TOWARD COMPREHENSIVE HEALTH COVERAGE FOR ALL: SUMMARIES OF 20 STATE PLANNING GRANTS FROM THE U.S. HEALTH RESOURCES AND SERVICES ADMINISTRATION

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PREFACE

In September 2000, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services set up a State Planning Grants (SPG) program to award one-year grants to states for creating comprehensive health insurance coverage plans for all citizens. Eleven states were selected in FY 2000 and nine states in FY 2001 for grants ranging from $800,000 to $1.6 million. The goals of the state grants were to 1) collect data on characteristics of the uninsured; and 2) design plans for providing these populations with access to affordable insurance coverage. The program also gives states the resources to identify and involve community stakeholders in the planning process.

Through the grants, the states collected qualitative and quantitative data on uninsured subpopulations and on the health insurance market to create state-specific and data-driven policy options. The plans developed through these HRSA grants can serve as models for other states seeking to conduct similar analyses of their uninsured populations and to implement effective coverage plans.

The Economic and Social Research Institute compiled summaries of the HRSA SPG reports based on the states' proposals as well as from October 2001 and March 2002 reports from the 20 states awarded grants. These summaries provide an overview of each state's activities and facilitate comparisons of information most useful to state and federal policymakers, government agencies, and researchers. The summaries include project objectives, project findings, policy options under consideration, and actions taken.

The summaries of the SPG reports include the following information:

- Project goals
- Planned project components and activities
- Grant amount and time frame
- Lead agency and project partners
- Brief history of state health reform
- Existing major access programs

- Project findings
  - key findings from data collection
  - state policy recommendations or options for reform
  - recommendations for federal policy
- Changes in project goals during the grant period
- Actions taken
- Next steps planned toward health reform
- Principal contact
- Links to state reports

Full state plans and reports are available from HRSA at: http://www.hrsa.gov/osp/stateplanning.

HRSA State Planning Grantee: Arizona	
Project Goals	Arizona's stated goals for this State Planning Grant (SPG) were the following: 1. The nine-member Statewide Health Care Insurance Plan Task Force will conduct public hearings, examine testimony, examine staff research results and recommendations, establish guiding principles, assess the feasibility of various strategies to address accessibility/affordability of health care, and submit a final report with recommended action steps to the Legislature and Governor by December 15, 2001; 2. The Arizona Health Care Cost-Containment System Administration (AHCCCSA) and consultants--in collaboration with other state agencies, the Governor's Office, and Legislature--will determine roles/responsibilities and time frames for tasks, establish a framework for research and analysis, and conduct research and analysis using specified demographic data; 3. By the end of the project, the AHCCCSA will have a. assisted the Task Force in planning hearings, meetings, and research/data collection; b. established a Technical Advisory Committee and facilitated committee meetings to solicit guidance on the design and selection of options to enhance health coverage in Arizona; c. reviewed and compiled existing information on current health care coverage in Arizona, as well as strategies used in other states; d. analyzed and tested proposed strategies, including soliciting input via community meetings/focus groups.
Project Components	Planned components of the project included: *Establishment of Project Staffing and Organizational Framework*: assigning specific roles and responsibilities, appointing the advisory committee, and defining the principles for health care coverage in Arizona;

	Research, Analysis and Preparation of the Health Insurance Report: compiling Arizona-specific information on coverage trends, health-benefit coverage profiles, status of Arizona's insured population; *Modeling Analysis*: defining initial framework for the models, conducting the analysis, and developing model options; *Development of Basic Health Insurance Plan*: reviewing model options and soliciting public input; *Selection of Plan(s) to Implement*: selecting a preliminary plan, collecting focus group input, finalizing and preparing final Task Force and Health Resources and Services Administration (HRSA) reports.
Grant Amount and Time Frame	$1,162,879; 3/1/01–2/28/02, with an anticipated extension through 3/31/03.
Lead Agency	AHCCCS http://www.ahcccs.state.az.us State Planning website http://www.ahcccs.state.az.us/Studies/default.asp?ID=HRSA
Project Partners	Governor's Task Force, Arizona Department of Health Services, Arizona Department of Insurance, UA College of Public Health, UA Rural Health Office
Brief History of State Health Reform	**AHCCCS**, Arizona's Medicaid system, was established in 1982 as the first statewide demonstration in the nation to be built on managed care principles. Arizona Long Term Care System (ALTCS) was implemented in 1988 to provide an array of health care, including long-term care services to eligible Medicaid populations. Also in 1988, Arizona implemented **HealthCare Group of Arizona**, offering HMO coverage subsidized indirectly by state reinsurance available to small businesses and self-employed individuals. In 1996, the **Premium Sharing Demonstration Program** was established to offer subsidized insurance to those under 200 percent of the federal poverty level (FPL) who earned too much to qualify for AHCCCS; the program has been extended to those under 400 percent FPL with certain chronic conditions and terminal illnesses. An initiative in the early 1990s raised the tobacco tax in the state and used a portion of the proceeds to expand health services, primarily

	through grants to safety-net programs. In 1996, the **Healthy Arizona Initiative** passed a ballot measure (Proposition 204) raising AHCCCS eligibility from 34 percent to 100 percent FPL. And in 1999, **Arizona KidsCare Program**, the state's Children's Health Insurance Program (CHIP), was established to cover children up to 200 percent FPL. In November 2001, AHCCCS implemented a **Prescription Drug Program** for certain low-income Medicare persons. In April of 2002, the state instituted a **Title XIX** coverage expansion for adults with incomes up to 100 percent FPL. Using tobacco settlement funds, $5.5 million was appropriated for FY 2002 for the **Primary Care Program**, in which 22 primary care agencies provide comprehensive care to low-income, at-risk residents. Also using tobacco funds, $4.5 million was appropriated for 17 **Community Health Centers** to provide primary care services to low-income Arizonans. The **Pima Community Access Program** was implemented in September 2001 to provide heavily discounted primary and specialty care, as well as hospital services. It also will establish a pool from which members can borrow to pay for high-cost services. The **Arizona Latino Medical Association** has implemented an initiative that, for a small annual fee, allows Latino families access to a network of practitioners and pharmacists who discount services and products 25–50 percent.
Existing Major Access Programs	AHCCCS, ALTCS, Premium Sharing Pilot Program, Prescription Drug Program, KidsCare, Title XIX, Primary Care Program, Pima Community Access Program, Arizona Latino Medical Association
SPG FINDINGS	
Insurance Data	❑ The rate of uninsurance in Arizona substantially decreased between 1998 and 2000, from 22.5 percent to 16 percent. The rate for those under age 18 has decreased sharply, from 26.3 percent in 1998 to 12.6 percent in 2000. ❑ Most of this gain is attributable to an increase in employer-sponsored coverage driven by Arizona's strong economy, and a number of efforts at the state level to increase both private and public health coverage.

	❑ The median household income in Arizona is 22 percent lower than the national median; 15.6 percent of the population lives below 100 percent FPL. ❑ Nearly three-quarters (74 percent) of the nonelderly uninsured reside in households with incomes below 200 percent FPL. ❑ Seventy-five percent of the uninsured are in households with at least one full-time worker; another 9 percent reside in a household with at least one part-time worker. ❑ Most of the uninsured in Arizona have been uninsured for two years or more. ❑ Though Arizona workers continued to pay less than the national average for premiums ($5,509.34 vs. $6,058.12 for family coverage in 1999), most survey respondents cited cost as a major factor in not acquiring health coverage. ❑ Case studies reveal that typical premium, coinsurance and deductibles can exceed 20 percent of the annual income of a family living at 200 percent FPL.
Employer Role	❑ Ninety-seven percent of firms in Arizona have fewer than 100 employees; the smallest of these (<10 employees) comprise 74.4 percent of all firms and are traditionally less likely to provide health coverage. Very large firms (1,000+ employees) account for only 0.2 percent of firms, but employ nearly one-fourth (23 percent) of the workforce. ❑ The number of Arizonans with employer-sponsored health coverage increased from 50.3 percent in 1996 to 59.4 percent in 2000 (the national average is 64.1 percent). ❑ The rate of employer-sponsored coverage differs markedly by race, with 69 percent of whites, 62 percent of blacks, and only 38 percent of Hispanics having this type of coverage. (For all other races combined, the rate is 56 percent.)

	❑ About 80 percent of full- and part-time employees who work in firms offering health coverage are eligible for it; of those, about 81 percent enroll in an employer-sponsored plan. When only part-time employees are taken into account, these numbers drop to 24.8 percent and 67.6 percent, respectively. ❑ Twenty-nine percent of private-sector firms offering coverage self-insure at least one plan.
State Policy Recommendations	In addition to the options laid out under "Next Steps," recommendations include: ❑ Introduce legislation to continue the efforts of the Task Force by continuing to develop strategies that will: 1. narrow the gap between existing public and private health programs; 2. restructure current state employee and retiree health care programs; 3. enhance existing public-supported programs; 4. improve the rural health care infrastructure. ❑ Continue support for HealthCare Group by subsidizing people with low incomes, streamlining benefits options, and revising the underwriting practices.
Recommendations for Federal Policy	❑ Allow states more flexibility in the operation of programs such as Medicaid and CHIP. ❑ Provide federal financial support for coverage expansions, such as subsidies for low-income individuals. ❑ Make available more timely and specific national survey data, especially with regard to employer-based coverage. ❑ Continue to fund state research on the uninsured, including the development of strategies to prevent erosion of the current coverage programs, given the current economic environment.

Change in Project Goals During Grant Period	While no specific changes were indicated, due to a budget crisis in the state and with the passage of Proposition 204 (described below), consideration of additional expansion options was not feasible. Instead, the focus was placed on maintaining the programs that have played an effective role in making health care affordable and available, and continuing to develop a framework for addressing the issue of accessibility and affordability.
Actions Taken	❑ Arizona established a Technical Advisory Committee to provide guidance in developing policy options. ❑ The University of Arizona was engaged to compile information on health care coverage in Arizona. ❑ Proposition 204, which amends the previous 1115 waiver and covers childless adults up to 100 percent FPL, was implemented on 10/1/01. It also has a component that allows individuals to "spend down" based on their medical bills to become eligible for health care. ❑ The Premium Sharing Program was expanded to a permanent statewide program. ❑ Implemented Breast and Cervical Cancer treatment, which adds a new section under Medicaid for women under 65 with no insurance who have been screened by the Department of Health Services and need treatment for breast and/or cervical cancer. ❑ Arizona's Health Insurance Flexibility and Accountability (HIFA) waiver was approved by Centers for Medicare and Medicaid Services (CMS) to cover parents of Medicaid and CHIP children with income 100–200 percent FPL. ❑ Three bills, SB 1056, HB 2286, and HB 2136, which emerged from recommendations by the Statewide Health Care Insurance Plan Task Force, have been introduced to narrow the gap between existing public and private health coverage programs, enhance existing publicly supported programs, and improve the rural health care infrastructure.

Next Steps	Arizona has received a one-year extension for its SPG. In that time, AHCCCSA will focus on the following: ❑ Employer-Sponsored Insurance Program: As part of the expansion under Arizona's HIFA waiver, the state is exploring the feasibility of instituting an employer-sponsored pilot program; ❑ Rural Provider Interviews: AHCCCSA will conduct interviews with targeted rural health providers in an effort to address the barriers that discourage providers from practicing in rural areas and develop strategies for creating a rural provider network; ❑ Small-Group Package: Sample rates are being developed for a model in which a small-group HMO plan would utilize the AHCCCS provider network.
Principal Contact	Linda Huff Redman, Ph.D., Project Director, AHCCCS, c/o Michal Goforth, 801 East Jefferson, Phoenix, AZ 85034 Telephone: 480/968-1963 E-mail: *Sashaaaron@aol.com*
Links to Reports	October 31, 2001. Interim HRSA State Planning Grant Report for Arizona *http://www.statecoverage.net/statereports/az.pdf* March 2002. Final Report to the Secretary http://www.statecoverage.net/statereports/az22.pdf

HRSA State Planning Grantee: Arkansas	
Project Goals	Arkansas's stated goals for this SPG were to: 1. establish the Arkansas Health Policy Roundtable, which will be staffed by a multidisciplinary team, to guide the SPG Program; 2. examine and summarize existing information on health insurance status in Arkansas; 3. collect and analyze primary qualitative data obtained from key informant interviews with large-employer and insurance company representatives, and from focus groups with employers and households; 4. collect and analyze quantitative data from employers and household mem**b**ers through new state data-collection efforts using surveys available nationally to further inform and guide the development of viable options for expanding insurance coverage; 5. identify, evaluate, and prioritize options for health insurance coverage under the guidance of the Health Policy Roundtable; 6. generate and submit final reports to the Arkansas Governor and General Assembly and to the Secretary of the Department of Health and Human Services, and initiate recommendations of the Roundtable.
Project Components	Planned components of the project included: *Establish the Arkansas Health Policy Roundtable* to provide advice and advocate for the project to ensure the involvement of multiple stakeholders, and to guide the development of solutions that provide access to affordable health insurance to all Arkansans; *Summarize and analyze existing data* on health insurance status in Arkansas; determine regions with similar socio-demographic, economic, and health insurance characteristics; and group counties for regional assessment of options and evaluation of potential impact;

	Collect primary data from key informants and focus groups to enhance understanding of likely responses to different options, through a. key informant interviews with leaders of organizations that have shaped the Arkansas insurance market; b. household focus groups with both insured and uninsured household members; c. employer focus groups with key groups required for success of potential expansion options; *Collect and analyze primary data from surveys* on households and employers using validated survey tools with reference data available for the region and the nation; *Develop coverage options for expanding health insurance coverage* after determining potential innovative solutions to the problem of providing access to affordable health insurance for all Arkansas citizens; *Generate report to the Secretary* based on the work of the Roundtable and the Project Team.
Grant Amount and Time Frame	$1,393,322; 10/1/00–9/30/01, with an extension through 9/30/02 of $866,519.
Lead Agency	Arkansas Center for Health Improvement *www.achi.net* State Planning Grant site *www.achi.net/StapePlan.htm*
Project Partners	American Cancer Society, Arkansas Advocates for Children and Families, Arkansas Department of Economic Development, Arkansas Department of Finance and Administration, Arkansas Department of Human Services (Division of Medical Services), Arkansas Chamber of Commerce, Arkansas Farm Bureau, Arkansas Hospital Association, Arkansas Health Insurance Commission, Arkansas Medical Society, Arkansas Nursing Association, Baptist Health, Blue Cross Blue Shield of Arkansas, Minority Health Commission, National Federation of Independent Businesses, State Employees and Teachers Association, Qualchoice, Community Health Centers of Arkansas, University of Arkansas for Medical Sciences, Arkansas Department of Health, University of Arkansas, Center for Survey Research, Flake-Wilkerson Market Insights LLC, Area Health Education Centers, Ray Scott and Associates, Arkansas House of Representatives, Arkansas State, Office of the Governor

Brief History of State Health Reform	The **Special Needs Revolving Trust Fund of 1993** was established to assist those who needed supplemental coverage for general health care and rehabilitative services. In 1996, a high-risk insurance pool was initiated. The **Medicaid Program for Low-Income, Disabled, Working Persons Act of 1999** enrolls low-income and disabled people under 250 percent FPL who are not eligible for supplemental security disability income. In 1991, **Medicaid** services were expanded to cover pregnant women and their children who live below 133 percent FPL. In 1992, the state instituted a **soft drink tax,** the proceeds of which are paid directly to the Arkansas Medicaid Trust Fund. The **Governor's Health Care Reform Task Force Report** of 1993 made recommendations that, in 1996, lead to the **ARKIDS First Program**, which provides health coverage to children <18 years from families with incomes as high as 200 percent FPL. Arkansas plans to use **Tobacco Settlement Funds** to expand coverage to pregnant women up to 200 percent FPL and individuals up to 100 percent FPL. The **Hometown Health Program** is assisting communities across the state in conducting health assessment and developing health-improvement strategies. **Health Insurance Consumer Choice Act** (Act 934) allows consumers to select insurance policies without state- mandated coverage options. The **Health Insurance Purchasing Group Act of 2001** (Act 925) allows small employers to pool purchasing power as nonprofit Health Insurance Purchasing Groups (HIPGs). The **Rural Health Access Pilot Program (RHAPP)** (Act 549) is a demonstration program allowing communities to organize and self-insure to increase access to care and stabilize local health care systems.
Existing Major Access Programs	Medicaid; Special Needs Revolving Trust Fund of 1993; High-Risk Insurance Pool; Medicaid Program for Low-Income, Disabled Working Persons; ARKids First; Hometown Health Program
SPG FINDINGS	
Insurance Data	❑ About 400,000 of Arkansas's 2.67 million citizens (15.2 percent) lack health coverage.

	❑ Twenty percent of working-age adults (19–64 years old) are uninsured. ❑ Of the 68 percent of uninsured adults who are employed, 51 percent work at least 35 hours/week. ❑ Forty-two percent of uninsured adults and 54 percent of uninsured children have family incomes 100–200 percent FPL. ❑ There is large regional variation in insurance rates within the state. ❑ Potential incentives to obtain insurance: Individuals of all income levels, particularly <200 percent FPL, are likely to be influenced by subsidies. Tax credits are more likely to influence higher-income individuals (>200 percent FPL). ❑ The uninsured are meeting their medical needs by delaying care, using safety-net providers, incurring long-term debt, filing for bankruptcy.
Employer Role	❑ Forty-four percent of employers offer health coverage to employees. ❑ Firms that don't offer coverage are most likely smaller and comprised of blue- collar employees. ❑ Cost is the overriding influence in employers offering health insurance; other factors are custom and practice of their industry, and sense of duty toward employees. ❑ Employers who offer coverage report cost increases of 25–80 percent in 2002. ❑ Many employers who offer coverage are containing costs by reducing the portion of premiums they contribute, restricting covered services, increasing copayments and deductibles, modifying utilization controls (e.g., tiered formularies), or dropping insurance and marginally enhancing wage rates. ❑ Through Medicaid, state employees and teachers, and the Arkansas Comprehensive Health Insurance Pool, the state government purchases coverage for 21 percent of the state's population.

State Policy Recommendations	The Arkansas SPG Roundtable, a 21-member group representing purchasers, consumers, and providers/insurers, with support from SPG staff and a broad-based Working Group, conducted the assessment of health insurance issues, reviewed all available options for reform, and recommended a prioritized list of strategic solutions. The following recommendations serve as a 5–10 year strategic plan to stabilize and expand Arkansas's health insurance market: ❑ Establish Community-Based Purchasing Pools/Cooperatives: Communities should organize, develop, and deploy community-based purchasing pools and cooperatives with support from the Arkansas Department of Insurance and insurance companies operating in the state. ❑ Increase ARKids Enrollment: Use aggressive outreach and enrollment, building on new school nurse enrollment strategies implemented in the fall of 2001, with continued monitoring and additional outreach efforts, if necessary, to ensure that all eligible children are enrolled. ❑ Expand Safety-Net Medicaid Program: Establish a safety-net insurance program to expand coverage with a minimal benefits package for currently uninsured adults (ages 19–64) to households earning up to 100 percent FPL or based on availability of funds. Package consists of six outpatient visits/year, two outpatient surgeries/year, seven inpatient hospital days/year, and two prescription drugs per month. Finance with tobacco settlement funds and other revenues, such as a medical use fee.

