STRETCHING STATE HEALTH CARE DOLLARS: BUILDING ON EMPLOYER-BASED COVERAGE

One of a Series of Reports Identifying Innovative State Efforts
to Enhance Access, Coverage, and Efficiency in Health Care Spending

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STRETCHING STATE HEALTH CARE DOLLARS: BUILDING ON EMPLOYER-BASED COVERAGE

INTRODUCTION

One of the ways in which states are trying to expand health care coverage is by building on employer-based health plans. Whether subsidizing an existing employer plan or creating a new and more affordable program for uninsured workers, states are using their dollars, regulatory/legislative powers, and purchasing clout to leverage employer and employee contributions in order to cover more people.

The primary role of employer-based coverage in the United States, as well as the significant gaps that might be filled with more public-private partnerships, are illustrated by the following facts:[1]

- 63 percent of the non-elderly in the United States had employer-based health coverage in 2002, making it the primary source of coverage for Americans.
- While 98 percent of large businesses (200+ employees) offered health benefits in 2003, only 65 percent of small firms (3 to 199 employees) offered coverage.
- Among workers in firms that offered benefits, only 68 percent were covered by their employer plan in 2003.
- In businesses that offered coverage, 19 percent of workers were not eligible to enroll in 2003.
- Of those workers who are eligible for the employer health plan, 17 percent decline the health plan, often because they feel they cannot afford their share of the premium.
- 82 percent of the uninsured live in a household with a working person, 70 percent live with a full-time worker, and 12 percent live in a household with a part-time worker.[2]

Despite the potential for building on the employer-based health coverage system through public support, many state efforts to date have shown only limited success. Obstacles have included: the need for very large subsidies to make coverage "affordable"; a lack of interest and cooperation by employers; administrative complexity and cost (e.g., determining cost-effectiveness or obtaining information from individual employers); difficulty in satisfying private health plans' procedures (e.g., narrow open-enrollment

periods); and the need for significant marketing efforts (including working with insurance brokers).[3]

Rather than abandon the goal, however, many states are devising new strategies. In this report we present examples of the following mechanisms being pursued in that spirit:

- Premium assistance for existing employer plan
- Reinsurance (indirect state subsidy)[4]
- Direct subsidization of new public-private plan
- State-negotiated health plan
- Pay-or-play approach.

Premium Assistance

Though "premium assistance" may be defined in many ways, we use the term here to describe programs in which states directly subsidize private-employer-sponsored health insurance available through the workplace. Premium assistance generally targets low-wage workers directly, though it could subsidize employer contributions as well (e.g., Massachusetts' Insurance Partnership). States may tap federal dollars to match the state's contribution by implementing a premium-assistance effort as part of a Medicaid or State Children's Health Insurance Program (SCHIP) expansion; or they may use only state dollars, as Oregon did in 1997 with its Family Health Insurance Assistance Program (FHIAP).

Vehicles for creating a premium-assistance program through Medicaid or SCHIP include Section 1906 of the Medicaid statute (also known as the Health Insurance Premium Payment [HIPP] program), "traditional" Section 1115 demonstration waivers, and Health Insurance Flexibility and Accountability (HIFA) waivers. As of August 1, 2003, eligible individuals may also receive premium assistance through a health care tax credit (HCTC) made available by the passage of the Trade Adjustment Assistance Reform Act of 2002.[5]

When it is cost-effective for them to do so, HIPP programs pay the cost of health insurance premiums, coinsurances, deductibles, and other services normally covered by Medicaid for Medicaid-eligible children with access to employer-based insurance.[6,7] However, most HIPP programs are quite limited (e.g., targeting people in specific disease

categories) and have faced many of the barriers cited above, though a few target broader groups and have enrolled significant numbers of people (e.g., Pennsylvania and Iowa).

States that have used federal waiver authority to establish premium-assistance programs have also struggled, but a few new approaches appear to be promising. Enrollment in Rhode Island's RIte Share program, for example, has expanded by bypassing the employer and providing the subsidy directly to workers, and by creating new information systems that track employer health plan information and facilitate mandatory enrollment for those who are eligible. Conversely, Illinois plans to avoid costly tracking of employer plans and provision of wrap-around benefits by allowing free movement between subsidized employer coverage and direct Medicaid coverage. And Utah is focusing on containing its costs while promoting workplace coverage by limiting the premium-assistance amount and targeting uninsured individuals only (see profiles below).

Federally funded tax credits toward the purchase of private insurance—a form of premium assistance—are now available to workers displaced by international trade and to early retirees (ages 55 to 64) who are beneficiaries of the Public Benefits Guarantee Corporation (PBGC). Through the Trade Adjustment Assistance Reform Act's health care tax credit, eligible individuals may be subsidized for 65 percent of the cost of their insurance premium.[8]

Reinsurance

While premium assistance offers direct subsidies to individuals purchasing insurance, "reinsurance" is an indirect way to reduce the price of private insurance premiums, thereby providing a more affordable option for uninsured workers. Reinsurance means that the state covers a portion of private insurers' claims; this "stop loss" mechanism may cover catastrophic claims above a certain dollar amount, or it may cover claims within a designated corridor.

Reinsurance is used by just a couple of states in programs that target small firms or low-income uninsured individuals. Under Healthy New York, a state-funded stop-loss fund pays for 90 percent of claims between $5,000 and $75,000. Additional features intended to keep premiums low include a reduced benefit package; required use of in-network providers; significant cost-sharing (copayments and deductibles); and a plan option that does not include pharmaceutical coverage.[9] Under Healthcare Group of Arizona, the state has been contributing a reinsurance subsidy covering claims between $20,000 and $100,000 and purchasing (commercial) catastrophic reinsurance coverage for

claims above $100,000. Though both programs have struggled, they are modifying their features so as to boost enrollment and improve financial viability. Presidential candidate John Kerry incorporates a reinsurance model in his health care reform plan.

Direct Subsidization of New Health Plan

A number of states are exploring a public-private partnership model in which a new health plan is developed for small businesses. Either a state-designated board or a private insurer administers the plan, and the state subsidizes the premium for low-income workers. This is the basis of Maine's Dirigo Health Plan[10] and New Mexico's State Coverage Initiative.

Some state-designed health plans may be "bare bones" to the point that the state may need a waiver to operate them if the financing includes Medicaid or SCHIP dollars. The intent is to help keep the premiums more affordable to the target population, though opponents argue that barebones plans are less attractive and offer inadequate protection. It will be important to monitor, evaluate, and learn from these experiments in coming years.

State-Negotiated Health Plan

A way for states to help make coverage more affordable to small businesses without actually subsidizing the coverage is to bargain on behalf of employers. States have much greater clout than individual small businesses when negotiating prices with pharmaceutical firms or premiums with health care plans. For example, through expansion of its Municipal Employees Health Insurance Plan (MEHIP), Connecticut is beginning to provide small businesses with access to state-negotiated health plans (similar to those offered to state employees) that offer lower cost and greater choice. Similarly, West Virginia's Small Business Plan will create a new health plan for uninsured small businesses based on state-employee reimbursement rates and multistate drug prices. Both of these programs maintain separate risk pools for the small business groups. (See program descriptions under "Snapshots: Additional 'Building on Employer Coverage' Initiatives," in this report.).

A variation on this model is to allow small businesses and uninsured workers to actually buy into the state-employee health plan. This option has been explored but not implemented over fears of "adverse selection"—i.e., that higher-risk individuals will purchase the coverage and raise the risk (and eventually the premiums) of the entire group.

Pay or Play

Finally, we include the pay-or-play model, whereby the state requires businesses to either provide coverage to their workers or pay into a fund that purchases coverage, on a large

scale, for those and other workers. The major advantage of this strategy is that it is a way for states to expand coverage through the employer-based system without major public outlays. Also, it is said to "level the playing field" by requiring all employers to contribute toward coverage—as opposed to having some pay for their own workers as well as for the uninsured through taxes and higher health care costs. The financial burden on businesses (particularly small firms) and any possible effect on employment are the major concerns raised by this strategy.

California has passed legislation to addresses these key concerns; the law exempts very small firms and provides for financial assistance to mid-level firms. Nevertheless, political and legal issues pose challenges to implementation (see profile below). States are watching to see how these challenges will be met.

Additional Resources

Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002: A Preliminary Analysis of Program Operation* (New York: The Commonwealth Fund, April 2004). http://www.cmwf.org/publications/publications_show.htm?doc_id=226530

Ed Neuschler and Rick Curtis, *Premium Assistance: What Works? What Doesn't?* Issue Brief (Washington, D.C.: Institute for Health Policy Solutions, April 2003).

Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (New York: The Commonwealth Fund, February 2001). http://www.cmwf.org/publications/publications_show.htm?doc_id=221287

Claudia Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs* (Portland, Maine: National Academy for State Health Policy, April 2003).

Barbara Yondorf, Laura Tobler, and Leah Oliver, *State Options for Expanding Heath Care Access,* Balancing Health Needs with Resources Series (Washington, D.C.: National Conference of State Legislatures, March 2004).

