



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

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budget surplus; additional revenue must be returned to the taxpayers. As a result, even though until recently Oregon had a booming economy, the state has few reserves to sustain itself in an economic downturn. If Oregon does not want to change state law to generate additional revenue (and there is little or no discussion about doing so), few options exist to pay for programs such as OHP.

In conclusion, several things can be learned from Oregon's experience in attempting to extend coverage while limiting benefits. First, the process hinged on a public and transparent discussion of priorities. This took a great deal of time and investment and is ongoing. In the end, this public discussion might be unsustainable because of the effort involved and the political capital expended to implement the program "democratically." Second, federal structures have not historically been flexible in accommodating this sort of approach. Finally, the evidence-based benefits list may be of only limited value in reining in costs over time. Even with the list, Oregon is experiencing the same upward trends in costs experienced by other states. Oregon may now be reverting to a more categorical approach, in part because of what the state perceives has been a lack of federal flexibility toward further benefit reductions (although that may be less true under the new HIFA initiative), but also because it may be difficult to get additional cost savings through this approach and the state is concerned about increasing costs in OHP.

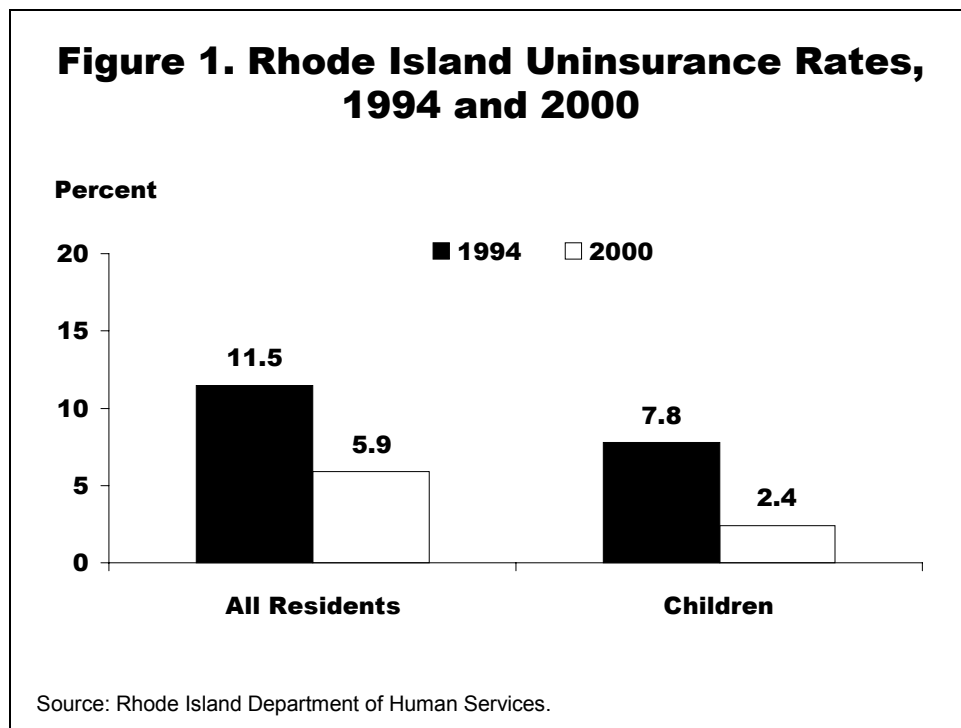
It appears there will be a budget crisis unless action is taken quickly. Governor John Kitzhaber appeared committed to having a five-year waiver in place that would implement the proposed changes to benefits and eligibility before he leaves office. However, the proposed changes cannot be implemented until the federal government approves the two waiver requests. It remains to be seen how the many issues raised above will be resolved to maintain one of the most concerted, sustained efforts by any state to provide their uninsured population with much-needed health care coverage.

RHODE ISLAND

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

Summary

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



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

consensus and support. State support for a Community Health Center–based safety net health plan paid off when commercial plans left the market or refused to accept new RItE Care enrollees. Also, a willingness to make mid–course corrections helped the state government overcome obstacles and address new challenges. Finally, a strong economy in the late 1990s provided a favorable climate for coverage expansion.

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

But the greatest challenge lies ahead, with severe budget constraints threatening the state’s ability not only to expand access further, but also to maintain the gains achieved to date. An important part of this challenge involves shoring up employment–based coverage through the RItE Share premium assistance program. RItE Share pays all or part of low–income employees’ share of the premium under employer–sponsored health coverage. Overcoming administrative difficulties and addressing employer concerns (particularly during a recession) have already led to adjustments in design, including one provision to bypass the employer entirely and another to make RItE Share participation mandatory. Nevertheless, officials acknowledge that this program remains a “work in progress.”

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

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

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

Background

In 1994, Rhode Island implemented RItE Care, a fully capitated Medicaid managed care program for “Family Independence Program” families (former AFDC families) and certain low–income women and children. The goal was to increase access to and delivery of

primary and preventive health care for low-income populations while slowing the annual escalation of costs for these populations.

