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State Strategies to Expand Health Insurance Coverage

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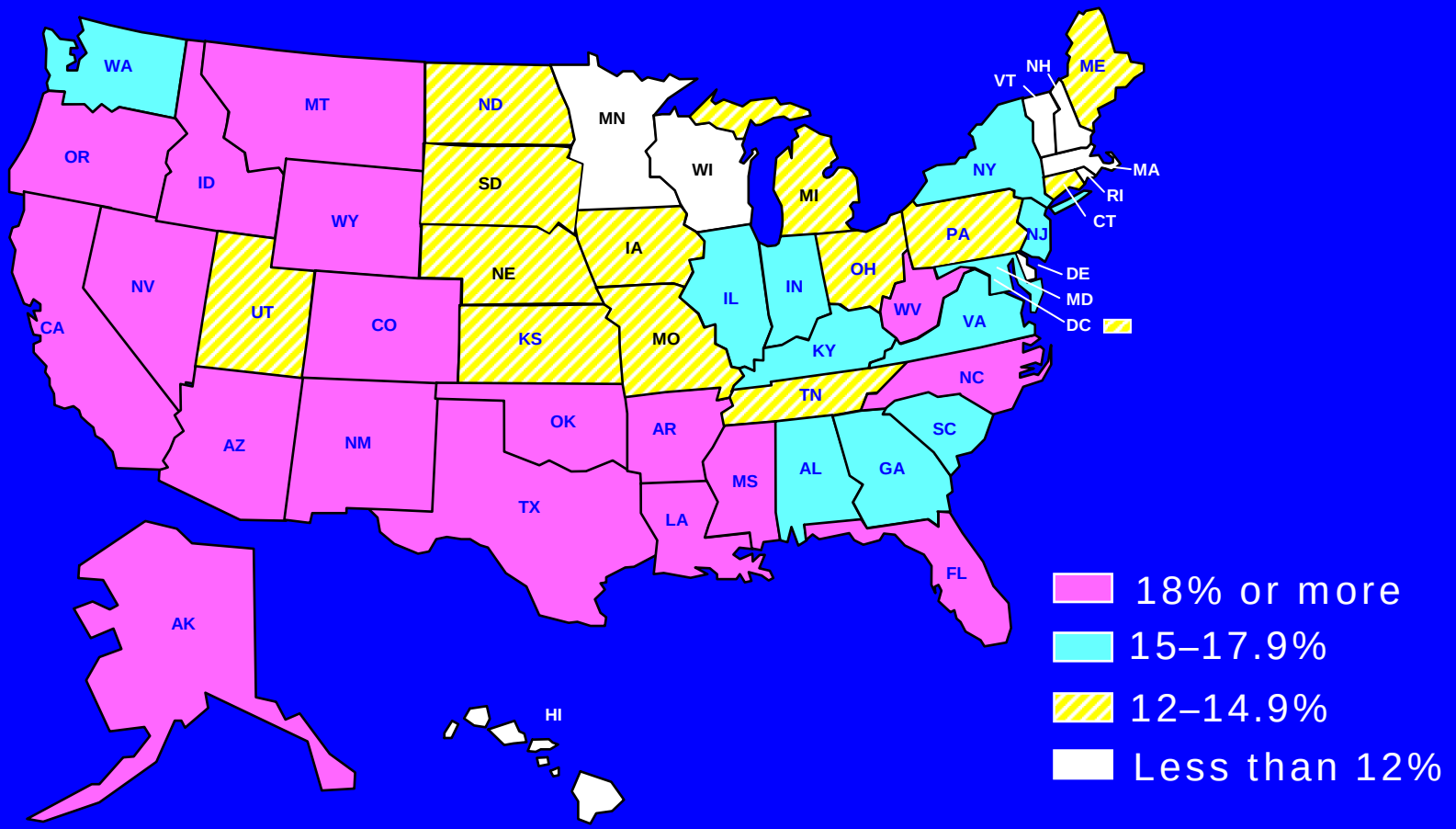
Percent of Non-Elderly Population Uninsured by State, 2001–2003



Source: *Health Insurance Coverage in America: 2003 Data Update Highlights*, KCMU/Urban Institute, September 27, 2004. Uninsured rates are two year averages, 2001-2003.