Matrix: State Activity—Building on the Employer-Based System

State	Program Name	Type of Strategy and Implementation Date		Participation
Current Examples				
Rhode Island[11]	RIte Share	Premium Assistance—SCHIP • Direct payments to employees • Systems redesign and mandatory enrollment	May 2001 Jan 2002 Feb 2004	5,500 enrollees as of Mar 2004
Illinois	FamilyCare	Coverage Expansion: Direct Coverage and Premium Assistance—SCHIP • Conversion of state's children premium-assistance program to Medicaid • Taps unused SCHIP funds • Free movement between direct coverage and premium assistance • Buy-in for families at 150 percent of the federal poverty level (FPL)	Phased in from Oct 2002 to FY '06 Oct 2002 Oct 2002 FY '06 (planned) FY '06 (planned)	49,000 parents as of April 2004 4,900 children in premium assistance as of April 2004
Utah	Covered at Work	Premium Assistance—Medicaid Plan Amendment	Aug 2003	60 enrollees as of June 2004
Pennsylvania[12]	Health Insurance Premium Payment	Premium Assistance—HIPP • Automated system for obtaining employer information, enrolling, tracking, etc. • Improved outreach, referrals	1994	Approx. 21,000 enrollees as of Apr 2004
Massachusetts	Family Assistance Premium Assistance Insurance Partnership	• Premium Assistance to low-income employees • Premium subsidies to employers with eligible workers	1998 1999	9,390 individuals as of June 2004 5,000 employers as of June 2004

State	Program Name	Type of Strategy and Implementation Date		Participation
New York	Healthy New York	Reinsurance • HMO product with scaled down benefits for low-income uninsured small firms and individuals • State reinsures (pays 90 percent) claims between $5,000 and $75,000	2001	Approx. 55,000 enrollees (12,000 from small firms) as of April 2004
Arizona	Healthcare Group of Arizona	Reinsurance • HMO product for small firms, state pays for reinsurance covering high claims • Offers customized benefit plans, enhances provider network, implements incentive-based marketing contract	2002[13] Planned 2004	11,000 workers and dependents from almost 4,000 firms as of Feb 2004
Initiatives to Watch				
Maine	Dirigo Health Plan	Subsidized health plan for small businesses and uninsured combined with: • Redirection of bad debt/charity care funds • Voluntary caps on insurer, hospital, provider prices • Forum to promote high quality, cost-effective care • Medicaid expansion for adults	Oct 2004 planned	NA
New Mexico	State Coverage Initiative	Subsidized health plan for uninsured workers • Public-private health plan for uninsured employed low-income individuals • Use of unspent SCHIP funds and county uncompensated care dollars	Pending; end of 2004 at earliest	NA

State	Program Name	Type of Strategy and Implementation Date		Participation
Arkansas	Employer-Sponsored Insurance Initiative, or Employer-State Health Insurance Partnership	Subsidized bare-bones health plan for small businesses • "Safety net" minimal benefit plan for small firms • Subsidized for employees up to 200% FPL, unsubsidized for employees above 200% FPL • Employer "tax" payments constitute state Medicaid contribution, drawing federal match • May be made available to adults up to 100% FPL	Pending HIFA waiver approval	NA
Connecticut	Expansion of Municipal Employees Health Insurance Plan (MEHIP)	State-negotiated health plan for small business • Small firms have access to lower cost and greater choice in health plans	Available May 2004 for August 2004 effective-coverage date	NA
West Virginia	Small Business Plan	State-negotiated health plan for small business • New health plan for uninsured small businesses • Carriers use state-employee reimbursement rates and multistate drug rates	Legislation effective June 2004; Plans expected to be available 4th quarter of 2004	NA
Idaho	Health Insurance Access Card	Premium Assistance • Phase I: low-income children have option of direct SCHIP coverage or $100/month premium assistance toward commercial insurance • Phase 2: premium assistance up to $100/month for low-income adults with access to employer-sponsored insurance	July 2004 Planned July 2005	NA
Michigan	Third Share Partnership	Premium Assistance—Three-share Model • Statewide plan for small firms with employee, employer, and state each contributing one-third of premium	Not indicated	NA

State	Program Name	Type of Strategy and Implementation Date		Participation
California	SB2-CA Health Insurance Act of 2003	"Pay or Play" • Employers must provide coverage or pay toward State Purchasing Fund • Development of cost containment and quality-improvement measures	Pending Nov 2004 ballot challenge	NA
Louisiana	LA Choice	Subsidized bare-bones health plan • New small-employer product with limited benefits and subsidies for low-income workers	Planned April 2005, pending HIFA waiver approval	Pilot expected to cover approx. 3,000 employees

STATE PROFILES

RHODE ISLAND: RITE SHARE IMPROVEMENTS AND OTHER STRATEGIES

Purpose/Goal

Rhode Island is attempting to expand enrollment of families eligible for RIte Care (the state's combination Medicaid/SCHIP health coverage program) into RIte Share, Rhode Island premium-assistance program. RIte Share leverages employer dollars, resulting in savings to the state for every family enrolled in premium assistance instead of in RIte Care with full public subsidy (see Efficiencies, below).

Key Participants

RIte Care and RIte Share are administered by Rhode Island's Center for Child and Family Health, Department of Human Services (DHS).

Program Description

RIte Share is a premium-assistance program for RIte Care-eligible individuals and families with access to "approved" employer-sponsored health insurance. The health plans are approved if they meet the state's coverage and cost-effectiveness criteria.[14] Importantly, DHS determines cost-effectiveness based primarily on the employer's health plan rather than each individual's situation; this is administratively simpler and limits adverse selection in the employer's plan.[15] The income threshold is 185 percent of the federal poverty level (FPL) for parents and 250 percent FPL for children and pregnant women.[16]

Under RIte Share, the state pays the employee's share of work-based insurance premiums (with families above 150% FPL making some contributions according to a sliding scale) and it also funds copays and wrap-around coverage for Medicaid benefits not in the employer's health plan. There is no minimum or maximum employer contribution, though most employers contribute at least half of the premium.

Bypassing the Employer

Many small employers have been resistant to getting involved in a government program. Some refused to cooperate with DHS in terms of providing information to the state on a regular basis, enrolling the RIte Share individuals in the company health plan, omitting the usual employee-premium payroll deduction, and accepting a DHS check in its place. As a result, after its initial year RIte Share enrollment remained significantly lower than anticipated.[17] In response, DHS enhanced employer-recruitment efforts, but perhaps more importantly it began allowing (in January 2002) direct premium-assistance payments to employees so that employers could essentially be bypassed.

That is, while an employer's health plan must be approved by the state, the firm does not have to *participate* in terms of changing its business practices. For those employers who do not participate, the employee's share of the premium is deducted from his or her paycheck (as usual), and the state subsidy is sent directly to the employee. For those employers who choose to pay the employee's share of premium without a payroll deduction, the state reimburses this "participating" employer.

Eliminating the need for employer participation has also allowed the state to enforce the provision that RIte Share enrollment be mandatory for eligible individuals. These modifications resulted in an additional 1,800 RIte Share enrollees in the first half of 2002. As of March 2004, more than three-fourths of RIte Share's 5,500 enrollees were reimbursed directly.

All in all, the process works as follows: If DHS determines that a RIte Care enrollee or applicant is employed, it then determines whether the employer offers coverage, whether the health plan is approved by the state, whether the employer has participated in RIte Share, whether RIte Share coverage in this case would be cost-effective for the state, and whether the individual is eligible for the coverage (e.g., enough hours worked). If the answers are uniformly positive, the individual is asked to enroll in the employer-sponsored plan, and (if the employer is not participating with the state) the employee's premium is automatically deducted by the employer from his or her paycheck.[18] DHS reimburses the employee *prospectively*—that is, the employee receives a check one month before the premium is due so that the family does not experience cash-flow problems.

Systems Redesign

The manual process of determining eligibility for RIte Share (through the steps outlined above) has been-labor intensive and slow, generally occurring *after* a person was enrolled in RIte Care. Subsequent attempts to transfer a family to RIte Share have been difficult and have often been met with resistance by families or employers. A recent management study, however, produced recommendations for a new operations system that would make identifying people eligible for RIte Share easier and more efficient.[19] The goal is to identify up front—when someone applies or recertifies for RIte Care—whether he or she should be placed directly into RIte Share.

The new system, based on the interfacing of multiple data systems, automatically determines whether an applicant's employer is one of about 140 who already participate in RIte Share, or whether the employer is one of more than 850 who do not participate

directly but whose insurance plan has been approved by the state. If a company is not "flagged"—i.e., it is on neither list—the applicant is sent a letter and form to take to his or her employer so that the state can obtain and review the requisite health insurance benefit information. If the employer is on the "approved but not participating" list and the applicant is deemed eligible, a letter to the applicant is generated describing RIte Share and asking the individual to enroll in the employer-sponsored plan.

Time Frame

Rhode Island began enrollment into RIte Share in May 2001. In January 2002, it began to reimburse employees directly if their employers were unwilling to participate. A management study exploring remaining barriers to RIte Share enrollment took place from 2002 to 2003, and a consequent systems redesign for easier identification of RIte Care participants eligible for RIte Share began in late February 2004.

Required Legislation/Authority

RIte Share was established through the Health Reform Rhode Island 2000 Act and a Medicaid State Plan Amendment. Direct employee payments and systems redesign were administrative adjustments and did not require legislation or waivers.

Financing Mechanisms

DHS used a portion of an $860,000 State Coverage Initiative grant (Robert Wood Johnson Foundation) to fund the internal-management study that assessed the barriers to enrollment in RIte Share. The state paid for modifications to the information systems, and the changes did not require new staff.

Efficiencies

DHS has determined that subsidizing a family in RIte Share plus providing wrap-around services costs the state slightly more than half the expense of covering the family through the RIte Care managed-care plan. In FY 2003, the cost of enrollment in a RIte Care health plan was $157 per member per month (pmpm), compared with $79 pmpm for RIte Share enrollees.[20] DHS has transitioned 4 percent of the RIte Care population into RIte Share, saving about 2 percent of the cost of the program—a significant amount. DHS estimates that for every RIte Share enrollee, the state saves enough to cover one child on RIte Care; and for every 1,000 RIte Share enrollees, total savings are $1 million.

Challenges

Although RIte Share enrollment has expanded (to about 4 percent of the RIte Care population), there is still a long way to go. Enrollment reached about 5,500 by March

2004, but a management report estimates that 15,000 RIte Care enrollees are eligible for RIte Share. It is anticipated that the system redesign will facilitate the transition of many of them to RIte Share at their next annual recertification.

Another challenge involves "churning"—low-income people going in and out of jobs, eligibility for public programs, and coverage. It is difficult for the state to keep track of these changes (especially when they are not informed by the individuals or employers) and to make necessary adjustments in coverage. Rhode Island has passed a law requiring that commercial insurers share their members' data with the state, thus giving DHS more current and accurate information about the status of Medicaid enrollees who also have commercial insurance. But addressing the churning problem remains a challenge for Rhode Island.

Replicating the RIte Share model would present a challenge for states that are not as generous as Rhode Island in terms of eligibility. DHS has determined that premium assistance is cost-effective primarily for families with income between 100% and 185% FPL. Many states do not offer family coverage, particularly for this income group. For such states, the administrative costs of establishing and maintaining a premium-assistance program may be too high for the "yield."