An important element of the Rite Care system was that it permitted the gradual expansion of eligibility for the program. Originally enacted in 1994 under a Medicaid Section 1115 Demonstration waiver, RItE Care since has expanded eligibility through several amendments to include pregnant women and children up to age 19 in families with income up to 250 percent of the federal poverty level (FPL) and parents with income up to 185 percent of the FPL. Care for portions of this population (children ages 8–18, parents between 100 and 185 percent of the FPL, and pregnant women between 185 and 250 percent of the FPL) is funded through the Title XXI State Children’s Health Insurance Program (CHIP).

The 1995–97 period was focused on shoring up the program. This included gaining the trust and support of consumers and advocates, adjusting the rate structure to reflect more accurately costs and secure provider participation, broadening benefits, instituting performance standards and an evaluation component to measure improvement in health outcomes, passing administrative reforms that would streamline the enrollment process (e.g., removing face-to-face interviews, allowing mail-in applications), and making other efforts to stabilize RItE Care.

This period was followed by several years dedicated to expanding access (1997–99). The state expanded coverage for parents through a Section 1931 Medicaid State Plan Amendment, incrementally expanded eligibility to children up to age 19 and up to 250 percent of the FPL, and implemented a major enrollment drive facilitated by federal funds dedicated to outreach.

By 1999–2000, however, a number of factors combined to bring RItE Care to the brink of crisis. The successes of the expansion efforts resulted in the swelling of the RItE Care rolls and budget well beyond projections (this was complicated by increasing Medicaid costs for the elderly and disabled). There were complaints that some of the new enrollment in RItE Care represented “crowd-out,” or substitution of public coverage for private insurance, as low-income workers dropped their employer-sponsored coverage to enroll in RItE Care.¹³ There was also major instability in the commercial insurance market. Double-digit premium increases in 1999 and 2000 threatened the continuation of employer-sponsored insurance, particularly for small businesses and low-wage workers.

¹³ One health plan estimated that 20 percent of its new RItE Care enrollees previously had private coverage.

Two of the five existing health plans in Rhode Island abruptly left the state in 1999, leaving 150,000 residents without coverage, including 7,000 RItE Care enrollees.¹⁴ Two other health plans stopped taking new RItE Care enrollees, leaving a sole remaining health plan (a community health center-affiliated, Medicaid-only health plan) to absorb new enrollees.

In response to the impending crisis, Governor Lincoln Almond convened a health care working group that resulted in the enactment of Health Reform Rhode Island 2000 in July of that year. This legislation, intended to make the private insurance market a more viable option for low-income people (and in essence relieving some state budgetary pressures), included: 1) creating RItE Share, a combined Medicaid/CHIP premium assistance program for RItE Care-eligible people who had access to employer-sponsored health coverage; 2) introducing cost-sharing for RItE Care and RItE Share enrollees with incomes above 150 percent of the FPL; 3) reforming the small-group insurance market, including rate stabilization; and 4) creating stronger financial solvency accountability standards for health insurers.¹⁵

Developed as a “marriage between employer-sponsored coverage and publicly sponsored coverage,” RItE Share was intended to reverse crowd-out, save the state money by tapping employer contributions, and promote private, employment-based insurance. RItE Share was implemented in February 2001, but early enrollment had been very slow. The state responded by making some administrative and design changes that have increased participation by low-income working families. State officials and others acknowledge, however, that this important component of Rhode Island’s access initiative presents significant challenges.

Whereas Rhode Island was approved (through a Medicaid Section 1115 waiver) to impose both copayments and premiums on enrollees with incomes above 110 percent of the FPL, it chose to implement only premiums (\$43 to \$58 per month) for enrollees above 150 percent of the FPL. State officials preferred not to erect a financial barrier at the time a health service was needed; they also viewed premiums as a more dependable, quantifiable source of revenue for the program. Consumer advocates are concerned, however, that even this modest cost-sharing may be overly burdensome to some people

¹⁴ The two health plans that left are Harvard Pilgrim Health Care of New England and Tufts Health Plan of New England.

¹⁵ Waiting periods before enrollment into RItE Care were passed but not implemented. Waiting periods are regarded as a last resort because they are seen as forcing families without access to affordable coverage into periods of uninsurance before they can get public coverage or subsidies for commercial coverage.

and lead to disenrollment. The state is monitoring the impact of the premiums, which began in January 2002.

The small-group insurance market reforms included adjusted community rating intended to reduce variability in premiums. As a result, some small businesses face higher premiums while others are better off than they were before, generating pressure from business and the insurance industry to retract the changes. Again, the state is conducting sample audits to assess the impact.

The final piece of the 2000 health reform legislation was to ensure the financial accountability of the health plans operating in the state. Rhode Island adopted stronger financial solvency standards, based on National Association of Insurance Commissioners (NAIC) recommendations, for all licensed health plans.

At about the same time, RIte Care increased reimbursement rates to adjust for the recent influx of parents, an older and more expensive population than children, and to encourage all plans to open their rolls to new enrollees to meet federal requirements regarding member choice.

Rhode Island is currently involved in a project to design an effective and comprehensive plan—building on the RIte Care/RIte Share base but not bound by it—to ensure access to health care coverage for all Rhode Islanders. This initiative, funded by two separate grants from private foundations, provides state officials with flexibility to think creatively about possible ways to reach the remaining 65,000 uninsured Rhode Islanders.¹⁶ Administrators hope to halve Rhode Island’s already low uninsurance rate by 2004. The major obstacle to achieving this goal, as well as the primary challenge to Rhode Island’s progress in expansion of access to date, is maintaining funding during an economic slowdown. Table 6 summarizes the current RIte Care and RIte Share programs.

