



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

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FIELD REPORT

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About the Economic and Social Research Institute

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

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Based on New Jersey’s experience in expanding coverage to parents and other childless adults, states may wish to take a more gradual approach to assessing the unmet demand for affordable insurance among the low-income adult population and the capacity of budgetary resources to meet this demand.

GEORGIA

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

Summary

Georgia made a concerted effort to place all of the state’s purchasing—under Medicaid, CHIP, and for its own employees—under one roof. It was successful in developing a streamlined public program enrollment system that substantially reduced the number of uninsured children. Georgia’s consolidation and integration of diverse health programs have enabled the state to leverage its purchasing power to foster improvements in coverage and access in a state with rural access barriers, reluctance by some providers to participate in public programs, and few organized systems of care. State officials have also forged partnerships with business leaders, providers, and community representatives to develop Georgia’s *Business Plan for Health*, a blueprint for coordinated public- and private-sector initiatives to improve access to health care. This plan brought together diverse stakeholders to develop a sweeping package of public, private, and community-based approaches to the problem of the uninsured. Central to the plan is the idea that public-sector expansions must go hand-in-hand with support for private-sector coverage.

Several factors have contributed to the Georgia’s success in developing and expanding public coverage programs for children, leveraging public financing, and developing the state’s *Business Plan for Health*. First, by focusing on children—a vulnerable population that generates public support—the state has maximized political support for comprehensively tackling a single task. Georgia has not only implemented effective outreach and enrollment policies to cover children, but has also created workable strategies to retain coverage for kids. Building on the existing Medicaid infrastructure, CHIP has served as a laboratory for the development of program improvements that are

now used in both Medicaid and CHIP. These improvements have contributed to a children's coverage program that is integrated and user-friendly.

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

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

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

Georgia's state leadership, however, is hopeful that even though the environment is not currently ripe for major coverage expansions or other new initiatives, the infrastructure recently built can serve as a foundation for new programs in the future. This infrastructure includes leadership from the governor and in the Department of Community Health, dialogue and partnerships with a wide variety of stakeholders, and experience developing creative approaches for leveraging the state's purchasing clout (Table 10).

Table 10. Georgia State Profile and Overview, 1999–2000

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

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

Background and History

Georgia has an uninsurance rate among the nonelderly population of about 19 percent, higher than the national average.⁴² As in the rest of the country, workers in small firms, those with low incomes, and people living in rural areas are more likely to be uninsured. While Governor Roy Barnes and a few other health care leaders such as Russ Toal, the former commissioner of the Department of Community Health, have focused attention on broader issues of uninsurance through the development of the *Business Plan for Health* and uninsured grants, momentum has been greatest for children’s health coverage. The state has thrown its energy into developing an innovative and flexible CHIP program, called PeachCare for Kids. In large part because of its success in outreach and enrollment for Medicaid and CHIP, the state now has more than 850,000 enrollees under age 21 in Medicaid and over 190,000 enrollees in PeachCare for Kids (Table 11).⁴³

Georgia clearly has had success with PeachCare for Kids and this new and innovative program has increased enrollment in Medicaid and CHIP. Another, less hopeful, reason for enrollment increases is the downturn in the economy. In November 2001, almost one-third (28%) of parents applying for PeachCare for Kids for their children indicated they had lost their health insurance because they lost their jobs, compared with 6 percent in June 2001.⁴⁴ This trend is expected to continue. The state’s economic situation is likely to erode the base of employer-sponsored coverage, already fragile in this agricultural state, while increasing pressure on public programs and decreasing funding for them. This confluence of factors will create some difficult decisions for the state in the future, as it already has in the 2003 budget cycle.

⁴² Custer, William. *Expanding Health Insurance Coverage in Georgia*. Author’s analysis of 1999 CPS.

⁴³ Governor’s State of the Union Address, January 2002.

⁴⁴ *Florida Times Union*, December 2, 2001.