	❑ Create Employer-State Health Insurance Partnership: Extend the safety-net benefits package through voluntary participation of employers unable to obtain insurance in the private market. If a federal waiver is approved, employers could buy in to Medicaid by paying the state match for low-income, eligible employees; the federal matching rate (73 percent Medicaid, 82 percent CHIP) would apply for workers under 200 percent FPL. Employers and employees would pay for workers above 200 percent FPL. ❑ Develop Small-Group Reinsurance Strategies: Require insurance companies to reinsure high-risk individuals in the small-group market, thus pooling the risk and minimizing the variances that negatively affect the cost of insuring all employees in a group; ❑ Educate Employees Via Wage/Benefit Compensation Summaries: Employers should consider providing workers with a report of annual employee compensation, to increase awareness of health care costs and benefits, facilitate discussions, help employees make better-informed decisions, and serve as recruitment and retention tools. ❑ Include Scientifically Supported Preventive Services: Incorporate evidence-based preventive medicine into proposed health insurance expansion activities to reduce the long-term burden of poor health. ❑ Optimize Federal Funds for Health Care Coverage: Identify options for new funding of clinical services, and expeditiously implement them. Consider establishing a state policy-development center to execute this recommendation.
Recommendations for Federal Policy	❑ Achieve Income Tax Neutrality for Health Insurance/Health Care Expenditures: Pursue legislation making all methods of purchasing health insurance tax deductible. ❑ Modify Medicare Program: 1) Develop an affordable prescription drug program for Medicare beneficiaries, and 2) Expand eligibility through buy-in options for the near-elderly and disabled.

	❑ Tie Medical Savings Accounts (MSAs) to Group Catastrophic Policies: Tying MSAs to group rather than individual catastrophic policies would spread the risk associated with adverse events and thereby reduce the frequency of premium increases or policy cancellations. ❑ Improve the U.S. Health Care System Through Additional Research: Increase research into the delivery, appropriate utilization, costs, and quality of health care delivery systems.
Change in Project Goals During Grant Period	Originally, Arkansas had proposed an independent survey of employers. Due to the complexity of this, they chose to utilize the existing Agency for Healthcare Research and Quality survey methods.
Actions Taken	The state completed its first empirical assessment and systematic evaluation of strategies to address its uninsured citizens.
Next Steps	❑ Arkansas has secured external funding through 2004 for further refinement of the recommended policies. Additional analyses, further refinement of strategies, and a readiness assessment for implementation were underway as of March 2002. Recommendations to the Secretary of the U.S. Department of Health and Human Services were requested by the summer of 2002. ❑ The likelihood that the recommendations will be undertaken depends on the state's ability to address obstacles such as limited state general revenue, term limits in the General Assembly (affecting institutional knowledge), and potential inaction at the federal level. Reform efforts will be strengthened by a strong commitment and the ability to effect change on the part of political and health leaders.
Principal Contact	Joe Thompson, M.D., M.P.H., Arkansas Center for Health Improvement, 5800 West 10th Street, Suite 410, Little Rock, AR 72204 Telephone: 501/660-7555
Links to Reports	October 2001. 2001 Roundtable Report http://www.statecoverage.net/statereports/ar.pdf March 2002. Roundtable Report 2002 http://www.statecoverage.net/statereports/ar2.pdf

HRSA State Planning Grantee: California	
Project Goals	California's stated goals for this SPG were to: 1. investigate a broad range of alternatives for expanding health coverage in California; 2. discover a. the range of viable strategies for attaining universal health coverage, based on California's specific issues; b. financing methods for these strategies; c. the institutional changes that would need to take place for each alternative approach; d. what effects could be expected on benefit levels, quality, access, range of services, reliance on preventive care, and stakeholders.
Project Components	Planned components of the project included: *Literature reviews and background papers* on research into factors affecting the uninsured in California, and on research into alternative approaches to achieving universal health care coverage; *Assessment of the effects of current proposals* and identification of gaps in proposals that will need to be addressed; *Development and analysis* of a full range of alternatives in order to define workable models for California; *Identification and inclusion of public and private partners* in discussions and development of alternatives and of implications of those alternatives for achieving universal health coverage; *Production of a project report* to the Secretary of Health and Human Services and the state legislature; *Ongoing public participation in all stages of the process* through various mechanisms, to assure stakeholder and technical expert input.
Grant Amount and Time Frame	$1,197,000; 3/28/01–3/28/02, with an anticipated extension until 3/31/03.

Lead Agency	California Health and Human Services Agency *http://www.chhs.ca.gov* Health Care Options Project http://www.healthcareoptions.ca.gov/default.asp SPG website www.healthcareoptions.ca.gov
Project Partners	California Health and Human Services (CHHS) Agencies, relevant CHHS departments such as Department of Health Services, California Research Library, California State Legislature, health policy and analytic experts, and key stakeholders including representatives of public interests, physicians, nurses, hospitals, consumers, labor
Brief History of State Health Reform	In 1990, the **Managed Risk Medical Insurance Board (MRMIB)** was created to advise the Governor and Legislature on reducing rates of uninsurance. MRMIB administers three health care programs: 1) **Major Risk Medical Insurance Program (MRMIP)**, for uninsurable adults; 2) **Access for Infants and Mothers (AIM)**, for uninsured pregnant women; and 3) **Healthy Families Program (HFP)**, for children in low-wage families (eligibility was raised from 200 percent to 250 percent FPL in 1999). **Medi-Cal**, the state's Medicaid program, provides health insurance to more than 50 percent of California's poor and 20 percent of the near-poor population, and pays for nearly 50 percent of the births in the state. **California Children's Services (CCS)** provides coverage to children age 21 years or younger with eligible chronic or severe conditions. **Child Health Disability Prevention Program (CHDP)** provides periodic preventive health services, including immunizations and dental care, to Medi-Cal–eligible children. Enacted in 1992, **AB 1672, small-group reform**, guaranteed-issue and renewal regardless of preexisting conditions for small employers with 2–50 employees. It also established the **Health Insurance Plan of California (HIPC)**, a purchasing cooperative for employers with 2–50 employees. **Cal-COBRA** extended COBRA principles to smaller firms. Private-sector projects such as **California Kids and Kaiser Permanente Cares for Kids Child Health Plan** are aimed at providing health benefits to uncovered children. Two HMOs in California have established U.S./Mexico care systems since the state approved **cross-border health coverage** in 2000.

Existing Major Access Programs	Medi-Cal, MRMIB, MRMIP, AIM, HFP, CCS, CHDP, HIPC, Cal-COBRA, California Kids, and Kaiser Permanente Cares for Kids Child Health Plan
SPG FINDINGS	
Insurance Data	❑ Twenty-two percent of the state's population is uninsured. ❑ More than 80 percent of the uninsured are working or have a family member who is employed. ❑ Many of the uninsured access care through safety-net providers—community clinics, county clinics, or hospitals—or though hospital emergency departments. ❑ Apart from cost, other barriers to insurance include prior experience, cultural and language barriers (lack of literacy in English or their language of origin), fear of immigration or other government authority, and the bureaucratic process, which can be confusing or intimidating. ❑ Almost two-thirds of the uninsured are from families that earn less than 200 percent FPL. ❑ Twenty-nine percent of uninsured children are eligible for HFP and 39 percent of uninsured children are eligible for Medi-Cal. ❑ Twenty-seven percent of nonelderly workers are Latino. In California, Latinos are more likely to be uninsured than those from other states.
Employer Role	❑ Approximately 74 percent of workers in California have employer-sponsored insurance. ❑ California ranks last in the number of citizens with job-based health insurance.

	❑ Many in the state's large immigrant population are noncitizens who are ineligible for public insurance programs, but who often work in low-paying jobs where employer-sponsored insurance is not provided. ❑ A higher proportion of California's workforce compared with the rest of the nation is employed in firms with three to nine employees. Because smaller employers are less likely to offer health benefits, a higher proportion of California's workers are uninsured.
State Policy Recommendations	The development of coverage options involved commissioning options papers by health policy experts. Proposals included: ❑ Expand current public programs and create a pay-or-play requirement for employers. All individuals would be permitted to join the new insurance program. Employers would pay a premium to the new program for any employee not covered by employer-sponsored insurance, and employees would contribute a percentage of their wages. ❑ Offer all workers and their families and all those eligible for Medi-Cal and Healthy Families the option of enrolling in a new program, called Choice. ❑ Expand eligibility under the current Medi-Cal and Healthy Families programs and increase outreach to increase enrollment of children into the program. ❑ Create a single publicly financed program that would be available to all residents. This would be financed through the folding in of existing public-program spending and administrative savings, a payroll tax, tobacco tax, and an increase in the income tax. Another funding source would be a payroll or other employer tax. This could also transfer the responsibility of financing and delivering health care to the public sector. ❑ Form a locally managed, incremental strategy by providing coverage through public authorities. Premiums would be subsidized on a sliding-scale basis with the subsidy coming from the State General Fund.

	❑ Expand coverage through a combination of refundable tax credits or vouchers targeted to small employers with significant numbers of lower-income workers, to families that have to pay more than a designated percentage of their income for employer-sponsored insurance, or to workers not offered employer-sponsored insurance; and through a public program expansion for indigent adults without minor children. ❑ Provide a subsidy to employers that have not provided health insurance within the previous six months for their uninsured employees and their families with incomes below 350 percent FPL.
Recommendations for Federal Policy	This section will be included in a follow-up final report.
Change in Project Goals During Grant Period	No change in project goals was indicated.
Actions Taken	Hosted a series of statewide symposia to seek public input of the nine coverage options proposed.
Next Steps	❑ Under consideration in Spring 2002 in the state legislature is AB32 (2001), the Cal-Health Program, which defines a basic benefits package as including inpatient and outpatient care, emergency care, mental health service, prescription drugs, etc. ❑ In June 2002, the California Budget Conference Committee approved funding to expand Healthy Families to cover uninsured parents up to 200 percent FPL. A federal waiver was approved in January 2002.
Principal Contact	Genie Chough, Assistant Secretary of Health and Human Services for California, 1600 Ninth Street, Room 460, Sacramento, CA 95814 Telephone: 916/654-3301
Links to Reports	September 2001. The California Healthcare Options Project: Interim Report *http://www.statecoverage.net/statereports/ca.pdf* March 2002. The California Healthcare Options Project: Status Update *http://www.statecoverage.net/statereports/ca21.pdf*

HRSA State Planning Grantee: Colorado	
Project Goals	Colorado's stated goals for this SPG were to: 1. develop reasonable options for expanding access to affordable health insurance coverage to all citizens of Colorado; 2. build on the initiatives and collaborations currently in place in order to provide a well-integrated approach to the problem, rather than parallel developments; 3. examine and address the access and coverage disparities that currently exist among Colorado's various subpopulations (e.g., racial and ethnic), and between those living in urban and rural (frontier) settings; 4. examine the interplay between access to affordable health care and economic impact in various regions of the state.
Project Components	Planned components of the project included: *Contract with consultants to conduct the following data collection and analysis:* 1) characteristics of Colorado's uninsured; 2) Medicaid reform; 3) survey households and employers; 4) conduct focus groups with employers; 5) analyze the impact of the Taxpayer Bill of Rights on proposed coverage options; 6) conduct simulations of options; 7) analyze the impact of Federal Employees Health Benefits Model; 8) identify and analyze potential sources of revenue; 9) hold town meetings in five Colorado regions; *Develop coverage options* based on analysis of data collected from the above-mentioned sources, to build upon Colorado's previous efforts toward offering affordable health insurance; *Prepare a report to the Secretary of Health and Human Services* detailing the findings from data collection and analysis and laying out the policy recommendations made by the Steering Committee.
Grant Amount and Time Frame	$1,300,000; 10/1/01–9/30/02, with an extension through 12/31/02, and an additional anticipated extension through 3/31/03.

Lead Agency	Colorado's Office of the Governor http://www.state.co.us/gov_dir/governor_office.html
Project Partners	Steering Committee (22-member team headed by a representative from the Governor's Office), Governor's Office, Colorado Medical Society, Colorado Department of Health Care Policy and Financing
Brief History of State Health Reform	In 1990, the Colorado legislature adopted the **Colorado Uninsurable Health Insurance Plan (CUHIP)**, which provides insurance to those who have been denied private insurance due to preexisting medical conditions. In 1994, the legislature passed **major insurance reform**, which provides guaranteed-issue and eliminated unfair practices in the small-group market. The legislation also facilitated the formation of voluntary purchasing cooperatives. Also in 1994, the **Department of Health Care Policy and Financing (HCPF)** was formed out of the **Colorado Medically Indigent Program**, the **Colorado Medicaid Program**, and the grant-funded **Health Care Reform Initiative**, and was charged with implementing statutory reforms and evaluating their effectiveness. In 1997, Colorado created the state-funded **Colorado Child Health Plan (CCHP)**, which was later expanded, and the **Child Health Plan Plus (CHP+)** to cover children from birth to 18 years of age. The **Essential Community Provider Grants Program** and the **Comprehensive Preventive and Primary Care Grant Program** were established in 1997 and 2000, respectively, to assist providers who traditionally served medically needy or indigent patients.
Existing Major Access Programs	CUHIP (Medicaid Program and Colorado Indigent Care Program), CHP+, Colorado Office of Rural Health, Essential Community Provider Grants Program, Comprehensive Preventive and Primary Care Grant Program

SPG FINDINGS	
Insurance Data	❑ More than 11 percent (11.7 percent) of Coloradoans lack health insurance. ❑ The rates of uninsurance are higher in nonurban areas: 10.7 percent in urban areas, 16.3 percent in rural areas, and 17.3 percent in the frontier. ❑ Hispanics have a significantly higher rate of uninsurance (22.4 percent) than non-Hispanics (9.2 percent). ❑ Almost 85 percent (84.9 percent) of uninsured adults have a permanent job. ❑ A majority (83.4 percent) of the uninsured are in good to excellent health.
Employer Role	❑ Almost three-quarters of full-time working Coloradoans (71.9 percent) have access to insurance through their employer. ❑ Less than one-quarter of Coloradoans who work part-time (23.4 percent) have access to coverage through their employer. ❑ For firms with less than 10 employees, 41.7 percent offer coverage, compared with 100 percent of firms with 1,000 or more employees.
State Policy Recommendations	Additional data and information are needed to develop a plan to address health care coverage issues.
Recommendations for Federal Policy	❑ The federal government should initiate, develop, and sustain a mechanism whereby states can continue to meet, exchange information, and network on health care–related activities that evolved through the grant process. ❑ At this time, Colorado is not in a position to make recommendations with respect to legislative or administrative policies.

Change in Project Goals During Grant Period	Colorado has focused on learning from the experiences of the first-round states as to which survey instruments yield the best results, alternatives for building political consensus, and innovative approaches for addressing a complicated problem. We are now emphasizing maintenance rather than expansion.
Actions Taken	❑ Conducted regional small-employer focus groups in April and May 2002 to identify factors that influence employers to offer or not to offer insurance to employees. ❑ Apart from data collection, no additional actions have been taken.
Next Steps	No specific next steps were identified in the report.
Principal Contact	Susan Williamson, HRSA Project Administrator, 4300 Cherry Creek Drive South, Denver, CO 80246 Telephone: 303/692-2324
Links to Reports	October 2001. Interim Report to the Secretary *http://www.statecoverage.net/statereports/co.pdf* April 2002. Interim Final Report to the Secretary *http://www.statecoverage.net/statereports/co9.pdf*

HRSA State Planning Grantee: Connecticut	
Project Goals	Connecticut's overall goal for this SPG was to develop a plan to provide access to affordable health insurance coverage to all Connecticut citizens. To achieve this, the state planned to meet the following key objectives: 1. Identify the characteristics of Connecticut's remaining uninsured citizens via a household survey and public opinion polling; 2. Conduct an insurance-market analysis in order to identify eligible populations and explore the feasibility of premium subsidies, e.g., a buy-in program for employer-sponsored insurance; 3. Design proposals to provide all uninsured citizens with access to health insurance through insurance expansion options.
Project Components	Planned components of the project included: *Collect and analyze data* from two major surveys—the Family Health Care Access Survey and an Insurance Market Survey—to determine the characteristics of the uninsured and the current state of the insurance market; *Develop coverage options and design programs* that provide health insurance coverage to citizens based on an analysis of the key policy and operational issues that are known or suspected barriers to optimal program implementation and results. The results of this analysis would help to develop a workable enrollment structure and feasible benefit options; *Prepare a report to the Secretary* that outlines a comprehensive strategy for insuring citizens of Connecticut, and that can be used by other states trying to expand insurance coverage.
Grant Amount and Time Frame	$668,110; 10/1/01–9/30/02, with an anticipated extension until 3/31/03.
Lead Agency	Office of Health Care Access *http://www.state.ct.us/ohca* State Planning website http://www.state.ct.us/ohca/reppubsframes.htm

Project Partners	Department of Social Services (the Medicaid and CHIP agency), Office of Policy and Management, other state agencies, members of the executive and legislative branches of the state government, private-sector organizations
Brief History of State Health Reform	Connecticut's **HUSKY** program provides both Medicaid coverage for children **(Part A)** as well as an insurance plan for uninsured children up to 300 percent FPL **(Part B)**. HUSKY Plus provides supplemental coverage to Part B recipients with special needs. In 2000, HUSKY A was expanded to parents of covered children. Connecticut also used the income disregard provision in the **CHIP** program to provide benefits to children up to 300 percent FPL. In 1995, Connecticut first implemented a mandatory **Medicaid managed care program**. In 1997, Connecticut mandated **Internal** and **External Grievance Procedures** through insurers and the state Insurance Department, respectively. The **Connecticut Business and Industry Association's Health Connection (CBIA Health Connection)** was established as a small-group purchasing cooperative for employers. Connecticut was one of the first two states to establish a **high-risk pool** for individuals denied insurance for health reasons. **Patient protection legislation** includes a set of mandated benefits. The Robert Wood Johnson Foundation has funded two programs—**The Children's Health Council and A Connecticut Healthcare Initiative for Expansion, Value and Efficiency (ACHIEVE)—**to help expand health insurance coverage to children and adults.
Existing Major Access Programs	HUSKY, CHIP, Children's Health Council, Medicaid, CBIA Health Connection, and Connecticut's high-risk pool.
SPG FINDINGS	
Insurance Data	❑ An estimated 5.4 percent of the population was uninsured at the time Connecticut conducted its survey. ❑ For at least 12 months before the survey, 3.8 percent of the population had been uninsured, and 5.6 percent reported that they were currently uninsured.