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States With Less Than 12% Uninsured, 2003–2004

	Percent Uninsured (ages 0-64)	Percent Employer (ages 0-64)	CHIP/ Medicaid Kids Eligibility Level* (%FPL)	Working Parents Eligibility for Public Insurance (%FPL)
Minnesota	9.3	73.1	275	275
New Hampshire	11.4	76.6	300/185	61
Rhode Island	11.5	66.6	250	192
Vermont	11.5	61.9	300/300	192
Hawaii	11.7	69.0	200	100
Wisconsin	11.7	69.1	185	185
Massachusetts	11.8	69.8	200/150	133
Delaware	11.9	69.7	200/133/ 100	120
U.S. Average	17.5	62.6	Median= 200%	Most don't cover

Sources: KCMU/Urban Institute Analysis of 2002 and 2003 CP, September 27, 2004; www.statehealthfacts.kff.org.

*Children's eligibility levels vary by age.

Primary Strategies Being Used by States to Expand Health Insurance Coverage

- Retain and expand employer participation
- Leverage federal matching funds
- Redesign programs
- Simplify and streamline program eligibility and redetermination
- Target special populations
- Generate new revenue

Retaining and Expanding Employer Participation: Maine's Dirigo Health

- New insurance product; $1250 deductible; sliding scale deductibles and premiums below 300% poverty
- Employers pay fee covering 60% of worker premium
- Began Jan 2005; Enrollment 6,369 as of 5/1/05
- MaineCare expansion proposed to cover parents up to 200% poverty

$1,250 Deductible	A	B	C	D	E	F
Monthly Discount	100%	80%	60%	40%	20%	None
Deductible						
Single	$0	250	500	750	1,000	1,250
Out of Pocket						
Single	$0	800	1,600	2,400	3,200	4,000
Employee Share of Premium*						
Single	$0	25	50	74	99	124

Note:
A=MaineCare; Poverty thresholds per discount:
B=150% FPL;
C=200% FPL;
D=250% FPL;
E=300% FPL;
F>300% FPL

* After discount and employer payment (for illustrative purposes only).

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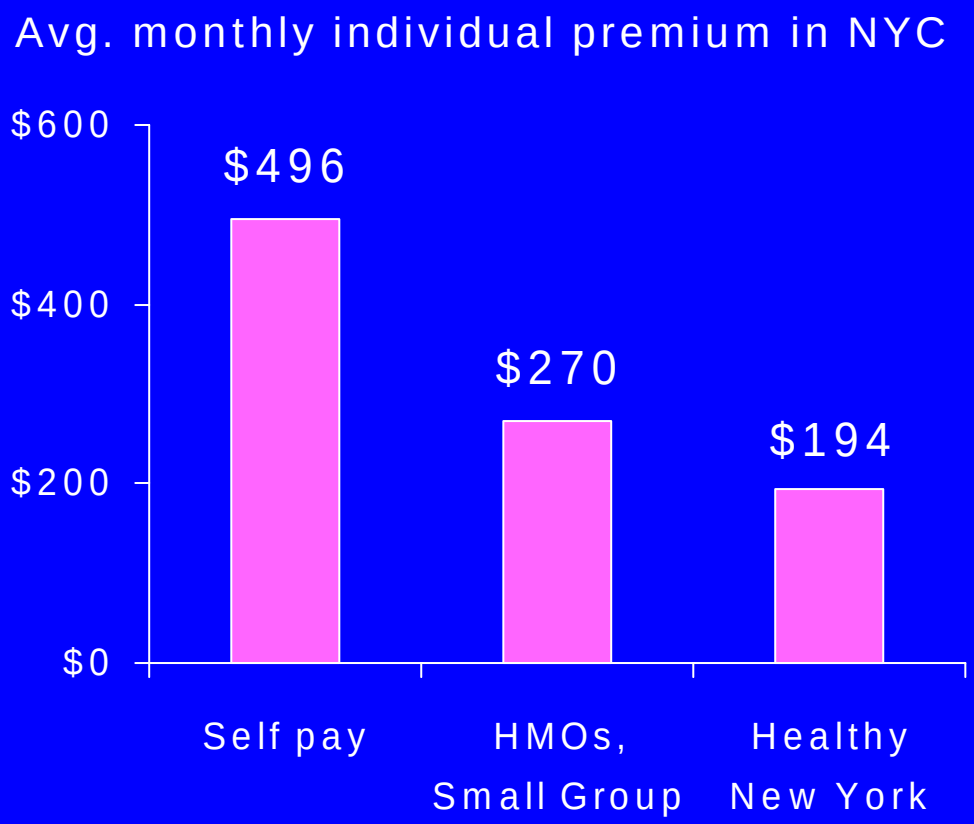
Retaining and Expanding Employer Participation: Healthy New York