PeachCare for Kids

PeachCare for Kids is the state’s CHIP plan, designed as a Medicaid look-alike program. PeachCare for Kids covers children from families at the Medicaid income limits up to 235 percent of the federal poverty level (FPL). Families with children over six years of age pay premiums at a rate of \$7.50 per month for individual children to a maximum of \$15 for families with more than one child enrolled. With enrollment in May 2002 of over 190,000, participation in PeachCare for Kids far exceeds the state’s two-year goal of enrolling 60,000 children. Georgia recently ranked fifth in the nation in CHIP enrollment after California, New York, Texas, and Florida.

Table 11. Georgia Public Program Enrollment, 2002*

Georgia	Number
Total enrolled in Medicaid	1,331,110
Adults over 21	478,660
Children 21 and under	852,450
Total enrolled in PeachCare for Kids	190,377
Total enrolled in public programs	1,521,487

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

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

Business Plan for Health

Approved by the state legislature in 2000, the *Business Plan for Health* is an ambitious package of recommendations for expansion in coverage and improvements in three areas: public-sector programs, private-sector interventions, and community initiatives. The *Business Plan for Health* proposed a variety of strategies to increase coverage, including development of a new pared-down essential care insurance product, coverage for parents of Medicaid-enrolled children to 150 percent of the FPL, and tiered tax credits for small businesses. A few, but not all, of these proposed changes have been implemented.

Development of the *Business Plan for Health* was carried out in a very open and participatory manner, resulting in a relatively high degree of buy-in from stakeholders—at least to the notion of a comprehensive plan if not to the details. Respondents described the planning document as a general blueprint and weathervane for future activities rather than an operational plan for expansion of coverage.

The state followed a multistep process to develop the plan. The policy staff in the Department of Community Health first systematically reviewed recent literature on coverage approaches and their effectiveness. Based on this review, a list of suggested strategies was developed and vetted by the governor. This list was shared with three working groups (providers, private employers and insurers, and advocates) for their input

and reaction. After these groups met and discussed the draft plan, the state invited group members to submit written recommendations and suggestions. Many of these recommendations were incorporated into the final version of the plan approved in 2000 by the governor and the legislature.

Uninsured grants

Although many of the more expansive initiatives laid out in the *Business Plan for Health* are on hold in part because of the state’s fiscal situation, the state has awarded nine demonstration grants to statewide and local organizations to implement projects and programs focused on the needs of the uninsured. An estimated \$2.9 million in state resources will be matched by contributions from local communities to finance these activities. Planned activities focus on three areas: private-sector initiatives (most notably development of a proposal to cover high-risk people deemed uninsurable), pharmacy coverage, and community-based initiatives.

Table 12. Georgia Current Access Programs

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

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

Elements Facilitating Development and Program Innovations

Making enrollment simple for families of Medicaid or CHIP children

Georgia has worked hard to make its enrollment process simple and easily navigable by families with a minimum of effort and without the need to understand the organization or complexities of the program. Seamlessness of the application process and of coverage, achieved through shared systems, rules, and provider networks, was a principal goal of the state when it decided to pursue a Medicaid look-alike model for CHIP rather than a stand-alone program. This integrated approach has a number of facets:

- The state has a simple, one-page application for children applying to Medicaid or PeachCare for Kids. This application can be filled out and mailed in or completed online (Georgia is the first state to implement an online application that families can complete on their own.)
- Both PeachCare for Kids and Medicaid allow families to self-declare their income on children's applications. Self-declaration minimizes the paperwork families must produce and the effort they must expend applying for coverage.
- Families who apply for coverage through PeachCare for Kids but whose children are found eligible for Medicaid may stay under the PeachCare for Kids umbrella, obtaining a PeachCare for Kids coverage card although technically remaining in the Medicaid program (including Medicaid benefits and cost-sharing). This ability to enter Medicaid coverage through multiple doors is a critical innovation.
- Because of shared systems (including an automated eligibility determination system) and identical rules on income determination, the PeachCare for Kids and Medicaid programs can transfer applications without the need for family involvement.

