the number of income bands from 40 to 6. Payments—which formerly had been calculated by computer and billed to the enrollee—could then to be published in "you-pay" tables, allowing applicants to calculate their premiums and submit an initial payment at the time of application. The program also hired a marketing professional to help design the application, consumer guide, and other materials for prospective participants.

The Use of Brokers

The fact that the Basic Health Plan was designed to enroll groups as well as individuals led the program to experiment with a different type of outreach. The Washington state legislature appropriated funds to pay insurance brokers and agents to find and enroll businesses and other groups in the program. This effort has been discontinued, not because it was found to be particularly effective or ineffective but because limited program funding and high early enrollment of individuals have left little capacity for enrolling groups.

Marketing by Managed Care Organizations

Some health insurance programs allow managed care organizations to market directly to consumers. Pennsylvania's Children's Health Insurance Program, New York's Child Health Plus program, and the Hawaii QUEST program allow direct marketing. Each has developed marketing standards and reviews all marketing materials developed by managed care organizations before they are used.

Delaware's Diamond State Health Plan does not allow direct marketing to program participants, but managed care organizations may attend or sponsor health fairs and other special promotional events. These events occur primarily during the open enrollment period, when enrollees have the opportunity to change health plans. Some managed care organizations also market the programs while educating current enrollees. For example, when health plans participating in Florida's Healthy Kids program send representatives to schools to conduct orientation sessions for new enrollees, the sessions often attract interested families who are not yet enrolled.

Enrollee Education and Assistance

Common techniques that programs use to provide education and assistance to enrollees include toll-free information hotlines, enrollment and benefit counselors, member services representatives, and orientation sessions for new enrollees. Although these are all important program features, their usefulness depends on how well they are implemented. For example, all programs have a toll-free number that applicants and enrollees can call for program information and advice. Some programs report, however, that they have had to expand the capacity of the system to accommodate more calls in a timely manner. Also, small changes can make a big difference in how effective the services are. When the Oregon Health Plan began printing its toll-free number on program membership cards, the volume of calls increased significantly. Programs may hold orientation sessions periodically, but if the sessions are held at inconvenient times or places or are not well publicized they may not be well attended.

All programs also have established grievance processes. Generally, enrollees are instructed to contact the managed care organization first if they have problems related to the medical care provided and then to contact program representatives if the problem cannot be resolved. Problems related to eligibility are brought directly to the program.

The Florida Healthy Kids program is one of the few programs that has a separate, program-specific grievance process. In six years of operation, six or seven grievances—all concerning program eligibility—have been brought before a subcommittee of the board of the Healthy Kids Corporation. The majority of other programs use established processes involving state ombudsmen or grievance boards that respond to problems from a number of state-sponsored programs. Thus, it is more difficult to obtain information about grievances for particular programs in those states.

WORKING WITH MANAGED CARE ORGANIZATIONS

Since the vast majority of enrollees in state-sponsored health insurance programs receive their health care through managed care organizations, the process of contracting with those organizations is central to program operations. From a program's perspective, one goal of the contracting process is to negotiate reasonable terms in order to operate a viable program. An equally important goal is to encourage managed care organizations to participate in the

program in order to provide choice for enrollees and foster competition among plans.

Most programs make an effort to ensure that residents have a choice of more than one managed care organization in the area where they live. For example, Delaware's Diamond State Health Plan contracts with four organizations, three of which are available as choices in each county. Table M shows the total number of managed care organizations contracting with each program statewide.

There is general agreement among administrators that contracts should be negotiated for a term of several years, as the process is time consuming and labor intensive on both sides. Managed care organizations also recognize that there will be start-up costs when new groups of people enroll. Working with a new group of enrollees to be sure they understand how the health plan operates and providing initial primary and preventive care for group members requires extra effort.

