



**EXPANDING HEALTH INSURANCE COVERAGE:  
CREATIVE STATE SOLUTIONS FOR CHALLENGING TIMES**

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Economic and Social Research Institute

FIELD REPORT

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## **ABOUT THE ECONOMIC AND SOCIAL RESEARCH INSTITUTE**

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

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## EXECUTIVE SUMMARY

During the past decade, states have made major strides in health coverage expansion through both public programs and publicly subsidized private insurance. These expansions were aided by a strong economy with low unemployment, budget surpluses due to increasing tax revenues, and an influx of tobacco settlement funds. Although the current budget shortfalls have placed most states in a “holding” or “cut-back” mode, history has proven that economic downturns are not permanent and that state revenues and opportunities eventually rise again. The path taken in response to short-term fiscal problems can even lay the groundwork for future health care reform to expand coverage.

This paper summarizes lessons from case studies of coverage expansions in 10 states.<sup>1</sup> The states were selected to represent a cross-section of those with innovative strategies and/or a history of successful coverage expansion. We also studied the final reports of the 20 states that received initial State Planning Grants from the Health Resources and Services Administration (HRSA) in 2000 and 2001 to determine what additional innovations lie ahead. The following themes and lessons emerged from this analysis:

- State-specific data are essential for identifying gaps in coverage and access, understanding the factors behind those gaps, developing strategies, and securing support for reform.
- There are opportunities to obtain external funding from public and private sources to support research and policy development.
- Designing a program for expansion (e.g., building on existing programs versus starting new programs) involves trade-offs concerning fragmentation, administrative complexity, financial stability, and state autonomy. The right balance for each state depends on ideological, historical, financial, and political factors.
- A common enrollment process and communication among various coverage programs eases transitions and minimizes having people “fall through the cracks.”
- Successful coverage reform requires political leadership and a clearly defined mission.

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<sup>1</sup> The case studies of Arkansas, Georgia, Michigan, New Jersey, New Mexico, New York, Oregon, Rhode Island, Utah, and Vermont are available for reading and downloading at [www.cmwf.org](http://www.cmwf.org), as are summaries of the Final Reports from the HRSA State Planning Grants.

- Partnering with employers to boost coverage is slow and fraught with difficulties, but new models are emerging.
- Essential ingredients for success are fostering dialogue among stakeholders, obtaining public input, and building broad-based coalitions to work actively for reform.
- Maintaining or expanding managed care capacity is an ongoing challenge; states may consider supporting a “backup” in the form of a Community Health Center–based safety net health plan.
- Challenges are involved in minimizing the substitution of private coverage for public coverage. Anti-crowd-out mechanisms such as look-back periods and minimum employer contributions may result in inequities and low participation.
- There is a need for creative approaches to economic realities, including stretching existing dollars to provide some coverage to the uninsured. Close monitoring and evaluation of these experiments, with a focus on the impact on access to care, is vital.

### **Current Strategies Under the Economic Downturn**

After years of prosperity, many states are now forced to cut back eligibility, benefits, and/or provider payments in their public health coverage programs. Yet, some states are continuing to try to expand coverage to additional populations (particularly low-income adults, parents, or workers) by redirecting state health care dollars rather than relying on new state expenditures, and often reallocating federal money (such as unused CHIP funds) and/or leveraging private dollars. Strategies being considered and/or pursued in the 10 study states and among the 20 states that received HRSA State Planning Grants for coverage expansion policy development fall generally into one of two categories:

1. **Experimenting with public coverage expansions**, such as modifying benefit packages and/or increasing cost-sharing for certain populations to allow for coverage of new populations;
2. **Expanding coverage through public–private linkages**, such as subsidizing employer-sponsored insurance premiums through Medicaid or CHIP to tap federal matching funds and retain employer/employee contributions; using public funds to reinsure private health plans, thereby promoting lower-cost options for businesses and individuals; and allowing employers and workers to buy in to public coverage (potentially under the Health Insurance Flexibility and Accountability initiative).

### *HIFA Approach*

Several states are pursuing coverage expansions through the new flexibility afforded them under the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. HIFA waivers granted by the federal government generally allow modifications to the Medicaid benefit package and/or increased cost-sharing for optional and expansion populations. HIFA demonstrations must be budget-neutral to the federal government, so states are reallocating several existing streams of federal money (e.g., unused CHIP allotments) to help finance the initiative in addition to generating savings through increased cost-sharing and cutting benefits for currently eligible populations.<sup>2</sup>

States have taken a wide variety of approaches to design programs under HIFA authority. In general, proponents believe that HIFA will help states reduce the number of uninsured by allowing them to stretch dollars to provide some benefits to previously uninsured people. Opponents are concerned that:

- Existing enrollees may lose access to important services if benefits are cut or cost-sharing discourages the use of services and reduces take-up rates;
- HIFA sets a dangerous precedent of allowing states to modify federally mandated benefits;
- If some people previously enrolled in Medicaid are shifted into private insurance (through HIFA premium assistance programs), they may not only lose certain Medicaid benefits, but they may also lose protections provided by being part of the public system (e.g., appeals procedures);
- Some cost-sharing measures may result in indirect cost-shifts to certain providers when patients cannot make their copayments or are not covered for certain necessary services, or when disproportionate share hospital funds are diverted to new coverage.

Whether and to what degree these concerns are realized will be seen over the course of implementing these initiatives, reinforcing the need for sustained independent evaluation of the programs.

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<sup>2</sup> States have three years to use federal CHIP funds appropriated in a given year. If states do not spend the money within that time, the federal government redistributes a portion of the unused money to other states that exhausted their initial funding. Any remaining unused money must be given back to the U.S. Treasury. On October 1, 2002, twenty-five states forfeited a total of \$1.2 billion in unspent 2000 CHIP funds. (Kaiser Network Daily Health Policy Report, October 15, 2002; [www.kaisernet.org](http://www.kaisernet.org))

## **Recommendations for Federal Policy**

In light of the difficult financial situation facing states, the federal government could consider the following actions to help states maintain gains in coverage that have been made and perhaps even provide assistance to increase coverage to currently uninsured populations:

- **Technical assistance:** Expand data collection and dissemination, serve as a clearinghouse for health-related information, and continue funding for policy research, development, and evaluation (as HRSA has done through the State Planning Grant program).
- **Demonstrations:** Permit states to explore coverage expansions through the new flexibility under HIFA and new statutory flexibility, as well as through community and multistate demonstrations.
- **Short-term financial assistance:** Explore ways to help fund state programs during the economic downturn, such as temporarily increasing the Federal Medicaid Assistance Percentages (FMAP), raising CHIP allotments for parents, offering a federal incentive match for hard-to-reach minority populations, increasing funding for the safety net, or providing support for state pharmaceutical initiatives.
- **Federal coverage expansion:** Take action to cover the uninsured by expanding Medicaid, CHIP, or Medicare and/or instituting a tax credit program. Although federal budget deficits make major federal investments unlikely in the short term, options should be debated and developed so that approaches are ready when economic conditions turn around.

## BACKGROUND

Over the past decade, many states have sought to expand health coverage for low-income children and adults, through both public program expansions and efforts to promote private insurance. These expansions were aided by a period of prosperity during the mid to late 1990s that was marked by relatively flush state coffers and an influx of dollars from a landmark tobacco settlement.<sup>3</sup> Federal welfare reforms in 1996 and the strong economy led to a decline in Medicaid rolls in the late 1990s. The dip in the traditional Medicaid population, however, was accompanied by the establishment of new public health coverage programs, including the implementation of the State Children's Health Insurance Program (CHIP) and a variety of Medicaid, CHIP, and state-sponsored coverage expansions to uninsured populations, which included low-income parents and some childless adults. A few states developed premium assistance programs involving public subsidies toward the purchase of private, employer-sponsored insurance.<sup>4</sup> After decades of increasing numbers of uninsured (from 31 million in 1987 to more than 44 million in 1998), the overall number of uninsured edged downward in 1999–2000.<sup>5</sup>

Different states made varying degrees of progress, with some taking the lead and reducing their rates of uninsurance considerably. The Economic and Social Research Institute (ESRI) has studied coverage expansion initiatives in numerous states with diverse characteristics to determine the elements that sparked and facilitated the more successful efforts. In addition, ESRI examined how these states are addressing coverage gaps during the current downturn in the economy. Whereas most states are trying to maintain the gains they had made or are making necessary cutbacks, a few states are continuing efforts to expand coverage to uninsured residents, but in ways that stretch existing state funds rather than require major new investments. This report focuses particularly on low-cost and no-cost coverage initiatives and suggests ways that the federal government can support such efforts.

To learn from states' experiences and identify promising models, 10 states were studied in-depth.<sup>6</sup> The experiences of 20 states that received State Planning Grants from

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<sup>3</sup> Based on a 1999 civil settlement, the major tobacco companies agreed to pay a total of \$206 billion to 46 states over 25 years; a separate settlement is providing the remaining four states a total of \$40 billion.

<sup>4</sup> See, for example, *Enhancing Health Coverage for the Working Uninsured: Lessons from Six State and Local Programs* (Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, The Commonwealth Fund, February 2001) and *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, The Commonwealth Fund, November 2000).

<sup>5</sup> Robert J. Mills, "Health Insurance Coverage: 2000," Current Population Reports, U.S. Census Bureau, U.S. Department of Commerce, September 2001.

<sup>6</sup> The 10 states studied were: Arkansas, Georgia, Michigan, New Jersey, New Mexico, New York, Oregon, Rhode Island, Utah, and Vermont. Individual case studies are available at [www.cmf.org](http://www.cmf.org). ESRI was assisted by the Center for State Health Policy at Rutgers University, which conducted the case study of New Jersey.

the Health Resources and Services Administration (HRSA) to develop coverage expansion strategies were also reviewed.<sup>7</sup> The criteria for selecting the 10 states included evidence of innovative strategies and/or a history of successful coverage expansion and diversity in size, population characteristics, socioeconomic conditions, coverage rates, geography, and rural/urban characteristics. Some states studied have been long-term leaders in health reform; others have just begun to explore coverage expansion options. A few states have been quite innovative in coverage expansion but were not included in this analysis because of the diversity criteria or because they have been recently studied in-depth by other researchers.<sup>8</sup>

The goal of this cross-state study was to draw lessons from specific state experiences, as well as to identify common themes across states. The findings may provide guidance to state and federal policymakers interested in supporting promising coverage expansion models. In studying state experiences, the following issues were examined:

- Necessary “ingredients” for coverage expansion initiatives over the past decade: What allows coverage expansion to take place in some states and not others? What makes some efforts successful while others flounder? How have states addressed and overcome obstacles to health reform?
- Successful and promising models for covering the uninsured: What initiatives have worked in the past and could be considered by other states? What are some new ideas states are developing?
- Innovative low-cost and no-cost approaches being pursued in the current budget crunch: What kinds of trade-offs are states making to reach previously uninsured populations? What is their plan for dealing with the potential adverse impact on certain populations whose coverage might change as a result of the planned health reform? What regulatory mechanisms are states using to obtain federal approval and financial support? What kinds of resistance are they facing and how are they addressing them?

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<sup>7</sup> Under the State Planning Grants program, HRSA provides one-year grants to states to develop plans for providing access to affordable health insurance coverage to all their citizens. For this research study, we reviewed the State Planning Grant proposals and the interim and final reports submitted by the 20 states that received grants in 2000 and 2001. Summaries of their interim and final reports are available at [www.cmwf.org](http://www.cmwf.org).

<sup>8</sup> Recent case studies of Minnesota and Massachusetts, for example, have been conducted. See Deborah Chollet and Lori Achman, *Approaching Universal Coverage: Minnesota's Health Insurance Programs*, The Commonwealth Fund, forthcoming; and Randall Bovbjerg and Frank Ullman, *Recent Changes in Health Policy for Low-Income People in Massachusetts*, Assessing the New Federalism, The Urban Institute, State Update No. 17, March 2002 (accessible at [www.urban.org/uploadedPDF/310431.pdf](http://www.urban.org/uploadedPDF/310431.pdf)).

- Major challenges lying ahead: What are the upcoming challenges? How do states plan to address them? How can the federal government help?

This research project resulted in two reports. The first, *Assessing State Strategies for Health Coverage Expansion: Summaries of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia*, presents lessons from four states' experiences.<sup>9</sup> This second report synthesizes findings from those four plus six additional states: Arkansas, Michigan, New Mexico, New York, Utah, and Vermont. Table 1 presents some basic characteristics of the 10 states studied. It illustrates the wide range in state size, rates of uninsurance, eligibility for public coverage, and existence of public premium assistance programs that encourage the purchase of private health insurance. (For more details on public program eligibility in the 10 states, see Appendix.)

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<sup>9</sup> The Commonwealth Fund, November 2002. It is available at [http://www.cmwf.org/programs/insurance/silow-carroll\\_statestrategieslong\\_565.pdf](http://www.cmwf.org/programs/insurance/silow-carroll_statestrategieslong_565.pdf).