Increasing continuity of coverage and care for children

In addition to focusing effort on the initial application process, program managers also have developed approaches to maximize retention and continuity of coverage:

- PeachCare for Kids and Medicaid have passive redetermination for enrolled children. This increases retention, because it means that children are automatically reenrolled. Families only need to return paperwork if there has been a change in their income or other factors affecting their eligibility status.
- PeachCare for Kids staff proactively review case files of Medicaid enrollees who remain under the PeachCare for Kids umbrella. If it is anticipated that the family will no longer be eligible for Medicaid based on the age of the child or the income of the

family, but can remain in PeachCare for Kids, the child is automatically rolled over from one program to the other. This promotes continuous coverage for children.

- PeachCare for Kids recently made enrollees eligible for the program in the month in which they apply, essentially replicating the protection provided by presumptive eligibility. In addition, children in PeachCare for Kids are automatically enrolled for one year.
- Families can retain providers as they move between PeachCare for Kids and Medicaid because both programs use the same network.

Leveraging Public Financing for Care and Coverage of the Uninsured

Placing all publicly financed coverage under one organizational roof

Approximately two-and-a-half years ago, the governor reorganized public coverage by bringing together the Medicaid program, the state health planning agency, and the state employee benefit program into a newly formed entity, the Department of Community Health. When PeachCare for Kids was initiated, it too was managed by this new department. The department also was charged with developing solutions to the problem of the uninsured in Georgia. Together, these public programs cover one-quarter of the state's residents. Pooling the enrollees from different programs gives the organization more visibility and leverage. This leverage can be used both to negotiate better coverage terms for Medicaid and public employees and to obtain broader buy-in for new initiatives to cover the uninsured.

Using a variety of regulatory and programmatic levers to create opportunities for coverage and care of the uninsured

The state has made creative use of regulatory authority and private/public partnerships to increase care and coverage for the uninsured and to improve program management.

Examples of this include:

- Allowing critical access hospitals (mostly rural hospitals with 15 beds or fewer) to buy in to the state employee benefit program to provide health benefits to hospital staff and their families. A number of these hospitals do not offer health benefits to dependents, in part because of already high and escalating small-group premiums.
- Requiring hospitals seeking a Certificate of Need (CON) to meet charity care requirements. Providers applying for a CON must demonstrate that 3 percent of revenues are devoted to charity care. In a recent case, a CON application for one of the most prominent hospitals in Atlanta was denied based on failure to meet this

requirement. It was ultimately granted after the hospital agreed to meet the state's threshold for charity care and to ensure that its entire medical staff participated in Medicaid.

- Requiring providers contracting with the state employee plan also to contract with Medicaid.
- Requiring hospitals participating in the state's Indigent Care Trust Fund (ICTF)—the main component of the state's disproportionate share funding to hospitals) to devote 15 percent of their ICTF allocation to primary care. The state is also stepping up monitoring of the ICTF allocation and has published a formula that providers must use to calculate charity care. The state allocates ICTF dollars first to rural hospitals, which are reimbursed for 100 percent of their indigent care costs. The remaining dollars are divided among urban hospitals.
- Simultaneously implementing a Pharmacy Benefit Manager (PBM) for both the state employee plan and Medicaid. The PBM uses a three-tier cost-sharing plan for both programs. This means that enrollees pay a higher copayment for brand-name drugs on the formulary than for generic products and experience a further increase in the copayment for brand-name products that are not on the formulary. The state also plans to develop shared disease management approaches for the two populations using the PBM. These programs would be aimed at managing chronic illness for people with conditions such as asthma, diabetes, and hypertension.

Developing the Business Plan for Health

Bringing diverse stakeholders to the table

The planning process to develop the *Business Plan for Health* included not only advocates and providers, groups that have traditionally contributed to planning and strategizing for Georgia's public programs, but also embraced private-sector representatives, including insurers and employers. This latter group of stakeholders, which had not formerly been involved, brought perspectives and input focused more on the private market than on public-sector programs. The emerging dialogue, spanning public coverage and private-sector issues, is considered a major asset created by the *Business Plan for Health* development process. The state continues to draw on this group of stakeholders for input and suggestions. Faced with the need to cut health program budgets, for instance, state officials contacted the working group participants for their thoughts and recommendations on how to move forward with the proposed reductions.