¹⁶ Funded by grants from the Rhode Island Foundation and the Robert Wood Johnson Foundation (RWJF) under State Initiatives in Health Care Reform (from January 2000 to December 2002) and from RWJF’s State Coverage Initiatives Health Care Program (from January 2002 to December 2004).

Table 6. Rhode Island Current Access Programs

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

Elements that Facilitated Development

Rhode Island's approach to increasing access to health care can be viewed as a planned incremental strategy combining expansion of public and private coverage with initiatives to improve direct access to primary care services and a corresponding attempt to reduce inappropriate care. To implement this multifaceted strategy in a cost-effective manner, the state relied on a managed care model and integrated the activities of various state departments and agencies. The state's relative success in reducing the number of uninsured and improving health-related outcomes can be attributed to the following factors.

Political Leadership and Expertise

Strong leadership in the governor's office, the legislature, and the state agency that administers the program has been critical to RItE Care's implementation and success.

RItE Care was first introduced under Democratic Governor Bruce Sundlun's administration in the early 1990s. Considered by many to be visionary, Sundlun championed the program and fostered a coordinated effort between the governor's office and the legislature, where there was considerable support for initiatives for children's health among both Democrats and Republicans. It has been noted that the "far right," which sometimes fights the expansion of public programs, has not been an influential player in Rhode Island. When Republican Governor Almond was elected in 1994, the implementation of RItE Care was well under way. The new governor was fully supportive of the program and continued its implementation.

Strong leadership also was evident at the State Department of Human Services (DHS), which was ultimately named the agency responsible for the RItE Care program. Christine Ferguson, Governor Almond's appointee for director of the DHS, was widely viewed as a politically savvy, extremely effective administrator and advocate of RItE Care throughout her six-year tenure. Similarly, Tricia Leddy, the administrator for DHS's Center for Child and Family Health, which directly administers RItE Care, is widely praised for her knowledge and administrative expertise—another key factor in the program's success.

Strong leadership also was credited with the decision to convert fully from fee-for-service Medicaid to managed care in one step, rather than moving incrementally to a primary care case management model. The risk of the latter approach was that the state could have gotten "stuck" at that interim stage because of political or financial pressures. In addition, the many expansions of RItE Care and the development of RItE Share depended on political leadership and solid knowledge of the federal waiver process.

Clearly Defined Mission

The development and implementation of RItE Care were facilitated by the state's clearly defined goal that children should enter school ready to learn and leave school ready to become active and productive members of society. In this framework, access to health coverage and appropriate health services for children, like a good education, is central to the development of "human capital." Expanding health care coverage to lower-income children and their parents was viewed as an "investment" that would pay subsequent social "dividends."

Placing RItE Care in this framework helped build bipartisan support for the program. Aided by seed money from private foundations to bring various players together, collaboration on RItE Care was achieved around a common goal. The effort led to the development of a number of public programs in other agencies and departments as well. In the same spirit, the state formed a "Children's Cabinet" in the early 1990s. This cabinet still meets regularly, and includes the governor, directors of all departments that are related to children's well-being (Human Services; Education; Children, Youth and Families; Mental Health Retardation and Hospitals; Health; and Administration), and representatives from both houses of the legislature. The cabinet helped establish common goals while acknowledging that incremental steps were needed to reach those goals. This effort was successful in building support among policymakers as well as the public.

Good Economic Climate

The economic boom of the 1990s was a necessary factor in the implementation and expansion of Rhode Island's health care access programs. State budget surpluses gave planners and legislators the latitude to experiment with new approaches and focus on expanding access and improving outcomes, rather than solely on containing costs. Leaders of the effort acknowledged that they would not have been able to implement and expand RItE Care during an economic downturn. In fact, there is widespread concern about Rhode Island's ability to sustain the significant gains achieved as budgets become tighter.

Expertise of Consultants and Management Firm

Both the use of consultants while developing RItE Care and RItE Share and the ongoing contracts with a management firm to perform many administrative functions are viewed by administrators, in retrospect, as being invaluable to RItE Care's success.

A Health Care Financing Administration (HCFA)—now Centers for Medicare and Medicaid Services (CMS)—Section 1115 waiver approval requirement that the state engage in a management contract resulted in DHS contracting with a consulting firm to

help administer RItE Care.¹⁷ Officials suggested that this requirement ensured that adequate resources were relegated to key management functions. They have been very pleased with the firm's expertise in developing rates and contracting with health plans, providing oversight and monitoring of health plan contracts, monitoring utilization and expenditures, coordinating federal matching funds, and other administrative tasks. The consultants are integrated into DHS's operations and even occupy offices in DHS buildings.

DHS also contracted with a local health services research firm to conduct research and evaluation activities required under the waiver.¹⁸ Program evaluation studies are conducted in close partnership with health service researchers at Brown University.