**Table 1. State Characteristics and Coverage Comparison of 10 Study States**

State	Population/ Percent Low-Income <sup>a</sup>	Percent Uninsured <sup>b</sup>	Medicaid/CHIP Eligibility for Children <sup>c</sup>	Medicaid/CHIP Eligibility for Adults <sup>d</sup>	Premium Assistance Programs/ Reinsurance
Arkansas	2,574,760 44% low income	Nonelderly adults: 19% Children: 12%	Up to 200% FPL	Pregnant women up to 133% FPL Adults up to 22% FPL	
Georgia	7,772,210 36% low income	Nonelderly adults: 19% Children: 10%	Up to 235% FPL	Pregnant women up to 200% FPL Temporary Assistance for Needy Families (TANF) adults up to 44% FPL	
Michigan	10,032,090 29% low income	Nonelderly adults: 13% Children: 8%	Up to 200% FPL	Pregnant women up to 185% FPL Caretaker relatives up to 50% FPL	
New Jersey	8,186,500 27% low income	Nonelderly adults: 16% Children: 9%	Up to 350% FPL	Pregnant women up to 200% FPL Parents up to 200% FPL Single adults/childless couples up to 100% FPL	Premium Assistance and wrap-around services available to parents/pregnant women up to 200% FPL, childless adults up to 100%, children up to 350% FPL with access to employer-sponsored insurance; when employer pays at least 50% of the premium; and if cost-effective to state.
New Mexico	1,792,150 47% low income	Nonelderly adults: 29% Children: 24%	Up to 235% Federal Poverty Level (FPL)	Pregnant women up to 185% FPL TANF adults up to 37% FPL	
New York	18,439,110 37% low income	Nonelderly adults: 20% Children: 11%	Up to 250% FPL Family full-cost buy- in for incomes greater than 250% FPL	Pregnant women up to 200% FPL Adults with dependent children up to 150% FPL Childless adults up to 100% FPL	State provides stop-loss protection for basic HMO plan available to small employers with low-wage workers, <sup>e</sup> and to individuals and self-employed persons with incomes up to 250% FPL

State	Population/ Percent		Medicaid/CHIP Eligibility		Medicaid/CHIP Eligibility for Adults <sup>d</sup>	Premium Assistance Programs/ Reinsurance
	Low-Income <sup>a</sup>	Percent Uninsured <sup>b</sup>	for Children <sup>c</sup>	for Adults <sup>d</sup>		
Oregon	3,404,950 32% low income	Nonelderly adults: 17% Children: 13%	Up to 170% FPL	Pregnant women up to 133% FPL Adults up to 100% FPL	Premium Assistance for individual policy or employer-sponsored insurance if incomes less than 170% FPL; assets/savings less than \$10,000; no health insurance for past 6 months	
Rhode Island	958,440 30% low income	Nonelderly adults: 8% Children: 4%	Up to 250% FPL	Pregnant women up to 250% FPL Adult parents up to 185% FPL	Premium Assistance for parents to 185% FPL, children and pregnant women to 250% FPL, with access to employer- sponsored insurance	
Utah	2,173,280 34% low income	Nonelderly adults: 17% Children: 10%	Up to 200% FPL	Pregnant women up to 133% FPL Adults up to 150% FPL		
Vermont	617,770 34% low income	Nonelderly adults: 14% Children: 8%	Up to 300% FPL through age 17 (up to 150% FPL for 18 year olds)	Pregnant women up to 200% FPL Custodial parents and caretaker relatives up to 185% FPL Noncustodial parents and other adults up to 150% FPL		

<sup>a</sup> This column includes the total population for the state and the portion of the population with incomes under 200% of the Federal Poverty Level. (Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on March 2000 and 2001 Current Population Surveys.)

<sup>b</sup> Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys.

<sup>c</sup> Children are defined as through 18 years old unless otherwise noted; income-based eligibility and specific program/benefit package may vary based on specific age groups.

<sup>d</sup> Excludes the elderly and disabled. Benefit packages may vary based on income and/or other factors. For more details on the eligibility breakdowns, see Appendix.

<sup>e</sup> To be eligible, an employer must have up to 50 eligible employees and at least half participate; more than 30% of the eligible employees earn less than \$30k/yr and at least one participates; no coverage over prior year (employer didn't offer); employer pays at least 50% single premium.

## **COMMON THEMES AND LESSONS FROM STATE COVERAGE EXPANSIONS**

### **Data Is Essential for Developing Strategy and Securing Support**

The collection and analysis of state-specific quantitative and qualitative data on health coverage, the uninsured, and insurance markets have proven useful, if not essential, for several different activities. State-specific data help to publicize the extent of the access problem. In New York, for example, research findings on deteriorating access to public and private insurance were picked up by the media, leading to serious discussions on policy reform options. In Arkansas, reform advocates trying to build support for greater spending on health care found it helpful to use community-based data to illustrate how local economies would benefit.

State-specific data also help identify target populations and/or geographic areas that are experiencing high uninsurance rates and reveal the underlying factors causing these high rates. Virtually all of the states receiving State Planning Grants and the additional states profiled relayed the importance of collecting and analyzing state-specific data to help them identify gaps in coverage in terms of both population (age, income, language/ethnicity) and regional characteristics. The states also found that a combination of in-state surveys, focus groups, and in-depth interviews, in addition to analyzing national data, provided them with an understanding of the elements contributing to those gaps.

Developing coverage options that target selected populations and address the underlying factors impeding their access to coverage is another use for these state-specific data. The State Planning Grant states were able to design policy options to address specific barriers to coverage. Many states confirmed through their research, for example, that many small firms wished to provide insurance but lacked an affordable insurance option; these states made recommendations to support the provision of lower-cost health plans for this market.

Finally, documenting progress from existing coverage programs helps to solidify support for continuing or expanding the programs. In Rhode Island, an extensive research and evaluation component has documented positive outcomes associated with RItE Care. This helped build legislative and public support for RItE Care's expansion to additional populations over the past decade.

In conjunction with the State Planning Grants, states have been able to work with the State Health Access Data Assistance Center (SHADAC).<sup>10</sup> SHADAC is a three-year, \$4-million initiative funded by the Robert Wood Johnson Foundation that provides technical assistance to states interested in gathering policy-relevant information about their uninsured and underinsured populations. It has played a key role in helping State Planning Grant grantees and other states conduct state-specific research, including designing survey instruments, developing sampling strategies, selecting vendors, and assessing existing data sources.

### **External Funding May Support Research and Policy Development**

Collecting and analyzing data is just one of many essential policy development activities. Preparing the “groundwork” includes, but is not limited to: developing policy options, educating and obtaining feedback from the public, building consensus among stakeholders, modeling reform scenarios to estimate impact on cost and coverage, selecting an option, developing administrative requirements, and designing implementation plans. Tight state budgets have made it increasingly difficult for state agencies to conduct these activities and many state agencies do not have the expertise in their agencies or even within state borders to conduct these activities. A number of states have filled the financial gaps with grants from the federal government and/or private foundations, although to do so takes knowledge about grant opportunities, grant-writing skills, and creativity.<sup>11</sup> Once awarded, grants can also be used to leverage other private and public funds. HRSA’s State Planning Grant program has provided one-year grants (ranging from \$721,000 to \$1.63 million) to states to develop policy options to expand coverage to all state residents. In addition to funding data collection and analysis described above, State Planning Grants finance consensus-building activities and technical assistance from experts within and outside state borders. After 20 states received State Planning Grants in 2000 and 2001 (those reviewed for this study), an additional 11 states plus the Virgin Islands received State Planning Grants in 2002.<sup>12</sup>

Private foundations have also provided needed resources to lay the groundwork for coverage expansion. The Robert Wood Johnson–funded State Coverage Initiatives (SCI)

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<sup>10</sup> See [www.shadac.org](http://www.shadac.org).

<sup>11</sup> Section 1115 demonstration waivers have provided states an opportunity to experiment with new coverage approaches and contain a research evaluation component—although the application process has been notoriously slow and difficult. One of the goals of the current HHS Secretary has been to speed up this approval process to encourage more state experimentation.

<sup>12</sup> State Planning Grant FY2000 grantees included Arkansas, Delaware, Illinois, Iowa, Kansas, Massachusetts, Minnesota, New Hampshire, Oregon, Vermont, and Wisconsin. State Planning Grant FY2001 grantees included Arizona, California, Colorado, Connecticut, Idaho, South Dakota, Texas, Utah, and Washington. State Planning Grant FY2002 grantees included: Alabama, Georgia, Hawaii, Indiana, Maine, Maryland, Montana, New Jersey, South Carolina, Virgin Islands, West Virginia, and Wyoming.

program, for example, offers “fast-track” Policy Planning Grants (\$75,000 to \$150,000) to support states in exploring and planning coverage expansions.<sup>13</sup> SCI also offers large demonstration grants (up to \$1.5 million) that support states needing assistance in designing and implementing a coverage expansion program. Arkansas, New Mexico, Oregon, and Rhode Island received these grants in 2001, and additional states will be selected in 2002. Additional federal and foundation grants (e.g., HRSA’s Community Access Program, the W. K. Kellogg Foundation’s Community Voices program, and the Robert Wood Johnson Foundation’s Southern Rural Access Program and Communities in Charge program) have provided technical assistance and funds to states for a variety of local initiatives.

In the future, grant funding may be used to track some of the new coverage expansion initiatives. Such evaluations can help determine which strategies work and should be used more broadly. Conversely, unsuccessful strategies can be studied to determine why they failed. Evaluation results can be disseminated broadly to avoid duplication of efforts or “reinventing the wheel,” and to allow states to learn from others’ mistakes. Given the controversy surrounding some of the new Section 1115/Health Insurance Flexibility and Accountability (HIFA) waivers that affect current beneficiaries or that use public funds to provide coverage that does not include many of the Medicaid benefits, it may be particularly important to support these evaluations.

### **Selecting a Vehicle for Expansion Involves Trade-Offs**

One of the most basic decisions states face involves selecting a vehicle for expanding coverage. One set of choices involves whether to expand coverage through public programs or to use public funds to encourage private-sector expansion. This is not a clear-cut divide, but rather a continuum, with pure public coverage expansion at one end, subsidies for private insurance at the other end, and a growing number of combined approaches in between. New York’s Family Health Plus, for example, is a Medicaid expansion for adults that resembles private insurance in terms of benefits, cost-sharing, and health plan choices. That state’s Healthy New York reinsurance program uses public funds to provide stop-loss coverage for private HMO plans offered to small businesses and uninsured individuals. These examples demonstrate that the distinction between public and private has become quite blurred. Selecting the right balance depends on philosophical and political factors such as the public’s attitude toward government and the political orientation of the governor and state legislature.

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<sup>13</sup> New Mexico is a past Policy Planning Grant recipient; Hawaii, Kansas, Maine, Mississippi, and West Virginia are current recipients.

Another set of choices involves building on existing programs rather than starting new programs. This decision is based in part on a state's past experience and its future goals. A state with a successful coverage program is more likely to expand that program, while a state with a program plagued with administrative bureaucracy and stigma may choose to begin a new, separate program free from "baggage." Some states, such as New Mexico, find it politically necessary to make their new coverage program appear private and distinct from a public program expansion; this was deemed essential to garner support from the business community, the public, and many legislators.

Conversely, many states anticipated the benefits of expanding coverage under one "umbrella" program. Oregon, Vermont, Rhode Island, and Georgia found it helpful to focus their efforts on establishing and then expanding one program, providing "seamless" coverage across different eligibility groups. This approach appears to minimize administrative complexity and allow families to be covered together (thereby encouraging more appropriate use of the health care system). A third set of choices involves a trade-off between stable federal financing and state autonomy. Coverage expansions through Medicaid and CHIP enjoy federal matching funds. Many states choose the CHIP route because of the enhanced federal match (which ranged from 65 to 83.26 percent for FY2002). There are limits to CHIP funding since it is a block grant program, while the Medicaid "entitlement" has more secure federal funding over the long run. However, obtaining federal dollars for Medicaid and CHIP is tied to meeting federal guidelines and requirements. Some states preferred greater autonomy, with state-funded programs free from such constraints. Yet the stability of such programs can be precarious, particularly during economic downturns. Thus, a few states are looking for ways to obtain federal matching funds for programs that were started using only state funds. For example, Oregon sought federal approval to place its popular but under-funded state FHIAP premium assistance program under the Oregon Health Plan umbrella.

Understanding the trade-offs when choosing a vehicle for coverage expansion is critical. This review of state experiences indicates that the "right" vehicle varies, depending on an individual state's history, politics, population characteristics, and philosophy.

### **Communication Among Programs Promotes Seamless Coverage**

Regardless of the coverage vehicle, it is important to build a system that allows for a common enrollment process and communication among programs in order to ease transitions and minimize people "falling through the cracks." Political factors led to New York's establishment of its CHIP program, Child Health Plus-B, as a health plan distinct

from its Medicaid program. It was built with a separate enrollment process, health plan contracts, and computer systems. There was no “master” information system that tracked people across various programs as their circumstances and eligibility status changed. The short-term consequence was a fragmented, complex system with different applications, enrollment sites, rules, and health providers for different members of the family. Also, there were serious complaints about people left uninsured when they were no longer eligible for one program but not automatically enrolled in another for which they were entitled. Only recently did the state develop one enrollment form for five different assistance programs. Much work remains, however, to promote communication, coordination, and seamless coverage among the health programs.

### **Importance of Political Leadership and a Clearly Defined Mission**

All of the states studied that were active in health reform had a strong leader, generally the governor, who adopted coverage expansion as a major priority and “sold” it to the public, legislators, and stakeholders. Michigan’s governor, for example, has publicly committed to enact coverage expansion before he leaves office due to term limits. This helped to speed the submission of a HIFA waiver application necessary for the reform. Vermont’s governor, a physician and longtime proponent of universal coverage, has been instrumental in ensuring generous public coverage for children in his state. Such leadership is not limited to elected officials. In New York, the charismatic leader of a very influential health care workers’ union played a leading role in building popular support for New York’s Family Health Plus coverage program for adults.

Establishment and public acceptance of specific goals regarding promoting health or expanding coverage to certain populations is important, enhancing policymakers’ ability to obtain support and enact necessary reforms.