	❑ Overall, 8.4 percent of Connecticut's residents went without insurance for some portion of the year preceding the survey. ❑ At the time of the survey, 9.1 percent of Hispanics were uninsured compared with 5.1 percent of the non-Hispanic population. ❑ Of the uninsured, 63.9 percent were employed and 6.8 percent were full-time students. Of those, 85.4 percent were permanently employed. ❑ More than 40 percent of the uninsured (41.4 percent) had access to coverage through their employer.
Employer Role	❑ Fifty-two percent of employers said they currently provide health insurance to employees. ❑ For employers with 50 or more employees, the number increased to 94 percent. ❑ For employers with four or fewer employees, the number declined to 26 percent. ❑ Of the employers who did not offer coverage, 18 percent said it was too expensive and 50 percent said they have too few employees. ❑ On average, employers experienced overall health-benefit cost increases of 15 percent. ❑ Fifteen percent of employees who are offered health coverage decline taking it. Twenty-five percent of those offered spousal coverage decline.
State Policy Recommendations	❑ Four recommendations were presented by the Institute for Health Policy Solutions; all dealt with providing subsidies to low-income workers to purchase employer-sponsored coverage, but varied based on eligibility and application processes. ❑ The recommended policy (House Bill 5023) includes provisions for providing low-wage workers who are eligible for public coverage, but do not take it up, with a subsidy to purchase employer-sponsored coverage.

Recommendations for Federal Policy	Connecticut recommends that the federal government continue to support work that will add to knowledge about state-level uninsurance issues and the characteristics of the uninsured.
Change in Project Goals During Grant Period	The goals of the project did not change. However, due to economic circumstances, the scope of the proposed policy was reduced.
Actions Taken	❑ Data have been examined and analysis conducted to determine the characteristics of Connecticut's uninsured population, and policy options have been developed to target communities in need. ❑ The Governor has proposed a "Small Employer Health Insurance Subsidy Initiative" (House Bill 5023) that would provide 3,000–5,000 low-wage workers with subsidies to buy into their employer-sponsored health plans.
Next Steps	❑ If "Small Employer Health Insurance Subsidy Initiative" is passed, a pilot program will be developed for low-wage workers who are eligible for, but do not wish to enroll in, a state-sponsored public program. ❑ Connecticut has received an extension of the grant and will spend the remainder of its funds and time conducting additional program-design activities needed for the subsidy initiative. ❑ The state will apply for a waiver to conduct a HIFA demonstration initiative.
Principal Contact	Mary Beth Reinhardt, Project Manager, 410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, CT 06134-0308 Telephone: 860/418-7014
Links to Reports	October 2001. Final Report to the Secretary http://www.statecoverage.net/statereports/ct.pdf March 2002. Interim Report to the Secretary http://www.statecoverage.net/statereports/ct9.pdf

HRSA State Planning Grantee: Delaware	
Project Goals	Delaware's stated overall goal for this SPG was to decrease the number of uninsured Delaware citizens through the creation and subsequent implementation of specific and varied strategies to make health insurance more affordable and accessible. The subgoals were the following: 1. Gain a thorough understanding of the characteristics, demographics, and patterns of Delaware's uninsured population; 2. Develop options and strategies for providing affordable health insurance coverage to all Delaware citizens; 3. Prepare a final report to the U.S. Secretary of Health and Human Services and State of Delaware leaders; 4. Evaluate the outcomes of the planning process.
Project Components	Planned components of the project included: *Form a committee and convene a policy retreat* with participants from the Delaware Health Care Commission and others who have been involved in compiling and analyzing existing data sources; *Analyze data and data gaps* by first identifying specific characteristics of target subpopulations and categories, and also 1) define which low-income and other income brackets to target, 2) further analyze the levels of coverage and costs of insurance offered by employers, 3) extrapolate existing data and gather additional information statistics; *Assess the fiscal climate and private-sector possibilities* to see what types of funding can be achieved through the General Assembly, and what private-sector funding opportunities are available; *Assess existing statewide resources and outreach strategies* that could assist or act as models for the completion and implementation of project goals;
	Develop options to best fit target populations under various scenarios, including expansion of opportunities for existing public health programs, employer-based strategies, strategies to target uninsured individuals directly; *Complete a cost analysis* of the various options;

	Prepare a final report for the Secretary of Health and Human Services, as well as state officials.
Grant Amount and Time Frame	$800,900; 10/1/00–9/30/01, with an extension through 9/30/02 of $194,000.
Lead Agency	Delaware Health Care Commission *http://www.state.de.us/dhcc* State Planning Grant site http://www.delawareuninsured.org
Project Partners	Delaware State Chamber of Commerce, Delaware Insurance Commissioner, Delaware Department of Health and Social Services, the University of Delaware Center for Applied Demography and Survey Research
Brief History of State Health Reform	Delaware has used several strategies to increase health insurance coverage. The income-based strategies include **Medicaid Expansions for Pregnant Women and Children**, which raised the income-eligibility threshold from 100 percent to 185 percent FPL for pregnant women and infants, and from 29 percent to 133 percent FPL for children under six. **Diamond State Health Plan** helped established Medicaid clients make the transition into managed care using an 1115 federal waiver and expanded coverage to adults up to 100 percent FPL. The **Delaware Healthy Children Program** used S-CHIP to establish a stand-alone managed-care plan for children below 200 percent FPL. Employer–based strategies included **an Individual Market Reform Study**, which established four illustrative reform models, none of which was pursued. Other efforts to assist with access to care were the **Voluntary Initiative Program**, which linked newly eligible Medicaid clients with primary care homes. The **Dupont Hospital for Children and the Nemours Foundation** operate 12 pediatric ambulatory care centers that use a sliding-scale assistance program. The **Delaware Prescription Assistance Program** provides assistance with drug coverage for elderly patients below 200 percent FPL without current coverage.
Existing Major Access Programs	Medicaid Expansion for Pregnant Women and Children, Delaware Healthy Children Program (CHIP), Diamond State Health Plan, Voluntary Initiative Program, Dupont Hospital for Children and Nemours Foundation.

SPG FINDINGS	
Insurance Data	❑ About 86,500 of Delaware's 783,600 citizens (12.7 percent) lack health insurance. ❑ Among the uninsured, 80 percent are above the poverty line and 30 percent live in households with incomes exceeding $50,000. ❑ Roughly 75 percent of uninsured children are living in households with incomes less than 200 percent FPL, making them eligible for Medicaid and CHIP. ❑ The three counties in Delaware have significantly different rates of insurance. The most urban county has the lowest percentage of uninsured, followed by the county with the oldest population, and the county with the youngest population. ❑ Delaware has a higher percentage of African American residents and a lower percentage of Hispanic residents than the rest of the U.S. Based on this, the lack of insurance for major race and ethnic groups as a whole is less prevalent in Delaware, since Hispanics are twice as likely to be uninsured than non-Hispanics.
Employer Role	❑ More than half of all Delawareans receive their health insurance through an employer. ❑ Sixty-two percent of Delaware's small businesses not offering health insurance have one to five employees, and 32 percent of small businesses not offering health insurance have 6–15 employees. ❑ The average turnover rate for a business not offering health insurance is 24 percent, compared with 13 percent for businesses offering health plans. ❑ More than half of the businesses not offering health insurance feel that they have a large obligation or some obligation to provide health insurance to their employees. ❑ More businesses would seriously consider offering health plans if there were an increase in the business' profits, if employees asked for it, and if it could be demonstrated that offering health plans would improve recruitment and retention.

State Policy Recommendations	Policy options recommended for consideration include: ❑ Provide a limited benefit plan for residents ages 9–64 who are at the federal poverty level and up to 200 percent FPL. Primary care, specialty care, laboratory and radiology, and prescription drugs would be covered. This is viewed as a mechanism to help fund some of the ambulatory services that the safety-net providers supply and to encourage primary and preventive care services. ❑ The One-Third Share Plan is a subsidized program with limited benefits so that the premiums for employers and employees can be kept low. Coverage is offered to employers of low-wage workers who have not offered coverage for the last year. ❑ Expand CHIP under an 1115 waiver to expand coverage to parents of CHIP children whose income is 100–200 percent FPL. This would be funded through the unused CHIP funds. ❑ Establish a subsidized purchasing pool intended for employees of small employers and people whose incomes are 200–300 percent FPL. The state would establish an entity that would act as a purchaser of health coverage. ❑ Subsidize premium costs of CHIP-eligible children to enroll the whole family in cost-effective employer-sponsored coverage when it is available. Employers would contribute a federally specified portion of the premium, and the state and employee would pay the rest.
Recommendations for Federal Policy	❑ Partner with states to understand better the construct of the system and evaluate whether continuing to build on it makes more sense than restructuring the system. ❑ Become financial partners with states in order to expand beyond the current system of public and private coverage. ❑ Continue support of federally qualified health centers, since a strong and viable safety net is critical to reach some segments of the population with primary and preventive services.
Change in Project Goals During Grant Period	No changes were identified.

Actions Taken	The state is continuing completion of the Uninsured Action Plan. Funding is through HRSA and proceeds from the tobacco industry settlement.
Next Steps	The Delaware Community Healthcare Access Program (CHAP) links safety-net providers in an enrollment-based system in which patients are assigned to a volunteer or low-cost medical home. It also provides access to a statewide network of volunteer or discounted medical subspecialty services. A Request for Proposal was used and contracted out in February 2002 to initiate an analysis of the capacity and financial viability of Delaware's four community health center programs. The information from this work will be focused on how CHAP may be used as a foundation for building a reimbursement strategy for safety-net providers. In March 2002, one of the health centers received classification as a federally qualified health center.
Principal Contact	Gregg Sylvester, M.D., Delaware Health Care Commission, Tatnal Building, 150 William Penn Street, Dover, DE 19901 Telephone: 302/739-6906
Links to Reports	October 2001. Final Report http://www.statecoverage.net/statereports/de.pdf March 2002. March 30th Addendum to the Final Report *http://www.statecoverage.net/statereports/de6.pdf*

HRSA State Planning Grantee: Idaho	
Project Goals	Idaho's stated goals for this SPG included the following: 1. The Data and Policy Teams would collect and analyze data that describes Idaho's uninsured population, as well as review programmatic structures, in order to develop a series of policy options; 2. The Model Development Team would undertake intensive data and policy analysis in order to develop a low-cost insurance strategy for small businesses; the strategy would be piloted statewide in order to assure appropriateness for both metropolitan and rural counties; 3. The Strategic Planning Team would assess all of the information gathered by the Data and Policy Teams, as well as the feasibility of the small-business model, and develop a strategic action plan to address the uninsured in the state of Idaho; the plan would include the strategy or strategies that seem most politically viable and would lead to coverage of the most people along with a potential timeline for implementation; 4. The Strategic Planning Team would host a minimum of eight community forums through local Chambers of Commerce to develop a dialogue with community leaders on the status of the uninsured and Idaho's proposed solutions.
Project Components	Planned components of the project included: *Collect and analyze data* to determine the current state of insurance markets in Idaho, estimate the numbers of uninsured and insured, and examine plans used in Idaho and elsewhere to address problems of uninsurance; *Develop a profile* of the current uninsured population in Idaho; *Review existing structures* to provide access to health coverage within the state, and develop policy options for using these structures to increase insurance rates;

	Share and disseminate information via biweekly Leadership Team meetings, weekly e-mail updates to all team members, and the development of a project website; *Develop a program design to provide health insurance coverage*, building on and refining a small-business insurance option; *Prepare a report* to the Secretary of Health and Human Services.
Grant Amount and Time Frame	$1,119,421; 3/1/01–2/28/02, with an anticipated extension through 3/31/03.
Lead Agency	Idaho Department of Commerce *http://www.idoc.state.id.us* The HRSA State Planning Grant website: *www.idahouninsured.org*
Project Partners	Office of the Governor, State Legislature Health Care Premium Task Force, Small Business Administration, Idaho Association of Counties, Blue Cross of Idaho, Regence Blue Shield of Idaho, Department of Health and Welfare, Department of Insurance, Department of Commerce, St. Alphonsus Medical Center, St. Luke's Medical Center, Cascade Community Hospital, McCall Memorial Hospital, Bureau of Indian Health, Idaho Hispanic Commission, Idaho Hospital Association, Idaho Division of the National Federation of Independent Business, Boise State University, Idaho State University, University of Idaho, Idaho Primary Care Association, Terry Reilly Health Services, Mountain States Group, Robert Wood Johnson Foundation, Idaho Commission for Hispanic Affairs, Idaho Medical Association, Idaho Commission on Nursing and Nursing Education, Idaho Nurse Practitioner Conference, WWAMI, Idaho Nephrology Associates, Nydic Open MRI of America, Ethan Allen, Metalcraft Inc., Veritas Advisors, Northwestern Group Marketing Services
Brief History of State Health Reform	In 1991–92, the Idaho Legislature undertook a review of Idaho's uninsured, titled **HCR23 Task Force**. The Task Force made a number of recommendations, several of which were enacted. In 1993 the Legislature passed the **Small Employer Health Insurance Availability Act**, which required small-group carriers to offer a Standard and Basic plan on a guaranteed-issue basis. It also called for limitations on rate differentials and the establishment of a reinsurance pool. In 2000, an individual **high-risk pool** was established along with an oversight committee to

	monitor its development. In 1994, the Legislature passed the **Individual Health Insurance Availability Act**, which provided for health coverage for people regardless of health status and past claims history. Also in 1994, **Senate Bill 1548 Medical Care Savings Accounts** was passed and then repealed in 1995 to be reinstated under the tax code. In 1998, Idaho established its **CHIP** program, and enrollment has exceeded expectations.
Existing Major Access Programs	Medicaid, CHIP, County Indigent Fund, Idaho Catastrophic Fund, High-Risk Pool
SPG FINDINGS	
Insurance Data	❑ Approximately 18 percent, or 200,000–240,000 Idahoans, lack health insurance, including about 15 percent of all children (1997–1999 Claims Processing Service, 2000 Behavioral Risk-Factor Surveillance Survey (BRFSS). Thus, about one of five Idahoans lack health insurance, and about one of four of Idaho's uninsured are children. ❑ Of those with insurance, about 63 percent are covered through private policies. ❑ More than 71 percent of Idaho's uninsured adults (ages 18–64) are employed or self-employed; when homemakers are included in these totals, about 80 percent of Idaho's uninsured adults come from working families. Sixteen percent of employed individuals and 35 percent of self-employed individuals are uninsured. ❑ In 1992, a Legislative Task Force identified four major categories of Idahoans that lack adequate insurance coverage: 1. Individuals who could be covered by expansions in Idaho's Medicaid program; 2. Employees of small employers (<50 workers) who don't provide coverage; 3. Individuals with a medical condition that makes them uninsurable; 4. Individuals who truly cannot afford coverage.

	❑ Idaho has significant Hispanic and Native American populations. Uninsured rates are higher in these populations, ranging from about 30 percent among English-speaking Hispanics, to about 38 percent among Native Americans, to about 65 percent among Spanish-speaking Hispanics. These populations comprise approximately 11 percent of Idaho's uninsured.
Employer Role	❑ Fewer than half of the responding employers (48 percent) offer health insurance to their employees. Only about 30 percent of Idaho's smallest businesses (0–5 employees) are able to provide insurance and yet there are 30,000 businesses of this size in Idaho. ❑ More than 90 percent of firms employing 21 or more offered health coverage to workers. ❑ Firms least likely to offer health insurance to their employees were in service industries (34 percent), construction (43 percent), and retail (46 percent). ❑ Fewer than half the firms with average employee salaries under $20,000 offer health insurance to their employees. ❑ The median increase in health care rates for employers in 2000 was about 16 percent, which caused 8 percent of those employers offering health coverage to drop the benefit, while 21 percent raised the employee contribution. ❑ The median cost of employer-sponsored coverage was $225 per employee per month. ❑ Fourteen percent of businesses offered health insurance to part-time workers, while only 3 percent offered it to seasonal workers.

State Policy Recommendations	Idaho chose policy options to target the following three distinct populations: 1) children under 200 percent FPL; 2) college students; and 3) adults below 200 percent FPL. The options considered are as follows: ❑ Mandate that college students enrolled in state institutions have health insurance; ❑ Enroll all children currently eligible for CHIP (up to 150 percent FPL) and then expand CHIP to 200 percent FPL; ❑ Cover adults to 200 percent FPL through either 1) a public–private partnership or 2) a CHIP expansion to parents. The report also suggests adopting the following recommendations made by the 1998 Idaho CHIP Task Force to the Director of the Department of Health and Welfare: ❑ Manage CHIP as a stand-alone program, not an extension of Medicaid, in order to give greater flexibility to the program as well as to separate it from any perceived negative stigma attached to Medicaid; ❑ Base eligibility on a sliding scale so that people pay some portion of the premium and copays based on their incomes; ❑ Restructure reimbursement to be closer to what service providers receive from private payers; ❑ Offer a benefit package similar to what is provided in private-sector insurance.
Recommendations for Federal Policy	❑ Consider changes in federal tax laws to make MSAs, defined contribution plans, and tax credits effective. ❑ Consider policies that allow individuals to choose the type of health care coverage and services that are best for them, and change federal tax laws to treat these options equitably so their merits (or lack thereof) are demonstrated. ❑ Allow states to exceed the 5 percent beneficiary cost-sharing limit in order to allow for a system that would encourage sliding-scale subsidies for people to purchase insurance based on income.