Additional technical assistance was obtained when developing Health Reform Rhode Island 2000 (under a State Initiatives in Health Care Reform grant) and specifically in the implementation of RItE Share.^{19,20}

Apparently "Simple" Structure

Rhode Island expanded state health care coverage through a joint Medicaid/CHIP program, and this concentrated focus contributed to its success, according to the program's administrator. Such an approach contrasts with the multilayered strategies taken by many other states that involve a combination of high-risk pools, premium subsidies, Medicaid expansion, separate CHIP programs, and other initiatives. Rhode Island officials did not dismiss the latter approach as being ineffective, but preferred a more consolidated effort.

Moreover, RItE Care—by design—appears to be one uniform program to the public. Consumers are blind to the complex and multiple financing sources and to the fact that many categories of enrollees are approved under various waivers, amendments, or legislation. There is one application form, regardless of whether the applicant meets criteria for Medicaid, Medicaid-expansion, CHIP, CHIP waiver, or none of these categories. Each population must be tracked separately "behind the scenes" for the state to obtain appropriate federal funding. Depending on the category, the federal government contributes at the regular Medicaid matching rate, the enhanced CHIP matching rate, or not at all, as in the case of undocumented immigrants who are financed by state-only dollars. Rhode Island is one of the few states that has attempted to enroll undocumented immigrants, who are normally left without coverage options. This illustrates the state's

¹⁷ The firm is Birch & Davis/ACS.

¹⁸ MCH Evaluation, Inc.

¹⁹ A Robert Wood Johnson Foundation-funded initiative administered by the Academy for Health Services Research and Health Policy.

²⁰ Among the consultants that provided technical assistance were the Institute for Health Policy Solutions and the Center for Studying Health System Change, both based in Washington, D.C.

commitment to reach hard-to-serve groups even when no federal financial assistance is available.

Unlike RItE Care, the RItE Share program has been perceived as overly complex, contributing, at least in part, to the low participation rates by employers. The state is trying to address this problem in a number of ways, discussed below.

Involvement of Consumers and Consumer Advocates

When RItE Care was first designed in the early 1990s, consumer advocates were very resistant to the managed care aspect of the program, fearing problems such as inadequate access to services, bureaucratic hassles and denials of care. Community members got together and requested the establishment of a consumer advisory group. DHS, aware of both significant public concern about RItE Care and a perception that DHS did not “listen” to its constituents, established a Consumer Advisory Committee in 1995 and invited public participation in the meetings. Both consumers and consumer advocates have been attending the meetings and continue to be actively involved. It was important that state officials made great efforts to listen carefully and respond to the concerns voiced by consumers.

This advisory process was instrumental in transforming consumer advocates from opponents of the public program to partners with DHS in determining the program’s evolution. When it was clear that managed care was inevitable, for example, advocates worked with the state to establish some patient safeguards. By 1996–97, consumer advocates were asking the legislature to expand RItE Care coverage to parents and child care providers.

Consumer advocates continue to be concerned about various aspects of and changes in the program. For example, they are currently apprehensive about the level of premium contributions required from RItE Care enrollees (\$43 per month). They see their role as raising unvoiced issues and concerns with the state.

In addition to the Consumer Advisory Committee, the RItE Share Business Advisory Committee is intended to provide the state with feedback from the business community and involve employers in the process of shaping RItE Share. Unlike the consumer group, however, some of these committee members perceive that their concerns are not being adequately addressed.

Incorporation of Safety Net

The fact that the state incorporated community health centers (CHCs) into the Medicaid managed care program appears to be another important factor in RItE Care's success. It also was critical to the survival of an integral part of the safety net in Rhode Island.

Rhode Island's CHCs were doing well under the fee-for-service Medicaid program. When RItE Care was being developed, the CHCs understood that they needed to be involved as managed care providers to remain viable and to continue serving low-income and uninsured clients. With the support and encouragement of DHS, the CHCs formed the Neighborhood Health Plan of Rhode Island (NHPRI), the only provider-sponsored health plan in the state. NHPRI serves the Medicaid population almost exclusively and currently covers about 60 percent of RItE Care enrollees.

The state entered into a risk-sharing agreement with NHPRI, thus protecting the plan from potential collapse when it was in financial crisis in 1997. An advantageous outcome of this arrangement was that the state gained access to additional information about costs, utilization, and other aspects of health care. NHPRI also works with the state to serve hard-to-reach populations; for example, NHPRI enrolled 2,000 foster children who had been on fee-for-service Medicaid and is working effectively in partnership with the state to address and meet the special needs of this population.

There are mixed views about maintaining a CHC-based health plan. Some private primary care physicians view the CHCs as giving lower-quality care than private practices, and object to the high incidence of self-referral within the safety net network that prevents effective mainstreaming of the RItE Care population. Others, however, cite the advantage of enabling much of the target population to maintain their regular source of care while opening up new private options as well. Supporters also note the CHCs' long experience working with low-income populations. In fact, Rhode Island's CHCs have a better record than private practices of providing lead screening and timely childhood immunizations to RItE Care children.²¹ NHPRI is rated "Excellent" by the National Committee for Quality Assurance, its highest rating for quality.