Table M

Number of Managed Care Organizations (MCOs)Contracting With State-Subsidized Health Insurance Programs

State	Program Name	Number of MCOs
Medicaid Section 1115 Waivers		
Expansions for all ages		
HI	Hawaii QUEST	6
MN	MinnesotaCare	8
TN	TennCare	10
Expansions primarily for adults		
DE	Diamond State Health Plan	4
OR	Oregon Health Plan	15
VT	Health Access Plan	2
State-Funded Programs		
Programs for all ages		
MA	Medical Security Plan	--
NJ	Health Access New Jersey	5
WA	Basic Health Plan	18
Programs for children		
FL	Florida Healthy Kids	8
NY	Child Health Plus	23
PA	Children's Health Insurance Program	5

Contract Length

Multiyear contracts foster a working relationship between the program and the plans, which can benefit both. For example, the program can set longer-term performance goals for participating health plans and work with the plans to monitor progress toward those goals. This is not yet a common practice, but MinnesotaCare program requires health plans to collect and submit encounter data, which are then used for long-term planning. Program administrators see specific long-term performance goals as the next logical step in the process.

While there are advantages to multiyear contracts, it is also important to build in some flexibility. Most programs sign multiyear contracts with automatic renewals or with options to renegotiate on an annual basis. In other words, although a program holds contracts with the same managed care organizations for a specified period, certain provisions of the contracts, such as the capitation rate, can be changed each year.

The Contracting Process

The ability to negotiate is key to an effective contracting process. Administrators report that their programs operate more like commercial insurance programs than like social service benefit programs, but the contracting process is more conducive to productive negotiation in some states than in others.

The director of the Healthy Kids program in Florida notes that her ability to discuss program-related data and costs with bidders improves the negotiating process. By contrast, staff from other states say they are constrained by state contracting policies that do not allow them to communicate as freely with bidders. Because the Healthy Kids program is not technically a state agency it has some independence from established state contracting rules, but an independent structure is not necessary for establishing new or different contracting procedures. For example, the Oregon Health Plan (an expanded Medicaid program) has worked with provider groups to establish service provider organizations that contract with the program. MinnesotaCare (another expanded Medicaid program) has the latitude to negotiate with each managed care organization regarding details of program operations, such as the distribution of providers.

Specificity in Contracts

Program administrators urge the need for specificity in contracts. Many programs, for example, take steps during the contracting process to ensure that a managed care organization has enough providers to serve participants in their service area in a timely manner.

- New York's Child Health Plus program has specified that enrollees must be able to reach primary care providers within 30 minutes, either by driving over primary roads or by taking public transportation. Rules related to service accessibility specify that care for urgent medical problems be available within 24 hours, that sick children be seen within 48 to 72 hours, as appropriate, and that routine care be available within

four weeks. Other factors considered in evaluating proposals from plans are the number of providers, office hours, presence of school-based health centers, quality of the physicians and the hospitals to which they admit, wheelchair accessibility, and number of providers who speak relevant languages other than English.

- The Florida Healthy Kids program imposes requirements related to location. Providers in plan networks must be located not more than 20 minutes by car from the families who will be enrolled in the program.

- To insure that providers will be available in rural areas of Washington, the Basic Health Plan requires that managed care organizations contracting with the program provide services countywide.

The contracting process may also examine a managed care organization's capacity to collect and report data. Several program administrators emphasized the need to be specific about the types of data collection and reporting required and to confirm that the information systems of the managed care organization and the program are compatible.

Contracts to Coordinate with Medicaid

Some state-funded program contracts are written to foster coordination with the Medicaid program.

- The latest request for proposals from New York's Child Health Plus program gives preference to managed care organizations that also contract with Medicaid.

- Washington's Basic Health Plan is now conducting a joint procurement with the state's Medicaid program for managed care organizations.

- Minnesota contracts with the same managed care organizations for all three of its state-sponsored health care programs for low income residents: MinnesotaCare, Medical Assistance, and General Assistance Medical Care. Managed care organizations that wish to participate in one program are obligated to serve participants of all programs. Contract negotiations for the three programs are combined, but two separate contracts are signed, one for MinnesotaCare and one for the two other programs.