	Idaho supports the federal government's plans to expand sample sizes for the Claims Processing Service and Medical Expenditure Panel Survey (MEPS) and Arkansas's proposal to develop an integrated database.
Change in Project Goals During Grant Period	❑ The goals of the project broadened from creating a product aimed at small businesses with a relatively low-wage workforce to include policy recommendations to cover children, college students, and uninsured adults. ❑ The steering committee recommended to the Governor that the state spend more money insuring the uninsured rather than being forced to overspend on safety-net care only when people are already sick.
Actions Taken	❑ Idaho State Planning Grant (ISPG) reviewed and analyzed data on the uninsured and developed several policy recommendations to help cover groups in need. ❑ ISPG has applied for a grant from the Robert Wood Johnson Foundation to continue working on plans to cover the uninsured.
Next Steps	ISPG has been granted a one-year extension and will use its remaining funds to develop program details and implementation plans. New money has also been approved by the legislature from Idaho's tobacco settlement fund so that the grant can continue its efforts. ISPG is also applying for a new grant to continue its work.
Principal Contact	Pamela Hunt, Director of Idaho State Planning Grant, 901 North Curtis Road, Suite 402, Boise, ID 83706 Telephone: 208/367-4771 E-mail: *pamehunt@sarmc.org*
Links to Reports	October 2001. Final Report to the Secretary http://www.statecoverage.net/statereports/id.pdf March 2002. Interim Report to the Secretary http://www.statecoverage.net/statereports/id3.pdf

HRSA State Planning Grantee: Illinois	
Project Goals	Illinois' overarching stated goal was to ensure 100 percent access to health insurance benefits for all of its citizens. To accomplish this and facilitate the creation of insurance products for the uninsured population, the objective of this SPG was to address the following questions: 1. Who are the uninsured in Illinois? Characteristics of the uninsured, including demographic data, duration of noncoverage, health status, use and source of services, employment status, availability and cost of employer-based coverage, and awareness of alternative sources of insurance, would be collected and analyzed. 2. What types of programs will best address barriers to insurance? The goal was to determine the extent to which products currently available address those barriers, and to determine what gaps between providers and the uninsured must be bridged to maximize the potential for success of implemented alternatives. 3. What programs are currently available in Illinois and what possibilities are there for expansion? The state would examine the development of programs and their strengths and weaknesses in terms of reducing the number of uninsured. 4. What is the best partnering structure to achieve this goal? The state would create an interactive system where the key stakeholders can meet to reach a consensus, where possible, on providing access to affordable health coverage for Illinois citizens.
Project Components	A Steering Committee had already been formed that would remain involved in the progression and implementation of the project and ensuing programs. It would consist of representatives from various interested parties who were instrumental in submitting the initial application. Planned project components included:

	Gather and analyze data on the uninsured and current programs using the following research methods: 1) a population-based survey of the uninsured; 2) expansion of the state's BRFSS; 3) analysis of existing data sets; 4) focus groups and discussions with key stakeholders; 5) personal interviews with strategic informants throughout the state. *Develop strategies to provide coverage and analyze them for cost-effectiveness*, in consultation with insurers, employers, interest groups, faith communities, and members of Public Health Futures Illinois. *Prepare and submit a final report* to the Secretary of Health and Human Services.
Grant Amount and Time Frame	$ 1,200,000; 10/1/00–9/30/01, with an extension through 9/30/02 of $194,000.
Lead Agency	Illinois Department of Insurance. http://www.state.il.us/ins/default.htm State Planning website. *www.ins.state.il.us/spg*
Project Partners	Governor's Office, Department of Public Health, Department of Public Aid, Department of Commerce and Community Affairs, Department of Human Services, Illinois Comprehensive Health Insurance Plan, faculty from Southern Illinois University and University of Illinois, local government, public health and social service agencies, faith groups, insurers, employers, providers, interest groups, community groups, members of Public Health Futures Illinois
Brief History of State Health Reform	The **Illinois Comprehensive Health Insurance Plan (ICHIP)** was established in 1987 as a high-risk insurance pool. In 1997, **HIPAA-ICHIP** was formed to assure compliance with the 1996 Health Insurance Portability and Accountability Act. **KidCare** is the State Children's Health Insurance Program, enacted in 1997. KidCare has five insurance programs (**KidCare Assist, KidCare Share, KidCare Premium, KidCare Moms and Babies, and KidCare Rebate**) covering children and pregnant women from below 133 percent FPL up to 185 percent FPL, with varying cost-sharing and benefit plans. The 1999 **Managed Care Reform and Patient Rights Act** established consumer-friendly initiatives including the Office of Consumer

	Health Insurance. **The Gilead Project** helps identify and enroll people eligible for special programs. Over the next three years, **Medicaid eligibility** will be expanded. The **Public Health Futures Illinois Partnership** promotes a broad public health system focused on prevention. **Health Care Purchasing Groups** was designed to help small employers offer health benefits, though take-up has been slow. Illinois' **Pharmaceutical Assistance Program** has helped low-income seniors and the disabled obtain prescription drugs since 1985. Legislation was introduced to create the **FamilyCare Program**, which consisted of an expansion of **KidCare** to parents.
Existing Major Access Programs	ICHIP, KidCare, Medicaid eligibility expansion, managed care reform, and Public Health Futures Illinois Partnership
SPG FINDINGS	
Insurance Data	Illinois used BRFSS data and a random-dial survey done by the University of Illinois-Chicago (UIC) to determine characteristics of the uninsured and newly insured (newly insured statistics were compiled via the UIC survey). ❑ Current Population Survey data show the level of uninsurance in Illinois to be 13.4 percent. However, UIC and BRFSS data both give a smaller number (9.7 percent and 9.8 percent, respectively). ❑ BRFSS data show that more than 36 percent of the uninsured are in households earning less than $15,000, and almost 29 percent are in households earning $15,000–$35,000 annually. ❑ UIC found that about 77 percent of the uninsured had incomes below 185 percent FPL, while 60 percent of the newly insured had incomes below 185 percent FPL. ❑ UIC showed more than 33 percent of the uninsured were 45–64 years old, compared with 26 percent of the newly insured.
	❑ In comparison to the newly insured, a greater number of the uninsured were 18–24 (13 percent vs. 8 percent) or ages 65 and older (8 percent vs. 3 percent). ❑ BRFSS show that 14.2 percent of people 18–29 years old are uninsured and that 8.1 percent of adults 30–64 years are uninsured.

	❑ 32 percent of the uninsured and 35 percent of the newly insured were in single- person households. ❑ The newly insured were more likely to be employed (75.5 percent) than the uninsured (64.3 percent). ❑ Among the uninsured, 22 percent were African American, 21 percent were Hispanic, and 57 percent were non-Hispanic white. ❑ Forty-nine percent of the newly insured had been without coverage for less than six months; 16 percent had been without coverage for more than 60 months. However, 33 percent of the uninsured had been without coverage for 60 months or more. Almost 50 percent had not had coverage in the previous 24 months.
Employer Role	❑ Uninsured workers are more likely to be employed in small firms with fewer than 50 employees (61 percent). ❑ More than half (54 percent) of newly insured workers are employed in firms with over 50 employees. ❑ More uninsured adults were employed in service occupations (26.4 percent), compared with the newly insured (20.3 percent). ❑ Employers who provide coverage said that maintaining coverage could be a struggle due to sharp increases in policy premiums. ❑ Affordability of coverage and cost containment were the major concerns expressed by employers in regards to providing health coverage to employees.
State Policy Recommendations	The Illinois process resulted in three areas being identified as priorities for policy development: ❑ FamilyCare: Supported by expansion of the KidCare Program, this program would cover the parents or guardians of children enrolled in the state's CHIP program with income up to 185 percent FPL. ❑ Incentives to small employers: The state is working to develop specific incentive programs by partnering with

	community groups that received Community Access Program grants. ❑ Education and marketing of insurance programs and products: Designed to enhance education and marketing and increase enrollment in existing public and private insurance programs.
Recommendations for Federal Policy	A national data clearinghouse should be created to collect and keep data that can be accessed by states and researchers.
Change in Project Goals During Grant Period	There were no changes during the grant period.
Actions Taken	❑ Illinois completed a survey and analysis of several data sources to help determine the number and characteristics of the uninsured in the state. ❑ Legislation (HB 23) was introduced in Spring 2001 to expand the KidCare program and, under a new name, FamilyCare, to cover adults and caretaker relatives up to 185 percent FPL and children up to 200 percent FPL. In February 2002, a waiver was submitted to CMS under the HIFA Demonstration Initiative. ❑ The state has created an Ombudsman Program for the Uninsured.
Next Steps	Illinois will begin implementing projects that can be funded and refining plans that will need additional funding. The state is optimistic that the FamilyCare waiver will be granted and that parents will begin to get coverage. It is anticipated that pilot projects for small employers will begin to be implemented.
Principal Contact	Madelynne Brown, Assistant Director of Insurance, Illinois Department of Insurance, 320 West Washington Street, Springfield, IL 62767-0001 Telephone: 217/785-1258
Links to Reports	October 2001. Interim Final Report to the Secretary *http://www.statecoverage.net/statereports/il2.pdf* March 2002. Final Report to the Secretary http://www.statecoverage.net/statereports/il5.pdf

HRSA State Planning Grantee: Iowa	
Project Goals	Iowa's stated goals for this SPG were to: 1. understand and respect the limits of the public's tolerance for policy changes needed to expand access to health insurance by directing the data-gathering efforts toward the "active public" and businesses; 2. build a complete and data-driven picture of Iowa's uninsured population to present a clear understanding of who the uninsured are, why they are uninsured, and the costs and benefits of covering the uninsured; 3. design coverage options that will incorporate data on the uninsured and Iowans' beliefs regarding expanding access to health insurance; 4. create a plan to achieve the goal of expanding access to health insurance that includes a strategic vision of how to achieve a necessary consensus; 5. prepare a report to the secretary that can be used by other states to expand their citizens' access to affordable health insurance.
Project Components	Planned components of the project included: *Form a "Citizens' Alliance,"* a public–private board made up of leaders from major stakeholder groups within Iowa that would review and assess data reports, coverage design options, and the strategic plan; *Collect data and analyze its components* to build a complete picture of Iowa's uninsured population, who they are, where they are, why they are uninsured, and what are the individual and population health and economic benefits; *Work with a Coverage Design Consultant* to match innovative insurance coverage designs with Iowa's financial, political, and demographic characteristics, and with Iowans' beliefs about uninsurance and access to health insurance;

	Organize regional seminars to present new data and new ideas regarding the uninsured and to gauge public understanding of the issues and public support for change; *Convene a Secretary's Report Team* to prepare an overview document to be presented to the Alliance prior to being submitted to the secretary.
Grant Amount and Time Frame	$1,323,730; 10/1/00–9/30/01, with extension to 9/30/02 of $211,328.
Lead Agency	Iowa Department of Public Health *http://idph.state.ia.us* Iowa's State Planning Grant *http://www.iowahealthonline.com/*
Project Partners	Iowa State Government: Economic Development, Human Services, Management, Personnel, Workforce Development, Iowa Insurance Commissioner
Brief History of State Health Reform	
Existing Major Access Programs	In 1990, the **Iowa Leadership Consortium (ILC)** brought together 36 health care providers, business leaders, and other representatives to address problems in Iowa's health care environment. This was a significant beginning to the process of reforming Iowa's health care and health insurance systems. In 1992, Iowa was awarded a $685,923 Robert Wood Johnson Foundation "State Initiatives in Health Care Reform" grant, which was used to answer research questions raised by the ILC. The **Iowa Health Reform Council ("Council")** succeeded the ILC in 1993 and conducted a public outreach program, which produced a set of reform recommendations on access, affordability, quality, accountability, delivery systems, and financing. The **Health Insurance Premium Payment Program (HIPP)**, implemented in 1991, mandated the purchase of employer-provided health insurance for those eligible for Medicaid when it is cost-effective to do so. In 1996, the state's Department of Human Services adjusted its computer systems to separate **Medicaid** from cash-assistance eligibility to avoid dropping beneficiaries from Medicaid following a loss in eligibility for cash assistance. Iowa's Title XXI plan expanded Medicaid to cover children up to age 19 with family incomes to

	133 percent FPL, and created **HAWK-I**, a subsidized private health insurance program that covers children up to age 19 with family incomes up to 200 percent FPL. The **Health Enterprise Planning Team (HEPT)** was created to formulate the executive branch's health care policy and legislative proposals.
SPG FINDINGS	
Insurance Data	❑ About 258,320 (9.1 percent) of Iowa's 2,850,121 million citizens lack health coverage. ❑ More than 22 percent of the Hispanic population were uninsured, compared with about 11 percent of the uninsured who identified themselves as black and 9 percent who identified themselves as white. ❑ Approximately 50 percent of Iowa's uninsured had family incomes below 200 percent FPL. ❑ More than 80 percent of the working-age uninsured were employed. ❑ The most common reasons for being uninsured were employer coverage was not offered or the individual was not eligible for the coverage offered. ❑ Apart from cost, other reasons for not purchasing health insurance include: individuals' beliefs that they or their dependents were not insurable due to health status; decision to spend money on other things after weighing the costs/ benefits of purchasing health insurance.
Employer Role	❑ Fifty-four percent of employers in Iowa offer health insurance to their employees. ❑ Fifty percent of workers in firms with less than 10 employees do not have employer-sponsored coverage. ❑ The percentage of firms offering insurance varies by industry: 40 percent in the retail sector, 45 percent in agriculture, 71 percent in manufacturing, and 85 percent in transportation. ❑ Insuring firms pay about 81 percent of the premium.

	❑ Fifty-eight percent of employers reported that one or more of their eligible employees had declined coverage, the majority because they were covered under their spouse's plan or were covered by some other source. ❑ The majority of employers who offered coverage reported that their primary reasons for offering coverage were to keep employees healthy, to attract or retain workers, and to be good corporate citizens. ❑ Small employers who do not currently offer coverage may do so if their bottom line improves, if employees demand coverage, if there is less turnover, or if companies receive help from the state in form of tax deductions, credits, or premium supports.
State Policy Recommendations	Policy options recommended for consideration include: ❑ Increase enrollment in Medicaid/HAWK-I through a series of additional outreach initiatives or by reducing enrollment barriers; ❑ Expand Medicaid eligibility for adults up to 200 percent FPL. Since there is no federal match for coverage of noncustodial adults, the state would pay for this segment of the population. This could be accomplished through: a. use of an alternative benefits package under Medicaid, which is similar to an employee health plan. The state would be permitted to use its unspent CHIP allotment to finance a new group of individuals; b. an enrollee premium that would partially offset benefit costs with member contributions; ❑ Provide short-term insurance coverage to the unemployed that is modeled after a state employees benefits package; there would be no premium while the individual is uninsured (the average period of unemployment benefits is 9.22 weeks); ❑ Provide subsidies directly to employers to help them purchase coverage for their workers; this would be targeted to small employers with low-wage workers, with eligibility restricted to firms that have not provided coverage for 12 months and that have a below-average payroll for small firms;

	❑ Create a low-cost health insurance product for employers who currently do not provide coverage, using a state subsidy through a reinsurance mechanism that pays a substantial percentage of health costs for high-cost cases.
Recommendations for Federal Policy	❑ Increase federal monetary support. Like many states, Iowa is facing fiscal difficulties, and additional federal support in the form of federal matching dollars and targeted tax credits could go far in increasing access to insurance. ❑ Alter the Internal Revenue Service statutes to reduce inequities in current statutes, thereby assisting workers in obtaining coverage through tax credits for employees and/or employers. ❑ Require that all children have health insurance as a precondition to enrolling in school.
Change in Project Goals During Grant Period	❑ The broad goals remained the same. ❑ Budgetary constraints have limited plans for access expansion. ❑ The public's perception has shifted from government responsibility in matters of health toward "homeland security."
Actions Taken	❑ Completed the data collection activities specified in the grant application. ❑ Administered telephone surveys, public focus groups, surveys to businesses, and regional forums. ❑ Identified feasible policies to help Iowans obtain coverage.
Next Steps	❑ The Alliance is finishing research activities in order to propose concrete steps to allow more Iowans access to affordable health insurance. ❑ Through additional funding from HRSA, Iowa is able to carry on with its efforts and work to refine and implement its data-driven plan.

	❑ The Citizens' Alliance is directing the second-year efforts on the strategies outlined in the State Policy Recommendations section, and securing the funding needed to finance coverage expansions.
Principal Contact	Anne Kinzel, HRSA SPG Project Director, Iowa Department of Public Health, Lucas State Office Building, Des Moines, IA 50319-0075 Telephone: 515/281-4346 E-mail: *akinzel@idph.state.ia.us*
Links to Reports	October 2001. Final Report to the Secretary http://www.statecoverage.net/statereports/ia.pdf March 2002. Interim Report to the Secretary http://www.statecoverage.net/statereports/ia5.pdf

HRSA State Planning Grantee: Kansas	
Project Goals	Kansas's stated goals for this SPG were to: 1. gather policy-relevant demographic and socioeconomic data on the uninsured in Kansas, with a focus on identifying subgroups that can realistically be reached through work-based coverage arrangements; 2. identify what alternative structures and conditions would motivate Kansas employers to participate in purchasing pools and other arrangements that would allow access to health coverage for Kansas workers; 3. develop several alternative approaches, based on this information, to subsidize coverage for uninsured Kansans or to create more favorable conditions for obtaining coverage; 4. provide enhanced technical analysis and support to facilitate the development of program rules, policies, and structures to reach uninsured workers in small firms.
Project Components	Planned components of the project included: *Analyze policy options and develop a five-year strategic plan* by appointing a Steering Committee to monitor data collection, develop policy options, and seek stakeholder input into the process; *Conduct household-level research* to find why substantial numbers of Kansans are without health insurance, focusing on the employment environment in Kansas that leaves a significant number of workers and their families without coverage; *Conduct focused research on probable small-employer responses to health insurance alternatives* to determine which proposals might work best to encourage these employers to take part in programs designed to increase the level of health coverage in Kansas; *Create detailed program designs for efforts to expand coverage for low-income workers employed by small businesses*, building on current legislation (the Kansas Business Health Partnership Act) aimed at expanding health coverage for workers in small firms; *Draft a report* for the Secretary of Health and Human Services.

Grant Amount and Time Frame	$1,298,205; 10/1/00–9/30/01, with an extension through 9/30/02.
Lead Agency	Kansas Insurance Department *http://www.ksinsurance.org* State Planning website http://www.ksinsurance.org/index.php?id=0150
Project Partners	Kansas Insurance Department, Kansas Department of Health and Environment, Kansas Department of Social and Rehabilitation Services, Kansas Department of Aging; University of Kansas School of Nursing, Health Services Research Group
Brief History of State Health Reform	In 1992, reforms were enacted that **guaranteed access to "standard and basic" plans and established uniform rating standards** for small employers. In addition, small employers were guaranteed access to all plans offered by an insurer. The same year, the **Kansas Health Insurance Association (KHIA)** was established as a high-risk purchasing pool. In 1999, **Health Wave** was established to work alongside the state **Medicaid** program to provide coverage to children under age 19 whose family income does not exceed 200 percent FPL. Kansas also participates in the **Robert Wood Johnson Foundation's (RWJF) Covering Kids Initiative**. In 1999, the **Public Health Improvement Commission** was established to identify gaps in and barriers to coverage. Beginning in January of 2000, a **revised KHIA program** made refundable, pre-employee **tax credits** available to employers who have not contributed to any premium on behalf of employees in the past two years.
Existing Major Access Programs	Medicaid, Health Wave, KHIA, RWJF Covering Kids Initiative
SPG FINDINGS	
Insurance Data	❑ About 224,880, or 10.5 percent, of Kansas' 2,654,052 million citizens lack health coverage. ❑ Of adults living at or below 100 percent FPL, 41.7 percent are uninsured, compared with 4.8 percent of those with incomes above 250 percent FPL. ❑ The highest rate of uninsurance for Kansans, related to employment circumstances, is for the unemployed, at 38.2 percent.