### **Partnering with Employers to Boost Coverage Is Slow, but New Models Are Emerging**

States examined in this study are searching for ways to partner with employers to share the cost of coverage for low-income workers. Premium assistance programs (e.g., Rhode Island’s RItE Share and New Jersey’s Premium Support Program) involve public subsidies that can be used toward the purchase of private employer-sponsored insurance. Getting such programs off the ground has been an unexpectedly difficult task, however, due to resistance by employers, unwillingness of public coverage enrollees to convert to private insurance, lack of awareness about the programs, and requirements concerning employer contribution levels.

New York's Healthy New York program offers a different model of public-private partnerships, whereby the state provides stop-loss protection to private HMOs that offer a basic health plan to small firms and individuals. Thus, the subsidy is provided directly to health plans, which will presumably pass the savings to consumers in the form of lower premiums. Yet initial enrollment in this program has been much lower than expected, raising questions about whether such savings are adequate to induce employers to purchase coverage.

Recent modifications to RIte Share and emerging models of other public-private partnerships offer some encouragement. After RIte Share was modified to subsidize employees directly (not requiring active participation by employers) and make participation of RIte Care (Medicaid/CHIP managed care) enrollees with access to employer insurance mandatory, enrollment in RIte Share increased dramatically in the first six months of 2002.

A new employer-based approach being developed in New Mexico and Arkansas reflects the recent flexibility in the Medicaid and CHIP programs granted to states by the federal government through the HIFA waiver process. The model is a hybrid premium assistance/buy-in program in which employers and employees can buy into health plans under contract with the state. For low-income workers, the coverage would be subsidized with Medicaid funds. Under New Mexico's approved HIFA waiver, the state would contract with private managed care organizations that would offer a standardized basic benefit plan and market directly to employers. Arkansas is developing a similar proposal that would allow employers with low-income workers to buy into a subsidized Primary Care Case Management Program. It will be important for policymakers to monitor the progress of such new initiatives.

### **Fostering Dialogue Between Stakeholders and the Public**

This study has underscored the need for coverage expansion proponents to build broad-based coalitions to promote and work actively for reform. While tensions among various interest groups are natural and unavoidable, efforts to reduce the adversarial quality of the relationships greatly enhance coverage programs' viability. In New York, an unusual alliance between hospitals and health care workers was instrumental in building public and political support for Family Health Plus, a new Medicaid managed care program for adults. In Arkansas, a statewide educational bus tour involving the representatives of various constituencies aided passage of a public referendum for using tobacco settlement funds for coverage expansion and other health care needs.

States cite the involvement of stakeholder groups in actually designing and implementing coverage expansions as a key factor for success. For example:

- All of the State Planning Grant states used the planning process to engage stakeholders in developing policy options, including them as active participants in the project.
- The development of the new benefit package for the Oregon Health Plan expansion was an open process, as the state encouraged stakeholders to weigh in on modifications to the list of covered health services.
- Consulting with the business community was very important to New Mexico as state policymakers were designing their HIFA waiver. The state conducted focus groups with employers to learn more about their concerns. After hearing feedback from the focus groups, the state designed a premium assistance program with a standardized benefit plan that is administratively simple for employers because they will not have to shop around for a plan.
- Including patient advocacy groups in the design and implementation of health care reform proved to be essential for ensuring adequate consumer protections, developing a program that functions well for participants, and providing critical “buy-in” among a program’s constituencies.
- Finally, the involvement of a third party to convene meetings among various groups was instrumental in some states (e.g., Rhode Island and New York) for developing policy options and promoting consensus for reforms.

### **Managed Care Capacity Concerns**

When designing public coverage expansions that rely on managed care to control costs, states need to pay particular attention to attracting and retaining health plans. This has been particularly challenging over the past few years, as many states have seen plans leaving the state in response to lack of profits. In such cases, the resulting lack of competition often contributes to an escalation of premiums and further declines in the small-group and individual markets.<sup>14</sup> Even among health plans that remain, it is often difficult to secure their participation as Medicaid providers if the reimbursement rates are considered inadequate.

In Arkansas, for example, a majority of health plans left the state due to lack of profits. In Vermont, all but three carriers left the state in large part due to insurance

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<sup>14</sup> See *State of the States*, prepared for State Coverage Initiatives, January 2002.

reforms. Vermont’s Medicaid program (VHAP) has a primary care case management component but no traditional managed care plan. Rhode Island saw two major health plans cease coverage in the state. Among the three that remained and participated in its RItE Care program, two plans stopped accepting new enrollees for a period of time due to what they perceived as inadequate capitation rates. In addition to working with health plans to establish mutually acceptable payment rates for public enrollees, states may be well served to maintain or help establish a “backup” in the form of a Community Health Center–based safety net health plan. While both Oregon and Rhode Island still have commercial plan participation in their programs, both states relied on such safety net health plans when commercial plans backed away from serving public enrollees. Another approach to securing capacity is *requiring* health plan participation. New York, for example, requires that all HMOs operating in the state participate in its Healthy New York program, whereby the state subsidizes the plans in the form of stop-loss coverage (the HMOs then set their own rates after a review by the state insurance department). Requiring health plan participation may backfire, however, if reimbursement payments are too low and the carriers are forced to leave the state entirely.

### **Challenges Involved in Minimizing Crowd-Out**

Expansion of eligibility for public programs—particularly without simultaneous promotion of private insurance—risks “crowd-out,” or the substitution of existing private coverage with public coverage. In Rhode Island, expansion in RItE Care eligibility months before a premium subsidy program was implemented led to initial crowd-out, which was reversed only with the mandatory shifting of eligible RItE Care enrollees to the new program.

To try to target public dollars to reduce the number of uninsured, states have established anti-crowd-out rules such as “look-back” periods. But such rules result in inequities and extra barriers, as people in the same income category receive different levels and types of coverage and subsidies. Similarly, rules to prevent crowd-out in premium assistance programs such as minimum employer contributions may also exclude employers who would like to participate but cannot meet the contribution requirements. Preliminary indications are that this may be contributing to low participation in Healthy New York among small firms.<sup>15</sup>

Indeed, states struggle to balance the need to treat families in similar economic situations fairly while avoiding giving currently covered persons or employers incentives to drop (or reduce contributions to) private coverage. This challenge led New Jersey to

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<sup>15</sup> The Lewin Group in partnership with Empire Health Advisors, “Report on the Healthy New York Program,” December 31, 2001.

offer higher-income enrollees a benefit package comparable to those found in the private sector (as opposed to a richer Medicaid benefit package), as well as to propose a state-subsidized premium support program for low-income families currently insured by their employers.

### **Need for Creative Approaches to Economic Realities**

The range of coverage strategies states are undertaking illustrates attempts to be creative and flexible under difficult economic conditions. Experimentation with Medicaid and CHIP modifications and new types of public-private partnerships to provide some health care benefits to uninsured individuals are examples of state attempts to “make the best out of a bad situation.” In many cases, the alternative may be across-the-board cuts that would result in more people without any health coverage.

## COVERAGE STRATEGIES UNDER CURRENT ECONOMIC CONDITIONS

After a period of surpluses in the 1990s, the economic slowdown beginning in 2000 brought a new reality for coverage expansion. State surpluses turned to shortfalls. Competition for increasingly scarce public dollars intensified, with health care representing just one of many needs, including education, infrastructure, and—after September 11, 2001—homeland security. State tax revenues declined at the same time that Medicaid costs surged, in part due to enrollment increases related to higher unemployment as well as escalating prescription drug and hospital expenses. Many states still have unspent federal CHIP funds, but struggle to come up with the state matching funds needed to access them.

The federal government, also experiencing deficits after a brief period of surpluses, is not poised to initiate major new public coverage programs. The Bush Administration has proposed a federal tax credit intended to promote the purchase of private health insurance among lower-income people, but its passage is far from certain. State governors have put forth several proposals to encourage short-term federal assistance, such as increasing the Federal Medicaid Assistance Percentages (FMAP), but these have not been acted upon to date. The federal government has also changed some of the rules surrounding the “upper payment limit” (UPL) methodology, putting further strain on some states’ Medicaid programs.

The economic situation has brought significant pressures on Medicaid programs to contain or reduce costs. States generally have a limited number of ways to do this and are considering all of their options.<sup>16</sup> These options include shifting Medicaid enrollees to managed care; cutting payments to health plans and providers; reducing eligibility; increasing cost-sharing; or cutting benefits. Each of these measures has limitations and potential adverse consequences. Many states believe that they have reached the limits of managed care savings, for example. After a time of driving down provider payments, states are considering renegotiating with providers to keep them “in the game,” while many health plans have stopped participating in Medicaid entirely.

Against this backdrop, public and private resources are being devoted to developing innovative, low-cost, or no-cost coverage expansion options at the state level. The administration, for example, is giving states greater flexibility to expand both public and private coverage through Medicaid and CHIP under the Health Insurance Flexibility

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<sup>16</sup> See Vernon Smith, Eileen Ellis, Kathy Gifford, Rekha Ramesh, and Victoria Wachino, *Medicaid Spending Growth: Results from a 2002 Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2002.

and Accountability (HIFA) demonstration initiative. The specific strategies the study states are now pursuing to expand coverage are outlined in Table 2, and fall generally into one of the following two categories:

1. **Experimenting with public coverage expansions**, such as modifying benefit packages and/or increasing cost-sharing for certain populations to enable coverage of new populations (often under the flexibility afforded states under the HIFA initiative); and
2. **Expanding coverage through public–private linkages**, such as subsidizing employer-sponsored insurance premiums through Medicaid or CHIP to tap federal matching funds and retain employer/employee contributions; using public funds to reinsure private health plans, thereby promoting lower-cost options for businesses and individuals; and allowing employers and workers to buy in to public coverage (potentially under the HIFA initiative).

One reason for the current interest in these coverage expansion strategies, at least in some states, has been the federal and private foundation support of policy development noted above. With the available funding, states have put into place planning groups, garnered support among stakeholders, and gathered new state-specific data, all of which has led to the development of menus of policy options. The initial 20 states that received State Planning Grants, for example, developed a wide range of expansion options, outlined in Table 4.<sup>17</sup> Most of the options considered involve building on existing public programs or enhancing private coverage (including reforming the insurance market). Other options require significant federal reforms such as federal tax credits for health coverage. Some options, due to changing economic conditions, have been put on hold or tabled, some are still under consideration, and some are being actively pursued and implemented.

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<sup>17</sup> See Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration*, The Commonwealth Fund, November 2002; available at [http://www.cmwf.org/programs/insurance/sacks\\_20hrsagrants\\_577.pdf](http://www.cmwf.org/programs/insurance/sacks_20hrsagrants_577.pdf).

**Table 2. Range of State Coverage Strategies**

<b>States</b>	<b>Current Major Coverage Programs</b>	<b>Recent or Planned Reforms</b>	<b>Status of Reforms</b>	<b>Funding for Recent or Planned Reforms</b>
Arkansas	<ul style="list-style-type: none"> <li>• Medicaid</li> <li>• ARKids First (Medicaid expansion)</li> </ul>	<p>Medicaid expansion to low-income adults</p> <hr/> <p>Employer buy-in to Medicaid</p>	<p>Proposed during the SPG process; planning to seek federal approval through a HIFA waiver</p> <hr/> <p>Proposed during the SPG process; planning to seek federal approval through a HIFA waiver</p>	<p>Medicaid funds, state portion financed through tobacco settlement funds</p> <ul style="list-style-type: none"> <li>• Tobacco settlement funds for state Medicaid portion</li> <li>• Federal Medicaid matching funds</li> <li>• Employer/employee contributions</li> </ul>
Georgia	<ul style="list-style-type: none"> <li>• Medicaid</li> <li>• PeachCare for Kids (Medicaid look-alike)</li> </ul>	Business Plan for Health	Many of the initiatives are on hold; the state awarded nine demonstration grants to statewide and local organizations for private-sector initiatives, pharmacy coverage, and community-based initiatives	State resources matched by contributions from local communities
Michigan	<ul style="list-style-type: none"> <li>• Medicaid</li> <li>• MICHild (CHIP)</li> </ul>	MIFamily HIFA initiative to expand coverage to parents (up to 100% FPL); pregnant women (up to 200% FPL); the disabled population (up to 350% FPL); and childless adults (up to 100% FPL)	Waiver submitted March 2002; placed on hold pending advice of newly elected governor taking office January 2003	Modifications to the benefit package; reallocation of existing state spending for some public beneficiaries and DSH dollars; unspent CHIP funds; redeployment of county funds allocated for health care

<b>States</b>	<b>Current Major Coverage Programs</b>	<b>Recent or Planned Reforms</b>	<b>Status of Reforms</b>	<b>Funding for Recent or Planned Reforms</b>
New Jersey	<ul style="list-style-type: none"> <li>• Medicaid NJ Care</li> <li>• NJ FamilyCare</li> <li>• NJ KidCare (Medicaid and CHIP)</li> </ul>	To control costs and keep the program solvent, the state closed FamilyCare enrollment to childless adults and parents, reduced some benefits, and increased cost-sharing for higher income families	<ul style="list-style-type: none"> <li>• Advertising was curtailed</li> <li>• Enrollment closed to non-General Assistance childless adults in 9/01</li> <li>• Parent enrollment closed, no new applications accepted after 6/02</li> <li>• All General Assistance beneficiaries no longer enrolled in FamilyCare starting 7/02<sup>a</sup></li> <li>• Scaling back benefits for some parental adults in FamilyCare in 9/02</li> <li>• Increased cost-sharing for higher-income families</li> <li>• HIFA waiver submitted, pending federal approval</li> </ul>	
New Mexico	<ul style="list-style-type: none"> <li>• Medicaid</li> <li>• New MexiKids</li> </ul>	HIFA waiver for adults at or below 200% FPL	Waiver approved August 2002; scheduled to begin February 2003	Unspent Medicaid and CHIP funds; employer contributions; individual contributions
New York	<ul style="list-style-type: none"> <li>• Healthy New York</li> <li>• Child Health Plus A</li> <li>• Child Health Plus B</li> <li>• Family Health Plus</li> <li>• Medicaid</li> </ul>	Enrolling individuals and small businesses into Healthy New York HMO plans Enrolling eligible adults into Family Health Plus, using new common enrollment form for FHP, CHP, and other programs Transitioning people from Disaster Relief Medicaid (put in place after September 11) into appropriate health programs	Less than 1% who qualify were enrolled as of 12/01; considering ways to encourage greater participation Began enrolling upstate 10/01, New York City in 3/02 Ongoing	State funds, individual premiums, and cost-sharing, employer and employee contributions Medicaid Medicaid