Leadership by a “Health Care Governor”

Respondents indicated that the governor has a detailed understanding of health care and a strong commitment to improving access. Examples of his leadership include development of the *Business Plan for Health* concept along with restructuring the Department of Community Health to bring together health planning with public coverage (Medicaid and state employer benefit plan) functions.

Obstacles and Issues

Relative absence of managed care

After a brief trial, the state’s Medicaid program backed away from enrolling people in health maintenance organizations and reverted to a traditional fee-for-service program (nationwide, about six of 10 Medicaid enrollees are now in HMOs). The absence of managed care as a cost management tool may have contributed to the state’s recent budget difficulties, although other states that rely heavily on managed care also have had difficulty holding down costs. Georgia is now trying to shift more enrollees out of the straight indemnity program and into preferred provider organizations (PPOs), in which a primary care case management approach is used. Under this approach, primary care physicians receive a small fee for serving as a “medical home” for Medicaid enrollees and guiding them through the health care system.

Recent fiscal challenges

Most respondents pointed to the state’s fiscal situation as the most significant barrier to expansion of coverage. The recent economic slowdown spurred the governor to request budget cuts of 2.5 percent for the 2002 fiscal year with an additional 5 percent planned for the 2003 fiscal year. For Medicaid, the cuts amount to \$80 to \$90 billion for 2002, with twice that amount the following year. In January 2002, the governor presented his 2003 budget outlining cuts to Medicaid. Certain elements of the *Business Plan for Health*, already approved, have been placed on hold in this proposed budget. These include expansion of children’s Medicaid coverage to families at 150 percent of the FPL, most helpful to low-income state employees who, because of federal eligibility rules, cannot enroll in the PeachCare program. Other initiatives included in the *Business Plan for Health* but not yet approved by the legislature are on hold indefinitely. The most significant of these is an ambitious plan to provide tax credits for small employers. In addition, the governor’s budget proposes to eliminate the second year of transitional Medicaid coverage for families leaving welfare.

The governor has announced that there will be no layoffs of state employees resulting from the budget crunch and that some programs, including the recently

developed cancer coalition, will be protected from cuts. The coalition is a major project launched by the governor to improve cancer prevention and treatment and to emphasize training and clinical research.

Difficulty obtaining private funding for new programs

Respondents agreed that using public funds to finance major expansion of coverage through either public programs or private insurance is unlikely in the near future. In the interim, the state has looked for additional sources of funds, including private grant funding, for some smaller initiatives, however, the state has not had a great deal of success obtaining funding from foundations and other grant programs.

Reimbursement rates

Although access to providers for enrollees in public programs remains relatively robust, some respondents indicated that physicians are backing away from participating in Medicaid, complaining that reimbursement levels are well below market rates. These respondents believed that major problems in access may emerge unless rates are increased. Proposed increases in reimbursement rates were scaled back even before the recent budget cuts were announced.

Lack of impetus to move forward

Few of the *Business Plan for Health* program elements have been implemented. One clear barrier is the recent fiscal situation, but other factors also seem to be at play. Some believe the governor is not pursuing coverage efforts as strongly as he did at the beginning of his administration and point to the allocation of the tobacco dollars primarily to programs other than expansion of coverage programs as an indicator of this. Although Georgia's current stasis can be attributed partly to the sluggish economy and dwindling state tax revenues, it also emerges from the inability to maintain momentum following a change in leadership in the health department. The previous director, Russ Toal, was a driving force behind comprehensive reform. He was also a point of connection to the governor's strong support for health care access improvement initiatives, as well as an effective counterweight to stakeholder opposition or hesitancy. Toal's absence left a void in policy leadership and advocacy for comprehensive reform that has not yet been filled.