Other Strategies for Leveraging Funds

In addition to the adjusted rules and new data system to promote enrollment in RIte Share, Rhode Island has implemented other strategies in recent years to leverage alternative funding sources. These methods have enabled Rhode Island to maintain its relatively generous RIte Care eligibility criteria for low-income families:

- Under a SCHIP 1115 waiver, Rhode Island converted parents (of children eligible for public health coverage) from Medicaid to SCHIP; by doing so, the state is receiving a higher SCHIP federal match for these enrollees.

- In January 2002, after federal approval through a Medicaid Section 1115 waiver, RIte Care began requiring enrollees with income more than 150% FPL to pay monthly premiums according to a sliding scale. As of March 2004, about 4,300 families are paying premiums, and some 150 families fall off the rolls each month because of nonpayment. DHS is examining the impact on these latter families, and whether they re-enroll over time.

- Rhode Island is achieving savings by transferring additional populations into Medicaid managed-care health plans. In 2002, shifting foster-care children (a total of 2000 children) from fee-for-service to managed care resulted in a one-third decline in hospital days and significant savings.[21] During State Fiscal Year 2004, DHS transitioned 3,500 children with special health care needs into RIte Care managed care; according to DHS, the resulting enhanced care coordination activities have had an immediate impact on improving access to preventive and primary care.

- The state has contained public expenditures by ensuring that Medicaid is the payer of "last resort." Toward that end, the Rhode Island General Assembly enacted legislation (Section 40-6-9.1) that enables a data match so that DHS may identify and pursue other sources of payment for covered services. Other health insurers are required to report information on private coverage for Medicaid-eligibles to DHS upon request. For the April 2002 to April 2003 period, the total cost avoidance (through denials and cost recoveries) resulting from this initial data match was estimated to be almost $984,000, or some $290,000 more than the average from state third-party liability activities prior to the data match.

For More Information

Web site: http://www.dhs.state.ri.us/dhs/famchild/shcare.htm

Contact: Tricia Leddy, Administrator, Center for Child and Family Health, Rhode Island Department of Human Services. Phone: (401) 462-6346 or (401) 462-2127. E-mail: tleddy@dhs.ri.gov.

ILLINOIS: FAMILYCARE WAIVER

Purpose/Goal

Illinois claims the distinction of being the only state to significantly increase access to care during the current budget crunch, both for children and parents, without benefit cuts or significant provider-rate reductions. It has been able to do this largely through a Health Insurance Flexibility and Accountability (HIFA) waiver that allowed it to tap the unused portion of its federal SCHIP allotment (both current dollars and previously "expired" dollars) in order to provide premium assistance and direct coverage to low-income parents. Converting state-funded premium-assistance program KidCare Rebate and other state programs to the Medicaid-SCHIP umbrella provided an influx of new funds for implementing the initial phase of the FamilyCare program. Additional state dollars and federal matching dollars are being used to fund subsequent phases, which will ultimately allow Illinois to expand public health coverage—with a premium-assistance option—to parents with incomes up to 185% FPL. The state estimates it will take approximately three years to achieve this goal.

Key Participants

KidCare, FamilyCare, and the premium subsidy are administered through the Illinois Department of Public Aid (IDPA). Applications may be filed through the mail or through the community offices of the Illinois Department of Human Services (IDHS), as IDPA does not have its own local offices. A number of advocacy groups have been very active in developing and promoting the FamilyCare program.

Program Description

KidCare and FamilyCare are umbrella terms for a number of Medicaid and SCHIP-funded programs in Illinois.[22] An expansion of KidCare in 2003 to children with income from 185% to 200% FPL extended eligibility to about 20,000 additional children.

The establishment of FamilyCare in late 2002 and its substantial expansion in 2003 represent a major enhancement in publicly subsidized coverage, particularly notable at a time when the majority of states have cut back eligibility or benefits or have imposed new cost-sharing. FamilyCare targets low-income working parents, some of whom have access to employer-sponsored coverage but are unable to afford the premium.

To be eligible during state FY 2004, adults had to have a child living with them, and family income could not exceed 90% FPL.[23] As of April 2004, slightly more than 49,000 parents/caregivers were enrolled in FamilyCare. Pending passage of the state FY 2005 budget, the eligibility level is scheduled to increase to 133 percent, and the state

expects an additional 56,000 enrollments during the new fiscal year to bring the total to over 100,000. When fully phased in, FamilyCare could cover up to 235,000 previously uninsured parents and caregivers with income up to 185% FPL.[24]

Currently, in families with income between 133% and 200% FPL, the children may be covered either in the SCHIP direct-coverage program or, if their parents choose, may participate in KidCare Rebate. In the latter case, parents receive a premium subsidy to help them take advantage of the dependent coverage available through employers.

As of Spring 2004, FamilyCare coverage was available only through the state's Medicaid-like coverage program. When eligibility expands to parents with income up to 185% FPL in FY 2006, families with income over 133% FPL will be eligible to choose either the state's insurance or a premium subsidy for the worker's employer-based coverage. As under KidCare, families with income above 150% FPL would essentially "buy in" to the state's insurance plan by paying premiums of $15 per month for one person, $25 for two, $35 for four, and $40 for five or more family members.[25]

A unique feature of the coverage expansion will be the ability of families earning between 133% and 185% FPL to move freely between premium assistance for employer-based insurance and direct public coverage (without any requisite change in family situation). This is intended to assure access to an affordable and adequate set of benefits without the need to audit individual employer health plans or provide wrap-around benefits; to assure seamless coverage when employment situations change; and to leverage employer dollars while building on the employer-based system.

Time Frame

In 1998, Illinois established SCHIP coverage for children in families with incomes up to 185% FPL,[26] and it began KidCare Rebate, a state-only premium-assistance program for children with income 133% to 185% FPL who have access to a parent's work-based health insurance or other private health insurance policy. As of April 2004, 4,900 children were enrolled in KidCare Rebate. In October 2002, the state launched the FamilyCare program, expanding parent/caregiver coverage from 38% to 49% FPL. In July 2003 (under the state FY 2004 budget) eligibility for KidCare expanded to cover children with income 185% to 200% FPL; and the FamilyCare program was expanded to cover parents/caregivers with income up to 90% FPL. As noted above, further expansions in income thresholds for parents are scheduled to be implemented as follows: 90% to 133% FPL in state FY 2005, and 133% to 185% FPL in FY 2006.

Required Legislation/Authority

Illinois obtained a HIFA waiver[27] from the Centers for Medicare and Medicaid Services (CMS) in 2002 that allowed the state to provide premium assistance and direct coverage to uninsured parents/caregivers with income up to 185% FPL and receive a federal match. The waiver also allowed the state to receive the enhanced federal SCHIP match for uninsured parents and caregivers, as well as the 50 percent Medicaid match for KidCare Rebate.

State legislation establishing Family Care was passed and signed into law earlier in 2002 (and was dependent upon the approval of the federal waiver). In 2003, state legislation extended income-eligibility for children in KidCare from 185% to 200% FPL, raising Illinois' eligibility level to the maximum allowed under federal law, and authorized the expansion of FamilyCare to the full extent of the level allowed by the waiver.

Financing Mechanisms

The FamilyCare program was designed to take advantage of an enhanced federal SCHIP match of 65 percent. This was made possible through what has been called the "SCHIP fix"—federal legislation passed and signed in August 2003 that preserves for state use a total of $2.7 billion in unspent federal SCHIP funds that would otherwise have been returned to the federal treasury. The SCHIP fix allows Illinois to use its full allotment of SCHIP dollars, including nearly $90 million in past unspent federal SCHIP funds.

Efficiencies

The ability to tap unused federal SCHIP funds for a new program (FamilyCare) and for a previously state-only program (KidCare Rebate) has allowed Illinois to stretch its dollars and expand eligibility without making cutbacks in other coverage programs. The fully implemented program was projected to cost about $180 million, of which the state contribution would be $63 million as a result of the enhanced 65 percent federal match.

In a spirit of bipartisan compromise, Illinois chose to structure the FamilyCare program to allow free movement between premium assistance and public coverage (when the premium assistance option takes effect in FY 2006). This will result in more people receiving direct coverage than if premium assistance were mandatory for those with access to employer coverage. But the state will be avoiding the administratively complex and costly tasks of setting minimum standards for employer-based insurance, auditing employer health plans to ensure that they meet those standards, and providing wrap-around coverage for services not covered under the employer plan. The goal is to create choice and an "anti-crowd-out" strategy—i.e., to preserve the private insurance base.

Challenges and Future Plans

In the 2005 Illinois state budget, $66 million is earmarked to raise the FamilyCare income eligibility level from 90% to 133% FPL—$23 million of that sum will be state dollars, with the rest coming from the enhanced federal match. Illinois plans to raise the income cap on FamilyCare to 185% FPL in FY 2006 but can only do so if there is sufficient state match to pay for the expansion.[28]

One major unknown is the extent to which families will choose premium assistance over direct coverage, thereby allowing the state to leverage employer contributions and ultimately save money. It will be important to carefully monitor the premium-assistance option to track the choices participants are making, the quality of the advice they receive from employers' human resources departments (which must be careful to avoid conflicts of interest in giving such advice), and the extent to which the option saves the state money.

For More Information

Web sites: http://www.kidcare.org and http://www.povertylaw.org

Contact: Anne Marie Murphy, Medicaid Director, Illinois Department of Public Aid. Phone: (217) 782-2570. E-mail: anne.marie.murphy@mail.idpa.state.il.us.

UTAH: COVERED AT WORK

Purpose/Goal

Utah's Covered at Work is a new health access program intended to encourage uninsured, low-income employees to enroll in employer-sponsored insurance (ESI), where available. Unlike Utah's existing Primary Care Network (PCN), which provides limited primary/preventive care to low-income uninsured adults without access to ESI, Covered at Work was designed to leverage private contributions (employer and employee premiums) to help the low-wage working population obtain comprehensive, private health insurance.