<b>States</b>	<b>Current Major Coverage Programs</b>	<b>Recent or Planned Reforms</b>	<b>Status of Reforms</b>	<b>Funding for Recent or Planned Reforms</b>
Oregon	<ul style="list-style-type: none"> <li>• Oregon Health Plan (OHP) (Medicaid and CHIP)</li> <li>• Family Health Insurance Assistance Program (FHIAP)</li> </ul>	<p>OHP incremental expansion to Oregonians with incomes up to 185% FPL; FHIAP expansion up to 185% FPL with request for federal matching funds</p>	1115 waiver and HIFA waiver submitted jointly to CMS in May 2002; approved October 2002	<ul style="list-style-type: none"> <li>• Individual cost-sharing</li> <li>• Decrease in benefits for some populations that creates additional funds</li> <li>• Unspent CHIP funds</li> <li>• Medicaid funds</li> </ul>
Rhode Island	<ul style="list-style-type: none"> <li>• Rite Care (Medicaid and CHIP)</li> <li>• Rite Share</li> </ul>	Rite Share, a premium assistance program that subsidizes low-income employees' share of the premium under employer sponsored coverage	Enrolling since May 2001	<ul style="list-style-type: none"> <li>• Federal and state Medicaid and CHIP funds</li> <li>• Premiums from members above 150% FPL</li> <li>• Employer contributions</li> </ul>
Utah	<ul style="list-style-type: none"> <li>• Medicaid</li> <li>• CHIP</li> <li>• Primary Care Network</li> </ul>	1115 Medicaid waiver to provide limited benefits to adults up to 150% FPL while reducing some benefits to current Medicaid enrollees (PCN)	Proposed during SPG process; began enrolling July 2002	<ul style="list-style-type: none"> <li>• Medicaid dollars</li> <li>• Enrollment fees</li> </ul>
Vermont	<ul style="list-style-type: none"> <li>• VHAP</li> <li>• Dr. Dynasaur</li> </ul>	Healthy Vermonters Program. Beneficiaries can purchase drugs at the Medicaid payment rate. Once approved by CMS, qualified individuals will receive an additional discount	Developed in June 2002 and began in July 2002; awaiting full CMS approval	Annual enrollment fee pending approval from CMS

<sup>a</sup> Instead, these General Assistance beneficiaries will receive a benefit package of community-based services provided on a fee-for-service basis. Hospital services, including hospital-based behavioral health services, will be reimbursed through the state's charity care program and substance abuse services will be provided through the Substance Abuse Initiative administered by the Division of Family Development.

## Experimenting with Public Coverage Expansions

### *“HIFA” Approach*

A primary mechanism states are using to expand coverage to new populations (particularly to low-income adults) while incurring minimal, if any, new state costs is the new HIFA demonstration authority.<sup>18</sup> Announced by the Centers for Medicare and Medicaid Services (CMS) in August 2001, HIFA offers states the ability to modify their current benefit packages for optional and expansion Medicaid and CHIP populations. States may then redirect the savings to expand coverage to previously uninsured populations, creating a controversial trade-off between “depth” of coverage versus “breadth” of coverage.

Several of the states studied have altered the benefit package and/or increased cost-sharing for certain populations to enable coverage of more people. There are several restrictions under HIFA that states must follow in order to gain federal approval.<sup>19</sup> First, the eligibility expansion must be statewide, although other features of the demonstration can be phased in. Second, states must continue to cover mandatory populations and provide them with the Medicaid benefit package specified in their state plan.<sup>20</sup> For optional Medicaid and CHIP populations, however, states may alter the benefit package, although the packages should include basic services such as inpatient and outpatient hospital services, physicians’ surgical and medical services, laboratory and X-ray services, and well-baby and well-child care.<sup>21</sup> States have the most flexibility around designing benefits for expansion populations, with the only requirement being that the package includes basic primary care services.<sup>22</sup> Cost-sharing for mandatory populations remains limited; but the states can impose higher levels of cost-sharing for optional and expansion populations (with some limits for optional children covered under Medicaid or CHIP). HIFA also emphasizes the use of private coverage mechanisms, and states are encouraged to coordinate public and private coverage for the target population. In fact, some of the flexibility around benefits and cost-sharing is intended to support the use of private group health premium assistance programs.

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<sup>18</sup> Although HIFA draws on public Medicaid and CHIP funds, the coverage expansion mechanism does not have to be public; one emphasis of HIFA has been on the coordination of public and private coverage for the low-income uninsured. Thus, while the HIFA approach will be discussed in more detail as an experiment with public coverage expansion, it will also be noted when it is used as a tool to expand coverage through the private market.

<sup>19</sup> For more information, see *Guidelines for States Interested in Applying for a HIFA Demonstration*, available at [www.cms.gov/hifa/hifagde.asp](http://www.cms.gov/hifa/hifagde.asp).

<sup>20</sup> CMS defines mandatory populations as those eligibility groups that a state must cover in its Medicaid State Plan, such as children under age 6 and pregnant women up to 133 percent of the FPL.

<sup>21</sup> CMS defines optional populations as groups that can be covered under a Medicaid or CHIP State Plan (e.g., those who can be covered without a Section 1115 demonstration waiver but who have incomes above the mandatory population levels).

<sup>22</sup> CMS defines expansion populations as those groups that can only be covered under Medicaid or CHIP if the state receives a Section 1115 waiver, such as childless, nondisabled adults.

The focus of the HIFA initiative is on populations with incomes below 200 percent of the federal poverty level (FPL), but if a state can demonstrate that there are already high coverage rates among that population and that covering individuals above 200 percent of the FPL will not cause “crowd-out” of private insurance, the state can use HIFA authority to move higher up the income scale. If the states follow the guidelines just described, CMS will expedite review of the application as well as give it priority over other waiver submissions. HIFA waivers, similar to other Section 1115 waivers, are approved for an initial five-year period.

HIFA demonstrations must be budget-neutral to the federal government, so that states are reallocating several existing streams of federal money to help finance the initiative.<sup>23</sup> Those streams include Medicaid Medical Assistance Payments, Medicaid Disproportionate Share Hospital (DSH) Payments, and CHIP funds. States also cannot receive a federal match for coverage programs that were previously state-only funded, unless the state-only program is expanded, and then a state maintenance-of-effort requirement will apply.

As of October 2002, seven states had received federal approval of their HIFA waivers (Arizona, California, Maine, New Mexico, Colorado, Illinois, and Oregon), while a few other states (Delaware, Washington, and New Jersey) have applications pending and one application is on hold at the state’s request (Michigan). The waiver proposals are summarized in Table 3. Oregon has chosen to expand coverage to state residents with incomes up to 185 percent of the FPL, primarily through its public program, the Oregon Health Plan. However, one component of plan involves expanding what has previously been a state-only program, the Family Health Insurance Assistance Program (FHIAP), to provide premium assistance for uninsured Oregonians with incomes up to 185 percent of the FPL to purchase private health insurance. Other HIFA proposals using private mechanisms are described further below.

In addition to the variation among program delivery mechanisms, the modified HIFA benefit package can cover different services, and while some states have one HIFA benefit package, others have different packages for different populations. The goal is to design coverage appropriate to the population, but less costly than the traditional full Medicaid package, so that the state can expand coverage to the maximum number of

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<sup>23</sup> States have three years to use federal CHIP funds appropriated in a given year. If states do not spend the money within that time, the federal government redistributes a portion of the unused money to other states that exhausted their initial funding. Any remaining unused money must be given back to the U.S. Treasury. On October 1, 2002, twenty-five states forfeited a total of \$1.2 billion in unspent 2000 CHIP funds. (Kaiser Network Daily Health Policy Report, October 15, 2002; [www.kaisernet.org](http://www.kaisernet.org))

people. For example, New Mexico has developed a standardized benefit package (similar to a basic commercial benefit package) that would be offered to all enrollees eligible for coverage under the HIFA waiver. In contrast, Michigan has tried to tailor the benefit package to meet the needs of the different populations served since the state could not afford to offer the full Medicaid benefit package to all newly eligible individuals under the budget neutrality rule. Therefore, while inpatient hospital services are not covered for childless adults with incomes below 35 percent of the FPL, mental health and substance abuse are covered because the state determined that there was a greater need for such coverage in the target population.

The states studied noted that the determination of the benefit package and the assumed impact on low-income enrollees has been of great concern to stakeholders. Patient advocates argue that higher cost-sharing discourages use of services and may reduce take-up rates. For example, cost-sharing at the point of service, particularly in the form of high deductibles and copayments, may discourage the use of important primary and preventive care. Imposing premiums on low-income people could discourage enrollment entirely. Yet cutting certain benefits (in lieu of or in addition to cost-sharing) could deprive some patients of needed care, leading to hardship and higher costs in the long term. “Partial” benefit packages may reduce the official number of uninsured, but leave people underinsured.

HIFA initiatives also raise concerns among advocates about the “slippery slope.” Once states have the authority to start modifying benefits for any current Medicaid population, advocates worry that previously protected groups will gradually lose more and more of the benefits they currently have. If some Medicaid enrollees are shifted into private insurance (through premium assistance programs), they may not only lose certain Medicaid benefits, but may also lose protections provided by being part of the public system (e.g., requirements that Medicaid children receive medically necessary treatment, appeals procedures, limits on cost-sharing, etc.). Whether and to what degree these concerns are realized will be seen over the course of implementing these initiatives, reinforcing the need for sustained independent evaluation of the programs.

In addition to these potential negative effects on patients, there may be some indirect consequences for providers. To the degree that previously uninsured individuals would gain coverage under a HIFA waiver, providers would benefit by receiving reimbursement for services that were previously uncompensated. Yet some of the cost-sharing measures imposed under HIFA waivers may result in indirect cost-shifts to providers. For example, if a state imposes a stiff copayment on inpatient hospital care, or

has a very limited hospital benefit, a person enrolled in the HIFA benefit package may not be able to pay. If that person is served (and those hospitals are obligated to take care of those patients), the hospital absorbs the cost, at least initially. To compound this problem, if the HIFA initiative is funded in part with disproportionate share hospital payments, as proposed in Michigan, the hospitals may not be able to recoup those uncompensated care costs in the ways they could have done formerly. States did not indicate that it was their deliberate strategy to shift costs to providers through their HIFA waivers, but it may be an unintended consequence.

Another problem facing primary care providers occurs when they see patients who have basic primary care coverage, but limited or no hospital coverage. This combination may place these providers in a difficult position when they need to refer the patients for secondary or tertiary care. It may also raise expectations on the part of patients, who may assume that because they are covered for primary care, they also will be covered for hospital services. Utah may face these issues under their plan—not technically through a HIFA waiver but under a similar approach—to provide coverage for low-income adults that does not include hospitalizations or specialty care. While hospitals and specialty physicians have agreed to donate some care, that does not constitute the same level of security that health insurance generally provides. Proponents argue, however, that the population affected is composed of individuals who previously had no coverage, and that “something is better than nothing.”

In implementing these initiatives, states also have to address the question of financing. New Mexico has used the HIFA template but, in its revised waiver submission, has chosen to scale back its coverage expansion so that benefits for currently eligible populations are not affected. Instead, New Mexico is relying on its unused CHIP allocation and Medicaid funds to finance the expansion. Michigan, while proposing to modify the benefit package as noted above, would also rely on reallocation of funds from several other sources: existing state spending for some public beneficiaries; disproportionate share hospital dollars; unspent CHIP funds; and county funds allocated for health care.

As noted above, Utah’s expansion, while similar in philosophy to a HIFA waiver, is a “traditional” Section 1115 waiver demonstration project. Since states may choose whether to apply for a HIFA waiver or use traditional Section 1115 guidelines, they may want to look carefully at some of the advantages of each. Under the traditional waiver authority, Utah was able to modify the benefit package for mandatory populations and replace a state-only program with a program that received a federal match. In addition, the

state did not include mechanisms that encouraged private insurance. However, because it was not the HIFA process, there was no promise of expedited review. Each state will need to consider its needs and existing set of programs carefully as it decides which waiver route to pursue.

Finally, those states relying on the reallocation of CHIP dollars may face challenges in the future. A recent Government Accounting Office report raises “both legal and policy concerns about the extent to which approved waivers are consistent with the goals and fiscal integrity of Medicaid and CHIP.” The report states that the Department of Health and Human Service’s decision to approve Arizona’s HIFA waiver allowing the use of CHIP funds to cover childless adults “is not consistent” with the CHIP program’s “statutory objective” to cover uninsured low-income children, and thus is “not authorized.” The report also states that the waiver could prevent the reallocation of unspent federal CHIP funds to other states that have used their allocations, a requirement under federal law.<sup>24</sup> It is not clear to what extent this report will influence existing or future waiver decisions.