The practice of contracting with the same managed care organizations for the Medicaid program and other state-sponsored health insurance programs has administrative advantages. Although the actual contract negotiations may be conducted separately, some of the tasks associated with managing the contracts can be accomplished more efficiently and at a lower cost than if carried out separately. Also, because they are big purchasers of care, states have been able to leverage their influence with managed care organizations. For

example, some states have required managed care organizations to guarantee the availability of health care providers in traditionally underserved areas. There are also benefits for enrollees, who can move from one program to while continuing to receive care from the same managed care organization.

Monitoring Health Care Quality

Monitoring health plans is probably the aspect of program administration with which state-funded programs have the least collective experience, in part because the programs are so new. Early efforts focused on enrolling participants and delivering care; the task of monitoring the plans and providers was not considered as urgent. Also, the managed care industry on which the programs rely is also relatively new, and the process of assuring health plan quality is evolving.

Monitoring is the task for which programs most frequently contract with outside organizations. Some programs, especially the expanded Medicaid programs, are able to realize cost efficiencies by using a single monitoring process for managed care organizations that contract with multiple programs in the state. New Jersey's independent Health Coverage Board, part of the state's Banking and Insurance Department, monitors the quality of service provided by all health insurers in the state. Since participants in Health Access New Jersey purchase coverage in the private market, there is no perceived need to establish a separate monitoring system for program participants.

Programs use different techniques to monitor access to care.

- Staff from TennCare and Florida's Healthy Kids programs make telephone calls to health care providers and request appointments to assess whether care is available in a timely manner.

- Plans contracting with TennCare are required to report the loss of a health care provider to the program. Program staff plot the provider network for each managed care organization by location and reevaluate the adequacy of the network each month.

Programs assess the quality of care provided by conducting site visits to health plans and providers and reviewing patient records. Also, it is becoming more common for programs to require that managed care organizations collect and submit specific data that can be used to measure quality.

- The contracts negotiated recently for New York's Child Health Plus program require health plans to submit data that are consistent with the New York State Department of Health Quality Assurance Reporting Requirements (QARR). Measures include the number of well-child care visits in the first year of life and in later years, the immunization status of patients, and other indicators.

- In 1997, Delaware monitored six measures from the Health Plan Employer Data Information Set (HEDIS), a standard data set used to measure quality in managed care organizations. The measures included increases and decreases in visits to primary care providers and to emergency rooms.

Finally, programs monitor the performance of managed care organizations by conducting participant satisfaction surveys.

- Delaware's Diamond State Health Plan is in the process of conducting two client satisfaction surveys. One asks program participants about the enrollment process. The other asks about the care provided through managed care organizations.

- A client satisfaction survey conducted by the Oregon Health Plan in 1996 shows that enrollees are generally satisfied with the program but feel there is a need for better communication between managed care organizations and enrollees.

In addition to conducting specific monitoring activities, several administrators stress the importance of working closely with managed care organizations, particularly during the early stages of the contract period.

- During the first six months of the program, Delaware's Diamond State Health Plan held weekly meetings with managed care organizations to discuss program implementation issues. The program continues to meet with project managers and enrollment brokers for the managed care organizations on a monthly basis.

PART 4. STRATEGIC LESSONS FROM STATE PROGRAMS

In addition to providing specific information about design and administrative issues and program costs, program officials offer several lessons on broader strategic management issues that influence the effectiveness of their programs' operations:

Coordination between the public and private sectors can yield important benefits for participants, programs, and states. Recognizing that their programs are small parts of complex health care systems, officials suggest that states are more likely to succeed in reducing the number of uninsured residents if they take a broad view. On the question of how high to set income eligibility limits, for example, there are two competing arguments. On one hand, it is important to offer coverage to people who would not otherwise have access to health insurance or could not afford it. On the other hand, if eligibility limits are set too high some employers might drop coverage or be less inclined to begin offering it. Thus, a state-subsidized health insurance program should ideally be designed in tandem with efforts to increase employer-sponsored health insurance. The goal should be to increase enrollment in state-sponsored programs while also increasing the number of people receiving employment-based coverage.