	❑ More than 95 percent of uninsured Kansans live in a household where at least one person has a job. ❑ Apart from affordability, the other barrier most cited by Kansans to explain the lack of insurance is access to employer-sponsored coverage. ❑ The uninsured are getting their care through a variety of sources, including safety-net clinics and local hospitals. Participants discussed problems in obtaining hospital and specialty care and pharmaceuticals.
Employer Role	❑ More than 80 percent (80.6 percent) of employers offer coverage. ❑ Of individuals in firms with 1,000 or more employees, 91.6 percent report access to coverage compared with 17.4 percent of those in firms with four or fewer employees. ❑ Employer-based insurance coverage varies according to region of the state, with the northwest portion of the state having the lowest rate (68.1 percent) and the eastern part of the state with the highest (85.1 percent). ❑ Eighteen percent of Kansans report that they declined employer-based coverage. ❑ Other alternatives to motivating employers not now providing coverage include: less state government involvement, more effective regulation of insurers, the variability of insurance costs, "leveling the playing field" between large and small employers.
State Policy Recommendations	Policy options recommended for consideration include: ❑ Maximize the use of current state policies that support or promote employer-based coverage: a. make maximum use of the current tax credit for small businesses, which is available under an existing statute to small employers newly providing insurance to their employees; b. have the Insurance Commissioner work with the Budget Office to simplify the process for applying for and obtaining credit;

	c. revamp a tax credit to provide greater incentive to employers not currently offering coverage and to reward small businesses when low-income workers do enroll in the plan they offer; ❑ Develop the Kansas Business Health Partnership (KBHP), a purchasing coalition required to offer at least two plans to all Kansas small businesses; this initiative (through existing legislation) is not yet operational; ❑ Take advantage of existing Medicaid regulatory policy that allows the state agency to pay premiums for employer health insurance for Medicaid-eligible individuals; ❑ Target specific subgroups of the Kansas uninsured. For example, revise rules to allow people ages 19–24 to continue coverage under their parents' health insurance plan; establish a health plan administered by facilities that currently serve a large population of uninsured patients; ❑ Expand Medicaid eligibility for adults up to 100 percent FPL.
Recommendations for Federal Policy	The federal government should provide access to state-level data that has specificity.
Change in Project Goals During Grant Period	While the goals have remained consistent, the timeframe to initiate action has changed due to the economic and political environments.
Actions Taken	Surveys were conducted among households, uninsured Kansans, and small- business owners, insurers, and brokers.
Next Steps	Continue to get the issues into the political agenda. This will begin with a statewide representation of an array of community leaders and stakeholders to discuss the uninsured in the state.
Principal Contact	Matthew D. All, Assistant Commissioner, Kansas Insurance Department, 420 Southwest 9th Street, Topeka, KS 66612 Telephone: 785-296-7804 email: *mall@ins.state.ks.us*
Links to Reports	October 2001. Finding and Filling the Gaps: Developing a Strategic Plan to Cover all Kansans *http://www.statecoverage.net/statereports/ks.pdf* March 2002. Follow-up Report to the Secretary http://www.statecoverage.net/statereports/ks4.pdf

HRSA State Planning Grantee: Massachusetts	
Project Goals	Massachusetts's stated goals for this SPG were to: 1. define "affordable" coverage for residents based on income and family status; 2. determine the most appropriate level of insurance coverage (benefits and deductibles) to serve as a "benchmark," based on the most prevalent insurance products in various categories of subscribers; 3. identify existing barriers to that benchmark level of insurance coverage (e.g., affordability, awareness, risk-taking behavior, competing priorities); 4. develop proposals for achieving universal access to affordable insurance that support and enhance the private insurance market while ensuring that the safety net of public programs is available to those who need it.
Project Components	Planned components of the project included: *Establish data collection priorities* to support a collaborative, interagency planning process promoting access to nonepisodic insurance coverage for all state residents; *Contract with one or more qualified vendor/consultant(s)* for data collection, analysis, and technical assistance; *Analyze and synthesize data from research sources*, including survey data and market data, through literature reviews, meta-analysis of existing data, and analysis of key characteristics of local insurance markets; *Develop feasible strategies to surmount existing barriers to coverage* and guarantee access to affordable insurance coverage for all Massachusetts residents; *Create a strategic plan for funding and implementing a model* to ensure that proposed coverage options are administratively feasible, politically viable, and cost-effective for the Commonwealth, its taxpayers, employers, and potential beneficiaries; *Write a report to the Secretary of Health and Human Services* that conforms to the guidelines to be issued by federal program staff.

Grant Amount and Time Frame	$1,086,195; 10/1/00–9/30/01, with an extension through 9/30/02.
Lead Agency	The Division of Medical Assistance *http://www.state.ma.us/dma* Massachusetts State Planning Grant *http://www.state.ma.us/hrsa/*
Project Partners	Division of Health Care Finance and Policy, Department of Public Health, Division of Insurance, Department of Employment and Training, Department of Revenue, Group Insurance Commission, Massachusetts State Senate and House of Representatives, University of Massachusetts, Health Care For All, Associated Industries of Massachusetts, Massachusetts Medical Society, Massachusetts Hospital Association, League of Community Health Centers, Massachusetts Association of Chamber of Commerce Executives, representatives of Massachusetts insurance companies, other participating organizations
Brief History of State Health Reform	In 1994, Massachusetts gained approval under a 1115 Medicaid waiver to establish a new umbrella term, **MassHealth**, to describe programs providing health insurance to eligible populations; increase income standards for Medicaid members to 133 percent FPL; and eliminate the asset test for eligibility. In 1997, through **a combination of Title XXI funding and under the 1115 Waiver to Title XIX**, Massachusetts expanded coverage to children below 200 percent FPL. Additionally, **MassHealth Family Assistance** implemented a previously introduced program, the **Insurance Reimbursement Program** (now called the **Insurance Partnership**), that provided an employer subsidy to workers and small employers, and a subsidy to low-income workers. Additionally, laws were enacted that target the small-group health insurance market (for businesses with fewer than 50 eligible employees), and the nongroup (individual) market.
Existing Major Access Programs	MassHealth (includes Medicaid and CHIP), the Insurance Partnership
SPG FINDINGS	
Insurance Data	❑ The overall rate of uninsurance in Massachusetts is 5.9 percent.

	❑ Fifty-seven percent of the uninsured have household incomes greater than 200 percent FPL; 20 percent of the uninsured fall below 150 percent FPL. ❑ The majority of both uninsured (71.7 percent) and insured (81.9 percent) adults are employed. The working uninsured are almost three times as likely to be self-employed as the working insured. ❑ Most of the uninsured live in the Boston metropolitan area (32 percent). ❑ Seventy percent of the parents of low-income children have heard of the Medicaid/CHIP programs, compared with 47 percent of parents nationally. ❑ The population groups particularly important in developing targeted coverage expansions were moderate-income households; low-income minorities who were not pregnant, disabled, HIV-positive, children, or belonging to some other category of coverage.
Employer Role	❑ Almost two-thirds (65.7 percent) of employers in Massachusetts offer insurance coverage to their employees. ❑ Company size matters: 63.4 percent of employers with 50 or fewer employees offer insurance to their workers, compared with 94.4 percent of employers with more than 50 employees. ❑ Employers report that the average annual premium cost of single health insurance coverage increased by 19 percent from 12 months ago. ❑ Employers with fewer than 50 employees are more likely to offer a health plan with no employee contribution required. ❑ Almost four-fifths (78.3 percent) of employees who are eligible for employer-sponsored coverage actually enroll in that coverage.
State Policy Recommendations	Policy options recommended for consideration include the following: ❑ Full enrollment of currently eligible individuals through targeted outreach and enrollment activities via health fairs,

	community centers, door-to-door visits, and by collaborating with schools; additional funds will be allocated through the budget process and will remain budget-neutral; ❑ Tax incentives for all individuals/families that lack access to employer- sponsored coverage; ❑ Expanded Family Assistance under MassHealth to parents of all eligible children up to 200 percent FPL; this approach would require additional funding from state appropriations, the federal Financial Participation in conjunction with an amendment to the 1115 MassHealth waiver; ❑ Requirement that all organizations receiving the majority of their revenue from the state offer their employees affordable coverage; this includes organizations bidding for a state contract and organizations that have contracts with the state; ❑ Sale of catastrophic policies with high deductibles in the individual and group markets, to be combined with MSAs; this is targeted to the uninsured who are relatively healthy, knowledgeable about their health care needs, and unlikely to buy standard policies; ❑ A single process for applying to all public programs; one state agency would be identified to create a system where the single process is made operational.
Recommendations for Federal Policy	❑ Allow the self-employed and those without access to employer-sponsored insurance to deduct the full cost of health insurance. ❑ Increase allotments to encourage states to expand CHIP to parents of children covered under CHIP. ❑ Redesign the administrative system supporting eligibility and enrollment activities for all state programs to achieve a simple, single process to determine eligibility.

Change in Project Goals During Grant Period	The state initially wanted to examine ways to alter programs slightly or create relatively inexpensive ways to insure the already small percentage of uninsured. However, as the 2001 economy began to slide, and Massachusetts was faced with a budget deficit, the grant shifted to focus on determining how to maintain health insurance coverage levels, as well as continuing research on policy options once the economy recovers.
Actions Taken	❑ Consensus-building among stakeholders through a Steering or Advisory Committee. The committee developed principles against which to judge the policy options. ❑ Data gathering and analysis. ❑ Preliminary recommendations based on the data findings.
Next Steps	❑ Continue working on quantitative and qualitative analyses and revise policy recommendations accordingly. ❑ A commission will be reconvened to study the uncompensated care pool. ❑ The Division of Medical Assistance is conducting the third household survey. ❑ Contractors were hired for legislators to assess models of a consolidated health care system.
Principal Contact	Jeremiah Cole, Project Director, Massachusetts Division of Medical Assistance, 600 Washington Street, 5th Floor, Boston, MA 02111 Telephone: 617/210-5425
Links to Reports	October 2001. Preliminary State Planning Grant Report *http://www.statecoverage.net/statereports/ma.pdf* March 2002. State Planning Grant Report http://www.statecoverage.net/statereports/ma18.pdf

HRSA State Planning Grantee: Minnesota	
Project Goals	Minnesota's overarching goal for this SPG project was to collect data to inform the development of health insurance coverage initiatives that would assure access to coverage for all Minnesotans. The specific goals were to: 1. expand knowledge of health insurance status for populations of color, American Indians, and rural communities, and use this knowledge to adapt current programs and/or create new initiatives; 2. evaluate the effectiveness of MinnesotaCare and Medicaid in reducing the number of uninsured people and make recommendations for adjustments to the programs to increase their effectiveness in reducing the uninsured population; 3. expand knowledge of conditions in the private market that have an impact on the number of uninsured people in the state.
Project Components	Planned components included: ❑ *Telephone and in-person surveys*, supplemented by in-person interviews, to obtain information on health insurance status from populations of color, American Indians, and rural communities, with oversamples of these three groups; ❑ *Data analysis* of the characteristics of the uninsured and individually insured who are potentially eligible for MinnesotaCare or Medicaid but not enrolled to help the state understand reasons for not enrolling or for disenrolling; analysis of research on the elasticities of demand to model uptake decisions in relation to the price of public coverage; a survey of a random sample of former MinnesotaCare enrollees to understand disenrollment decisions; ❑ *Analysis of the private health insurance market*, including current health insurance coverage, the availability of private health insurance, and health insurance information from employers, to analyze how people decide whether to accept employer-based insurance;

	❑ *Qualitative research* consisting of focus groups with populations of color, American Indians, rural Minnesotans, and interviews with key informants.
Grant Amount and Time Frame	$1,630,932; 10/1/00–9/30/01, with an extension through 9/30/02 of $246,006.
Lead Agency	Minnesota Department of Health: *http://www.health.state.mn.us/*divs/hpsc/hep/hrsa/spg.htm
Project Partners	Minnesota Department of Human Services; Minnesota Department of Economic Security; University of Minnesota Schools of Public Health, Education and Development, and Statistics; Amherst H. Wilder Research Center; Center for Cross Cultural Health
Brief History of State Health Reform	Established in 1976, the **Minnesota Comprehensive Health Association** is a high-risk pool for individuals who are unable to purchase private health insurance at standard market rates or without restrictive clauses because of preexisting conditions. The **Prepaid Medical Assistance Program** dates to 1983 when the state received demonstration authority from the Health Care Financing Administration (now CMS) to serve all Medicaid recipients in three counties using a capitated, prepaid model. It serves a diverse population, including pregnant women, children, certain needy adults, and the elderly. In 1987, with the creation of the **Children's Health Plan (CHP)**, Minnesota became the first state to offer subsidized health insurance coverage to low-income uninsured children ineligible for Medicaid. In 1993, the CHP program was discontinued and all children covered at that time were converted to the **MinnesotaCare** program. In 1992, the Minnesota legislature passed the "HealthRight Act," which was later renamed the "MinnesotaCare Act." MinnesotaCare is funded through a tax on health care providers and enrollee premiums. Enrollees pay a monthly premium for their health insurance based on family size, the number of people covered, and income. In July 1995, MinnesotaCare began to receive funding through its 1115 Medicaid waiver to cover children and pregnant women whose income is at or below 275 percent FPL. Income eligibility for single adults and childless couples was set to 175 percent FPL in July 1997. Other reforms under this act were targeted to individuals and small employers. Only recently, in June 2001, has Minnesota received a waiver to access the state's

	CHIP funds. The state continues to review options that would allow Minnesota to draw on additional CHIP funds available. During the 2001 legislative session, an initiative was passed to form a reinsurance fund for small businesses (10 or fewer employees) that would cover 90 percent of claims $30,000–$100,000.
Existing Major Access Programs	Minnesota Comprehensive Health Association, Prepaid Medical Assistance Program, MinnesotaCare, small-employer reinsurance pool
SPG FINDINGS	
Insurance Data	❑ A relatively small number of Minnesotans (5.4 percent) are uninsured. ❑ Of the uninsured, 80.9 percent have a permanent job and 76.6 percent work more than 31 hours per week. ❑ More than 50 percent of the uninsured population have incomes above 200 percent FPL. ❑ Just over 7 percent (7.1 percent) of Caucasian residents were uninsured, 3.1 percent of Asian residents were uninsured, and 33.6 percent of Hispanic residents were uninsured. ❑ In developing coverage expansion ideas, particular attention was paid to those who have access to coverage, either through their employers or through public programs. ❑ Although the uninsured are more likely to lack a regular source of care, the survey found no difference in emergency room use of the uninsured and privately insured.
Employer Role	❑ Ninety-four percent of employers not offering health insurance have fewer than 50 employees. ❑ The average cost of insurance policies (1997) was $157/month for an individual and $410/month for families. Employers paid an average of 82 percent of individual and 70 percent of family policy premiums.

	❑ In firms offering coverage, those with a majority of employees earning less than $7/hour had a take-up rate of 74 percent; companies with the majority of employees earning $7–$10/hour and companies with the majority earning more than $10/hour had the same take-up rate (89 percent). ❑ All firms, regardless of size, had average take-up rates of between 85 percent and 91 percent. ❑ Firms with fewer than 10 employees paid, on average, more of the health insurance premium cost (81 percent) than those of any other size: 10–49 employees (68 percent), 50–199 employees (66 percent), 200+ employees (70 percent). ❑ Currently, people who have employer-based coverage available and whose employer contributes at least 50 percent of the premium are ineligible for MinnesotaCare. Low-income people who cannot afford 50 percent of the premium may be locked out of MinnesotaCare and have no access to affordable health coverage. ❑ Minnesota is targeting much of its expansion to populations that have access to coverage (either through employer-sponsored plans or public programs), but do not take up coverage for financial or other reasons.
State Policy Recommendations	Private market options recommended for consideration include: 1. Subsidies for low-income people to purchase private coverage; 2. Individual insurance market reform; 3. Extend the ability for young adults, ages 18–24, to be covered as dependents under parental policies. Public program options recommended for consideration include: 1. Expand MinnesotaCare eligibility to people whose employers subsidize less than 70 percent of premiums or establish a sliding employer-subsidy eligibility level; 2. Consider changing eligibility criteria for public insurance programs for seasonal workers and farmers;

	3. Drop premium payment for American Indian children; 4. Improve retention in public programs of enrollees who continue to be eligible and lack other coverage options; 5. Increase administrative flexibility in the application process and in collecting premium payments; 6. Reduce the frequency with which public program enrollees must rectify their eligibility. Options related to outreach, education, and cultural sensitivity include: 1. Outreach and communication about the value of and need for health insurance (including non-English outreach and education campaigns); 2. Improve cultural sensitivity/competency at all levels of the system; 3. Reduce stigma associated with public insurance programs.
Recommendations for Federal Policy	❑ Offer federal tax credits for purchasing health insurance, of sufficient size to encourage and enable individuals to purchase high-quality coverage. ❑ Increase flexibility of CMS in approving state Medicaid and CHIP waivers that give states flexibility in establishing and administering insurance programs. ❑ Provide adequate funding for Indian Health Services to ensure the provision of high-quality care services for American Indians. ❑ Provide support for ongoing, state-specific monitoring of the uninsured. ❑ Encourage more timely release to state analysts of unaggregated state-specific estimates from federally-collected data sources.
Change in Project Goals During Grant Period	Since the beginning of the grant period, the budget outlook has changed. As a result, policymakers have used the information to examine ways to best preserve the current situation.