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<sup>24</sup> *Medicaid and SCHIP: Recent HHS Approvals of Demonstration Waiver Projects Raise Concerns.* Government Accounting Office (GAO-02-817) July 12, 2002.

**Table 3. Highlights of Approved and Pending HIFA Waivers**

States	General Description/ Delivery System	Funding	Primary Populations Affected (Projected New Enrollment)	Cost-Sharing/Benefits
<i>Waiver Approved (as of October 2002)</i>				
Arizona (Approved Dec. 2001)	<ul style="list-style-type: none"> <li>Expansion of coverage of existing Arizona Health Care Cost Containment System Administration</li> <li>Delivery system will utilize the health plans and Regional Behavioral Health Authorities already in place</li> </ul>	<ul style="list-style-type: none"> <li>CHIP allotment plus reallocated CHIP funds</li> </ul>	<ul style="list-style-type: none"> <li>Adults without dependent children, with incomes up to 100% FPL (est. 27,000)</li> <li>Parents of CHIP children with incomes 100%–200% FPL (est. 21,250)</li> </ul>	<ul style="list-style-type: none"> <li>Medicaid 1115 demonstration acute care benefit package—the same as existing CHIP</li> <li>Same cost-sharing as Arizona Medicaid; copayments ranging from \$1 to \$5</li> <li>Medicaid 1115 demonstration acute care benefit package—the same as existing CHIP</li> <li>Same cost-sharing as existing CHIP program (\$5 copayments, small monthly premium for families with incomes greater than 150% FPL)</li> </ul>
California (Approved Jan. 2002, revised Mar. 2002)	<ul style="list-style-type: none"> <li>Extension of the current CHIP program to parents</li> <li>Delivery system is the same as for CHIP children</li> </ul>	<ul style="list-style-type: none"> <li>CHIP allotment plus reallocated CHIP funds</li> <li>Tobacco settlement</li> </ul>	<ul style="list-style-type: none"> <li>Custodial parents/caretakers/legal guardians of Medicaid or CHIP-eligible children, with incomes up to 200% FPL and not eligible for Medi-CAL (est. 275,000<sup>a</sup>)</li> </ul>	<ul style="list-style-type: none"> <li>Benefit packaged similar to CHIP and generally available to state employees, but with slightly different vision and dental benefits</li> <li>Families at or below 150% FPL will pay a \$10 premium per month; those above 150% will pay a \$20 premium per parent per month</li> <li>Copayments capped at \$250 per family</li> </ul>
New Mexico (Approved Aug. 2002)	<ul style="list-style-type: none"> <li>Establishes a standardized basic benefit plan marketed to employers and employees directly by private MCOs</li> </ul>	<ul style="list-style-type: none"> <li>Unspent CHIP and Medicaid funds, employer, employee and individual premium sharing</li> </ul>	<ul style="list-style-type: none"> <li>Uninsured adults (childless and parents) up to 200% FPL (est. 40,000)</li> </ul>	<ul style="list-style-type: none"> <li>Basic benefit package; excludes vision, dental, podiatry, long-term care, others</li> <li>Employer contributes \$75/month</li> <li>Employee premium sharing and copayments based on a sliding scale</li> </ul>

<b>States</b>	<b>General Description/ Delivery System</b>	<b>Funding</b>	<b>Primary Populations Affected (Projected New Enrollment)</b>	<b>Cost-Sharing/Benefits</b>
Maine (Approved Sept. 2002)	<ul style="list-style-type: none"> <li>MaineCare for Childless Adults is a new program which uses the same delivery system as the state's current Medicaid and CHIP programs</li> </ul>	<ul style="list-style-type: none"> <li>Relinquishing part of the state's disproportionate share hospital (DSH) allocation</li> </ul>	<ul style="list-style-type: none"> <li>Childless adults with incomes up to 125% FPL (est. 11,480)</li> </ul>	<ul style="list-style-type: none"> <li>State Medicaid benefits package</li> </ul>
Colorado (Approved Sept. 2002)	<ul style="list-style-type: none"> <li>The Adults Prenatal Coverage in CHIP+ program is an expansion of coverage of the current CHIP program</li> </ul>	<ul style="list-style-type: none"> <li>CHIP allotment and other available state funds</li> </ul>	<ul style="list-style-type: none"> <li>Pregnant women with incomes 134% to 185% FPL (est. 13,000)</li> </ul>	<ul style="list-style-type: none"> <li>Benefits similar to typical employer-based commercial insurance</li> <li>Copayments consistent with existing CHIP plan: \$1 to \$3 if incomes up to 150% FPL; \$3–\$15 if incomes more than 150% FPL</li> <li>Maximum cost-sharing 5% income</li> <li>Unlike CHIP, no annual enrollment fee</li> </ul>
Illinois (Approved Sept. 2002)	<ul style="list-style-type: none"> <li>Creation of KidCare Parent Coverage, known as FamilyCare</li> <li>Provides coverage to low-income families and people with serious medical conditions at high risk of losing health coverage</li> <li>The state will phase in coverage, beginning with parents up to 49% FPL</li> </ul>	<ul style="list-style-type: none"> <li>Medicaid and CHIP funds, required cost-sharing</li> </ul>	<ul style="list-style-type: none"> <li>Parents of CHIP and Medicaid children up to 185% FPL (est. 335,089)—but initial phase limited to 55% FPL (est. 48,000)<sup>b</sup></li> </ul>	<ul style="list-style-type: none"> <li>Choice of direct coverage or premium assistance for employer-based insurance</li> <li>Direct coverage includes Medicaid benefits but without home and community based services and abortions</li> <li>Copayments ranging from \$1 to \$3 depending on income</li> <li>Monthly premiums</li> </ul>

<b>States</b>	<b>General Description/ Delivery System</b>	<b>Funding</b>	<b>Primary Populations Affected (Projected New Enrollment)</b>	<b>Cost-Sharing/Benefits</b>
Oregon (Approved Oct. 2002)	<ul style="list-style-type: none"> <li>Formation of the Oregon Health Plan 2 (OHP2) which is an amendment to the current Oregon Health Plan</li> </ul>	<ul style="list-style-type: none"> <li>CHIP allotment, savings from benefit modification, cost-sharing, and Medicaid funds</li> </ul>	<ul style="list-style-type: none"> <li>Adults (parents and childless) with incomes 100% to 185% FPL;</li> <li>Currently covered adults with incomes less than 100% FHP transferred to 'OHP Standard'</li> <li>Children from 170% and 185% FPL (est. 60,000)</li> </ul>	<ul style="list-style-type: none"> <li>'OHP Standard' provides plan similar to private insurance coverage for adults, with premiums and copayments on sliding scale</li> <li>'OHP Plus' maintains current Medicaid/CHIP benefit package for children, mandatory populations, with small copayments</li> <li>FHIAP subsidizes premiums and copayments for private insurance on sliding scale</li> </ul>
<i>Waiver Pending</i>				
Delaware	<ul style="list-style-type: none"> <li>New Delaware Healthy Adults Program for certain existing optional Medicaid enrollees, and individuals who become eligible for a second year of transitional Medicaid</li> </ul>	<ul style="list-style-type: none"> <li>Current CHIP allotment and required premiums</li> </ul>	<ul style="list-style-type: none"> <li>Pregnant women with incomes 133% to 200% FPL</li> <li>Uninsured adults with incomes up to 100% FPL</li> <li>Families who lose eligibility for Section 1931, with incomes 65% to 75% FPL</li> <li>Transitional clients between 65% and 185% FPL in second year of transition (est. 7,075)</li> </ul>	<ul style="list-style-type: none"> <li>Benefits are the same as existing CHIP benefits but adults will not receive extended 31-day mental health/substance abuse services</li> <li>Family Premiums: \$10/month if incomes 101%-133% FPL; \$15/month if incomes 134%-166% FPL; \$25/month if incomes 167%-200% FPL</li> <li>\$10 copayment for inappropriate use of an emergency room</li> </ul>
New Jersey	<ul style="list-style-type: none"> <li>Standardizes the service package for all adults (excluding TANF) in NJ FamilyCare, to enable enrollment of additional parent applicants pending enrollment as of June 15, 2002</li> </ul>	<ul style="list-style-type: none"> <li>Savings from reduced benefit package (to supplement CHIP allotment)</li> </ul>	<ul style="list-style-type: none"> <li>Benefit change for parents currently enrolled in FamilyCare with income less than 133% FPL</li> <li>Parents with applications for FamilyCare pending as of June 15, 2002 (est. 12,000). (The program closed to additional parents after June 15, 2002.)</li> </ul>	<ul style="list-style-type: none"> <li>Modifies benefits from comprehensive Medicaid package to the most commonly sold commercial HMO plan in state</li> </ul>

<b>States</b>	<b>General Description/ Delivery System</b>	<b>Funding</b>	<b>Primary Populations Affected (Projected New Enrollment)</b>	<b>Cost-Sharing/Benefits</b>
Washington	<ul style="list-style-type: none"> <li>Expand eligibility through Basic Health Plan</li> </ul>	<ul style="list-style-type: none"> <li>CHIP allotment and any reallocated CHIP funds, and required cost-sharing</li> </ul>	<ul style="list-style-type: none"> <li>Adults (parents and childless) up to 200% FPL (est. 20,000)</li> </ul>	<ul style="list-style-type: none"> <li>Same as Basic Health benefit package, with permission to impose premiums (up to 2.5% family income), copayments, and benefit reductions (for nonemergent dental, and routine vision and hearing)</li> <li>Permit enrollment freeze for optional Medicaid adults if necessary</li> </ul>
<i>Temporarily Inactive</i>				
Michigan	<ul style="list-style-type: none"> <li>MIFamily is a Medicaid expansion that would expand coverage to pregnant women and the disabled population and provide coverage for adults on a county-by-county basis; includes a premium assistance component for eligible persons with access to employer-sponsored coverage</li> </ul>	<ul style="list-style-type: none"> <li>Savings from benefit package modifications for certain groups</li> <li>Unspent CHIP funds</li> <li>Local funds (among participating counties)</li> <li>Reallocation of existing state spending for some public beneficiaries and DSH dollars</li> </ul>	<ul style="list-style-type: none"> <li>Working disabled adults with incomes up to 350% FPL</li> <li>Parents and those acting as parents with incomes up to 100% FPL</li> </ul>	<ul style="list-style-type: none"> <li>Full Medicaid benefits</li> <li>HMO benefit to those under 50% FPL</li> <li>HMO-like benefit with reduced inpatient coverage for those between 50%–100% FPL</li> <li>Full Medicaid benefits</li> </ul>
				<ul style="list-style-type: none"> <li>Reduced benefit package includes outpatient; Rx drugs, mental health, and substance abuse services</li> <li>Counties may partner with state to develop coverage options with at least same benefits as listed in bullet above</li> </ul>

<sup>a</sup> This estimated enrollment includes several other groups covered by the waiver such as temporary coverage for: individuals who are found, during CHIP redetermination, to be potentially eligible for Medi-Cal; individuals who were previously enrolled in CHIP but have been determined to be Medi-Cal eligible prior to the end of a continuous eligibility period; and individuals who are found, during Medi-Cal redetermination, to be potentially eligible for CHIP.

<sup>b</sup> This waiver covers an additional 8,548 people in several other categories, such as uninsurable persons and children 133% to 185% FPL. Each of these groups has a different benefit package. For more details, see the Illinois HIFA waiver.

Source: State HIFA waivers available at <http://www.cms.gov/hifa/default.asp>.

### *Prescription Drug Strategies*

Prescription drug costs have been soaring, and this increase, along with a resurgence of hospital cost escalation, is an important Medicaid cost driver. While states have been focusing on implementing drug coverage programs primarily for low-income seniors who do not have access to other pharmaceutical coverage through Medicaid or private insurance, these strategies are often considered to be part of a state's overall coverage expansion plans and are therefore briefly mentioned here. There are also some efforts to address Medicaid pharmaceutical costs directly. Vermont, for example, has had multiple pharmacy coverage programs. It is developing state programs to help the elderly and others afford prescription drugs, and it is partnering with other states to develop a multistate purchasing initiative intended to lower drug costs in the Medicaid program. Its most recent pharmaceutical initiative, the Healthy Vermonters Program (HVP), began in July 2002 and targets two distinct groups of Vermonters who do not have drug coverage: elderly or disabled residents receiving Medicare or Social Security benefits with incomes up to 400 percent of the FPL and residents of any age who have incomes up to 300 percent of the FPL. Currently, the program is state-funded and beneficiaries are able to purchase drugs at the Medicaid payment rate. The state requested CMS approval to amend Vermont's current Section 1115 Medicaid demonstration waiver to give beneficiaries an additional discount based on manufacturers' rebates and the state's contribution to the program of up to 2 percent.

Vermont began its multistate purchasing initiative, the Pharmacy Benefit Management Program, in November 2001 by partnering with Maine and New Hampshire. The three states hired a pharmacy benefit manager to provide expertise, maintain quality of care, control pharmaceutical expenditures, and reduce administrative costs for drug purchasing in their public programs. By March 2002, an initial Preferred Drug List was implemented to encourage the use of therapeutically equivalent prescriptions at a lower cost for all enrollees in Vermont's publicly administered pharmacy programs.

### *County-Based Coverage Expansion*

One final public coverage strategy that should be noted is Michigan's use of counties as a vehicle for coverage expansion. State and local policymakers in Michigan, believing that all health care is local and looking for a way to maximize resources (broadly defined), have supported the implementation of a series of county-based indigent care programs. The state's role has been to provide funding incentives using disproportionate share hospital funds and upper-payment-limit strategy payments for counties to develop their own programs. The seven participating counties, with federal and state money available, have

developed a series of indigent care programs that utilize local resources to best fit the needs of the local populations.