Finally, NHPRI was always "open" when other health plans either permanently or temporarily closed their doors to RItE Care enrollees because they considered the

²¹ Vivier, Patrick M., et al., "A statewide assessment of lead screening histories of preschool children enrolled in a Medicaid managed care program," *Journal of Pediatrics*, August 2001; and Vivier, Patrick et. al., "An analysis of the immunization status of preschool children enrolled in a statewide Medicaid managed care program," *Journal of Pediatrics*, November 2001.

reimbursement rates to be inadequate. Having NHPRI as a strong partner with the state was essential for the survival of the program.

Dedication to Improving Health

A key to Rhode Island's health care access expansion strategy was the state's dedication not merely to reducing the number of uninsured but also to improving health care. The state set performance standards for health plans serving RItE Care enrollees, collected data through ongoing evaluation studies, and took an interdisciplinary, comprehensive view of health care.

Setting Performance Standards

According to state officials, a turning point in the RItE Care program was when the state "took control" of quality of care by switching from a "passive" request for proposal (RFP) process to setting "bid specifications" with performance goals and incentives. The state defined what it wanted to purchase rather than just buying what the health plans chose to offer. For example, the state built into its contracts with health plans a performance award for certain outcomes, with the provision that a certain portion of the award must be passed on to physicians to encourage high-quality care. The performance measures included administrative, access, and clinical measures. The state also offers partial awards to health plans that display improvements on certain measures.

Initially, RItE Care set five specific health improvement goals that were selected as indicators of the program's success in improving access and quality (improved prenatal care, improved birth outcomes, increased inter-pregnancy intervals, increased childhood immunization rates, and decreased lead poisoning). These indicators are continually measured at the program level, often using public data. Contract-based performance measures brought quality improvement to a new level. With the use of health plan-specific encounter data and administrative data, the state could evaluate 25 measures of health quality and access at the individual plan level and focus effort and improvement on key areas. Further, because all of Rhode Island's health plans participate in RItE Care, it is assumed that the resulting improvement in quality care transfers to private patients as well.

One of the state's initial requirements of health plans participating in RItE Care was that the provider network must be the same as the network for private employer health plans. In that way, the state ensured that any physician taking private patients was required to take RItE Care patients as well. Although health plans initially balked at this requirement, and some physicians reportedly "get around" this rule and continue to discriminate against public enrollees, the precedent has been established and, overall,

Medicaid patients have had access to many more practitioners since RItE Care was enacted. Virtually all primary care physicians participate in RItE Care, whereas only one-third participated in pre-RItE Care Medicaid.

Collection and Use of Data

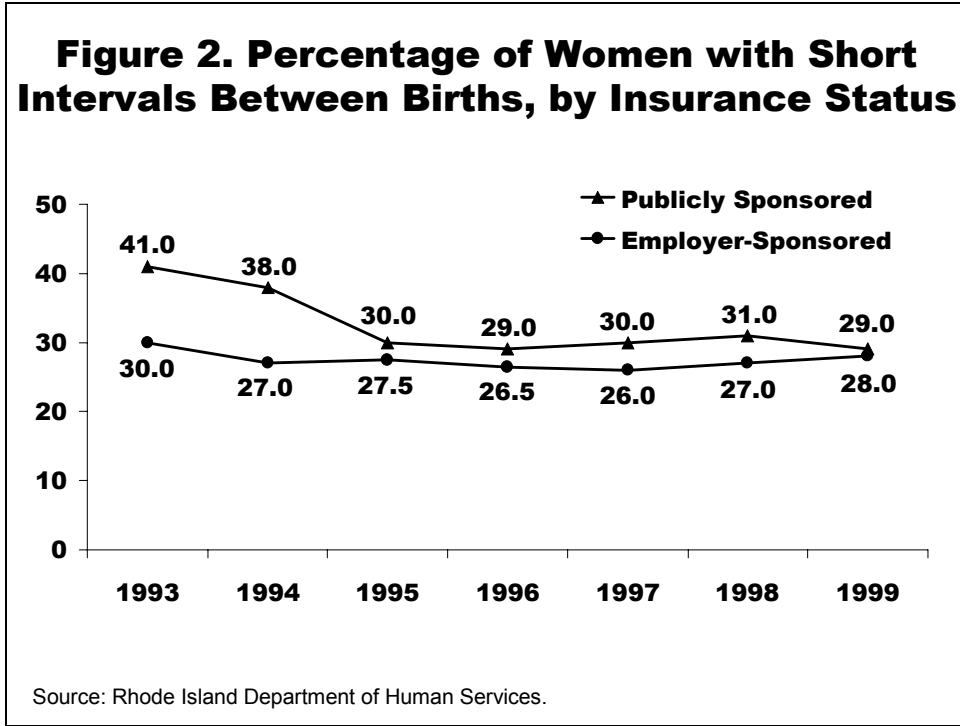
Rhode Island has been a leader among states in using data to monitor and improve health care as well as to publicize and build support for its access expansion program. Outcomes research was built into Rhode Island's initial Medicaid waiver. The state began collecting data in 1995–96 and had documented improved outcomes measured by consumer satisfaction by 1997. Since then, improvements have been demonstrated in many areas including prenatal care, birth outcomes, inter-birth intervals, lead screening, pediatric preventive care, and decreased emergency room use and hospital utilization.