Barriers to developing insurance market reforms

To be successful, many of the envisioned innovations on the private side would need to be paired with reforms of the small-group and individual insurance markets. These changes are under the purview of the state's insurance commissioner, an elected official. Respondents reported slow progress developing some of these market reforms, especially

in the individual market. A number of reforms focused on the small-group market are already in place. Along with guaranteed-issue and guaranteed renewability, the state limits how much premiums can vary in the small-group market based on health status, risk, or other demographic factors and also limits insurers' ability to deny coverage to individuals based on preexisting conditions.

Dispersed and rural population

The state's demographics and size are viewed as a challenge to developing effective coverage programs and ensuring access. This problem has a number of facets. First, ensuring provider access is inherently difficult in rural areas, which constitute a large portion of the state. Second, the start-up costs for new statewide efforts are high because the state government needs to work and negotiate with 159 different county governments. Third, many of the rural providers, and particularly the critical access hospitals, are at risk of closing because of financial difficulties.

Difficulties putting together a combined public and private approach

Although most respondents supported the notion of private-sector coverage strategies in Georgia, the state has reportedly backed away from the main private-sector initiatives outlined in the *Business Plan for Health*. The mainstay of the plan was an employer tax credit designed to provide tiered benefits to employers and favoring rural employers and those who had not before offered coverage. Officials in the Department of Community Health suggested that the tax credit for uninsured workers was tabled because cost estimates prepared by researchers at Emory University "came back much higher than expected," but the size of the cost estimates reflected the amount of the credit, eligibility standards, and the projected take-up rate. As the recent debate in Congress showed, there is no single version of a tax credit—several different ones are under consideration with widely varying amounts and eligibility criteria. Georgia might consider working with cost estimators to try to identify an affordable yet potentially effective package.

So far, the right combination of public and private programs that is politically as well as financially feasible, and effective, has not emerged. There has been some discussion of developing coverage for the parents of CHIP-covered children using a purchasing pool or premium payment approach, however, there are no concrete plans to move forward with this program.

Looking Ahead: Challenges and Lessons for Other States

Georgia has developed a model program for providing health coverage to children through CHIP and along the way has facilitated enrollment in Medicaid among those

eligible but previously not participating. The state has been innovative in developing a seamless enrollment system with multiple points of entry and the ability to shift families across programs to ensure continuity of coverage without burdensome redeterminations. Enrollment of children surpassed expectations and strong coverage retention policies have minimized disenrollment or lapses in coverage. The state also has supported early intervention, preventive health, and better access to care by reallocating a portion of disproportionate-share hospital dollars to primary care, supporting community programs to provide direct services to the uninsured, and using its purchasing leverage to increase provider participation in Medicaid. Georgia also has consolidated several departments under one agency and set up a working group of diverse stakeholders to provide community input to the state's decision-making process.

A primary challenge in Georgia is to develop a way to support employer-sponsored coverage. Public support for major Medicaid expansions to cover more adults is likely to be weak. Therefore, a breakthrough to reduce the number of uninsured working-age adults will probably require some combination of leveraging public funds to support job-based coverage or introducing insurance market reforms to make coverage in the individual market more affordable.

Georgia also may eventually consider resurrecting its plans for a tax credit, and it could consider less costly ways to implement such a program. It is important to note that no state has found an easy way to bolster employer-sponsored coverage for lower-income workers. The key challenge is finding a subsidy that is big enough to induce a sizable take-up rate, but not so big that it will overtax the state's budget.

The experience in Georgia demonstrates the need for a comprehensive approach to expansion of coverage that blends together efforts to enhance enrollment of those already eligible for public coverage, expansion of eligibility when feasible, and support for private coverage. Getting such a blended, multifaceted approach off the launch pad will require leadership from the top, skilled staff work, and in some cases technical assistance from outside the state government. The stakeholder infrastructure, and a measure of goodwill, are still in place from the prior attempt at health care reform. An important question is whether the state will do the technical and political work needed to capitalize on previous planning experience and restart its initiative.