The primary goal of the program is to provide access to health insurance for those who have coverage available at work but cannot afford the premiums, thereby reducing the size of the state's uninsured population. In contrast to some premium-assistance programs in other states, Covered at Work's financial assistance is reduced over time (in relatively small increments), and it places no contribution or minimum-benefit requirements on employers. In this way, Utah limits its financial burden, while hoping that recipients will move toward self-sufficiency in purchasing health coverage. But although the effects of this relatively recent program are as yet unknown, some observers suggest that these same features may not provide enough financial incentive to induce large numbers of low-income workers to enroll.

Key Participants

Covered at Work, which is part of the state's Medicaid program and is administered by the Utah Department of Health, Office of Children's Insurance and Access Initiatives, began in August 2003. It was developed by a subcommittee of PCN's steering committee that included diverse stakeholders—business representatives, health insurance agents, consumer advocates, state legislators, and representatives from the Utah Medical Association. The state has partnered with various groups to secure the program's implementation. For example, the Utah Association of Health Underwriters, which sells coverage to employer groups, has been trained to share information about Covered at Work with its contacts in order to promote enrollment.

Program Description

Eligibility

To be eligible, workers must be 19 to 64 years old with household incomes equal to or less than 150% FPL. Employees' share of ESI premiums must exceed 5 percent of their income, they must be U.S. citizens or legal residents, and they must not be qualified for Medicaid, Medicare, Veteran's benefits, or student health insurance. Individuals who are

currently enrolled in PCN but then obtain access to ESI are able to transition to Covered at Work with no waiting period. Employers are not obliged to pay a certain portion of the premiums, nor is there a minimum benefit requirement.

Subsidy

The Covered at Work program provides eligible workers with a subsidy of $50 per month (or the required employee contribution, whichever amount is lower) to help pay their share of the premium. Spouses can also qualify for this subsidy, in which case the total subsidy for the family can reach $100 per month. Employees pay their premium share up-front and then receive a reimbursement check each month. To encourage a shift toward self-sufficiency, the subsidy phases down over five years: up to $50 per month in years one and two; up to $40 per month in year three; up to $30 per month in year four; and up to $20 per month in year five.

The Utah Department of Health recommends that potentially eligible individuals apply to Covered at Work about 30 days prior to an employer's open-enrollment period under its ESI program (see Outreach, below). Once they are notified that they qualify for Covered at Work, employees can apply for insurance through their employer and begin to receive their subsidy. There is a six-month waiting period for Covered at Work if prior health coverage was voluntarily terminated, and no waiting period if the individual was uninsured or if prior health coverage was terminated involuntarily.

There is a $50 annual fee, and participants must renew enrollment each year. Covered at Work has capacity for about 6,000 people. As of June 2004, about 60 people were receiving subsidies from this program, which is still gearing up.

Outreach

The state is not conducting a mass-media campaign for Covered at Work, given its enrollment cap, though there is a targeted outreach plan to enroll individuals. The Utah Department of Health has been working directly with insurance brokers who then collaborate with employers to target potential enrollees. Additionally, public-relations and direct-mail campaigns have been conducted, and there is a new Web site specifically devoted to Covered at Work. The state plans to regularly evaluate the program's enrollment status and implement new outreach efforts as needed.

Time Frame

In February 2002, Utah received approval for an 1115 Medicaid waiver to develop its PCN program, which provides limited primary and preventive care benefits to adults with

annual incomes up to 150% FPL. As a second phase of PCN, the state submitted a waiver amendment that permitted the establishment of Covered at Work, which began enrolling individuals on August 1, 2003. The waiver was approved in May 2003 and lasts for five years, after which the state may request an extension.

Financing Mechanisms

Covered at Work combines employer, employee, and state and federal Medicaid funds for the purchase of private insurance. The budget for Covered at Work is $3.6 million annually, out of a total PCN annual budget of $17.2 million for FY 2004. The federal government contributes 72 percent and the state contributes 28 percent. The budget is based on an 1115 waiver requirement for budget neutrality compared with prior Medicaid expenditures. As noted above, enrollees pay an annual fee of $50.

Efficiencies

Covered at Work stretches state dollars by leveraging private funds to help eligible uninsured workers obtain comprehensive health insurance. Further, the program is expected to reduce health care expenditures in the long term because individuals receive primary and preventive care that should help avoid costly hospitalizations, or treatments for chronic conditions, later on. Covered at Work is efficient because it builds on existing entities: it is administered through Medicaid's administrative structure; the steering committee and program staff were already in place; and individuals are enrolled in their employer's own insurance programs. The subsidy phase-down is intended to help employees move toward self-sufficiency, with the hope that ultimately they will not require public subsidies at all.

Challenges

One important question about Covered at Work is whether the $50-per-month subsidy, which is phased out over five years, is enough to persuade and enable low-income employees to purchase ESI. The state maintains, however, that the subsidy amount—being based on discussions with insurance agents, data on the average PCN contribution per enrollee per month, and budget constraints related to the cost neutrality requirement—is realistic.

Meanwhile, one of the major challenges to date has been the *process* of enrolling individuals in the program. Enrollment in Covered at Work must coincide with an employer's open-enrollment period or occur during new-hire periods, which imposes serious constraints; companies have their open-enrollments periods only once or twice a

year, typically in January and July. But the state has revised its marketing materials to explain the program's process, and it anticipates growth to occur during these months.

Future Plans

The Utah Department of Health is continuing to improve its materials for Covered at Work, including development of its own Web site, to better describe the enrollment process and distribute this information to potentially eligible audiences and their employers. Because Covered at Work is part of the same waiver that created PCN, the two programs were initially associated with one another. However, the state is now making a conscious effort to distinguish between them, particularly in light of recent limitations on PCN enrollment. It also plans to continue working with partners to promote outreach, and will regularly evaluate the program's progress.

For More Information

Web site: http://health.utah.gov/caw

Contacts: Michael Hales, Director, Covered at Work, PCN. Phone: (801)538-6689. E-mail: mthales@utah.gov. Anna West, Outreach Coordinator, Covered at Work, PCN. Phone: (801)538-6847. E-mail: awest@utah.gov.

MAINE: DIRIGO HEALTH PLAN

Purpose/Goal

The Dirigo Health Plan,[29] proposed by Governor John Baldacci and passed by the Maine legislature in June 2003, is a multifaceted set of reforms aimed at achieving three major goals: (1) ensure access to affordable coverage for the uninsured and underinsured; (2) slow down the growth of health care costs; and (3) improve quality of care. Its primary vehicles are a new health-insurance product for small businesses, the self-employed, and the unemployed, with subsidies for low-income people; and expansion of Medicaid to additional parents and adults without dependent children.

The state hopes to provide coverage to about 41,000 uninsured and underinsured individuals in its first year alone, and to 189,500 individuals over the course of the first five years of operation, essentially creating a condition of universal coverage.[30]

Key Participants

The Governor's Office of Health Policy and Finance (OHPF) is responsible for overseeing the entire reform initiative. The Office's Dirigo Health Agency (DHA), created out of the authorizing legislation, will design, implement, and administer the Dirigo health insurance plan and will work closely with the private insurance company that offers the plan. The DHA will also oversee the Maine Quality Forum (see Program Description). The board of the DHA was appointed by the Governor and approved by the legislature.

Program Description

The key components of the Dirigo Health Plan are as follows:

- Establishment of an insurance product for small businesses' employees, self-employed workers, and the unemployed who do not have access to affordable coverage
- Expansion of MaineCare (Medicaid) to cover adults without children and disabled persons up to 125% FPL, and parents up to 200% FPL (children are presently covered to 200% FPL)
- Development of a State Health Plan addressing issues of efficiency, quality, and access
- New criteria for the state's Certificate of Need program to limit the dollar amount of capital expenditures and investments in technology
- Regulation of insurance premiums in the small group market

- Keeping down costs of care by working with hospitals, providers, and insurers to voluntarily place limits on revenues and cost increases
- Development of the Maine Quality Forum for the purpose of educating consumers, providers, and payers so that they can make informed choices.

These components are related to the program's three major goals in the following ways:

Access: Dirigo Health Insurance Plan

Eligibility requirements

- FOR SMALL BUSINESSES: Business must employ at least 2 but not more than 50 eligible employees, and the majority of employees must be employed in the state.
- FOR EMPLOYEES OF DIRIGO-ELIGIBLE BUSINESSES: Employees must work at least 20 hours a week (not including those who work on a temporary or substitute basis or do not work more than 26 weeks a year). Any employee whose employer offers Dirigo and meets the hourly working requirements is eligible for the program, regardless of income (with the understanding that premium discounts are provided for those with income below 300% FPL). A worker who is employed in a Dirigo-*eligible* business that does not offer Dirigo or other health insurance may also be eligible for coverage.[31]
- FOR SELF-EMPLOYED OR UNEMPLOYED: Self-employed individuals who work and reside in Maine, as well as unemployed residents, are eligible for Dirigo Health coverage.

Benefits

The Dirigo Health Plan will offer comprehensive coverage, including primary and preventive services, in- and outpatient hospital care, and prescription drugs. It will cover preventive services at 100 percent and will offer the HealthyMe Rewards Program, which gives $100 to participating members if they achieve the health improvement goals they've set with their doctor. Dirigo will provide all state-mandated benefits, including mental health parity. Dirigo Health and the participating insurer will be allowed to use benefit riders to provide access to specialty services not covered under the mandatory-benefits package, such as dental and vision care.

The Dirigo Health Agency is considering two products under the health plan, each with a different maximum deductible and out-of-pocket costs. Option 1 would have a maximum $1,250 deductible, cap out-of-pocket spending at $4,000, and cost

approximately $282 per month for an individual. The employer share (60 percent) would amount to $169, putting the employee's share at $113. Option 2 would have a $1,750 deductible and a projected monthly premium of $260 for an individual. The employer's share would be $156, and the employee's share would be $104.