Ensuring participants' continuity of access to health care providers is another area where a broad view can be helpful. Available data from current state-funded programs show that families often move from one program to another as their financial circumstances and eligibility status change. Programs in three states have made arrangements to ensure that individuals shifting between the state-sponsored program and Medicaid can remain with the same managed care organization and continue to see the same health care providers. New York's Child Health Plus program gives preference to plans that also contract with Medicaid, Washington's Basic Health Plan conducts joint procurements with the state's Medicaid program, and Minnesota contracts with the same managed care organizations for all three state-sponsored health care programs. By contrast, because Health Access New Jersey participants receive coverage through commercial insurers, they may be able to stay with their provider if they have an opportunity to enroll in employment-based coverage.

Finally, some administrators point out that state-sponsored programs can benefit from coordinating their systems, such as managed care quality monitoring activities. If resources are pooled for administrative tasks, more people can be enrolled in programs with limited funding.

Program operations can be phased in gradually, but it is also important that a state be committed to full implementation. Asked for advice about implementing programs, administrators frequently state that it is best to phase in certain operations over several months so that program staff have time to identify problems and correct them as they arise. Every effort should be made to avoid "bad press" at the start of the program, and this

can be accomplished more easily if there is time to remedy problems.

In the area of application and enrollment, for example, staff from several states report being overwhelmed by the number of applications received at the start of the program. Several suggest that programs enroll a distinct population first—such as a county or region, a category of participants, or participants below a certain income level—to enable staff to identify trouble spots that are not apparent until the program is operational.

Some administrators stress that, although it is prudent to phase in program operations, it is vital that the state be committed to full implementation of the program. In other words, administrators do not recommend that states start with pilot programs. MinnesotaCare officials recall, for example, that skepticism about the availability of managed care organizations in certain parts of the states might have led to a decision to postpone full implementation of the program. Yet such a delay could have jeopardized statewide coverage, since the program itself provided the impetus for managed care organizations to become established in some areas. Oregon Health Plan officials report that their efforts to help providers form organizations that could contract with the plan accelerated the growth of federally qualified health maintenance organizations in locations where health care providers were scarce.

Knowledge about the insurance industry and a business orientation are crucial to the success of a program. Whether they work with expanded Medicaid programs or state-funded health insurance programs, administrators commonly mention differences between their programs and the traditional Medicaid program. They frequently cite the value of prior experience in the insurance industry in carrying out their current responsibilities. Pointing to the shift toward managed care, several officials also emphasize the need to understand the distinctive characteristics of managed care operations, such as substantial start-up costs and the need for adequate time to establish systems for enrollment counseling, premium collection, quality assurance, and management information.

Another common sentiment is that program administrators need a strong business sense and a sensitivity customers in order to attract and retain program participants, especially those not accustomed to state programs. Some administrators suggest working with marketing professionals.

Workable guidelines for negotiating with managed care organizations—similar to those used in the commercial sector—are very important to the successful administration of programs. This view is shared by administrators who have considerable latitude to engage in frank discussions with potential contractors and by those who feel constrained by state policies that allow for little communication with bidding organizations.

Programs that perform most administrative functions in-house have access to

information that can be used as a powerful management tool. Administrators use program data to make decisions to improve operations, reduce costs, and plan for the future. One factor that appears to have some bearing on the availability of management information is the administrative structure of program. Some programs contract with third-party administrators for day-to-day operations, while others perform most operations in-house.

Administrators who take a more activist approach comment that direct involvement with program operations allows them to understand which aspects of the program are working well and are cost effective and which need improvement. They believe they anticipate problems more readily and see the need for change earlier than they could if others were running the program. This suggests that programs that contract with outside entities to perform administrative functions should require frequent, detailed reporting of information about program operations and costs.

States should be willing to refine a program on the basis of experience. Many administrators cite an ability to adapt to changes as a strong asset. Although most of the programs are new, most have already been redesigned, limited, or expanded. Such changes may occur for a number of reasons. A state legislature may amend the scope of the program or its rules. Changes in funding may necessitate the addition of a waiting list or tighter eligibility rules. Changes in federal programs and policies and in the broader health care market can also influence state programs. Or, as a program gains experience, its staff may advocate for changes to make the program run more smoothly or efficiently.