The Michigan HIFA waiver builds on this role of the counties by encouraging them to voluntarily cover people, such as low-income childless adults, who do not qualify for Medicaid. For childless adults below 35 percent of the FPL, the state has established a uniform benefit package that includes outpatient, mental health, and substance abuse services. Counties may choose to cover childless adults up to 100 percent of the FPL; as long as counties offer at least this minimum benefit package, they have flexibility around benefits and eligibility for this group. They can, for example, supplement the package, and they are responsible for choosing the delivery mechanism for services (e.g., either fee-for-service or the Medicaid managed care delivery system).

This strategy of devolution is not common among the states studied, but provides an additional lever other states might consider as they look for ways to implement coverage expansions. Michigan's program is voluntary, and it may be more difficult to implement this strategy in a state that does not have a history of county responsibility for developing such indigent care programs.

### **Expanding Coverage Through Public–Private Linkages**

The second set of state coverage expansion strategies is being pursued through linkages with the private sector. With both states and employers experiencing budget pressures and escalating health costs, it is increasingly difficult for either the public or private sector to shoulder the cost of new coverage on its own. Rather, states are looking for ways to bolster private insurance, and/or give employers and individuals access to lower-cost public coverage.

In the past, states have pursued these efforts through traditional Section 1115 research and demonstration waivers, Medicaid's Health Insurance Premium Payment (HIPP) program, insurance market reforms, and state-funded or local initiatives.<sup>25</sup> More recently, the federal government has encouraged states to use the HIFA waiver approach to coordinate public and private coverage for low-income uninsured populations.

#### *Premium Assistance*

One important way for states to support private insurance is by subsidizing insurance premiums paid by low-income individuals and/or employers. For example, Rhode Island

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<sup>25</sup> Health Insurance Premium Payment (HIPP) programs, authorized under section 1906 of the Social Security Act, allow states to subsidize employer-sponsored coverage for workers with Medicaid-eligible family members if it is cost-effective to the state.

and New Jersey's premium assistance programs, RItE Share and NJ Premium Support Program, pay the employee share of employer-sponsored insurance for individuals who are eligible for RItE Care or NJ FamilyCare (each state's Medicaid/CHIP managed care program) and have access to employer insurance.<sup>26</sup> Oregon's FHIAP similarly subsidizes the cost of private insurance (either employer-sponsored or a non-group policy) for individuals with incomes up to 170 percent of the FPL. This program has been state-funded, but as noted above, Oregon has received approval through a HIFA waiver to expand this program to individuals with incomes up to 185 percent of the FPL and obtain a federal match.

In addition to allowing flexibility in benefits and cost-sharing, the HIFA initiative encourages premium assistance programs through Medicaid and CHIP by eliminating specific cost-effectiveness tests required under HIPPP programs and Section 1115 waivers (although aggregate costs for those enrolled in such programs should not significantly exceed the costs of enrolling those people in public coverage). Any state using private-coverage mechanisms under a HIFA waiver must, however, monitor changes to employer-sponsored coverage to ensure that HIFA coverage is not replacing existing private coverage. In general, states are struggling to minimize such crowd-out with mechanisms including "look-back" periods (whereby eligibility depends on being uninsured for a minimum period of time) and minimum employer contribution levels, while not making eligibility overly restrictive and discouraging participation.

Other challenges for premium assistance programs involve the need to minimize the extra administrative burden on businesses and to publicize the new program to employers and employees. States have faced resistance by employers as well as individuals who are already enrolled in comprehensive public coverage and fear losing benefits. Rhode Island has addressed these obstacles through bypassing the employer and transferring current RItE Care enrollees with access to employer insurance into the premium assistance program, if eligible. Premium assistance programs pose administrative challenges to states as well. They must track coverage and payments for individuals and providers outside the public coverage system and in some cases monitor the private plan benefits for each enrollee and provide "wrap-around" services for those not covered. New Jersey has found that the state's reforms in the small-group insurance market earlier in the decade, which standardized all benefit packages offered to businesses with two to 50 employees, have assisted the state considerably in assessing cost-effectiveness in their Premium Support Program.

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<sup>26</sup> Certain other criteria concerning the minimal benefit package and employer contribution apply as well; see Silow-Carroll et al., *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (The Commonwealth Fund, November 2002).

### *Reinsurance*

Another public–private approach involves state activities to ensure that affordable insurance plans are available in the private market. This has been particularly important in states with a large proportion of very small businesses, which generally face higher premiums and are less likely to provide coverage. Yet state insurance regulations intended to keep insurance affordable and available for higher-risk patients, such as community rating and guaranteed issue, have actually led to small–group carriers leaving the market in some states, resulting in fewer choices and little competition to control escalating premiums.<sup>27</sup>

In the Healthy New York program, the state is taking a “backdoor” approach to subsidizing insurance coverage. Rather than providing premium subsidies directly to workers, New York is subsidizing private health plans through stop–loss protection against large claims. The intent is for the health plans to pass along savings in the form of lower premiums to small groups and individuals. In addition, a scaled–down benefit package made possible through exemptions of certain state benefit mandates helps reduce the price of the Healthy New York product.

Challenges facing Healthy New York and similar approaches include ensuring that savings are in fact passed on as lower premiums, and that such reductions are enough to make coverage affordable to the target uninsured populations. Another challenge involves finding the right balance between scaling back benefits to make coverage more affordable and creating a product that provides adequate protection and is desirable to the public. Again, mechanisms to reduce crowd–out may also discourage participation among target populations.<sup>28</sup> Healthy New York is struggling with these issues, and officials plan to make necessary modifications along the way.

### *Buy-Ins to Public Coverage*

A third type of public–private partnership to expand coverage involves allowing employers and/or individuals to buy into public Medicaid or CHIP coverage. This approach addresses the lack of affordable private insurance options in the private market in many states and allows small businesses and individuals to enjoy the benefits of economies of scale and greater negotiating power with health plans.

As noted earlier in this report, New Mexico and Arkansas are developing a model that combines elements of premium assistance and buy–in programs. New Mexico has

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<sup>27</sup> *State of the States*, Prepared for State Coverage Initiatives, January 2002.

<sup>28</sup> The Lewin Group in partnership with Empire Health Advisors. “Report on the Healthy New York Program,” December 31, 2001.

established a standard basic benefit package and will contract with managed care organizations, which will market the plans to firms. Employers would contribute at least \$75 per enrollee per month; employees with income below 200 percent of the FPL would contribute according to a sliding scale (from \$0 to \$35 per month), and the remainder would be subsidized through Medicaid. Such hybrid programs, as well as “pure” buy-in programs, face challenges at both state and federal levels. Legislation proposed in Vermont that would allow workers with incomes up to 300 percent of FPL to buy into the state’s public coverage (VHAP) was not passed by the state legislature. Further, this model requires approval by CMS if it taps federal Medicaid or CHIP funds. HIFA may provide an appropriate vehicle for federal approval and state experimentation, though many details need to be worked out. It will be important to monitor the progress of these approaches that pool public and private dollars to expand coverage to uninsured populations.

### **Maintaining and Finding Savings in Existing Coverage Programs**

Regardless of whether they have been able to move forward with coverage expansions, many states have been forced to implement or plan cost-cutting measures in existing programs.<sup>29</sup> For example, Utah capped CHIP enrollment as of January 2002. While the state conducted a two-week open enrollment session in early June 2002, plans to reopen CHIP enrollment have been placed on hold. Additionally, the state has chosen to reduce its dental benefits to both the CHIP and Medicaid populations, and adults face the elimination of speech, hearing, and podiatry services as of July 2002.

Despite their efforts to retain existing benefits, Vermont has also been forced to increase cost-sharing and cut back on some benefits. In the 2001 legislative session, adult dental care was dropped and vision benefits were frozen under VHAP. Vermont is also exploring reducing some benefits to the elderly in their pharmaceutical programs, specifically VScript Expanded, which currently provides limited pharmaceutical coverage for the low-income elderly with incomes between 175 percent and 225 percent of the FPL.

While maintaining its efforts to enroll eligible children in its FamilyCare program, budget pressures have forced New Jersey to scale back its expansions to adults. It closed enrollment to childless adults in September 2001, and stopped accepting applications from all parents as of June 15, 2002. In addition, effective July 1, 2002, all General Assistance beneficiaries are no longer enrolled in FamilyCare managed care plans, but receive a benefit package of community-based services provided on a fee-for-service basis. Finally,

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<sup>29</sup> Vernon Smith, Eileen Ellis, Kathy Gifford, Rekha Ramesh, and Victoria Wachino. *Medicaid Spending Growth: Results from a 2002 Survey*. Kaiser Commission on Medicaid and the Uninsured, September 2002.

in order to preserve the program for children, the state has scaled back the benefit package for some currently enrolled adults. Effective September 1, 2002, parents receiving the full Medicaid package of services will receive a benefit package that mirrors the most widely sold commercial HMO package in the state. For higher-income families who currently share some of the costs of the program, copayments and premiums will increase, effective September 2002.

*Strategies from HRSA State Planning Grant Reports*

At the time the ideas in their State Planning Grant reports were developed, states may not have foreseen the financial constraints that loomed ahead. Even so, for many states, these ideas were proposals that were not linked to a certain source of funding. It is unclear how many states could have proceeded to implementation and how many would have been bogged down in the process of reaching consensus or securing financing. They are included here (Table 4) to illustrate the directions that most interested states that had gone through the planning efforts described above.

**Table 4. Range of Policy Options Considered by State Planning Grant Recipients, 2000–01**

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**Building on Existing Public Programs**

- Simplify and improve outreach
  - Maximize federal matching funds
  - Expand eligibility  
For example, to parents of Medicaid-eligible children, working uninsured with access to employer-sponsored insurance, offer full-cost buy-ins to Medicaid, extending short-term coverage for unemployed through the Unemployment Insurance program
  - Support employer-sponsored coverage  
For example, through Medicaid Health Insurance Premium Payment and CHIP programs, using HIFA flexibility in terms of reduced employer benefit package and cost-sharing rules
  - Use Section 1115/HIFA waivers for Medicaid/CHIP innovation  
For example, extend CHIP to parents and modify benefit packages and cost-sharing for existing or new populations
  - Bolster the safety net  
For example, create primary/preventive care packages for the uninsured, build on CAP grants, or propose employer/employee/public one-third share models
- 

**Enhancing Private Insurance Coverage**

- Aggregate small-group purchasing power into pools
  - Institute reinsurance mechanisms
  - Offer state tax credits to employees or employers
  - Reform insurance market  
For example, allow basic benefit packages, guaranteed issue, pooling, risk adjustment
  - Educate/inform consumers and employers about private insurance options
- 

**Other Options**

- Build on (proposed) federal tax credits
  - Tie state contracts to provision of health insurance with minimum employer contribution
  - Establish trust fund using voluntary employer/employee contributions to finance reforms
- 

Sources: State Planning Grant Program: Synthesis of State Experiences (Interim Report), prepared by the Academy for Health Services Research and Health Policy, December 2001; State Planning Grant Interim and Final reports for 2000 and 2001 grantees, October 2001 and March 2002, available at <http://www.statecoverage.net/hrsa.htm>.

## ROLE OF THE FEDERAL GOVERNMENT

In light of the difficult financial situation facing states, there are some potential roles for the federal government that would help states maintain gains in coverage that have been made, help them avoid scaling back coverage, and/or even provide assistance to increase coverage to currently uninsured populations.

Based on information gathered from the 10 state studies and from the review of the State Planning Grant states, the authors delineated four general areas, described below, where the federal government could provide such assistance. Table 5 synthesizes the State Planning Grant states' recommendations for federal policy.<sup>30</sup>

### **Technical Assistance and Policy Development Support**

One area in which the federal government has already provided funding, and may continue to do so, is through the State Planning Grant program. An important component of each of these grants was the collection of state-specific qualitative and quantitative data on the uninsured and employer coverage. Another important component was the states' use of the planning process to engage stakeholders, often putting together planning committees to develop a menu of policy options given their specific state context. The federal government should continue to provide funds for states to conduct such policy research and planning activities that explore various options for coverage.

These activities would build on another function HRSA has served during the course of the state planning grant program: facilitating communication among states on best practices and serving as a clearinghouse for information on what other states are doing. States appeared to find this helpful, and this function will become increasingly important as states move beyond the planning stages, begin implementation, and eventually obtain evaluation results. These options would not require much new federal funding and could leverage other funds since there are foundation programs that also support work around state coverage expansions.

### **Demonstrations**

The federal government could provide nonfinancial assistance by continuing to allow state flexibility around coverage expansion options as under HIFA, or even expanding waiver flexibility further or enhanced statutory flexibility to encourage state innovation. The federal government should consider allowing childless adults to be covered through Medicaid State

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<sup>30</sup> For more a more detailed discussion of state recommendations to the federal government that came out of the State Planning Grant experience, see Chapter 7 of *State Planning Grant Program: Synthesis of State Experiences* (Interim Report), prepared by the Academy for Health Services Research and Health Policy. December 2001.

Plan Amendments rather than waivers, or granting permanency to Section 1115a expansion populations. Also, some states would like greater flexibility to implement community-based demonstrations, and/or multistate or regional coverage or purchasing projects.

Prescription drugs are a big issue in Medicaid and have recently been one of the biggest drivers of Medicaid cost increases, particularly for elderly, blind, and disabled populations. As described earlier, Vermont, among other states, has been developing pharmaceutical programs to increase access to drug coverage for specific populations (generally seniors). The federal government can help these efforts by continuing to allow new waivers or approve amendments to expand current programs.