Enrollees with income below 300% FPL will receive discounts on monthly payments, deductibles, and out-of-pocket costs, calculated on a sliding scale according to the member's annual household income. Thus the employee share would actually be lower than that described above ($113 for Option 1 or $104 for Option 2). For example, a single adult with annual income of $14,500 who chooses Option 1 will initially be responsible for $113 a month in premium charges. However, based on his income and family size, Dirigo reimburses him $50, lowering his share to $63 per month. This person's deductible will also be lowered to $500, and his out-of-pocket spending cap to $1,600.[32]

Cost-Sharing

- Employers will pay a minimum of 60 percent of the monthly premium for eligible employees. Employers will also pay a program fee of between $150 to $350, based on how many individuals they employ who will be eligible for the program.
- Individuals below 300% FPL will receive discounts on their monthly payments, and reduced deductible and out-of-pocket costs, on a sliding scale.
- Enrollees above 125% FPL for childless adults and 200% FPL for parents are subject to a $15 copayment for primary care office visits, $25 copayment for specialty care office visits, and a three-tiered formulary-based copayment for pharmaceuticals of $10/$25/$40.

MaineCare Expansion and Wrap-Around

As noted above, MaineCare will expand up the income ladder. It will include adults without children and disabled persons with income up to 125% FPL (already approved by Centers for Medicare and Medicaid Services through a HIFA waiver);[33] and parents with income up to 200% FPL. Also, a person who works for a Dirigo-participating employer and also qualifies for MaineCare coverage will enroll in both programs, resulting in MaineCare covering part of the individual's monthly payments as well as deductible and out-of-pocket maximum costs. The enrollee will be subject to minimum copays of $3 for provider office visits and $2.50 for prescription drugs. These individuals will be eligible to receive the full range both of Dirigo benefits, as well as MaineCare benefits. Self-

employed and uninsured individuals who apply for Dirigo but are income-eligible for MaineCare will be automatically enrolled in the MaineCare program.

High-Risk Pool

Dirigo Health will contrast its experience with that of states using high-risk pools (coverage specifically aimed at individuals with preexisting health conditions). It will compare rates of uninsured, premium costs, and trends; and it will report the resulting information to the legislature by October 1, 2007. A high-risk pool will be proposed to the legislature if Dirigo's experience indicates that such an approach would be superior.[34]

Cost-Containment

A number of activities, including the following, have been or will be put into place to control spiraling health care costs:

- A biennial State Health Plan to set goals for cost containment and establish measures for achieving those goals. For instance, it will provide direction and establish new criteria for the Certificate of Need (CON) program and create statewide health expenditure targets for Maine.
- A one-year moratorium on new CON projects, and extension of CON to ambulatory surgical centers and private physician's offices
- Reduction of uncompensated care costs
- A statewide Capital Investment Fund to limit the total dollar amount of capital expenditures and new technology investments that require CON approval
- A voluntary 3 percent limit on provider-price increases, hospital margins, and underwriting gains
- Authorization of the Governor's Office of Health Policy and Finance to develop rate-setting and global budgets if the voluntary price controls are inadequate
- A requirement of electronic claims submission by 2005, with loans and assistance to providers
- Creation of the Commission to Study Maine's Hospitals to collect hospital data, study facility needs, and design a blueprint for the future of Maine hospitals.[35]

Quality

Initiatives to improve quality of care include:

- The biennial State Health Plan, which will set quality and health-improvement goals for Maine and articulate measures for achieving those goals
- Establishment of the Maine Quality Forum, which will coordinate data and quality initiatives in four principal ways:
    - Collecting and disseminating evidence-based research
    - Providing consumers with information that helps them compare provider performance
    - Consumer education to promote healthy lifestyles
    - Technology assessments to inform CON and State Health Plan.
- The Commission to Study Maine's Hospitals will include in its report a discussion of hospital outcomes and statewide accessibility to quality services.

Time Frame

- A one-year State Health Plan will be issued in July 2004 and the first biennial State Health Plan will be issued in July 2005 to coincide with the state budget biennial.
- Enrollment in the Dirigo Health Insurance plan is scheduled to begin by October 1, 2004. The Commission to Study Maine Community Hospitals will submit its report and proposed legislation in November 2004.
- Cost-containment voluntary measures were implemented in September 2003. As of July 2004, virtually all of the state's hospitals have pledged to work toward meeting the voluntary cap, as has Anthem Blue Cross and Blue Shield of Maine, the state's largest insurance carrier. No other carriers have pledged that they will try to meet the cap.
- CON moratorium began May 1, 2003, and expired in May 2004; new criteria for the CON program are set forth in the one-year State Health Plan and is being adopted by the DHHS.
- The methodology for establishing the Capital Investment Fund received public comment in early July 2004; implementation requires legislative approval.

Required Legislation/Authority

The Dirigo Health Program was authorized under LD 1611/HP 1187, which was signed into law by Governor John Baldacci (D) on June 18, 2003. The statute is Public Law 2003, Chapter 469, Part B, which took effect on September 13, 2003.

Financing Mechanisms

According to the state, only the Dirigo Health Insurance component and Dirigo Health Agency staff will require new funding, which will come from the following:

- Appropriations of $53 million made available through federal fiscal relief to get the program off the ground in Year One
- Monthly payments from employers, employees, and others enrolled in the Dirigo Health Plan
- Federal matching dollars for MaineCare eligibles
- From Year Two on, the state will apply an assessment (a Savings Offset Payment) capped at 4 percent of health insurers' revenues, including third-party administrators and excess-loss carriers (reinsurers).

The Dirigo Health Plan is projected to cost approximately $90 million in the first year; this will cover 41,000 members, with 31,000 of them eligible for and receiving discounts.

Efficiencies

The most visible component of the Dirigo reforms is the Dirigo health insurance product. The state contends that by providing insurance to those who previously could not afford coverage, it will cut the amount of money spent on uncompensated care while at the same time improving health status and health outcomes. A hope is that the lowered uncompensated-care costs faced by hospitals will in turn limit private-coverage premium increases, thereby helping employers. It is expected that other efficiencies will be achieved through the cost-containment strategies described above.

Challenges and Future Plans

Many of the reform activities are still in the planning stage or in the earliest phases of implementation. Thus one of the primary challenges simply involves getting the Dirigo Health Plan off the ground. A second but no less difficult challenge relates to the Plan's financing. The OHPF and legislature claim that after a one-year infusion of funding to get the plan up and running, financing will come in large part from the redistribution of funds that were previously used to pay for uncompensated care.

It is unknown whether such an impact could in fact be realized in just one year. In general, however, expanding coverage can have a significant *long-term* effect on lowering uncompensated care costs. Meanwhile, OHPF anticipates significant additional cost

savings from implementation of the Capital Investment Fund, the one-year CON moratorium, expansion of the CON program and more robust criteria, voluntary limits on cost growth, and other cost-control measures. OHPF projects achieving universal access to coverage by 2009.

For More Information

Web sites:
Governor's Office of Health Policy and Finance: http://www.healthpolicy.maine.gov
Commonwealth Fund report (Rosenthal, Pernice):
http://www.cmwf.org/programs/insurance/dirigo_062304.pdf

Consumers for Affordable Health Care:
http://www.mainecahc.org/coaltion/articles/DIRIGO.htm

Franklin Community Health Network:
http://www.fchn.org/DirigoHealth/LD1611_Summary.asp

Contacts: Trish Riley (Executive Director) and Adam Thompson (Legislative and Constituent Liaison), Governor's Office of Health Policy and Finance. Phone: (207) 624-7442.

California: Health Insurance Act of 2003 "Pay or Play" Employer Mandate

Purpose/Goal

The purpose of California's "pay-or-play" employer-mandate legislation is to extend health coverage to the state's 4 to 6 million uninsured people, most of whom live in the household of a worker. The legislation will extend coverage to workers while shielding small companies from the burden of paying for health coverage. For medium- and large-size firms, the legislation's goal is to make the funding of health coverage obligatory.

Key Participants

The key participants in the new system are private employers, a State Health Purchasing Fund (which receives annual fees from employers who elect not to offer health coverage themselves), and the Managed-Risk Medical Insurance Board (MRMIB), which will define a set of benefits and enter into contracts with health plans to cover employees whose employers do not offer coverage. In addition, a 27-member statewide commission will develop measures for better managing health costs and improving quality of care.

Program Description

The Health Insurance Act of 2003 (SB 2) and a companion bill (AB 1528) were signed into law on October 5, 2003. SB 2 requires employers (with 20 or more workers) that do not offer coverage to pay a fee to the state so that it may provide the employees with health insurance. Employers must pay at least 80 percent of the fee for any employee who has worked for at least three months and at least 100 hours per month,[36] and employees pay the remainder. For firms with 20 to 49 workers, the required fee or proof of coverage will not take effect unless the legislature first enacts a tax credit for those firms equal to 20 percent of the employer's net cost of the fee. Companies with 200 or more employees will be required to contribute toward coverage for dependents as well as workers.

The California small-group insurance reforms that require insurers to sell coverage to all applicants and that limit these insurers' ability to vary premiums based on risk—provisions that now apply to firms with fewer than 50 workers—is extended to firms with up to 200 workers.

A newly created State Health Purchasing Fund will be administered by the MRMIB, an organization that already manages Healthy Families (California's version of the SCHIP program), and several other programs.

Employers who decide to "play" rather than "pay"—that is, to offer and fund their own health coverage plan—will apply to the state's Employment Development Department for a credit against their fee. To qualify for what would be, in effect, a waiver of the fee, employers covered by SB 2 must pay at least 80 percent of the premium, with employees picking up the rest. Low-income workers (below 200% FPL) have their contributions capped at an amount equal to 5 percent of their wages.

Time Frame

SB 2 takes effect for firms with 200 or more workers in January 2006 and for firms with 50 to 199 workers in January 2007.

Required Legislation/Authority

The main authorizing legislation, SB 2, which has been enacted, applies to employers with 50 or more employees. In order for the pay-or-play requirement to apply to firms with 20 to 49 workers, the state will have to enact a tax credit for these companies.

Financing Mechanisms

The law requires that all of the medical and administrative costs of the new state insurance program be funded by fees. Thus employers and employees will provide the financing, with employers paying at least 80 percent under both the play and pay options.

The state will realize substantial savings on employers who choose the pay option and who employ workers enrolled in Medi-Cal. Because MRMIB will transfer that money to Medicaid, which will then apply the federal match, the state will "make money" on these employed Medi-Cal enrollees.