There is a strong willingness to use data to inform key program decisions. For example, when data indicated very high neonatal intensive care unit (NICU) utilization, the state investigated and found that many babies who were not appropriate candidates for NICUs were nonetheless admitted to the units and remained in NICUs for long periods of time. In response, the state decided to carve this benefit out of those covered by the participating health plans, manage it by placing a staff person directly in the primary NICU in the state, and change the reimbursement structure. Although NICU admission rates have remained fairly constant, the length of stay has declined since these changes were made.

This example demonstrates how Rhode Island studied patterns of care, found overuse or underuse of services, and responded. Rather than accepting the status quo of the health care delivery system, they seek out ways to make the system more cost-effective and to improve outcomes.

Members of an interdepartmental evaluation team similarly use public health data to identify and solve problems and publish articles documenting research results. These data are being converted into a user-friendly format for “marketing” the program to potential enrollees, state legislators, and federal agencies. For example, Rhode Island has documented and publicized a marked reduction in the proportion of RItE Care women with short intervals (e.g., less than 18 months) between giving birth. An emphasis on family planning helped close the gap between publicly sponsored RItE Care enrollees and employer-sponsored insurance enrollees (Figure 2).

Consumer advocates now are concerned that, with people moving into employer-sponsored plans through RItE Share (from the RItE Care managed care plans), the state will lose its ability to track their health status and utilization patterns.



Comprehensive Approach to Health Care

RItE Care has been successful in large part because it looks beyond insurance to focus on the overall health of its target population. This philosophy emerges from the program’s early history. Planning for Rhode Island’s Medicaid managed care plan began as a partnership between the state’s Department of Health (DOH), which was interested in the expansion of coverage to uninsured children, and the Department of Human Services (DHS), which was interested in improving access to primary care for its existing Medicaid/AFDC families and decreasing the high use of emergency departments for routine care. When it was decided to house the program at DHS, many DOH public health officials transferred to DHS to administer the program. The two departments continue to have a collaborative relationship through the evaluation team, the Children’s Cabinet, and other joint projects. For example, the departments share data to facilitate DOH’s focus on the continuing gaps in access, such as in oral health care, despite enrollment in Medicaid.

The state’s comprehensive approach also is exemplified in its efforts to control lead-based paint. If a RItE Care child is diagnosed with lead poisoning, the state conducts a lead abatement intervention in the family’s apartment. This includes cleaning walls,

purifying air, and, in a unique program, replacing windows using state and federal Medicaid funds.²²

RIte Care administrators have generated research findings associating health coverage with better health outcomes, and those outcomes, in turn, with lower costs. The state's own research has revealed that if low-income people get health coverage, better patterns of care follow. The state has learned that inappropriate patterns of care are the real "cost drivers," as opposed to a generous benefit package.

State Flexibility

According to state officials, there is a commitment to continuous quality improvement within state government that parallels what the state expects of health plans. This is manifested in the state's willingness to make mid-course corrections. Incorporation of performance standards, changes in reimbursement and risk relationships with health plans, and the implementation of and modifications to RIte Share exemplify the state's flexibility.

Nonadversarial Relationship with Health Plans

Whereas the relationship between Rhode Island's health plans and state government has been difficult at times,²³ DHS officials attributed RIte Care's success in part to the department's nonadversarial approach to the insurance industry. The health plans were actively informed of the RIte Care strategy as it was developing and were given the opportunity to provide feedback even before the initial RFPs were sent out. The state also has learned that the health plans must receive fair compensation if they are to participate in state programs.

When RIte Care began, the capitated reimbursement rates offered were admittedly inadequate, resulting in health plans declining to participate until the state increased its offer. As costs increased, complaints of inadequate reimbursement resurfaced in 1995–96, and after listening to providers and consumers, the state changed its contracts. Although budget constraints prevented the state from significantly increasing its payments to health plans, it renegotiated the risk arrangements and "took back" some services to allow for improved compensation to providers. Specifically, the state reduced the health plans' risk by creating stop-loss provisions for certain potentially high-cost services and offering to remove some high-cost services (e.g., NICU services) and to substitute direct state

²² Landlords are required to pay the state back when they sell the apartment, unless they choose to pay back earlier.

²³ According to some, the relationship between the insurers and the legislature has been fairly adversarial over the years.

control. Similarly, state officials have learned that it is worthwhile to pay primary care providers sufficiently to spend more time on office visits, which will decrease inappropriate care in the long run. That is, it is not cost effective to skimp on primary care.

These measures helped temporarily. In 2000, however, of the four plans originally participating in RItE Care, one left the state and two others were no longer accepting new RItE Care patients (one of these considered leaving the program permanently). Only NHPRI accepted new enrollees until the state was able to increase rates in the spring of 2001. The three health plans that are still operating in Rhode Island enroll RItE Care members.

“Safe Place” for Dialogue

To achieve the shared goals and collaboration discussed above, it was necessary to have a “safe place” to bring together the various constituents (the health care industry, consumers, and state agencies). This was accomplished with the help of committed local entities that offered funds, neutrality, and a conference room.