Of course, some state experimentation might have beneficial outcomes, and some might have unintended harmful consequences (e.g., hurting access for certain low-income populations whose benefits are affected by the new HIFA waivers). Thus, in addition to providing flexibility, the federal government should require evaluations to carefully track the impact of these initiatives.<sup>31</sup> If the new programs are expanding access, other states should be able to learn from those experiences, and if populations are experiencing adverse consequences, the federal government should be careful before approving other waivers with similar mechanisms until the problems are addressed and overcome.

### **Short-Term Financial Assistance**

All states are currently struggling with Medicaid costs and are finding it increasingly difficult to generate the state match for the program. While some states have had reserve funds for Medicaid, these are quickly being depleted. Many states feel that, without some form of short-term financial assistance from the federal government, there may be more cuts on the horizon in their Medicaid programs. State governors have introduced several proposals to encourage short-term federal assistance, such as a temporary increase in the Federal Medicaid Assistance Percentages (FMAP).<sup>32</sup> The governors have also requested flexible health and social service grants and a one-year “hold harmless” (that would postpone new financial burdens) for states that experienced a reduction in their FMAP for the 2002 fiscal year.

Some State Planning Grant states suggested other possible vehicles for short-term federal assistance. They include increased CHIP allotments for parents, a federal incentive

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<sup>31</sup> An emerging project from the Assistant Secretary for Planning and Evaluation (ASPE) to evaluate the new HIFA waivers is one such example of this type of work.

<sup>32</sup> See National Governors Association Policy Position EC-2. *State Fiscal Relief and Medicaid Flexibility Policy*. Adopted Annual Meeting 2002, effective Annual Meeting 2002 to Annual Meeting 2004. Available at [www.nga.org](http://www.nga.org).

match for hard-to-reach minority populations, and greater support for the safety net, which includes Federally Qualified Health Centers, Indian Health Services, 340B Drug Pricing to Rural Health Clinics, and Critical Access Hospitals. A less direct form of assistance would be financial incentives for providers to institute best practice protocols to manage chronic disease and improve quality of care.

### **Federal Program Expansion**

The final category of possible federal assistance would be a long-term undertaking and would involve congressional action to expand coverage. This could be done in a variety of ways, and might involve significant federal expenditures.<sup>33</sup> There have been recent congressional proposals for a federal tax credit (or other changes in tax policy) to subsidize the cost of coverage for lower-income uninsured people, as well as various proposals for Medicaid or CHIP eligibility expansions.<sup>34</sup> Recommendations by State Planning Grant states include sliding-scale subsidies toward premiums (e.g., through federal tax credits), tax deductibility for all methods of purchasing health insurance, a federal Medicaid match for employer and employee cost-sharing, ability for small employers to buy into Federal Employees Health Benefits Program (FEHBP) plans, and ability for the near-elderly and people with disabilities to buy into Medicare.

Additionally, if the federal government were to develop and implement Medicare prescription drug coverage, state resources and energy currently being expended on these programs could be redirected toward coverage programs for the uninsured. State governors also support changes in federal policy that would increase the size of pharmaceutical discounts given to states by manufacturers under the Medicaid rebate program.<sup>35</sup> If the federal government could work with the states to develop some relief for prescription drug prices, it might relieve some of the pressure from the Medicaid program generally.

Of course, these approaches could be combined. However, since it is unclear what level of federal resources will be available in the near future, states may continue to focus on coverage approaches that require no or relatively small federal investments.

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<sup>33</sup> For examples of a range of approaches to coverage, see Jack A. Meyer and Elliot K. Wicks, editors. *Covering America: Real Remedies for the Uninsured*. Washington, D.C.: The Economic and Social Research Institute, June 2001.

<sup>34</sup> For example, some federal legislators have proposed that the federal government allow states to do CHIP expansions to parents and pregnant women without waivers. Another recent proposal would allow states to receive the full FMAP rate to provide Medicaid benefits to recent legal immigrants.

<sup>35</sup> One way in which to do this would be to tie the rebate to the Average Wholesale Price, rather than the Average Manufacturer's Price, thus offering states a deeper discount on pharmaceuticals than what they currently receive. See National Governors Association Policy Position EC-3. *Medicaid Drug Rebate Program Policy*. Adopted Annual Meeting 2002, effective Annual Meeting 2002 to Annual Meeting 2004. Available at [www.nga.org](http://www.nga.org).

**Table 5. Synthesis of State Planning Grant States' Recommendations to the Federal Government**

Technical Assistance	Federal Flexibility	Short-Term Financial Assistance	Federal Program Expansion
<ul style="list-style-type: none"> <li>• Make national and state-specific survey data better available through a national data clearinghouse</li> <li>• Fund research on the uninsured, planning and policy development, and pilot testing</li> <li>• Increase research into delivery, appropriate utilization, cost/affordability, quality of health care delivery systems, and coverage expansion programs</li> <li>• Facilitate and coordinate communication among states considering similar waiver strategies</li> <li>• Redesign the administrative system supporting eligibility and enrollment activities so that all states can be consistent</li> </ul>	<ul style="list-style-type: none"> <li>• Allow states more flexibility in operating Medicaid and S-CHIP programs; increase flexibility of CMS to approve waivers such as HIFA 1115 waivers</li> <li>• Grant permanency to 1115a expansion populations</li> <li>• Provide flexibility to states to implement SPG-developed strategies and pharmaceutical programs</li> <li>• Provide greater flexibility to implement community-based demonstrations</li> <li>• Support multistate or regional demonstrations (e.g., employer purchasing pools, multistate Medicaid purchasing)</li> </ul>	<ul style="list-style-type: none"> <li>• Increase CHIP allotments for parents</li> <li>• Provide an incentive match for hard-to-reach minority populations</li> <li>• Strengthen the safety net; e.g., continue or increase support of Federally Qualified Health Centers, Indian Health Services, 340B Drug Pricing to Rural Health Clinics and Critical Access Hospitals</li> <li>• Provide incentives for providers to institute best practice protocols to manage chronic disease and improve quality of care</li> </ul>	<ul style="list-style-type: none"> <li>• Pursue legislation making all methods of purchasing health insurance tax deductible; specifically for the self-employed and those without access to employer-sponsored coverage</li> <li>• Expand Medicaid; e.g., allow a federal Medicaid match for employer and employee cost-sharing for adult coverage expansions</li> <li>• Expand Medicare eligibility through buy-in options for the “near-elderly” and people with disabilities</li> <li>• Develop an affordable Medicare prescription drug program</li> <li>• Alter the Internal Revenue Statutes to assist workers through tax credits for employees and/or employers to purchase health coverage</li> <li>• Allow a system of sliding-scale subsidies for people to purchase insurance based on income</li> <li>• Allow small employers to buy into FEHBP health plans</li> </ul>

Sources: State Planning Grant Interim and Final reports for 2000 and 2001 grantees, October 2001 and March 2002, available at <http://www.statecoverage.net/hrsa.htm>.

## CONCLUSION

Some states may choose to follow the path of Oregon, New Mexico, and others and try to expand health coverage even during the current economic downturn. Other states may feel the need to “sit tight” and forgo coverage expansion plans for the near future. But history has proven that economic downturns are not permanent; eventually state revenues and opportunities will increase. In this light, all states should be planning ahead, regardless of the path taken in the short term.

The current period of retrenchment and reallocation should not preclude states from learning from other states’ experiences, and exploring and planning more ambitious coverage expansion policies. On the contrary, even if states cannot fund the policy options they develop due to current political or financial constraints, they can lay the groundwork by putting in place the kinds of conditions delineated in this report. When funds are available or the political climate is favorable, states that plan ahead will be in a better position to move forward.

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**APPENDIX. INCOME ELIGIBILITY LEVELS FOR PUBLIC PROGRAMS  
IN 10 STUDY STATES<sup>a</sup>**

<b>State</b>	<b>Medicaid/CHIP Eligibility for Children<sup>b</sup></b>	<b>Program Eligibility for Adults<sup>c</sup></b>
Arkansas	Children up to 133% FPL (Medicaid) Children between 133% and 200% FPL (CHIP)	Pregnant women up to 133% FPL (Medicaid) Adults to 22% FPL
Georgia	Newborns up to 200% FPL (Medicaid) Infants to age 1 up to 185% FPL (Medicaid) Children age 1 to 5 up to 133% FPL (Medicaid) Children age 6 to 18 up to 100% FPL (Medicaid) Children through age 18 up to 235% FPL (CHIP)	Pregnant women up to 200% FPL (Medicaid) TANF adults up to 44% FPL (Medicaid)
Michigan	Infants to age 1 up to 185% FPL (Medicaid) Children age 1 through 18 up to 150% FPL (Medicaid) Children between 150% and 200% FPL (CHIP)	Pregnant women up to 185% FPL (Medicaid) Caretaker relatives up to 50% FPL (Medicaid)
New Jersey	Children up to 133% FPL (Medicaid) Children between 133% and 350% FPL (CHIP) <sup>d</sup>	Pregnant women up to 200% FPL (Medicaid) Parents up to 133% FPL (Medicaid) Parents between 133% and 200% FPL (CHIP) Single adults/childless couples up to 50% FPL (Medicaid) and up to 100% FPL (state-only) <sup>e</sup>
New Mexico	Children up to 185% FPL (Medicaid) Children between 185% and 235% FPL (CHIP)	Pregnant women up to 185% FPL (Medicaid) TANF adults up to 37% FPL (Medicaid)
New York	Infants to age 1 up to 200% FPL (Medicaid) Infants to age 1 between 200% and 250% FPL (CHIP) Children age 1 to 18 up to 133% FPL (Medicaid) Children age 1 to 18 between 133% and 250% FPL (CHIP) Family full-cost buy-in for incomes greater than 250% FPL (CHIP)	Pregnant women up to 200% FPL (Medicaid) Adults with dependent children up to 150% FPL (Medicaid) Childless adults up to 100% FPL (Medicaid) <sup>f</sup>
Oregon	Children to age 6 up to 133% FPL (Medicaid) Children to age 6 between 133% FPL and 170% FPL (CHIP) Children age 6 through 18 between 100% and 170% FPL (CHIP)	Adults up to 100% FPL (Medicaid) Pregnant women up to 133% FPL (Medicaid)

<b>State</b>	<b>Medicaid/CHIP Eligibility for Children<sup>b</sup></b>	<b>Program Eligibility for Adults<sup>c</sup></b>
Rhode Island	Children to age 8 up to 250% FPL (Medicaid) Children age 8 through 18 up to 250% FPL (CHIP)	Pregnant women up to 185% FPL (Medicaid) Pregnant women between 185% to 250% FPL (CHIP) Adult parents up to 100% FPL (Medicaid) Adult parents between 100% and 185% FPL (CHIP) Licensed family child care providers with children through age 18 and who care for children enrolled in the Department of Human Services subsidized child care program (Medicaid)
Utah	Children to age 6 up to 133% FPL (Medicaid) Children age 6 to 18 up to 100% FPL (Medicaid) Children through age 18 up to 200% FPL (CHIP) <sup>g</sup>	Pregnant women up to 133% FPL (Medicaid) Adult parents up to 53.4% FPL (Medicaid) Adults up to 150% FPL (Medicaid) <sup>h</sup>
Vermont	Children through age 17 up to 225% FPL (Medicaid) Children through age 17 between 225% and 300% FPL (CHIP) 18-year-olds to 150% FPL (Medicaid)	Pregnant women up to 200% FPL (Medicaid) Custodial parents and caretaker relatives up to 185% FPL (Medicaid) Noncustodial parents and other adults up to 150% FPL (Medicaid)

<sup>a</sup> This table does not describe asset tests or other eligibility criteria.

<sup>b</sup> Children are defined as through age 18 unless otherwise specified.

<sup>c</sup> Adults are defined as age 19 through 64; does not include elderly, disabled, or medically needy categories of Medicaid.

<sup>d</sup> New Jersey has four different benefit packages for children: Plan A (full Medicaid managed care, no cost-sharing) covers children under 19 with family incomes up to 133% of the FPL or less; Plan B (modified commercial-type plan, no premium) covers children with family incomes between 134% and 150% FPL; Plan C (modified commercial-type plan, premium and copayments) covers children with family incomes between 151% and 200% FPL; and Plan D (average commercial HMO benefits, sliding-scale premiums, copayments) covers children with family incomes between 201% and 350% FPL. There is also a six-month waiting period for plans B, C, and D but some exceptions are allowed for families with incomes below 200% FPL.

<sup>e</sup> Under New Jersey's multiplan system (see prior footnote for plan descriptions), Plan A (full Medicaid managed care, no cost-sharing) covers parents up to 133% FPL, pregnant women up to 200% FPL, single adults/childless couples up to 50% FPL, and individuals on General Assistance. Plan D covers parents who do not otherwise qualify for Medicaid up to 200% FPL, and single adults/childless couples between 51% and 100% FPL.

<sup>f</sup> New York's regular Medicaid package covers adults with dependent children up to 85% FPL and childless adults up to about 50% FPL (varies by county). Its Medicaid expansion program Family Health Plus (commercial-type benefits) covers adults with dependent children between 85% and 150% FPL, and childless adults between 50% and 100% FPL.

<sup>g</sup> Utah's CHIP program is divided into two parts: CHIP A and CHIP B. CHIP A is for children up to 150% FPL and CHIP B is for children between 151% and 200% FPL

<sup>h</sup> Utah's Medicaid expansion for adults up to 150% FPL who do not otherwise qualify for Medicaid covers primary and preventive care services only.