Because the law does not define the minimum benefit package for the pay option, leaving that up to MRMIB, it is difficult at this point to estimate the real cost impact of the law. It also remains to be determined whether the fee will be a percentage of payroll or a fixed amount per worker, like a premium. With respect to employers choosing the "play" option, the law allows some latitude with respect to benefits. Thus, while it is clear that employers must pay at least 80 percent of the cost for either option, the base against which that percentage is applied has not yet been determined.

Efficiencies

In addition to the state's savings described above, this program presents two possible sources of new efficiencies. First, to the extent that large numbers of employers pay instead of play, MRMIB will be buying health care for a large number of workers. MRMIB, an

experienced health care purchaser, may be able to negotiate better rates and perhaps hold plans and care systems more accountable for quality improvement than could an array of individual companies, each buying separately.

Second, the newly formed 27-member commission is charged with developing proposals that help bring about statewide cost savings and better quality of care.

Challenges and Future Plans

The future of SB 2 is uncertain, as it faces four major challenges. First, the law will be on the ballot for repeal in November 2004. Second, it could be challenged in court on ERISA [Employee Retirement Income Security Act] grounds. Third, the law could face a major constitutional challenge. And fourth, SB 2 might have negative effects on profits, wages, or prices.

The Ballot Initiative

Opponents of the new law gathered enough signatures to get a repeal measure on the ballot in November 2004. A lawsuit was filed, led by Senator John Burton (who was a major sponsor of SB 2), to block the ballot initiative on the grounds that the wording of the title and the printing were not accurate enough to be understood. The state District Court ruled in Burton's favor. But an appeal filed by opponents of SB 2 was successful, with the State Appellate Court finding that the ballot initiative's wording, while a problem, was accurate enough to proceed.

ERISA Litigation Possible

A very real ERISA challenge could follow quickly on the heels of the ballot initiative if voters choose not to repeal SB 2. And it is possible that such litigation could be initiated even sooner.

Because ERISA allows states to specify the kinds of plans that insurers can sell to employers, it indirectly regulates—at least to some degree—the kinds of coverage that employers can offer employees. But ERISA preempts states from treating a *self-insured* employer plan as insurance.

Two elements in SB 2 thus make it vulnerable to a successful ERISA challenge: the provision specifying that an employer can get a credit only by offering a health plan that conforms to certain benefit requirements in the law; and the requirement that the employer pay at least 80 percent of the cost. These features could be interpreted as regulating self-insured employers' benefit plans. If, instead, the law held that employers get

a credit against their fee for *any* kind of health coverage they offer, the ERISA challenge would be more difficult to make.

Possible Constitutional Challenge

Opponents could challenge SB 2 as violating the state constitution's requirement that any law resulting in increased taxes be enacted with a two-thirds majority in both chambers of the legislature. SB 2 had a solid majority, but not two-thirds. Of course, the bill's authors anticipated this problem, which is one reason why they labeled the pay option a fee instead of a tax. But opponents could argue that this is merely a minor semantic distinction.

Labor Force and Wage Effects

Because SB 2 requires employers who previously did not offer employee coverage to now pay for coverage in one way or another, and it requires all employers with 200 or more workers to pay for dependent coverage as well, labor costs will rise for many employers. Economists generally agree that most of this additional cost will be passed back to employees in reduced wages, perhaps not immediately but at least over time.[37] Thus in the long run, there should be no significant effect on employment because employee-compensation costs should be roughly the same. But in the short run, employers may not be able to respond by reducing wages. They may instead try to pass some of the cost forward to their customers through higher prices, absorb some of it themselves in the form of lower profits, or reduce hours of work for some employees and not replace others who are lost through attrition.

Effects may be inferred from past experience with increases in the minimum wage, a similar policy. Though no major layoffs are likely, an exception could be at minimum-wage firms, which cannot legally pass back the cost to employees by lowering wages and probably have less flexibility to pass costs forward to customers. Some reductions in employment are possible at these firms.

For More Information

Web sites:

Legislation:
http://info.sen.ca.gov/pub/bill/sen/sb_0001-0050/sb_2_bill_20031006_chaptered.pdf

California HealthCare Foundation analysis and links:
http://www.chcf.org/press/view.cfm?ItemID=21764

SNAPSHOTS OF ADDITIONAL "BUILDING ON EMPLOYER-BASED COVERAGE" INITIATIVES

PENNSYLVANIA: HEALTH INSURANCE PREMIUM ASSISTANCE PROGRAM (HIPP)

Implemented 1994

Pennsylvania has one of the country's largest HIPP "buy-in" programs, with more than 21,000 members enrolled as of April 2004. For people eligible for Medicaid who have access to employer-sponsored health coverage, the program pays the worker's share of the premium. By not providing direct Medicaid coverage for many of these individuals, the program achieved a savings goal of $76.3 million in FY 2003. These savings have been attributed to effective outreach (involving the building of relationships with employers throughout the state) and an automated process for enrollment, tracking, and analysis to determine whether a person's membership in HIPP will be less costly to the state than direct coverage. This automated system interfaces with Department of Public Welfare (DPW) eligibility files, stores case records, and generates payments. Because DPW collects information directly from employers, potential HIPP enrollees thus do not have to obtain and submit such information for determining eligibility. Also, software capabilities allow administrators to identify necessary modifications for addressing market/employment changes and to respond to inquiries in an efficient manner.

For More Information: http://www.statecoverage.net/pdf/pennsylvaniaprofile.pdf.

NEW YORK: HEALTHY NEW YORK

Implemented 2001

Healthy New York is a state-run program in which a standardized insurance product is offered by all licensed HMOs to low-income uninsured small businesses,[38] self-employed people, and individuals. The program is able to keep premiums lower than regular commercial plans[39] by limiting the scope of its benefit package, requiring use of in-network providers, imposing copayments and deductibles, and providing state-funded reinsurance. With early enrollment lower than expected, the state made adjustments to reduce premiums further, and it expanded eligibility. For example, it changed the stop-loss claim range so that it would pay 90 percent of claims between $5,000 and $75,000 (to reflect a healthier-than-expected risk pool); this produced an average premium reduction of about 17 percent. Other adjustments included simplifying recertification, eliminating some copayments, creating greater flexibility in employer-contribution requirements, and offering health plans with or without prescription-drug benefits (the latter alone reduced premiums further by about 12 percent). Enrollment increased to approximately 55,000

members by April 2004. About 22 percent of enrollees are from small businesses, 19 percent are sole proprietors, and 59 percent are individuals.

For More Information: Eileen Hayes, New York State Insurance Department. E-mail: ehayes@ins.state.ny.us.

ARIZONA: HEALTHCARE GROUP OF ARIZONA

Implemented 1988, ongoing modifications

The Healthcare Group of Arizona is a public-private partnership between the Arizona Health Care Cost Containment System (AHCCCS, the state's Medicaid agency) and two private health plans. It offers a small-business HMO product that is administered by AHCCCS and exempt from state insurance regulations for commercial plans. The program was implemented in 1988, but is undergoing structural and marketing modifications to boost enrollment and slowly eliminate state subsidization.

Employers and employees share the full cost of premiums. However, responding to adverse selection and significant losses in the 1990s, the state began subsidizing the program. It currently covers a portion of claims above $20,000 and under $100,000, purchases catastrophic reinsurance coverage for claims above $100,000, and reimburses health plans for losses. In an effort to further increase enrollment, the program is introducing customized benefits packages, enhancing the provider network, and implementing a new marketing campaign that may include wellness programs with member-reward incentives. The program is also trying to attract the participation of enough health plans to offer choice and diversity of arrangements for enrollees. To this end, proposed legislation would allow more flexibility in contracting with health plans and specialized provider networks, dropping a state requirement that only plans participating in Medicaid may be offered by the Healthcare Group of Arizona. As of February 2004, approximately 11,100 workers and dependents were enrolled. Of the more than 3,800 businesses participating, 92 percent were firms with one to three employees.[40]

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SNAPSHOTS OF INITIATIVES TO WATCH

NEW MEXICO: STATE COVERAGE INITIATIVE PROGRAM

Approved 2002, implementation planned July 2005

In 2002, New Mexico received a HIFA waiver from the Centers for Medicare and Medicaid Services (CMS) to use unspent SCHIP funds to subsidize premiums for parents of Medicaid and SCHIP children, as well as for uninsured low-income employed individuals. Through a public/private partnership, the state would work with commercial managed-care organizations to design and administer a low-cost health coverage product that provides basic coverage including behavioral health and substance abuse treatment. The health plans would be available to employees with family income up to 200% FPL who have been uninsured for at least six months, and to employers who have not provided insurance in the last 12 months.

The waiver was designed by the previous statehouse administration, and recently won the support of the Richardson administration after a review for feasibility. The plan leverages employer contributions with state and federal funds. It requires a special $3 million appropriation from the state legislature next year, which would be matched by $13 million in federal dollars. In addition, a few counties are planning to contribute a portion of their uncompensated care funds. If the state funds are made available, the program could be launched in July 2005, and initially could provide insurance to 40,000 state residents.

ARKANSAS: EMPLOYER-SPONSORED INSURANCE INITIATIVE

Under development, pending HIFA waiver approval

The Arkansas Employer-Sponsored Insurance Initiative (also referred to as the Employer-State Health Insurance Partnership), would provide a "safety net" benefit package for the working uninsured with incomes at or below 200% FPL. Enrollees would receive coverage for up to six outpatient visits per year, two outpatient surgeries per year, seven inpatient hospital days per year, and two prescriptions per month. Small employers would pay the state's portion of the Medicaid match to enroll their low-income employees. But the federal match (either 73% or 82%, depending on whether the individual is Medicaid- or SCHIP-eligible), would finance the majority of the program. Employers could also choose to buy safety-net coverage for employees above 200% of the FPL, but without the federal subsidy. The state estimates that some 220,000 people could obtain coverage through this waiver program.