Actions Taken	Completed research to fill in knowledge gaps of the uninsured in Minnesota.
Next Steps	❑ Like many states, Minnesota is facing a budget shortfall. As a result, it is unlikely that expansions of health coverage will be a priority; rather the focus will be on maintaining current levels of coverage. ❑ Minnesota will use the information gathered as a baseline to monitor the effect of the economic downturn on the general health marketplace.
Principal Contact	Scott Leitz, Director, Health Economics Program, Minnesota Department of Health, 121 East 7th Place, Suite 400, St. Paul, MN 55101 Telephone: 651/282-6361
Links to Reports	October 2001. Final Report to the Secretary http://www.statecoverage.net/statereports/mn.pdf March 2002. Interim Report to the Secretary http://www.statecoverage.net/statereports/mn20.pdf

HRSA State Planning Grantee: New Hampshire	
Project Goals	New Hampshire's overarching goal for this SPG was to develop a health insurance coverage plan that would eliminate uninsurance in New Hampshire. Specific goals were to: 1. prepare concise information on the uninsured and their willingness to participate in health insurance arrangements through the collection and analysis of data that will enable the state to prepare recommendations; 2. expand support and consensus around the issue of the uninsured and bring fact-based decision-making to the forefront in policy debates; 3. address the shortcomings in past efforts to expand coverage, including the development of more precise and current information, and the cooperation of additional stakeholders and partners; 4. develop an implementation plan based on recommendations that will provide coverage to all groups not currently eligible for health insurance or not enrolled in health insurance; 5. implement health care reforms that will expand access for the uninsured based on a public–private process of collaboration and education; 6. provide the Secretary and other states with the experience and insight from New Hampshire's efforts at expanding coverage.
Project Components	Planned components of the project included: *Revise the New Hampshire Health Insurance Coverage and Access Survey* with an updated focus on the growing minority population, the isolated rural areas of the state, and the high-population centers in the larger cities; *Conduct an employer-based survey and convene a series of focus groups* that would provide a clearer picture of the challenges facing small businesses in purchasing insurance, the current trends in employer-sponsored coverage, and the options for designing publicly subsidized coverage;

	Convene a focus group of adults to understand better the values families place on health care and health coverage, the influences on their buying decisions, and their attitudes and opinions on coverage; *Develop a series of program options and policy principles* to meet the goal of complete coverage for the uninsured; this will be accomplished by looking at benchmark practices, developing a description of potential Medicaid eligibility changes, coordinating a strategy for achieving universal access to affordable coverage, and establishing comprehensive databases; *Develop a business plan* that will address issues based on the previous attempts at expanding coverage; *Establish a comprehensive plan* to brief the public and policymakers on coverage expansion options, obtain public input, communicate the product of the work, and advocate for the plan's adoption and implementation; *Submit a report to the Secretary* that specifies the lessons learned.
Grant Amount and Time Frame	$1,033,315; 10/1/00–9/30/01, with an extension through 9/30/02 of $189,780.
Lead Agency	The New Hampshire Department of Health and Human Services *http://www.dhhs.state.nh.us*
Project Partners	Department of Insurance, Department of Justice and Employment Security, New Hampshire Healthy Kids Corporation, Attorney General's Office, Economic and Labor Market Information Bureau, SB 183 Adult Coverage Subcommittee comprised of legislative, business, and human service provider leaders
Brief History of State Health Reform	In 1993, the New Hampshire Legislature passed the Healthy Kids Act to address the growing problem of uninsured children. The act created the **Healthy Kids Corporation**, a private, nonprofit organization whose mission was to increase coverage for New Hampshire children. When Title XXI was passed in 1997, Healthy Kids was a natural choice to expand coverage. The CHIP expansion built on the **Medicaid** program (later named **Healthy Kids Gold**), which covered families with incomes less than 185 percent FPL, and established the **Healthy Kids Silver**, consisting of a subsidized portion covering families 185–300

	percent FPL, and an unsubsidized portion covering families with incomes 300–400 percent FPL. In the 1999 legislative session, SB 183 created a Subcommittee to research and develop options for affordable health insurance for low-income working adults.
Existing Major Access Programs	Healthy Kids, Medicaid, grants to community safety-net providers
SPG FINDINGS	
Insurance Data	❑ Almost 85 percent (84.4 percent) of New Hampshire residents are privately insured; 7.3 percent are covered by public programs; and 8.3 percent are uninsured. ❑ Of uninsured residents, 71.8 percent are employed; nearly 84 percent of the working uninsured are employed full time. ❑ Eighty percent of uninsured working adults work in firms that do not offer health coverage or are ineligible for the coverage their firm provides. ❑ Of uninsured adults, 76.2 percent were uninsured for at least six months at the time of the New Hampshire survey. ❑ While only about 5 percent of children 17 and under lack health coverage in New Hampshire, 16 percent of people ages 18–24 and 13 percent of people ages 25–34 are uninsured. ❑ A livable-wage study found that a New Hampshire resident would have to earn roughly 200 percent FPL before he or she could begin to pay for health coverage. ❑ If subsidies were provided to pay for coverage, they would have to be sizable. Only 23 percent of the uninsured said they would participate in a plan costing $90 a month; 90 percent said they would participate in a plan costing $30 a month.
Employer Role	❑ Over 70 percent (71.2 percent) of New Hampshire firms offer health benefits to employees, accounting for 94.3 percent of the workforce.

	❑ About one-fourth of New Hampshire employers providing coverage report premium levels for individual insurance to be $110–$184 per month; one-fourth report premiums of $185–$224/month, one-fourth report premiums of $225–$289, and one-fourth report premiums of $290–$485. ❑ Over half of employers offering coverage pay 85–100 percent of the premium for their employees. ❑ Eighty-six percent of employees who were offered coverage accepted it. ❑ Only 56.8 percent of employers with two to 10 employees offer health coverage, but 89.3 percent with 11–50 employees and 100 percent with more than 50 employees offer health benefits.
State Policy Recommendations	The project resulted in the following policy options and considerations: ❑ Expansion in coverage should focus on lower-income individuals earning less than 200 percent FPL; ❑ Explore options that would provide coverage for adults with children who are eligible for CHIP; ❑ Focus expansion on workers in small firms since they are more likely to be uninsured, or on the firms themselves; ❑ Expand CHIP to the parents of eligible children, and to childless adults, securing a 65 percent federal match; ❑ Follow the One-Third Option, which would divide costs evenly among employer, employee, and public moneys; ❑ Sufficiently large tax credits to assist individuals and families in buying health insurance, and help those who are already insured to maintain coverage; ❑ Healthy Link Program, using cooperating doctors to provide free care to uninsured individuals; success would depend on the willingness of doctors to provide services and their ability to handle a larger number of patients.

Recommendations for Federal Policy	❑ Establish federal tax incentives to encourage small employers to provide health coverage for their employees and allow them to buy into FEHBP plans. ❑ Implement Medicare prescription drug benefit for seniors and improve Medicare reimbursement to hospitals to reduce cost-shifting to the private sector. ❑ Expand 340B Drug Pricing to Rural Health Clinics and Critical Access Hospitals. ❑ Allow a federal Medicaid match for employer and employee cost-sharing for adult coverage expansion options. ❑ Allow the enhanced state match rate for CHIP and Medicaid-eligible, but not enrolled, hard-to-reach minority populations. ❑ Provide incentives for providers to institute best-practice management protocols to handle chronic disease and improve quality of care.
Change in Project Goals During Grant Period	No changes were indicated in the report.
Actions Taken	Senate Bill 183 Adult Coverage Subcommittee has attempted to shift the debate toward a discussion that would lead to support for the uninsured and expansions in coverage.
Next Steps	No next steps were indicated in the report.
Principal Contact	Steve Norton, Project Director, Office of Decision Support, NH Department of Health and Human Services, 129 Pleasant Street, Concord, NH 03301 Telephone: 603/271-4297
Links to Reports	October 2001. Interim Report http://www.statecoverage.net/statereports/nh.pdf March 2002. Interim Report http://www.statecoverage.net/statereports/nh6.pdf

HRSA State Planning Grantee: Oregon	
Project Goals	Oregon's overall goal was to collect and analyze information necessary to design a plan for universal coverage. Specific goals included: 1. Increase health insurance through the expansion of both public and private financing; 2. Increase the proportion of eligible people who apply for and receive Medicaid coverage; 3. Improve the capacity and capability of Oregon's safety-net clinics to provide needed care to the uninsured populations, including Hispanics and other immigrants, as well as to the homeless.
Project Components	Planned components of the project included: *Collect and analyze data:* conduct surveys, focus groups, literature review, and one-on-one interviews to augment earlier and existing data-collection efforts; new data will capture information about changes in coverage, cost and market structure, detailed view of the uninsured population and the barriers they face, and employer offer and contribution rates; *Analyze options to increase coverage:* assess the current delivery system and the features that need to be strengthened; develop strategies to expand access; determine sources of revenue to support options; develop evaluation system to assess crowd-out, quality of care, satisfaction, and fraud; address administrative issues; begin drafting waiver applications if necessary; *Build consensus among constituent groups:* keep stakeholder groups informed and involved in planning process; establish partnerships, and gain collaboration needed to implement strategies; *Prepare report:* draft report with recommendations for attaining universal coverage; disseminate to relevant agencies and educate public; obtain and address feedback; finalize and submit report to HRSA.
Grant Amount and Time Frame	$1,253,264; 10/1/00–9/30/01, with an extension through 9/30/02 of $193,821.

Lead Agency	Office for Oregon Health Plan Policy & Research *http://www.ohpr.state.or.us* State Planning website http://www.ohppr.org/hrsa/index_hrsa.htm
Project Partners	Advocates, business, labor, insurance industry, provider community and associations, research/policy/advisory groups, state agencies
Brief History of State Health Reform	**Insurance Pool Governing Board**, established in 1987, promoted small- business coverage through a declining tax credit. In 1989, **Oregon Health Plan (OHP)** included **Medicaid** expansion, the **Oregon Medical Insurance Pool (OMIP)** high-risk pool, and an employer mandate (which was later rescinded before implementation). In 1991, the **Health Resources Commission** was created to conduct technology assessments. Small-group insurance reforms were implemented in 1991 and 1995. The state-funded **Family Health Insurance Assistance Program (FHIAP)**, established in 1997, offers premium subsidies for low-income uninsured residents; a long waiting list prompted the state to seek federal support through **Title XXI (CHIP)**. Oregon's CHIP program has extended coverage to additional low-income children.
Existing Major Access Programs	OHPlan-Medicaid expansion, CHIP, OMIP, FHIAP
SPG FINDINGS	
Insurance Data	The uninsurance rate in 2000 was 12.3 percent (423,149 people). ❑ Of the uninsured, 67.2 percent are at or below 200 percent FPL. ❑ The uninsurance rate among adults 19–64 increased in 2000 to 15.7 percent. ❑ Eighty-three percent of private-sector workers are employed in firms that offer health insurance. ❑ Seventy-four percent of uninsured working-age adults are employed.

	❑ About one-third of uninsured workers (77,000 people) have access to ESI; of these, up to 62,000 are eligible for coverage; among those eligible, an estimated 35,000 workers have incomes below 200 percent FPL.
Employer Role	❑ ESI is favored by workers: 75 percent favor using state funds to help small employers offer insurance; 66 percent favor requiring all employers to offer coverage. ❑ Employer contribution levels are decreasing, employee cost-sharing is increasing, and employers are offering fewer choices of plans. ❑ The FHIAP premium subsidy program is operating at enrollment capacity and has a long waiting list; it is very popular among participants. ❑ Oregonians are skeptical about using tax credits to assist low-income individuals to purchase insurance. ❑ Employers' decisions about offering health coverage are based on cost, profitability of firm, ability to attract workers, and industry norms. ❑ Employers are interested in subsidies and tax credits to help them purchase coverage.
State Policy Recommendations	Oregon has decided to pursue two waiver approaches: 1. "OHP2" would create two different benefit packages and expand FHIAP, while expanding coverage to more Oregonians: ❑ OHP Plus would provide current OHP benefit package to people eligible for Medicaid (without a waiver), General Assistance recipients, and pregnant women and children up to 185 percent FPL; ❑ OHP Standard would provide a reduced benefit package with increased cost- sharing (similar to commercial insurance) up to a capped enrollment to adults who are not otherwise eligible for Medicaid (parents, singles, and couples) with incomes up to 185 percent FPL;

	❑ FHIAP, the state premium subsidy program, would obtain federal matching funds to subsidize private health insurance for uninsured Oregonians with incomes up to 185 percent FPL, up to a capped enrollment. OHP2 expansion may enroll about 40,000 in Medicaid and FHIAP and 10,000 in CHIP. OHP2 would be financed through savings from reduced benefits for some adults and increased federal matching funds. 2. "CHIP Too," a 1115 waiver application under CMS review, would allow the state to use $5 million of its annual CHIP allocation directly to fund safety-net providers for primary health care and preventive services received by uninsured children presumably eligible for CHIP, but for whom the application process has not been completed. CHIP Too would use $5 million from its annual S-CHIP allocation, matched by a state or local contribution of $1.6 million (financed in part from state allocation to the safety net).
Recommendations for Federal Policy	❑ Act as facilitator and coordinator for communication among states considering similar waiver strategies; for dialogue regarding interaction of individual tax credits and high-risk pools; and serve as an information clearinghouse. ❑ Provide funds to support projects, such as further study of underinsurance, impact of premiums and cost-sharing on low-income people, evidence-based information; technical assistance on use of state-specific information; research exploring solicitation of public input on policy. ❑ Show flexibility in matching state and other funds for people who would otherwise be uninsured; continue support for state efforts to allocate resources across broader population. ❑ Continue to support and strengthen the safety net.
Change in Project Goals During Grand Period	Oregon's major goals have remained the same. However, due to an effort to preserve a dental benefit based on public input, the process resulted in more emphasis on cost-sharing than on eliminating benefits.

Actions Taken	❑ State legislature passed HB 2519 in July 2001, calling for submittal of Section 1115 waiver allowing greater flexibility on benefits and eligibility; and greater latitude to families regarding choice of coverage options (ESI, Medicaid, CHIP); ❑ Held community meetings concerning process for designing OHP Standard benefit plan; ❑ Submitted 1115 waiver request for CHIP Too in June 2001; ❑ Advisory committee representing safety-net providers is preparing a detailed policy and procedure manual for CHIP Too; ❑ Created a committee to identify gaps in primary care access, and strategies to fill them; ❑ Selected an information-systems firm to install practice management system in Community Health Charities to facilitate implementation of CHIP Too.
Next Steps	Under a grant from the Robert Wood Johnson Foundation State Coverage Initiatives program, Oregon will continue to pursue its expansion efforts. It plans to submit the OHP2 waiver, and is continuing to pursue issues related to benefits, eligibility, and coordination with ESI. It plans to continue to develop options for implementation, learn from the efforts, and communicate lessons to other states and the federal government.
Principal Contact	John Santa, M.D., Administrator, Office for Oregon Health Plan Policy and Research Telephone: 503/378-2422 ext. 401 E-mail: *john.santa@state.or.us*
Links to Reports	October 2001. Final Report to the Secretary http://www.statecoverage.net/statereports/or.pdf March 2002. Final Report to Secretary: *Addendum* *http://www.statecoverage.net/statereports/or30.pdf*

HRSA State Planning Grantee: South Dakota	
Project Goals	South Dakota's overall goal was to study the uninsured population in South Dakota and devise a viable plan to provide access to affordable and quality health insurance coverage. Specific goals included: 1. Form an Interagency Work Group to direct the data-gathering and analysis activities and recommend specific options for providing the State's uninsured population with access to affordable and quality health insurance coverage; 2. Gather and analyze the necessary data through comprehensive statewide household and employer surveys, focus group interviews, and stakeholder interviews; 3. Formulate viable coverage options and identify potential funding sources for providing access to quality health insurance coverage; 4. Satisfy all grant requirements and submit a report to the Secretary of Health and Human Services outlining the state's plan for providing access to affordable, quality health insurance.
Project Components	Planned components of the project included: *Convene an Interagency Work Group* of state government officials who were charged with the responsibility of monitoring progress of the grant program and providing technical input to all major decisions concerning the grant; members of the Work Group include staff from South Dakota Department of Health, Department of Social Services, Department of Human Services, and Division of Insurance; *Contract with The Lewin Group*, of Falls Church, Virginia, to complete the data- collection and analysis; Conduct comprehensive, statewide household and employer surveys, focus group interviews, and stakeholder interviews to gather previously unavailable information about the uninsured population;

	Analyze and interpret the data results, which will guide the Task Force in identifying strategies to eradicate the state's uninsured population; *Formulate viable options for consideration*, involving specific action steps for developing private and public health insurance coverage; Determine which insurance reform options would best provide access to the uninsured; Submit a final report to the Secretary of Health and Human Services.
Grant Amount and Time Frame	$1,056,812; 3/1/01–2/28/02, with an anticipated extension through 3/31/03.
Lead Agency	South Dakota Department of Health *http://www.state.sd.us/doh*
Project Partners	Department of Social Services, Department of Commerce & Regulation, Department of Human Services, representatives of the state's Native American tribes, Indian Health Service, health care professionals, health care facilities, the business community, major health care insurers, the agricultural community, health care consumers
Brief History of State Health Reform	The first significant laws requiring provisions on employer group-health plans were enacted in 1984 and required insurers of employers with under 20 employees (not subject to COBRA) to provide continuation of coverage upon an employee's leaving. In 1991, legislation was passed setting forth rate requirements for small-employer health insurance plans. The 1994 Legislative Session produced a law requiring portability and renewability of all fully insured employer plans, regardless of size. In 1995, legislation brought a requirement that standard and basic plans be marketed to all small employers in this state on a guaranteed-issue basis regardless of the existence of prior coverage. Also in 1995, the state expanded its **Medicaid** program to include all poverty-level children under the age of 19. Legislation was passed in 1997 with the purpose of complying with and having requirements consistent with the Health Insurance Portability and Accountability Act of 1996. In 1999, through the creation of **CHIP**, the eligibility income level for children in both CHIP and Medicaid was raised to 140 percent FPL. In 2000, a separate CHIP program was created called **CHIP-NM** (CHIP non-

	Medicaid), in which the income eligibility level was increased to uninsured children with family incomes between 140 percent and 200 percent FPL. South Dakota expanded the **Home and Community Based Waiver Program** to include both children with developmental disabilities and the elderly. The state also increased financial support for the **Indian Health Services** facilities.
Existing Major Access Programs	Medicaid, CHIP, CHIP-NM, Indian Health Services
SPG FINDINGS	
Insurance Data	❑ Just over 8 percent (8.1 percent) of South Dakota residents were uninsured. ❑ Over 50 percent of South Dakota's uninsured had family incomes below 200 percent FPL. ❑ Among uninsured households with wage earners, 45 percent reported that two or three wage earners lived in the household; 14 percent of primary wage earners without insurance were farmers or ranchers. ❑ Apart from cost, reasons cited for not having insurance were good health, waiting for employer coverage, and needed medical care cost less than health insurance. ❑ Rates of uninsurance varied by as much as 5 percent, depending on region of the state. The highest rates were in the south central and northwest regions.
Employer Role	❑ Fifty-five percent of private employers in South Dakota offer health insurance to their employees. ❑ One hundred percent of firms with over 50 employees offer insurance; 70 percent of firms with 11–50 employees, 54 percent of firms with 3–10 employees, and 17 percent of firms with two employees offer insurance. ❑ In the Pierre/Mobridge/Rapid City region, 44 percent of employers offered insurance, while 63 percent of firms offered it in the Sioux Falls area.