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**#598** *Building Quality into RIte Care: How Rhode Island Is Improving Health Care for Its Low-Income Populations* (December 2002). Sharon Silow-Carroll, Economic and Social Research Institute. RIte Care, Rhode Island's managed care program for Medicaid beneficiaries, Children's Health Insurance Program enrollees, and certain uninsured populations, has made quality improvement a central goal. This report examines the state's initiatives aimed at improving care for pregnant women, children, and others, including efforts focused on preventive and primary care, financial incentives, and research and evaluation.

**#597** *Assessing State Strategies for Health Coverage Expansion: Profiles of Arkansas, Michigan, New Mexico, New York, Utah, and Vermont* (December 2002, Web publication). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors discuss, in detail, initiatives undertaken to maximize health insurance coverage in Arkansas, Michigan, New Mexico, New York, Utah, and Vermont.

**#587** *Assessing State Strategies for Health Coverage Expansion: Summary of Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These summaries of case studies look at four states' unique as well as shared experiences and draw lessons for other states. (See pub. **#565** for the full case studies.)

**#577** *Toward Comprehensive Health Coverage for All: Summaries of 20 State Planning Grants from the U.S. Health Resources and Services Administration* (November 2002, Web publication). Heather Sacks, Todd Kutyla, and Sharon Silow-Carroll, Economic and Social Research Institute. In 2000, the DHHS' Health Resources and Services Administration awarded grants to 20 states to create comprehensive coverage plans for all citizens. These summaries report on the progress of states' coverage expansion efforts, detailing the history of reform, data on uninsured populations, actions taken, and goals for future efforts. Available at [www.cmwf.org](http://www.cmwf.org).

**#565** *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* (November 2002). Sharon Silow-Carroll, Emily K. Waldman, Jack A. Meyer, Claudia Williams, Kimberley Fox, and Joel C. Cantor. These case studies provide an in-depth account of four states' efforts to expand health coverage, detailing their relative strengths and weaknesses and highlighting what appear to be the key factors for success.

**#574** *Employer Health Coverage in the Empire State: An Uncertain Future* (August 2002). According to this report, the combination of a weak economy, higher unemployment, and rising health care costs is placing pressure on New York State employers to eliminate or scale back health benefits for workers, their dependents, and retirees.

**#559** *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (August 2002). Based on a Commonwealth Fund survey of health insurance in the workplace, this report finds that two of five workers experienced increases in their premiums or cost-sharing, or both,

during 2001. Although public support for job-based health insurance remains strong, many workers are not confident that employers will continue to offer coverage to them down the road. Workers are even more uncertain about their ability to get good health care in the future.

**#509** *Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity* (June 2002). Mark Merlis. This report examines trends in out-of-pocket spending, the components of that spending, and the characteristics of families with high out-of-pocket costs.

**#557** *Eliminating Racial/Ethnic Disparities in Health Care: Can Health Plans Generate Reports?* (May/June 2002). David R. Nerenz, Vence L. Bonham, Robbya Green-Weir, Christine Joseph, and Margaret Gunter. *Health Affairs*, vol. 21, no. 3. The absence of data on race and ethnicity in health plan and provider databases is a significant barrier in the creation and use of quality-of-care reports for patients of minority groups. In this article, however, the authors show that health plans are able to collect and analyze quality of care data by race/ethnicity.

**#556** *Do Enrollees in 'Look-Alike' Medicaid and SCHIP Programs Really Look Alike?* (May/June 2002). Jennifer N. Edwards, Janet Bronstein, and David B. Rein. *Health Affairs*, vol. 21, no. 3. In their analysis of Georgia's similar-looking Medicaid and SCHIP programs, the authors present three possible explanations for the differences in access to care between the two populations: Medicaid families are less familiar with and supportive of systems requiring use of an assigned primary care physician, the families face more nonprogram barriers to using care, and physicians have different responses to the two programs.

**#527** *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets* (May 2002). Jon R. Gabel, Kelley Dhont, and Jeremy Pickreign, Health Research and Educational Trust. This report identifies solutions that might make tax credits and the individual insurance market work, including raising the amount of the tax credits; adjusting the credit according to age, sex, and health status; and combining tax credits with new access to health coverage through existing public or private group insurance programs.

**#518** *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income.

**#507** *Lessons from a Small Business Health Insurance Demonstration Project* (February 2002). Stephen N. Rosenberg, PricewaterhouseCoopers LLP. This report finds that the recently concluded pilot project, the Small Business Health Insurance Demonstration, launched by the New York City in 1997, was successful in providing a comprehensive, low-cost insurance option for firms with two to 50 workers. But poor implementation and marketing, plus flaws in product design, prevented the program from catching on among small businesses.

**#528** *The APHSA Medicaid HEDIS Database Project* (December 2001). Lee Partridge, American Public Human Services Association. This study (available on the Fund's website only) assesses how well managed care plans serve Medicaid beneficiaries, and finds that while these plans often provide good care to young children, their quality scores on most other measures lag behind plans serving the commercially insured.

**#512** *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64, some 38 million adults, was uninsured

for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

**#513** *Maintaining Health Insurance During a Recession: Likely COBRA Eligibility* (December 2001). Michelle M. Doty and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, examines the potential as well as limits of COBRA eligibility as a strategy for protecting workforce access to affordable health care benefits.

**#514** *Experiences of Working-Age Adults in the Individual Insurance Market* (December 2001). Lisa Duchon and Cathy Schoen. This issue brief, based on The Commonwealth Fund 2001 Health Insurance Survey, describes the difficulties faced by those without access to group health coverage in obtaining adequate, affordable individual health insurance.

**#478** *Universal Coverage in the United States: Lessons from Experience of the 20th Century* (December 2001). Karen Davis. This issue brief, adapted from an article in the March 2001 *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, traces how the current U.S. health care system came to be, how various proposals for universal health coverage gained and lost political support, and what the pros and cons are of existing alternatives for expanding coverage.

**#511** *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance* (November 2001). Jeanne M. Lambrew, George Washington University. This report documents the link between loss of health insurance and unemployment, estimating that 37 percent of unemployed people are uninsured—nearly three times as high as the uninsured rate for all Americans (14%). The jobless uninsured are at great financial risk should they become ill or injured.

**#485** *Implementing New York's Family Health Plus Program: Lessons from Other States* (November 2001). Rima Cohen and Taida Wolfe, Greater New York Hospital Association. Gleaned from research into the ways 13 other states with public health insurance systems similar to New York's have addressed these matters, this report examines key design and implementation issues in the Family Health Plus (FHP) program and how Medicaid and the Child Health Plus program could affect or be affected by FHP.

**#484** *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (November 2001). Katherine Swartz, Harvard School of Public Health. According to the author, Healthy New York—a new health insurance program for workers in small firms and low-income adults who lack access to group health coverage—has so far been able to offer premiums that are substantially less than those charged in the private individual insurance market.

**#475** *Business Initiatives to Expand Health Coverage for Workers in Small Firms* (October 2001). Jack A. Meyer and Lise S. Rybowski. This report weighs the problems and prospects of purchasing coalitions formed by larger businesses to help small firms expand access to health insurance. The authors say that private sector solutions alone are unlikely to solve the long-term problem, and the public sector will need to step in to make health insurance more affordable to small businesses.

**#502** *Gaps in Health Coverage Among Working-Age Americans and the Consequences* (August 2001). Catherine Hoffman, Cathy Schoen, Diane Rowland, and Karen Davis. *Journal of Health Care for the Poor and Underserved*, vol. 12, no. 3. In this article, the authors examine health coverage and access to care among working-age adults using the Kaiser/Commonwealth 1997 National Survey of Health Insurance, and report that having even a temporary gap in health coverage made a significant difference in access to care for working-age adults.

**#493** *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that

building on insurance options that currently exist—such as employer-sponsored insurance, the Children’s Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation’s 15 million uninsured women.

**#472** *Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools* (August 2001). Lori Achman and Deborah Chollet, Mathematica Policy Research, Inc. The authors argue that high premiums, deductibles, and copayments make high-risk pools unaffordable for people with serious medical conditions, and suggest that by lifting the tax exemption granted to self-insured plans, states could provide their high-risk pools with some much-needed financing.

**#464** *Health Insurance: A Family Affair—A National Profile and State-by-State Analysis of Uninsured Parents and Their Children* (May 2001). Jeanne M. Lambrew, George Washington University. This report suggests that expanding Medicaid and State Children’s Health Insurance Program (CHIP) coverage to parents as well as children may not only decrease the number of uninsured Americans but may be the best way to cover more uninsured children.

**#445** *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (February 2001). Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, Economic and Social Research Institute. As with publication **#424** (see below), this report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, but looks more closely at programs in six of the states discussed in the earlier report.

**#439** *Patterns of Insurance Coverage Within Families with Children* (January/February 2001). Karla L. Hanson. *Health Affairs*, vol. 20, no. 1. Using the 1996 Medical Expenditure Panel Survey, this article examines patterns of health insurance within families with children, determining that 3.2 million families are uninsured and another 4.5 million families are only partially insured.

**#415** *Challenges and Options for Increasing the Number of Americans with Health Insurance* (January 2001). Sherry A. Glied, Joseph A. Mailman School of Public Health, Columbia University. This overview paper summarizes the 10 option papers written as part of the series *Strategies to Expand Health Insurance for Working Americans*.

**#476** “*Second-Generation” Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review*, vol. 22, no. 2. This study of Medicaid managed care programs in seven states finds that the programs require state policymakers to make difficult tradeoffs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at [www.cmwf.org](http://www.cmwf.org).

**#422** *Buying into Public Coverage: Expanding Access by Permitting Families to Use Tax Credits to Buy into Medicaid or CHIP Programs* (December 2000). Alan Weil, The Urban Institute. Medicaid and CHIP offer administrative structures and plan arrangements with the capacity to enroll individuals and families. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes permitting, but not requiring, tax-credit recipients to use their credits to buy into Medicaid or CHIP. Available online only at [www.cmwf.org](http://www.cmwf.org).

**#419** *Allowing Small Businesses and the Self-Employed to Buy Health Care Coverage Through Public Programs* (December 2000). Sara Rosenbaum, Phyllis C. Borzi, and Vernon Smith. Public programs such as CHIP and Medicaid offer the possibility of economies of scale for group coverage for small employers as well as individuals. This paper, part of the series *Strategies to Expand Health Insurance for Working Americans*, proposes allowing the self-employed and those in small businesses to buy coverage through these public plans, and providing premium assistance to make it easier for them to do so. Available online only at [www.cmwf.org](http://www.cmwf.org).

**#424** *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured* (November 2000). Sharon Silow-Carroll, Stephanie E. Anthony, and Jack A. Meyer, Economic and Social Research Institute. This report describes the various ways states and local communities are making coverage more affordable and accessible to the working uninsured, with a primary focus on programs that target employers and employees directly, but also on a sample of programs targeting a broader population.

**#411** *ERISA and State Health Care Access Initiatives: Opportunities and Obstacles* (October 2000). Patricia A. Butler. This study examines the potential of states to expand health coverage incrementally should the federal government decide to reform the Employee Retirement Income Security Act (ERISA) of 1974, which regulates employee benefit programs such as job-based health plans and contains a broad preemption clause that supercedes state laws that relate to private-sector, employer-sponsored plans.

**#392** *Disparities in Health Insurance and Access to Care for Residents Across U.S. Cities* (August 2000). E. Richard Brown, Roberta Wyn, and Stephanie Teleki. A new study of health insurance coverage in 85 U.S. metropolitan areas reveals that uninsured rates vary widely, from a low of 7 percent in Akron, Ohio, and Harrisburg, Pennsylvania, to a high of 37 percent in El Paso, Texas. High proportions of immigrants and low rates of employer-based health coverage correlate strongly with high uninsured rates in urban populations.

**#385** *State Experiences with Cost-Sharing Mechanisms in Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report examines the effect of cost-sharing on participation in the State Child Health Insurance Program (CHIP).

**#384** *State Experiences with Access Issues Under Children's Health Insurance Expansions* (May 2000). Mary Jo O'Brien et al. This report explores how the design and administration of state incremental insurance expansions affect access to health insurance coverage and, ultimately, access to all health care services.

**#380** *Educating Medicaid Beneficiaries About Managed Care: Approaches in 13 Cities* (May 2000). Sue A. Kaplan, Jessica Green, Chris Molnar, Abby Bernstein, and Susan Ghanbarpour. In this report, the authors document the approaches used and challenges faced in Medicaid managed care educational efforts in 13 cities across the country.

**#366** *National Medicaid HEDIS Database/Benchmark Project: Pilot-Year Experience and Benchmark Results* (February 2000). Lee Partridge and Carrie Ingalls Szlyk, American Public Human Services Association. This report summarizes the first year of a project to create national summaries of state Medicaid HEDIS data and national Medicaid quality benchmarks against which each state can measure its program's performance.

**#368** *Managed Care in Three States: Experiences of Low-Income African Americans and Hispanics* (Fall 1999). Wilhelmina A. Leigh, Marsha Lillie-Blanton, Rose Marie Martinez, and Karen Scott Collins. *Inquiry*, vol. 36, no. 3. This article examines the experiences of low-income Hispanics, African Americans, and whites enrolled in managed care plans in Florida, Tennessee, and Texas and compares them to their racial/ethnic counterparts enrolled in fee-for-service plans.

**#260** *State-Subsidized Health Insurance Programs for Low Income Residents: Program Structure, Administration, and Costs* (April 1998) Laura Summer, Alpha Center. In an effort to determine states' success in covering uninsured populations, the author interviewed public insurance officials in 12 states and reviewed their programs' administrative structures, use of managed care, eligibility rules, and application and enrollment processes.