CONNECTICUT: MEHIP EXPANSION TO SMALL BUSINESSES

Implementation 2004

In June 2003, the state approved using its purchasing power to negotiate health plans for small-employer groups under its existing Municipal Employee Health Insurance Program (MEHIP). Established in 1998, MEHIP has offered state-negotiated health plans, similar to those for state employees, to municipal employees and workers in nonprofit organizations.[41] Taking effect in August 2004, eligibility for MEHIP is expanding so that state-arranged health plans from three large insurers, which also serve state employees, are available to all small businesses (with 50 or fewer employees).[42] Though the state hopes to attract firms that have not had insurance before, the program is open to all small businesses. Under the program, the employer selects the insurer, while the employee chooses from one of 10 point-of-enrollment and point-of-service plan options.[43] Firms and especially employees may have greater choice of health plans than are generally available to small businesses.[44]

For More Information: http://www.mehip.org/

WEST VIRGINIA: SMALL BUSINESS PLAN

Implemented 2004

In March 2004, West Virginia passed legislation intended to make comprehensive, affordable health coverage available to uninsured businesses with 2 to 50 employees.[45] Toward that end, it is now creating a public-private partnership, called the Small Business Plan, between insurance carriers and the state's Public Employees Insurance Agency (PEIA), which negotiates and administers coverage for state employees and some other public groups. The plan was developed by the Policy Advisory Council, a broad-based group of stakeholders (representing insurers, consumers, and providers, among others) that grew out of West Virginia's State Planning Grant activities. Under the Small Business Plan, participating insurers could use PEIA's reimbursement rates and the prescription-drug prices negotiated through PEIA's multistate purchasing plan (see *Pooled and Evidence-Based Pharmaceutical Purchasing* report) for the new insurance product. These provisions, combined with smaller administrative fees for the insurers, are expected to result in Small Business Plan premiums that are 20 to 25 percent below the usual market rate. The plan will be funded by premiums alone, and will not receive state subsidies. The plan should be available in the fourth quarter of 2004.

For More Information: http://www.westvirginia.com/peia/

IDAHO: HEALTH INSURANCE ACCESS CARD

Phase I implementation July 2004; Phase II planned for July 2005

The Idaho Health Insurance Access Card is a two-phase premium-assistance program to help obtain private-insurance coverage for children and adult employees (and their spouses) of small businesses. Idaho also implemented a new and separate "CHIP-B" direct-coverage program, for children with family income of 151% to 185% FPL, that offers a modified-benefits package[46] [CHIP stands for Children's Health Insurance Program]. CHIP-B and the Children's Access Card went into effect at the same time, in July 2004, thus beginning Phase I.

Idaho families whose children are eligible for CHIP-B have the option of choosing its direct benefits or the Access Card premium subsidy of up to $100/month per child (up to $300 per family) to purchase private insurance. The private plan must cover physician and inpatient services, but there is no requirement that it be actuarially equivalent to the direct-benefits coverage, nor is there a minimum employer contribution required. The CHIP-B and Children's Access Card programs share a cap of 5,600 individuals for state FY 2005. The state utilizes open-enrollment periods to manage the cap.[47]

Phase II, the Adult Access Card program, is scheduled to begin in July 2005. Individuals with incomes up to 185% FPL, who do not qualify for Medicaid, and who work in small businesses (2 to 50 employees) will be eligible for premium assistance (up to $100 per person per month) to purchase insurance through their employer. The employer must pay 50 percent of the employee's (and, if chosen, his or her spouse's) premium. As of September 2004, the Idaho Access Card program is awaiting CMS approval to operate under HIFA waiver authority.

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MICHIGAN: THIRD SHARE PARTNERSHIP

Proposed by Governor; legislation introduced in 2004

In early 2004, in her State of the State address, Michigan's Governor Jennifer Granholm introduced the Third Share Partnership, a health insurance plan for small businesses whereby the employee, the employer, and the state each contributes one-third of the premium. In June 2004, third-share legislation was introduced that would designate community-based entities (local governments or nonprofit organizations) to manage the new health plan. They would develop a health benefit package, negotiate service arrangements with local providers, sign up small businesses in the area that have no health

insurance for their employees, and handle claims. Under this proposal, small businesses and their employees would each pay 30 percent of the cost of the coverage plan, and the remaining 40 percent would be paid by a state grant.

The third-share proposal is modeled after successful community-based programs in the state's Muskegon and Wayne Counties. The former program, Access Health, is a county-wide endeavor for working uninsured individuals in small to mid-size businesses. Access Health enrollment began in September 1999, and in 2003 it served approximately 1,500 people in 400 businesses (described further in the *Innovative Use of Uncompensated Care Funds* report).

LOUISIANA: LA CHOICE

Under development, pending HIFA waiver approval

The Louisiana Department of Health and Hospitals (DHH) plans to submit a HIFA waiver proposal to CMS for expanding health coverage to several populations. One component of the waiver involves creation of a limited-benefit coverage product for small employers, using reallocated Disproportionate Share Hospital (DSH) dollars to help subsidize premiums for workers with income under 200% FPL.[48] The state is now conducting a survey to determine the demographics and utilization needs of those currently benefiting from DSH funding in order to assess the impact of these funds' proposed reallocation. A pilot program, called "LA Choice," is expected to begin enrolling employees in April 2005. Planners hope to cover approximately 3,000 individuals.

MASSACHUSETTS: FAMILY ASSISTANCE PREMIUM ASSISTANCE AND INSURANCE PARTNERSHIP

Employee premium assistance began 1998; employer subsidies began 1999

The Family Assistance Premium Assistance (FAPA) and Insurance Partnership (IP) programs offer subsidies to help low-wage workers, small firms, and low-income self-employed individuals pay their shares of employer-based health insurance premiums. Premium assistance for workers is available to individuals who have family income up to 200% of FPL; are self-employed or work for small firm (no more than 50 full-time employees), OR have children and work for any size firm; and their employer offers coverage that meets the state's benchmark standards and pays at least half of health insurance premiums. Further, the state provides premium assistance on behalf of eligible children regardless of who the parent's employer is as long as the employer contributes at least 50% of the cost and benefits meet the basic benefit level.[49]

The Insurance Partnership (IP) is intended to encourage small businesses with low-income employees to begin or continue to offer health benefits. It pays $400 (individual), $800 (couple or adult plus child), or $1,000 (family) per year toward the employers' premium contribution for each qualified employee. Firms are eligible if they employ no more than 50 full time workers, offer comprehensive coverage, and contribute at least half of the premium.

Medicaid funds finance premium assistance for childless adults and the IP subsidies, while a combination of Medicaid and SCHIP funds finance premium assistance for parents and children. As of June 23, 2004, 9,390 individuals (4,940 children and 4,450 adults) received FAPA, and there were nearly 5,000 employers (small firms and self-employed) participating in IP with approximately 13,000 covered lives.

For More Information

Web sites:

http://www.mass.gov/portal/index.jsp?pageID=eohhs2terminal&L=5&L0=Home&L1=Consumer&L2=MassHealth+and+Insurance&L3=MassHealth+Coverage+Types&L4=Applicants+and+Members+Under+Age+65+and+Families&sid=Eeohhs2&b=terminalcontent&f=masshealth_consumer_covtypes_ier_famassist&csid=Eeohhs2

http://www.insurancepartnership.org/

NOTES

[1] Henry J. Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace, 2004 Update* (Menlo Park, Calif.: Kaiser Family Foundation), http://www.kff.org/insurance. [Ed. note: Same cite for all bullets on this page except the last one.]

[2] Urban Institute/Kaiser Commission on Medicaid and the Uninsured analysis of March 2002 Current Population Survey, http://www.kff.org.

[3] Sharon Silow-Carroll, Emily K. Waldman, and Jack A. Meyer, *Expanding Employment-Based Health Coverage: Lessons from Six State and Local Programs* (New York: The Commonwealth Fund, February 2001); Ed Neuschler and Rick Curtis, *Premium Assistance: What Works? What Doesn't?* issue brief (Washington, D.C.: Institute for Health Policy Solutions, April 2003); and Claudia Williams, *A Snapshot of State Experience Implementing Premium Assistance Programs* (Portland, Maine: National Academy for State Health Policy, April 2003).

[4] Katherine Swartz, *Markets for Individual Health Insurance: Can We Make Them Work with Incentives to Purchase Insurance?* (New York: The Commonwealth Fund, December 2000); Sherry Glied, "Challenges and Options for Increasing the Number of Americans with Health Insurance," *Inquiry* 38 (Summer 2001): 90–105; and Deborah Chollet and Lori Achman, *Approaching Universal Coverage: Minnesota's Health Insurance Programs* (New York: The Commonwealth Fund, February 2003).

[5] Stan Dorn and Todd Kutyla, *Health Coverage Tax Credits Under the Trade Act of 2002* (New York: The Commonwealth Fund, April 2004).

[6] Employer-based coverage is considered cost-effective if its costs are likely to be lower than the costs to the state of providing direct Medicaid coverage.

[7] If the eligible child's parent must enroll in an employer-sponsored insurance plan in order for the child to have access, Medicaid will subsidize the parent's premium. But it will not pay the parent's coinsurance or deductibles, nor will it cover wrap-around services.

[8] HCTCs may only be used to purchase "qualified" health plans, which include either COBRA coverage or a health plan that is certified by the HCTC administrator. As of June 2004, three states offer only "mini-COBRA" as their state-qualified plan; while 28 states offer something more universally available—most often a high-risk pool or a plan in the nongroup market, though in a few states community-rated plans are available.

[9] Swartz, *Markets for Individual Health Insurance*, 2000.

[10] Jill Rosenthal and Cynthia Pernice, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine* (Portland, Maine: National Academy for State Health Policy, June 2004).

[11] Other states with SCHIP Premium Assistance: Maryland, Massachusetts, Virginia, Wisconsin.

[12] Other states with HIPP/Medicaid Premium Assistance: Georgia, Iowa, Massachusetts, Missouri, Rhode Island, Texas, Virginia, Wisconsin, Oregon.

[13] The public–private small-group product was implemented in 1988; the reinsurance mechanism began in 2002.

[14] About 80 percent of all commercial plans were approved for RIte Share participation. Plans with high up-front deductibles were not approved.

[15] This avoids smaller families being placed into RIte Care and larger families being placed in employer-sponsored insurance/RIte Share—which could increase the employer health plan's group claims experience per family.