	❑ Employers classified as agricultural, manufacturing, wholesale and transportation are most likely to offer insurance to their workers; construction and retail are least likely. ❑ 81 percent of the worker's insurance premium is paid for by their employer. ❑ Firms that do not currently offer coverage are likely to be influenced by lowered monthly premiums and stabilized premiums at renewal time. ❑ South Dakota is unique because of the small percentage of employers that are self-insured and the small percentage that offer HMO and PPO plans; thus employers may have less leverage to assure value-oriented purchasing of insurance for their employees.
State Policy Recommendations	The following policy options were recommended for consideration: ❑ Expand income eligibility levels under Medicaid and CHIP to 200 percent FPL for parents and all other adults below 133 percent of FPL; ❑ Create a Medicaid buy-in for small employers and low-income people. Provider rates, administrative costs, and prescription drugs are all lower under Medicaid than under private plans. This option would be funded by premium contributions. ❑ Provide a premium subsidy for qualifying low-income people below 200 percent FPL who do not have access to employer-sponsored coverage. ❑ Directly subsidize small employers by offering vouchers for a certain percentage of health insurance premiums to assist them in providing coverage for their workers. ❑ Create a low-cost health insurance product for employers who currently do not provide coverage. The state subsidy is through a reinsurance mechanism that pays a substantial percentage of health benefit costs for high-cost cases.

Recommendations for Federal Policy	❑ Provide financial assistance to states. With respect to Medicaid budget shortfalls, a change in federal priorities, a drop in the federal budget surplus, and drops in state tax revenue have made states wary of coverage expansion. This includes funding programs such as the Indian Health Service, which provides medical attention to Native Americans within coverage areas. ❑ Federal tax credits for purchasing health insurance coverage. This could be particularly helpful for South Dakota because the state has no individual or corporate income tax and the median household income is nearly 20 percent lower than the nation as a whole. ❑ Provide resources and support to facilitate efforts to identify those with inadequate coverage: 1. Define "underinsurance" and measure the affordability of adequate health care; 2. Determine why individuals do not sign up for available public or private coverage; 3. Study frontier health care practice models and identify solutions to diminished availability and access to care.
Change in Project Goals During Grant Period	No changes in the project goals were indicated.
Actions Taken	Data collection and analysis through focus groups, in-person interviews, and telephone interviews.
Next Steps	Governor Janklow indicated his intention to issue an Executive Order establishing a committee of key stakeholders that would devote time to more detailed analysis of policy options and consensus building.
Principal Contact	Bernie Osberg, Office of Rural Health, South Dakota Department of Health, 600 East Capitol Avenue, Pierre, SD 57501 Telephone: 605/773- 3364
Links to Reports	October 2001. South Dakota State Planning Grant Interim Report *http://www.statecoverage.net/statereports/sd.pdf* March 2002. Final Report of the State Planning Grant *http://www.statecoverage.net/statereports/sd1.pdf*

HRSA State Planning Grantee: Texas	
Project Goals	Texas's stated overall goal for this SPG was to develop a well-designed, data- supported plan that incorporates an understanding of cultural and other factors affecting Texans who are currently uninsured; encourages Texans to take advantage of existing private and public programs; and creates new insurance options. This would be achieved by meeting the following goals: 1. Identifying social, economic, and administrative obstacles to reducing Texas's uninsured rate; 2. Developing specific benefit plan options with associated enrollee costs and state funding; 3. Identifying steps that are necessary to ensure maximum enrollment while reducing crowd-out; 4. Achieving stakeholder understanding and support of the project's findings and recommendations.
Project Components	Planned components of the project included: *Assemble a considerable amount of data and information* through surveys and interviews with uninsured individuals, business leaders, and insurers to determine demographic characteristics of the uninsured and assist in policy development; *Work with consultants to analyze policy and benefit plan development* and create a proposal for making changes to the existing system to increase access and participation; *Hold a statewide planning conference* that would serve as a forum for interested parties to express their views and opinions on proposed measures to increase the number of insured Texans; Draft a report to the Secretary of Health and Human Services.
Grant Amount and Time Frame	$1,350,735; 10/1/01–9/30/02, with an anticipated extension through 3/31/03.
Lead Agency	Texas Department of Insurance *http://www.tdi.state.tx.us* State Planning Grant website *http://spg.tdi.state.tx.us*
Project Partners	Department of Health, Public Insurance Council, Texas Health Insurance Risk Pool, CHIP, Advocacy Inc., Center for Rural

	Health Initiatives, Health and Human Services Commission, Texas Hospital Association, Texas House of Representatives, Texas Senate, Mental Health Association of Texas, Small Business United of Texas, Texas Medical Association, Chamber of Commerce, Consumers Union, Commission on Drug and Alcohol Abuse, Texas Association of Health and Life Insurers, Indigent Care Collaboration, Texas Association of Health Plans, Department on Aging, State Medicaid Office, Texas Association of Insurance Officials
Brief History of State Health Reform	In 1993, the legislature adopted the **Small Employer Health Insurance Availability Act** to improve access to insurance for employees of small firms. Established in 1997, the **Texas Healthy Kids Corporation** is a nonprofit corporation that administers a program to provide insurance subsidies to families earning less than 185 percent FPL. Also in 1997, the **Texas Health Insurance Risk Pool (THIRP)** became operational to guarantee access to health care to certain federally defined eligible individuals. In 1999, the **Blue Ribbon Task Force on Uninsured Texans** was appointed to examine issues of uninsurance and make recommendations to ensure access to insurance for all Texans. Texas established its **CHIP** program in 2000 to cover children 18 and younger with family incomes below 200 percent FPL. The **Texas State Center for Rural Health Initiatives** sponsors a number of programs designed to reach rural Texans.
Existing Major Access Programs	Medicaid, CHIP, Healthy Kids Corporation, THIRP
SPG FINDINGS	
Insurance Data	❑ Almost a quarter (21.4 percent) of the total population of Texas is uninsured. Roughly 1 million of the uninsured are eligible for Medicaid but not enrolled. ❑ Twenty-five percent of the uninsured have incomes below 100 percent FPL; 29 percent of the uninsured have incomes above 250 percent FPL. ❑ Approximately 69 percent of all uninsured adults are employed. One of the primary reasons cited for Texas's high uninsurance rate is the lack of access to employment-based coverage as compared with other states.

	❑ Hispanics make up 58 percent of the uninsured population. ❑ The population groups that were particularly important when developing targeted coverage expansion options were employers (75 percent of the firms with fewer than 50 employees did not offer insurance); the nonpoor uninsured; and low-income adults who are not eligible for Medicaid.
Employer Role	❑ Fourteen percent of all employers in Texas did not offer coverage to their workers; 43 percent of small employers (two–50 workers) versus 3 percent of larger employers did not offer coverage. ❑ Workers in construction, manufacturing, and wholesale/retail trade account for 53 percent of all uninsured Texas workers. ❑ Eleven percent of companies with a majority of minimum-wage workers offer insurance compared with 66 percent of companies having predominantly salaried workers. ❑ Employee contribution levels for family coverage were 25 percent higher in Texas than the national average. For small businesses, the employee contribution level was 50 percent higher than the national average.
State Policy Recommendations	Major policy options to be considered include the following: ❑ Small-employer reforms financed by small-business employers and employees. Specific recommendations include revising the basic and catastrophic plans (increasing deducible ranges under basic plan, allowing carriers to add transplant benefits to the basic plan) to compare more favorably with current shelf products; 1. Revise rating requirements for small-business employer health plans; 2. Create a statewide small employer purchasing alliance. ❑ CHIP buy-in for parents; some CHIP money still is unspent; but since enrollment in Texas is growing rapidly, this may not be true in as little as two years; ❑ Insurance education and information for small businesses and individuals: 1. Publish a small-employer nonbiased rate guide;

	2. Conduct local community health insurance fairs throughout Texas to provide informational sessions on various insurance topics.
Recommendations for Federal Policy	❑ Make data more available and more timely, but review the process by which MEPS data is provided to states; ❑ Provide funds for states to repeat survey activities with the goal of establishing a long-term funding process.
Change in Project Goals During Grant Period	Due to time constraints of a 12-month study, the changes in economic conditions, and the difficulty of executing many survey activities in a short time, obtaining consensus within the time provided was unlikely. As a result, a list of options for consideration was developed rather than a final list for adoption.
Actions Taken	A statewide conference was held in late January 2002 to provide all interested Texans with the opportunity to participate in the SPG process and to provide a forum for discussing the various policy options.
Next Steps	The following activities are planned: ❑ Conducting additional actuarial development of plan benefit provisions; ❑ Collecting updated cost data from insurers and HMOs, enrollment information and participation data in the small-employer market, and other information; ❑ Surveying insurance agents in Texas; ❑ Working with appropriate legislators and legislative staff to inform them of this study and the recommendations for expanding coverage.
Principal Contact	Dianne Longley, Project Director, State Planning Grant Division, 333 Guadalupe – MC 302-5A, Austin, TX 78701 Telephone 512/322-4100 Fax 512/305-8202 E Mail: dianne.longley@tdi.state.tx.us
Links to Reports	October 2001. Texas State Planning Grant Interim Report. *http://www.statecoverage.net/statereports/tx.pdf* March 2002. Final Report. Texas State Planning Grant. *http://www.statecoverage.net/statereports/tx9.pdf*

HRSA State Planning Grantee: Utah	
Project Goals	Utah's stated goals for this SPG were to: 1. collect data via the Utah Health Status Survey to assess needs and help develop coverage options; 2. establish a public–private partnership for the systematic study and development of implementation strategies that increase access to health care coverage and reduce the number of uninsured Utahans; 3. seek creativity in the design of a seamless, integrated statewide system for health care delivery to the uninsured, and develop strategies for integrating delivery with other services for low-income residents; 4. build on recent success in the CHIP program and community-based efforts to manage the Medicaid-TANF delinking process, and implement strategies built on existing relationships; 5. develop a financially sound business plan for the financing of each health coverage option; 6. identify desired outcomes by uninsured groups and set performance indicators that allow the determination of measurable improvement in the reduction of the uninsured in Utah.
Project Components	Planned components of the project included: *Use a comprehensive set of data-collection activities* to address the current health insurance patterns in the state, and to make predictions about how various government actions might affect those patterns; *Conduct quantitative analysis of the current situation* using a household survey to gain demographic information of Utah's uninsured, including children; *Conduct qualitative surveys with uninsured individuals and employers* to help understand the point of view of the people whose behavior the aim is to modify;

	Use discrete choice analysis to allow valid prediction of the value that consumers place on various attributes of insurance and newly developed insurance products; Establish a collaborative planning group to come up with an approach to developing coverage options and program designs that would identify strategies to lowering the number of uninsured Utahans; *Develop an approach for preparing a report* to the Director of Health and Human Services, with the help of the Steering Committee and the Project Director.
Grant Amount and Time Frame	$1,102,000; 4/1/01–3/31/02, with an anticipated extension through 3/31/03.
Lead Agency	Utah Department of Health *http://hlunix.hl.state.ut.us* State Planning Grant website http://168.179.113.242/index.html
Project Partners	Division of Health Care Financing, CHIP, Public Health Assessment, Center for Health Data, Department of Insurance, Department of Human Services, Department of Workforce Services, Local Health Departments, Chamber of Commerce, Private Insurers, Utah Medical Association, The Utah Hospital Association, Utah Issues (local advocacy organization), Public Employees Health Plan, Utah Community Health Centers, individuals representing the uninsured
Brief History of State Health Reform	Prior to 1993, most of Utah's efforts to improve access to health care were limited to safety-net initiatives. One significant safety-net initiative was the **Utah Medical Assistance Program**, which began in 1977 and provided limited medical care for low-income adults 18–65 with serious medical illnesses who do not qualify for Medicaid or any other medical assistance program. In response to recommendations from Utah's **Health Care Policy Options Commission**, the state initiated a **Health Print** in 1992. Central to the Health Print's goals was the formation of the **Utah Health Policy Commission (HPC)**. Over the course of its tenure, HPC recommended and supported passage of many initiatives, including, in 1994, Health Care Reform I and II, the first creating the HPC and the second establishing coverage for children at or below 100 percent FPL; and in 1996 submitting a Medicaid 1115 waiver to provide Medicaid eligibility to people

	at or below the poverty line. In 1996, the **Primary Care Grants Program (PCGP)** was created to target Utah's low-income population without insurance coverage. In 1998, HPC created Utah's **CHIP** program, which covers children up to 200 percent FPL. In February 2002, HHS approved a federal 1115 Medicaid waiver that allowed Utah to provide a limited medical benefits package in order to insure more people. The **Primary Care Network** (PCN) was scheduled for implementation in July 2002.
Existing Major Access Programs	Medicaid, CHIP, Utah Medical Assistance Program, PCGP, PCN
SPG FINDINGS	
Insurance Data	❑ About 197,962 of Utah's 2,295,967 million citizens (8.67 percent) lack health coverage. ❑ Approximately 43 percent of uninsured adults have incomes 100–200 percent FPL. ❑ Individuals who had never married were more likely to be uninsured (15.2 percent), but respondents who were married or living as married accounted for a larger percentage of uninsured in the state (55.4 percent). ❑ Almost 26 percent (25.84 percent) of Hispanics living in Utah were uninsured, compared with 7.19 percent of non-Hispanics. ❑ Subpopulations with higher percentages of uninsured were particularly important to target, including adults without a high school education (26 percent), unemployed adults (19 percent), and residents of rural health districts, among others.
Employer Role	Will be addressed in the employer focus groups and key-informant interviews and summarized in a follow-up final report.

State Policy Recommendations	After reviewing a series of proposals from project work groups, the project steering committee found the most support for the following: ❑ Primary Care Network (PCN) model (the 1115 waiver): This proposal, recently approved by CMS, would target a new eligible population of adults up to 150 percent FPL. Outreach will be conducted through local and community health departments and centers. The PCN will be financed in part through Medicaid and in part through 50 percent cost-sharing, as required by the state employee plan. Enrollment was scheduled for July 2002. ❑ Continue to investigate cost-sharing: An eligibility threshold would be set based on wage or poverty level. Sixty percent of financing would come from employer and employee contributions, and 40 percent would come from community funds. ❑ Combine a 1931 expansion and an 1115 CHIP waiver for parents. Either of these options, combined with the PCN, could provide coverage for a large segment of the target population.
Recommendations for Federal Policy	Awaiting input from Utah Issues (under contract to study these issues).
Change in Project Goals During Grant Period	This will be completed for a follow-up, final report.
Actions Taken	❑ In February 2002, HHS approved a federal 1115 Medicaid demonstration waiver to reduce benefits to people enrolled in Medicaid in order to finance new coverage expansion. Under the proposal (PCN), the state will extend Medicaid primary care and preventive services to 25,000 low-income adults who would not otherwise have had access to health insurance. ❑ Governor Michael O. Leavitt signed into law House Bill 122, which enabled more uninsured working Utahans to obtain health coverage similar to the PCN through a partnership with employers and the private insurance market.

	❑ Utah has been looking closely at Muskegon County, Michigan, to examine its cost-sharing model and possibly develop a three-way cost-share among state, employer, and employee. A two-day workshop/discussion with the director of the program was held in November 2001.
Next Steps	A survey of Utah employers is being completed.
Principal Contact	Shane Carlson, Project Manager. Utah Department of Health, 288 North 1460 West, P.O. Box 143101, Salt Lake City, UT 84114-3101 Telephone: 801/538-6406 E-mail: *scarlson@doh.state.ut.us*
Links to Reports	October 2001. Final Interim Report http://www.statecoverage.net/statereports/ut.pdf March 2002. Updated Interim Report http://www.statecoverage.net/statereports/ut4.pdf

HRSA State Planning Grantee: Vermont	
Project Goals	Vermont's stated goals for this SPG were to: 1. design and conduct in-depth quantitative and qualitative research of Vermont's population at both statewide and local levels to better understand demographics and characteristics of the uninsured; 2. design and conduct in-depth qualitative research of Vermont's employer, health-insurer, and provider communities to improve understanding of their perceptions of public and private health coverage in the state and to gauge reactions to likely responses to coverage strategies; 3. perform actuarial analyses to assist in pricing coverage options and for evaluating financing issues; 4. facilitate collaboration across various state agencies and private organizations participating in the development and/or regulation of coverage options within Vermont.
Project Components	Planned components of the project included: *Conduct a general population survey* addressing the health insurance coverage status of Vermont residents, with an oversample of specific subpopulations; *Convene a series of focus groups* and structured one-on-one interviews with employers and associations to explore perceptions of the current health care market and delivery system, in terms of accessibility and affordability; *Convene a Work Group of public- and private-sector representatives* to help identify barriers to coverage from the insurer/health plan perspective, and to help market-test and refine proposals; *Convene a Work Group of clinical representatives* to provide quality, access, and outcomes perspectives for proposed health coverage and program design options; *Conduct an actuarial analysis* of different strategies to increase insurance coverage;

	Evaluate alternative coverage options and programs that might be responsive to the needs of Vermont's uninsured; *Market-test each coverage option and program design* selected by the Steering Committee through the use of consumer focus groups, employer interviews, and sessions with insurer/provider/public health Work Groups; *Prepare an implementation estimate* that includes high-level analysis of expected utilization charges within the delivery system; estimates of administrative and service delivery costs, premiums, funding sources; and the anticipated number of participants.
Grant Amount and Time Frame	$1,288,892; 10/1/00–9/30/01, with an extension through 9/30/02.
Lead Agency	Vermont Agency of Human Services http://www.dsw.state.vt.us/districts/ovha/ovha22.htm
Project Partners	Office of the Governor; Vermont State Legislature; Department of Prevention, Assistance, Transition, and Health Access; Office of Vermont Health Access; Department of Health; Department of Banking, Insurance, Securities, and Health Care Administration; Vermont Coalition of Clinics for the Uninsured; Vermont Medical Society; Vermont Association of Hospitals and Health Systems; Chamber of Commerce; Blue Cross Blue Shield of Vermont; Vermont Commission on Health Care Values and Priorities; Office of State Health Care Ombudsman; Bi-State Primary Care Association; The Business Roundtable
Brief History of State Health Reform	In 1989, Vermont created the **Dr. Dynasaur program**, which provided state-funded health assistance to children six years and younger, as well as pregnant women who did not qualify for Medicaid up to 200 percent FPL. By 1992, the program had expanded to cover children up to age 17, up to 225 percent FPL, and was integrated into the state Medicaid program. This was later expanded under the CHIP program to cover children up to 300 percent FPL. In 1991, Vermont passed the **Act 160 Legislative Initiatives**, which required all insurers with small-employer products (50 or fewer workers) to guarantee-issue policies at community rates and committed the state to the goal of universal health insurance coverage. The **Vermont Health Access Program (VHAP)** was designed to operate under a 1115 Medicaid waiver. The waiver was granted in 1995 and

	recently extended to ensure that it would remain operational until at least 2003. VHAP covers custodial parents and caretaker relatives up to 185 percent FPL, noncustodial parents and other adults up to 150 percent FPL, aged and disabled through 105 percent FPL, and pregnant women through 200 percent FPL. The **VHAP Pharmacy Program** replaced the **V-Script program**, initially started in 1989. The programs were initially designed to provide pharmaceuticals to low-income elderly citizens. It has been expanded to cover Medicare beneficiaries up to 175 percent FPL and other individuals with incomes up to 300 percent FPL.
Existing Major Access Programs	Dr. Dynasaur, VHAP, Medicaid
SPG FINDINGS	
Insurance Data	❑ About 51,390 (8.4 percent) of Vermont's 608,829 citizens lack health coverage. ❑ The uninsured include people at all income levels; 21.6 percent of the uninsured had incomes below FPL; 29.6 percent had incomes 100–200 percent FPL; 22.3 percent had incomes 200–300 percent FPL; and 26.3 percent had incomes greater than 300 percent FPL. ❑ More than three-quarters of the uninsured population were employed; 66.5 percent of the uninsured were working full time and 10.5 percent were working 30 hours or less per week. ❑ Most Vermonters believe that the government and employers should be responsible for providing health insurance, although they were wary of a government-only system, such as a single-payer model. ❑ Tax credits, subsidies, or other incentives to health insurance elicited concern about "red tape," complicated applications, and inflexible eligibility standards. There was also little support for a low-cost insurance option.