Program administrators stress, however, that when contemplating program changes, policymakers must recognize that retooling and redesign inevitably require an expenditure of resources. The addition of an asset test means changes in application materials and enrollment procedures, while a change in the premium or copayment structure demands special efforts to ensure that participants understand the new rules. Administrators recommend that the full implications of program change be considered in advance.

Current programs would benefit from access to additional information. Regardless of differences their programs, officials in all the states grapple with many of the same questions. They note that, even as they operate programs, they need information to make those programs more effective.

One question they often raise is how the program subsidy should be structured. Data on the affordability of premiums for different income groups could help establish premium levels that would draw applicants or limit enrollment, depending on the needs of the state.[39] Administrators also want information about the consequences of different methods of limiting enrollment. The most common approach has been to cap enrollment and maintain waiting lists. Yet waiting lists pose some potential disadvantages, such as undermining future

[39] See Leighton Ku and Teresa Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*, Urban Institute Working Paper, March 1997.

outreach efforts if additional funds become available and encouraging the retention of the least healthy enrollees, causing premium rates and program costs to rise. Some administrators suggest other approaches to limiting program size, such as MinnesotaCare's strategy of raising income eligibility limits for adults more slowly than originally planned.

Finally, administrators want more information about why people leave programs. Most states collect data on why program participants leave one health plan to enroll in another, few know why participants leave programs. Program staff report that common reasons are "nonpayment of premium" or "loss of eligibility," but it is not clear why premiums are not paid or participants are no longer eligible. Some people may stop paying premiums or lose eligibility because they get other coverage. Others may be unable to afford the premiums or may fail to fulfill administrative requirements, perhaps because the requirements are too complex. Enrollees may also drop coverage because they are not convinced it is worthwhile: for example, they may not realize that preventive care is available for children or they may not know how to get access to it. These possibilities point to the need for more specific information about enrollment patterns and perceptions of the program among enrollees and those who are eligible but not enrolled.

Systematic and detailed examination of some administrative procedures—particularly those related to assuring access to care—would be helpful to program officials. This report shows that a variety of approaches are used for similar tasks in state-sponsored health insurance programs. Program administrators indicate that they would welcome more specific information about how their colleagues in other states reach potential participants, enroll them in programs, and collect premiums once they are enrolled. They are also interested in knowing more about state mechanisms to assure continuity of coverage and care for low income residents.

In the area of outreach, it would be useful to identify programs that have conducted needs assessments and gathered data on program participation before designing and implementing outreach campaigns. Follow-up data on the effectiveness of particular outreach efforts could be especially valuable.

Several aspects of the enrollment process should be examined more thoroughly Policies requiring applicants to provide information about their current and prior income status could be compared, looking at what information is required and for what prior period. There is also interest in knowing more about asset tests and limits used by different states and about requirements that program applicants be uninsured for a period of time prior to application. For each aspect of the enrollment process, it would be useful to know what sort of documentation is required and how the information is verified.

The comparative advantages of collecting premiums in a lump sum or on a monthly basis deserve attention, as does the effectiveness of coupon books and billing systems. It would also be useful to know what proportion of participants pay the premiums on time and

happens when premiums are not paid. An assessment of the cost of the premium collection effort relative to the amount of money collected should also be conducted.

Questions about systems to assure continuity of coverage are particularly timely, as states plan to broaden health insurance coverage for children. If new programs are implemented, steps should be taken to link them to existing programs. Also, most families that leave welfare programs—either because they have found jobs or because they are removed from welfare rolls—are eligible for Medicaid or state-sponsored programs. Data from the Census Bureau show, however, that many people do not enroll in programs for which they are eligible. A relevant question is whether states have systems in place to assure that people leaving Medicaid have an opportunity to enroll in state-sponsored programs and vice versa. State efforts to ease these transitions or effect them automatically would be of particular interest.

Detailed and comprehensive examination of these issues, leading to concrete recommendations for “best practices” in each area, would be useful to state officials in managing health insurance programs for low income residents.