[16] In families with income between 185%–250% FPL in which children are eligible and parents are not eligible, RIte Share will contribute toward family coverage under an employer plan if it is less expensive to the state than paying for direct RIte Care coverage for those children.

[17] Employer resistance is attributed to perceptions that RIte Share: (1) asks employers to pay premiums for employees who were previously on RIte Care rolls; (2) could hurt morale among employees who do not receive similar public assistance; (3) imposes new administrative costs; and (4) may cause cash-flow problems while waiting for state reimbursements for the employee's share of the premium. (Sharon Silow-Carroll et al., *Assessing State Strategies for Health Coverage Expansion: Case Studies of Oregon, Rhode Island, New Jersey, and Georgia* [New York: The Commonwealth Fund, November 2002].)

[18] According to state law, eligibility for RIte Share is considered a qualifying event for enrolling employer coverage in Rhode Island, and the employee does not have to wait for the next open enrollment period. An exception is for self-insured businesses, for which ERISA pre-empts state law.

[19] *RIte Share Enrollment: Business Process Analysis* (Providence, R.I.: Rhode Island Department of Human Services, April 2003).

[20] This RIte Share cost includes wrap-around services provided by the state, but does not include administrative costs. Thus the actual savings are slightly less than 50 percent, according to DHS administrators.

[21] AcademyHealth, *State of the States 2003* (Washington, D.C.: Academy Health, January 2003).

[22] They include: KidCare Assist (Medicaid, children 0%–133% FPL), KidCare Share (SCHIP, children 133%–150% FPL), KidCare Premium (SCHIP, 150%–200% FPL), KidCare Rebate (HIFA waiver premium assistance, 133%–200% FPL), FamilyCare Assist I (Medicaid and HIFA waiver parents, 0%–49% FPL) and FamilyCare Assist II (HIFA waiver parents 49%–90% FPL). Source: Jane Longo, "Workshop for State Officials: Creative Strategies in Challenging Times, KidCare Rebate, Premium Assistance in Illinois," July 2003, http://www.statecoverage.net.

[23] To increase enrollment and ease the burden on low-income families, the parents of children already enrolled in KidCare need not fill out a separate application for Family Care but may communicate with the caseworker in the IDHS office to request being added to the children's existing case.

[24] Center for Health Services Research and Policy, Department of Health Policy, George Washington University, *State HIFA Waiver Plans* (Washington, D.C.: George Washington University, February 2003).

[25] Ibid.

[26] Children ages 6–18 with income up to 133% FPL were added to a Medicaid look-alike program, and children ages 0–18 with income 133%–185% were enrolled in a separate SCHIP program.

[27] Under the Health Insurance Flexibility and Accountability initiative.

[28] John Bouman, Sargent Shriver National Center on Poverty Law release, http://www.povertylaw.org/advocacy/familycare_next_steps.cfm.

[29] *Dirigo*—Latin for "I lead"—is Maine's official state motto.

[30] Conversation with Adam Thompson, Legislative and Constituent Liaison, Governor's Office of Health Policy and Finance; and Consumers for Affordable Health Care fact sheet.

[31] However, in order to avoid crowding out private employer insurance, there is a 12-month waiting period for employees whose employer drops an employer-sponsored insurance plan. After 12 months, the employee may enroll as an individual. Additionally, employers may switch from an existing employer-sponsored plan to Dirigo Health without a waiting period.

[32] "Health Access: Small Business Edition," Consumers for Affordable Health Care Newsletter, Spring 2004.

[33] MaineCare coverage for adults without dependent children was expanded in 2002 to those with income up to 100% FPL.

[34] The legislation also discusses the development of disease management protocols for Dirigo enrollees with certain chronic care conditions.

[35] The Commission will present a report to the legislature with proposals for legislation in November 2004.

[36] "The Health Insurance Act of 2003: An Overview of SB 2" (Oakland, Calif.: California HealthCare Foundation), p. 1.

[37] That is, in the long-run the value of total compensation will stay approximately the same, but employees' take-home pay (or other employee benefits) will be lowered by the amount the employer has to pay for new coverage under the "play" option or for the fee under the "pay" option.

[38] Businesses are offered Healthy New York if they have 50 or fewer eligible workers, of whom at least 30 percent earn less than $32,000/year, and if the employer has not provided coverage for the prior 12 months.

[39] In its first year of implementation, premiums were found to be about 30–50 percent lower than health plans in the individual market and 15–30 percent lower than plans in the small-group market. See Katherine Swartz and Patricia Seliger Keenan, *Healthy New York: Making Insurance More Affordable for Low-Income Workers* (New York: The Commonwealth Fund, November 2001).

[40] "A Strategy for Addressing Arizona's Uninsured" (Phoenix: Healthcare Group of Arizona, February 2, 2004).

[41] Originally established for employees of municipalities, eligibility for MEHIP has been extended to businesses with 501(c)(3) tax status, community action agencies, members of personal-care-assistant associations, and individuals eligible for a federal health coverage tax credit. As of June 2004, approximately 13,000 individuals from municipalities and nonprofit organizations were enrolled.

[42] The MEHIP plan is designed by law to remain separate from the state employee plan, not affect the state employee-plan premiums or coverage, and be available to any group it is authorized to cover regardless of claims experience and past or future health care costs.

[43] Small-group premiums in the state of Connecticut are subject to small-group rating laws that incorporate community rating. Thus, given the same set of circumstances for a particular small group (e.g., plan design, effective date, and employee demographics), MEHIP and non-MEHIP premiums would be identical. To the extent that the MEHIP plans vary from those available outside MEHIP, the rates may vary from commercial market plans. However, given that the

MEHIP plans are generally not available outside of the MEHIP, the rates will likely vary from the commercial market plans.

[44] MEHIP plans offer variations in copays, certain optional benefits, levels of coverage, and types of HMO and point-of-service arrangements.

[45] Small firms qualify if they have been without coverage for at least six months prior to June 13, 2004, the effective date of the legislation. After that date, firms qualify if they have been without coverage for at least 12 months.

[46] CHIP-B differs from Idaho's existing CHIP-A program, which is a SCHIP-Medicaid expansion and offers full Medicaid benefits.

[47] The cap could be increased to allow more enrollees, if approved by the legislature.

[48] Other components of the first phase of waiver activities include: coverage expansion to include employed parents of children enrolled in SCHIP; and expansion, using federal dollars, of a currently state-funded high-risk pool for the indigent. The state's legislature has signaled that it would appropriate the $1.5 million requested for Phase One in the FY 2005 budget, pending CMS approval of the waiver. However, the state is considering dropping a second phase of the waiver, which would create a limited Medicaid benefit for uninsured people who do not meet the required cost-effectiveness criteria for receiving premium assistance through HIPP.

[49] Adults without children contribute $27 per month per adult ($54 per couple), and the subsidy covers the remaining employee premium contribution. Families with children pay $10 per month per child, up to a maximum of $30 per family (including parents).

RELATED PUBLICATIONS

Publications listed below can be found on The Commonwealth Fund's website at www.cmwf.org.

Stretching State Health Care Dollars During Difficult Economic Times: Overview (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. This overview report summarizes a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending. topics include: building on employer-based coverage; pooled and evidence-based pharmaceutical purchasing; targeted care management; and innovative use of uncompensated care funds.

Stretching State Health Care Dollars: Pooled and Evidence-Based Pharmaceutical Purchasing (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Many states are implementing drug-cost-containment mechanisms that do not merely pass state expenditures on to consumers in the form of higher copayments and deductibles but instead put innovative approaches in place that reduce state costs so as to expand or maintain access. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

Stretching State Health Care Dollars: Care Management to Enhance Cost-Effectiveness (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. With more than three-quarters of current Medicaid spending devoted to people with chronic conditions, states are pursuing efficiencies through various types of "care management" strategies for high-cost individuals. These services can be provided directly or contracted out to specialized vendors. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

Stretching State Health Care Dollars: Innovative Use of Uncompensated Care Funds (October 2004). Sharon Silow-Carroll and Tanya Alteras, Economic and Social Research Institute. Experts warn that providing uncompensated care could become more difficult for hospitals in the years ahead as a result of their rising costs and lower operating margins, limited state revenues, cuts in Medicaid DSH, and a growing uninsured population. These trends have spurred strategies in several states aimed at reducing the need for expensive uncompensated services over the long term. This is one of a series of four reports identifying innovative state efforts to enhance access to care, coverage, and efficiency in health care spending.

Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine (June 2004). Jill Rosenthal and Cynthia Pernice. Jointly supported by The Commonwealth Fund and The Robert Wood Johnson Foundation, this report by the National Academy for State Health Policy comments on the status of Maine's Dirigo Health Reform Act, which aims to provide affordable coverage for all of the state's uninsured—approximately 140,000—by 2009.

Expanding Health Insurance Coverage: Creative State Solutions for Challenging Times (January 2003). Sharon Silow-Carroll, Emily K. Waldman, Heather Sacks, and Jack A. Meyer, Economic and Social Research Institute. The authors summarize lessons from 10 states that have innovative strategies in place for health insurance expansion or have a history of successful coverage expansion. The report concludes with recommendations for federal action that could help states

maintain any gains in coverage made and possibly extend coverage to currently uninsured populations.

Small But Significant Steps to Help the Uninsured (January 2003). Jeanne M. Lambrew and Arthur Garson, Jr. A number of low-cost policies could ensure health coverage for at least some Americans who currently lack access to affordable insurance, this report finds. Included among the dozen proposals outlined is one that would make COBRA continuation coverage available to all workers who lose their job, including employees of small businesses that are not currently eligible under federal rules.

Medicaid Coverage for the Working Uninsured: The Role of State Policy (November/December 2002). Randall R. Bovbjerg, Jack Hadley, Mary Beth Pohl, and Marc Rockmore. *Health Affairs,* vol. 21, no. 6 (*In the Literature* summary). The authors conclude that insurance coverage rates for low-income workers would increase if state governments chose to do more for their uninsured workers. But states decline to tackle this issue for several reasons. Federal law requires them to cover many low-income nonworkers before they insure workers. As well, poorer states cannot afford much coverage for their low-income workers.