The Rhode Island Foundation, in conjunction with the Kids Count project (funded by the Annie E. Casey Foundation) provided a place for various players to come together and “roll up their sleeves.” The foundation arranged the Leadership Roundtable on the Uninsured in 1998, bringing together the top leadership in the state to address the issue of the uninsured, and facilitated the governor’s working groups, which led to Health Reform Rhode Island 2000. The local foundations also leveraged additional funds from out-of-state foundations for improved access and children’s causes.

Advantages of a Small State

According to numerous respondents, the small size of the state has been an important ingredient that has facilitated health care reform over the past decade. When legislators, administrators, and interest group representatives live and work within a relatively small geographic area, both unplanned and planned meetings occur frequently and communication is facilitated. For consumer advocates, for example, Rhode Island offers unusual access to DHS officials.

Obstacles and Issues

The current success of Rhode Island’s comprehensive health care access program masks the fact that there were serious challenges that needed to be addressed, obstacles that needed to be overcome, and mistakes that might have been avoided. Below we delineate some of these challenges and the lessons learned.

Initial Disorganization

An initial plan to share RItE Care administration between two state departments (DOH and DHS) is viewed by some as a mistake that fueled disorganization and rivalry between the agencies. Anchoring the program in one agency that took ownership and ultimate responsibility, while encouraging interdepartmental cooperation and collaboration, was deemed critical for the emergence of a strong program.

Underpayments to Health Plans and Providers

As described above, there were a few periods when state reimbursement rates under RItE Care were deemed insufficient by health plans and/or practitioners, placing their continued participation—and RItE Care’s viability—at risk. Primary care physicians, for example, were paid well below market rates, and two health plans stopped accepting new RItE Care enrollees in 2000, generating a crisis point in the program. There has been some criticism that the state should have been more closely in touch with the concerns of health plans so that it could have acted early and averted a crisis. Although the state has responded over the years by changing risk arrangements and increasing rates, many physicians believe that rates should increase further.

Even though state officials understand the need to compensate health plans fairly, they are currently faced with escalating health care costs and tightening budgets. Exacerbating the problem is the fact that health plans are currently at a different stage than they were in the early 1990s. According to industry representatives, health plans were “burned” by Medicare because they were induced to participate in Medicare+Choice (Medicare’s managed care program) and then squeezed by relatively low reimbursement rates. This experience makes some plans reluctant to take on public enrollees and unwilling to take a gamble on a relationship that may not be profitable.

Unstable Insurance Market

Rhode Island’s small and unstable insurance market posed challenges to access expansion initiatives. In addition to trying to get RItE Care up and running, Rhode Island was faced with the sudden departure of two of the five health plans from the state and from the Medicaid program. There are complaints that the governor and the insurance department should have done more to prevent this occurrence. Although the state has since made efforts to stabilize rates and strengthen financial solvency standards, there has been strong resistance to some of these measures.

Further, with only two commercial health plans remaining in the state, there are complaints that these plans hold a disproportionate amount of influence and have

successfully blocked additional access expansion efforts, such as allowing employers to buy in to RItE Care.

Undeveloped Managed Care Market

The state of Rhode Island was challenged with imposing a Medicaid managed care program on an undeveloped managed care market. There was much resistance by consumer advocates, who feared that access would decline because of “gatekeeping.” Primary care physicians, who were not accustomed to being true care managers, also were initially resistant. RItE Care took the brunt of provider resistance to basic managed care practices as the first purchaser in the state to require that every member have a primary care provider available 24 hours a day, seven days a week (through cross-coverage arrangements), and who would coordinate all of the member’s care, including authorizing specialty care visits and nonemergency treatment in a hospital emergency department.

There are complaints that some private primary care physicians find ways to avoid serving RItE Care patients and that there is inadequate policing against these practices. Most agree, however, that the market has adapted to the new model.

Enrollment Crisis

Perhaps the greatest challenge to Rhode Island’s access expansion effort was when RItE Care enrollment soared in 1999–2000. As described earlier, many factors contributed to this situation, including the deterioration of the small-group insurance market, escalating health care costs, expansion of RItE Care eligibility, and enhanced outreach efforts. The governor responded by convening a special health care working group that resulted in significant health care reforms in 2000, including the enactment of the RItE Share premium assistance program.

Failure to Coordinate Premium Assistance with Expansion of Eligibility

In hindsight, state officials learned an important lesson about timing: a new premium assistance program should begin in conjunction with expansion of eligibility to families. Expansion in RItE Care eligibility to parents in 1998 allowed some employees to drop employment-based health insurance to join the public program, providing financial savings to employers. When RItE Share was later implemented, employers naturally would not volunteer to take those employees back into their company’s health plan. This forced the state to modify the program so that RItE Share was not dependent on the voluntary participation of employers.

Lack of Business Support for RItE Share

Bad timing was only one of many factors behind the lack of business community support for RItE Share. Employers who were asked to join the RItE Share Business Advisory Committee to help design the program believed that the state did not address their concerns. (The employers, however, did help develop the program's cost-effectiveness test and other features.) Resistance was also apparently related to misconceptions among employers about the rules and design of the program, reflecting inadequate communication and marketing by the state. About 80 percent of all commercial plans were approved for RItE Share participation. Plans with high up-front deductibles were not approved, and this may be a problem in the future as more employers choose high-deductible plans to address escalating premium costs.