Employer Role	❑ In firms with fewer than five employees, 26.6 percent of workers are offered coverage compared with over 90 percent of workers in firms with more than 50 employees. ❑ Employers typically offer one plan, and employees typically pay about 20 percent of the premium. ❑ Employers view insurance as one of the most valuable benefits they can offer. Reasons for offering insurance include increasing employee compensation with a tax-free benefit, keeping employees healthy and productive, and having access to group health insurance for themselves. ❑ Those who do not offer insurance cite cost—including premium levels, unpredictability of costs in the future, and the time required to research and administer plans—as the primary reason for not doing so. ❑ Employers view reducing costs as the key to expanding insurance coverage and show interest in employer tax incentives, more competition in the market, an affordable plan that is free of state-mandated benefits, and pools to negotiate lower rates.
State Policy Recommendations	A Steering Committee consisting of representatives from the various interest groups met regularly and participated in planning and advising on the different policy recommendations. Based on the evaluation of the different policy options, their specific recommendations are the following: ❑ Increase participation among Medicaid/VHAP/Dr. Dynasaur–eligible people: The state could substantially reduce the number of uninsured by increasing enrollment in existing programs. Outreach programs for Dr. Dynasaur in schools and through employers could be expanded, while the premiums for children above 225 percent FPL could be eliminated.

	❑ Buy in to VHAP: Individuals without access to employer coverage living below 300 percent FPL could be permitted to purchase coverage under the VHAP program by paying a premium. Small employers could also be given the option of purchasing coverage for their employees and dependants through VHAP. While the premium would be equal to the full cost of coverage, this would still likely be lower than purchasing comparable coverage in the private sector. ❑ Incrementally expand VHAP up to 300 percent FPL: This would affect primarily adults between the current VHAP eligibility level and 300 percent FPL. Vermont has the option under section 1931(b) of the federal Medicaid law to increase the income level for parents under Medicaid to match the maximum income level at which children are eligible for Dr. Dynasaur (300 percent FPL); ❑ Create a small-employer tax credit: Provide subsidies directly to employers to help them provide coverage to their workers through a refundable tax credit. Eligibility would be limited to firms that have not provided coverage for at least 12 months and to firms with an average payroll below the average for small firms in the state. ❑ Encourage access to direct services for people who do not have insurance: A number of hospitals have established direct-care programs for the uninsured in nursing rooms, with particular emphasis on those with chronic conditions. These individuals are given regular appointments with physicians to provide preventive care for chronic illnesses. This could be applied statewide.
Recommendations for Federal Policy	❑ Maintain existing commitment of federal participation in 1115a waivers that have achieved coverage expansions: VHAP, which is currently operating under a 1115a waiver, will need to be renewed at some point. It is recommended that CMS grant permanency to 1115a expansion populations by considering them part of the Medicaid spending base at the point of consideration of a new waiver.

	❑ Create additional tax incentives directed at small employers to encourage the provision of health insurance: The federal government should use its tax authority to provide incentives to small businesses. This could be accomplished through a refundable tax credit to employers who are not now providing coverage. ❑ Establish a Medicare drug benefit: Modernization of Medicare through the creation of a drug benefit would potentially make state resources available to either maintain existing initiatives or finance some of the options laid out above.
Change in Project Goals During Grant Period	There were no changes indicated.
Actions Taken	In the winter of 2001, Governor Dean appointed the Bipartisan Commission on Health Care Availability and Affordability to examine the options for expanding coverage to the uninsured.
Next Steps	Vermont is continuing to weigh the options to insure the remaining 5–10 percent of the population.
Principal Contact	Paul Wallace-Brodeur, Director of the Office of Vermont Health Access, Office of Vermont Health Access, 103 South Main Street, Waterbury, VT 05671-120 Telephone: 802/241-3985
Links to Reports	October 2001. Interim Final Report http://www.statecoverage.net/statereports/vt.pdf March 15, 2002. Final Report http://www.statecoverage.net/statereports/vt7.pdf

HRSA State Planning Grantee: Washington	
Project Goals	Washington's stated goals for this SPG were to: 1. achieve a comprehensive understanding of the social, economic, demographic, and health status characteristics of our uninsured population, including the reasons for their status as uninsured, and how Washington's uninsured compare with those in other states; 2. create a strategic plan to impose economic and administrative discipline on purchasing, payment, and delivery systems to secure additional money for subsidized health coverage and to provide more affordable coverage for the general market; 3. generate a detailed approach to test the viability of community-based delivery and financial flow arrangements that involve public and private purchasers in partnership with local communities and their health care delivery systems; 4. create a six-year full access plan, to provide affordable health coverage to all Washingtonians.
Project Components	Planned components of the project included: *Create a point-in-time profile of the uninsured*, including the reasons why they are without health insurance; this will include gathering existing data, as well as new data, and holding meetings with stakeholders; *Establish a process and tools for the periodic capture and analysis*, over time, of the drivers of noncoverage, in order to help understand the evolving nature of health coverage infrastructures; *Design and conduct a feasibility study* to determine the cost-benefit of an ongoing effort to stay abreast of changes in the environment, and review the results with stakeholders; *Develop market discipline tools* and partnerships to reduce health care costs and expand access by forming an advisory group and taking an inventory of collaborative administrative efficiency initiatives;

	Develop a detailed work plan to pilot two community-based purchasing arrangements to achieve 100 percent access with the help of an advisory board that will help to define local access constraints and define community-based purchasing strategies; *Draft a report* to the Secretary of Health and Human Services.
Grant Amount and Time Frame	$1,320,400; 10/1/01–9/30/02, with an extension through 9/30/02.
Lead Agency	Office of Financial Management *http://www.ofm.wa.gov/* HRSA State Planning Grant Site http://www.ofm.wa.gov/accesshealth/accesshealth.htm
Project Partners	Partners include a consortium of state policymakers, major state purchasing and regulatory agencies, other governmental entities, concerned citizens, public and private organizations, professional groups.
Brief History of State Health Reform	Washington's **Medical Assistance Program (Medicaid)** covers children up to 200 percent FPL and pregnant women up to 185 percent FPL. The **CHIP** program covers children up to 250 percent FPL. In 1993, Washington initiated the **Washington Health Services Act**, which established the **Health Services Account**. The account provides subsidized coverage to all residents with incomes up to 200 percent FPL. The act also made the already existing **Basic Health Plan** (which covers low-income individuals up to 200 percent FPL who are not otherwise eligible for Medicare or Medicaid coverage) a permanent statewide program. Washington makes **State Direct Grants to Safety-Net Providers** totaling $70 million. Washington also supports the **Washington State Health Insurance Pool** for people who are unable to obtain insurance in the private market.
Existing Major Access Programs	Medicaid, CHIP, Health Services Account, State Basic Health Plan, State Direct Grants, State Health Insurance Pool

SPG FINDINGS	
Insurance Data	❑ About 484,000 (8.3 percent) of Washington's six million citizens lack health coverage. ❑ Two-thirds of the uninsured were in families with income levels below 200 percent FPL. ❑ More than half of the uninsured, 53 percent, are adults without dependent children. ❑ Children whose parents are uninsured comprise 75 percent of the uninsured population of children. ❑ Over 75 percent of the uninsured are in families or households with at least one worker. ❑ The East Balance region, which represents the most rural, eastern counties, has the highest uninsured rate, at 15.7 percent.
Employer Role	❑ Eighty percent of all workers are employed in businesses that offer coverage. ❑ Fifty-four percent of workers in businesses with fewer than 10 workers are offered coverage compared with 92 percent of workers in businesses with 50 or more employees. ❑ Almost 20 percent of the uninsured have employer-sponsored coverage available and over 34 percent of the uninsured are self-employed. ❑ Employment-based insurance covers nearly 71 percent of the population under age 65.
State Policy Recommendations	Recommended state policy options include: ❑ Individual/Family Incentives: Subsidies to help low-income people buy individual coverage and to help high-risk people buy individual coverage; subsidies or reforms for transitional coverage (e.g., COBRA); subsidies of employee contributions to employer-sponsored insurance; ❑ Employer Incentives: Voluntary subsidies to employers, play-or-pay mandate on employers;

	❑ Purchasing Pools: Employer-based purchasing pools, individual or individual/small-market purchasing pools, other community-based purchasing pools, mobile-worker purchasing pools; ❑ Direct Safety-Net Subsidies: Expand the Community Health Services Grant Program, create discount health cards for individuals, expedite Rural Health Center designation, increase payment to providers via health plan contracts, tax credits for nonprofit hospitals and for providers, and uncompensated care pools; ❑ Regulatory and Market Reform: Relief from benefit mandates, individual and small-group market regulations, high-risk pool expansion, universal catastrophic coverage.
Recommendations for Federal Policy	❑ Additional support with surveying or other data efforts: Increased funding for planning, policy development and pilot testing, support and standardizing state- level data collection, increasing access to federal data resources, exploring opportunities to improve data collection for longitudinal and transitional analyses; ❑ Additional research to assist in identifying the uninsured or developing coverage-expansion programs: Research options for maximizing funding and improving health outcomes with Indian Health Service, further review of affordability levels, help refocus implementation efforts and research toward meaningful reform; ❑ Medicaid and CHIP: Increased flexibility and streamlined administrative requirements, clarifying possible conflicts with regard to cost-sharing for Native Americans; a study of pharmacy rebates; incentives to small employers to offer coverage, individuals to buy coverage, or states to expand coverage that are equally available to all. ❑ Medicare: Enact drug benefits, explore opportunities to streamline assignment of provider identification numbers.
Change in Project Goals During Grant Period	No changes were indicated.

Actions Taken	Washington created a SPG program office within the Governor's Executive Policy Office.
Next Steps	❑ The Governor and Insurance Commissioner are exploring the formation of a jointly chaired health care council. With the initial research phase coming to an end, the state is planning to: 1. Share, discuss, and refine initial research with the interested individuals and organizations; 2. Refine the quantitative analyses regarding impact of specific policy options, and perhaps market-test a smaller subset of options; 3. Continue to build partnerships related to coverage and administrative simplification strategies; 4. Ensure that the complex results have broad practical utility for existing public programs and their potential redesign; 5. Find a home for the work of the grant and for identifying leaders to keep the work moving forward; ❑ Washington is actively pursuing a Medicaid waiver to include expansions to populations currently not eligible.
Principal Contact	Vicki Wilson, Ph.D., Project Director, Washington Office of Financial Management, P.O. Box 43113, Olympia, WA 98504-3113 Telephone: 360/753-5459 E-mail: *Vicki.Wilson@ofm.wa.gov*
Links to Reports	October 2001. HRSA Interim Report http://www.statecoverage.net/statereports/wa.pdf March 2002. HRSA Progress Report http://www.statecoverage.net/statereports/wa6.pdf

HRSA State Planning Grantee: Wisconsin	
Project Goals	Wisconsin's stated goals for this SPG were to: 1. design and implement the research necessary to identify more clearly and provide new information about the characteristics and circumstances of Wisconsin's uninsured population; 2. expand access whenever possible through private coverage while developing new policy options to improve and expand access through existing public program models or infrastructure; 3. address gaps in knowledge about private coverage from a statewide perspective; 4. develop effective, efficient, accessible human service systems that provide quality care; 5. foster effective communication and partnerships with other organizations, communities, service providers, consumers, families, and the general public.
Project Components	Planned components of the project included: *Collect new, statistically valid information* about health insurance offered by private employers in the state; *Assess small-employer attitudes toward health coverage* and their perceived roles and responsibilities, and identify the impediments to their sponsoring health insurance; *Support research analysis and design* of a private employer health care purchasing pool that attracts participation from small businesses; *Add additional questions* to the existing Family Health Survey and utilize the existing data to expand information about health insurance coverage and provide a more detailed understanding of the uninsured; Develop, design, and prepare to implement a new statewide health survey; *Conduct research* on health care coverage disparities among rural and other populations and validate the impact of existing public insurance programs;

	Perform an actuarial analysis to determine the type and value of benefits provided under employment-based health plans typically available to low-income families; *Convene a statewide conference* highlighting the planning grant, data collection, and analytic activities.
Grant Amount and Time Frame	$1,350,000; 10/1/00–3/30/02, with an extension through 9/30/02.
Lead Agency	Department of Health and Family Services *http://www.dhfs.state.wi.us* Link to the Wisconsin Final Report to HRSA and other SPG project documents: *http://www.dhfs.state.wi.us/medicaid1/state-grant/index.htm*
Project Partners	Within the Department of Health and Family Services: Bureaus of Fee-for-Service Health Care Benefits, Health Information, Managed Health Care Programs and Health Care Eligibility; Office of the Commissioner of Insurance, Department of Employee Trust Funds, Department of Administration, Milwaukee General Assistance Medical Program, Dane County Health Council, Wisconsin Primary Care Health Association, Institute for Health Policy Solutions, Agency for Healthcare Research and Quality, University of Wisconsin Survey Center, Wisconsin Network for Health Policy Research
Brief History of State Health Reform	**BadgerCare**, Wisconsin's CHIP program, has operated since July 1999 and currently covers families with incomes up to 200 percent FPL. In one year, 71 percent of the eligible, uninsured children were enrolled in CHIP or in Medicaid. In addition, 52 percent of eligible, low-income adults were enrolled in the program. Also in 1999, a provision of Wisconsin Act 9 authorized the design and operation of a private employer health care coverage program, **Private Employer Health Care Coverage Program (PEHCCP)**. The legislation created administrative infrastructure to establish a new risk pool for private employers to purchase group health insurance on behalf of their employees. In addition, Wisconsin operates a number of publicly funded programs that provide health care to Wisconsin residents otherwise unable to obtain care. These programs include the **Health Insurance Risk Sharing Pool**, which offers health insurance to residents who, due to their medical

	conditions, are unable to find adequate health care in the private market and are not eligible for public programs; **WisconCare**, which is a small program operating in 17 Wisconsin counties with high unemployment rates, providing a limited scope of outpatient primary care and inpatient maternity/delivery services; and the **Relief Block Grant** Program, which is an optional state- and county-funded program administered at the county level providing medical care to eligible dependent persons. **Milwaukee County** administers the largest relief block grant program in the state, known as the **General Assistance Medical Program (GAMP)**. The program utilizes community-based primary care providers within a coordinated delivery system at locations throughout the county. **SeniorCare** began providing prescription drug coverage for seniors with incomes under 240 percent FPL in September 2002.
Existing Major Access Programs	BadgerCare, Medicaid, Health Insurance Risk Sharing Pool, WisconCare, Relief Block Grant Program, including Milwaukee County's GAMP
SPG FINDINGS	
Insurance Data	❑ Slightly more than 4 percent of Wisconsin residents are uninsured. ❑ Seventy-four percent of the population receives coverage through their employer; 10 percent of the population is covered under Wisconsin's two major coverage programs, Medicaid and BadgerCare. ❑ Almost half of the uninsured have household incomes less than $25,000. ❑ American Indian and Hispanic populations are more likely to be uninsured; 11 percent of American Indians and 12 percent of Hispanics are uninsured. ❑ Health insurance premiums and deductibles are considerably higher for Barron County dairy farm families who purchased their own insurance.
Employer Role	❑ Eighty-two percent of employees are offered employer-sponsored coverage, with a take-up rate of 78 percent.

	❑ Forty-six percent of small employers (50 or fewer workers) offer insurance, compared with 98 percent of large employers. ❑ Thirty-four percent of low-income employees compared with 17 percent of all employees reported that their employer did not offer health care coverage to them; low-income employees were also more likely to decline coverage (28 percent compared with 22 percent). ❑ On average, Wisconsin employers pay 81 percent of the cost for the most comprehensive, lowest-cost single-coverage policy they offered their employees. ❑ Apart from cost, other reasons cited by employers for not offering insurance were that their employees had coverage through some other source, lack of incentives to provide it, and the hassle or responsibility of administering coverage.
State Policy Recommendations	Policies supported include: ❑ Expanding access to publicly subsidized health insurance for uninsured low-income working adults without children; ❑ Expanding access to coverage through private/public buy-ins; continued support for enrollment in BadgerCare HIPP employer buy-in program; ❑ Strengthening partnerships with local governments and community agencies to provide basic primary care and prevention programs (absent federal initiatives). At the same time, with a potentially significant budget deficit approaching, and with new programs enacted to satisfy public demand for prescription drug coverage for the elderly and targeted Medicaid expansions, the Administration and Legislature are now considering administrative and benefit reductions.
Recommendations for Federal Policy	❑ Continue financial support for states to administer data collection efforts that help them understand health insurance coverage issues in their respective states; ❑ Invest in research on new health care cost-containment strategies;

	❑ Focus on assembling the information obtained through the various SPG programs to develop viable strategies for improving access to health care coverage when adequate resources again become available.
Change in Project Goals During Grant Period	The project did not change appreciably during the grant period.
Actions Taken	❑ In the course of the SPG funding period, the state's biennial budget was debated and signed into law by the Governor. This included health-related policy proposals to provide prescription drug coverage for the elderly under SeniorCare, Medicaid coverage to uninsured women diagnosed with breast or cervical cancer, and a tobacco control endowment trust fund to support community-based and statewide public health programs aimed at reducing tobacco use. ❑ The state redesigned the Wisconsin Family Health Survey, including a Spanish translation instrument that would help strengthen the data of this growing minority group.
Next Steps	❑ The new Wisconsin Family Health Survey will be ongoing and continue to provide new information about the insured and uninsured populations. ❑ SPG research may also support possible legislative initiatives. For example, the analysis of the BadgerCare HIPPHR supports the modifications necessary to improve access and enrollment of low-income working families with access to employer-based insurance in the program.
Principal Contact	Russ Pederson, Section Chief, Division of Health Care Financing, Department of Health and Family Services, 1 West Wilson Street, Madison, WI 53703 Telephone: 608/266-1720
Links to Reports	October 2001. Final Report to the Secretary http://www.statecoverage.net/statereports/wi.pdf March 2002. Addendum to the Final Report to the Secretary *http://www.statecoverage.net/statereports/wi11.pdf*