There are even greater concerns among small employers, however, who feel burdened by high costs and low profits during an economic downturn. They view RItE Share as an extra hardship that: 1) asks them to pay their share of premiums for employees who were previously on RItE Care rolls; 2) could hurt morale among employees who do not receive similar public assistance; 3) imposes administrative costs related to changing the employee payroll deduction for certain workers and keeping track of a new payment source; and 4) may cause cash-flow problems related to waiting for the state to reimburse them for the employee's share of the premium.²⁴

The state is responding to some of these concerns by enhancing employer recruitment efforts, exploring possible incentives to increase participation, and allowing direct premium assistance payments to employees so that employers may be bypassed. Under the latter approach, employers are blind to workers' involvement in RItE Share. With this provision, the program's success will not hinge on employers' willingness to participate. The state also requires eligible enrollees to switch from RItE Care to RItE Share and makes RItE Share mandatory for RItE Care applicants who have access to employer-sponsored insurance. These modifications led to an additional 1,800 RItE Share enrollees in the first half of 2002. Despite these changes, however, representatives of the small business community say they are "not hopeful" about the program.

Looking Ahead: Lessons for Other States and Challenges

Many lessons can be drawn from Rhode Island's experiences in expanding access to health care. A clearly defined mission and strong leadership are critical, and the involvement of consumers, health plans, and other stakeholders is important for building support and

²⁴ Also, the state faced administrative difficulties coordinating wraparound and supplemental benefits with private coverage that involved deductibles.

ensuring protections for enrollees. Incremental expansion of one major program, with centralized administration but coordination with other departments and agencies, was a formula that worked well in this state. Creating a stop-loss provision and taking direct control of potentially high-cost services are examples of creative responses to budget constraints that other states may want to consider. The difficulties in getting Rhode Island's premium subsidy program up to speed point to the need to implement such a program simultaneously with (rather than after) expansion of the public program to ensure ease of administration for employers, educate the business community about the details and benefits of the program, establish direct subsidies to employees, and require participation. The state's emphasis on quality, through performance standards, use of data, and a comprehensive approach to health, has succeeded in terms of improved outcomes and efficiency; other states may want to follow Rhode Island's lead in this area.

Looking ahead, state officials maintain that the primary challenge is to maintain RIte Care in the face of severe budget constraints. Additional challenges involve building up employer-sponsored coverage and expanding access to additional groups of uninsured people.

Sustainability in an Economic Downturn

States are facing budget shortfalls, and Rhode Island is no exception. As a result, RIte Care administrators will be struggling to prevent cutbacks in eligibility and/or benefits. Further, because the program has been associated with improved outcomes, many fear that scaling back coverage will lead to declines in health.

By instituting cost-sharing in the form of premium contributions among a portion of RIte Care beneficiaries, the state hopes to contain costs and thereby prevent cuts in coverage and eligibility. Consumer advocates, however, fear that low-income people will not be able to afford their share and will drop out altogether. Advocates estimate that about 6,000 people will "fall off" the program. Early monitoring indicates that among the 5,200 families newly subjected to monthly cost-sharing in January 1, 2002, 87 percent had paid their premiums as of mid-March 2002. Many of those who had not paid cited availability of other coverage. Clearly, it will be crucial to continue monitoring cost-sharing in the upcoming months and years.

Expanding Employer-Sponsored Insurance

Designing a viable program that encourages private employer-based insurance is a primary—albeit elusive—goal. There is concern that, with escalating premiums, employers will opt out of providing health coverage entirely.

State administrators are making an effort to boost private coverage through RItE Share, but there is widespread acknowledgment that this program will need to evolve to meet changing economic circumstances. Ongoing challenges include administrative complexity, excessive financial burdens on employers, and possible loss of access to utilization data on RItE Share enrollees. Marketing as well as clear communication with the business community and low-income workers are critical.

The state has considered allowing businesses to buy into RItE Care (which could offer coverage with much less premium volatility and perhaps at somewhat lower cost than coverage purchased directly from commercial carriers), but one of the health plans has opposed the proposal, presuming it would lose private business. The state also has considered offering a subsidy to employers to encourage employment-based insurance. This, however, would require significant new funding that is not currently available. Instead, the state has taken an alternate route. By bypassing employers and making participation mandatory, the state has seen RItE Share enrollment soar since January 2002. The state is closely monitoring and evaluating its progress.

Filling Remaining Gaps

A final challenge for the future involves identifying the remaining gaps in coverage and creating a seamless system of care. State officials want to know, and are making efforts to learn, who leaves RItE Care and RItE Share and why, who remains uninsured and why, and how the uninsured obtain access to care. They understand the need to build support for public assistance to adults without dependent children and other uninsured populations (for example, by expanding RItE Care eligibility to these groups), but acknowledge how difficult this will be in a time of fiscal constraints.

In sum, there is much concern about how to sustain Rhode Island's expansion of access to health care in a declining economy. Administrators and legislators stress the need to continue to work collaboratively, to acknowledge that the market is changing, and to continue making mid-course corrections. They suggest using past success as a motivator and making a business case for continuing to expand access to health care, for example, by using "investment" language rather than "entitlement" language. Still, the state sees federal government financing as instrumental. As one state official put it, "We know the experiment works. The question is money."