- State provides stop-loss funds:
  - 90% of claims between $5,000 and $75,000
- Slimmed down HMO benefit package
- Low-wage small firms, self-employed eligible
- Began January 2001; At the end of 2004, enrollment of 76,704
- Lowers premium relative to individual and small group market

Source: Testimony by James Tallon, President of the United Hospital Fund, *New York State Insurance Committee Hearing: The Cost of Health Insurance*, April 15, 2003; updated by Commonwealth Fund, October 2004.

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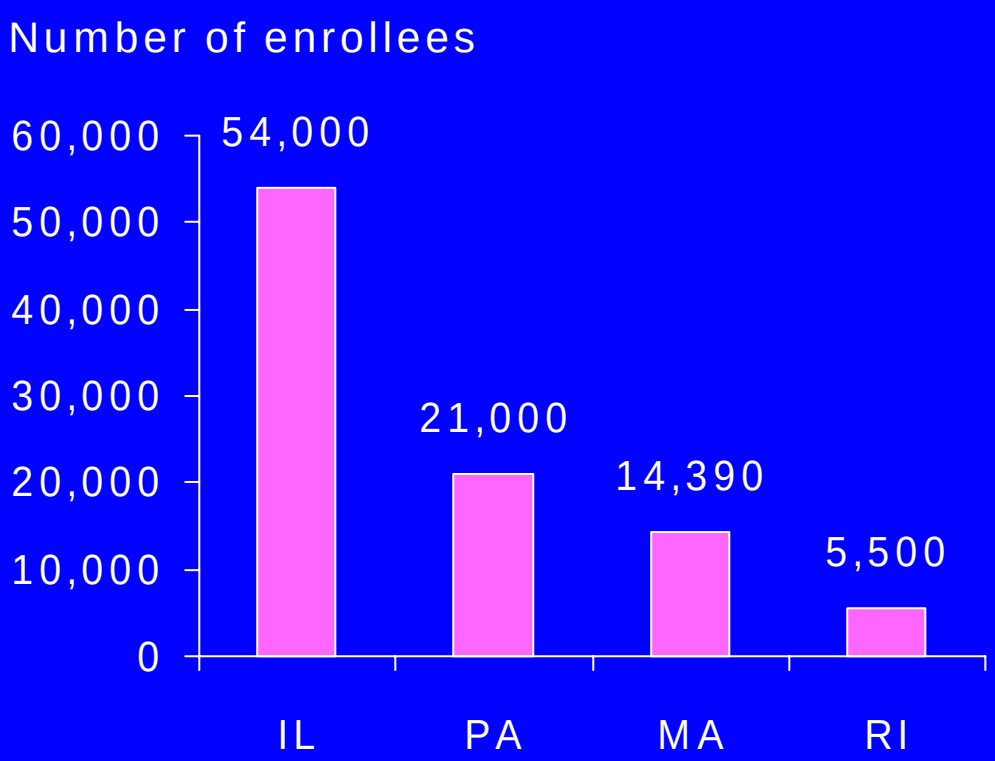
Retaining and Expanding Employer Participation: Premium Assistance

Examples of Premium Assistance Programs



- 12 states subsidize private employer-sponsored insurance for Medicaid/CHIP eligibles
- Program complexity has been a barrier; Rhode Island has simplified to promote participation

Sources: Silow-Carroll, *Stretching State Health Care Dollars: Building on Employer Based Coverage,* Commonwealth Fund, October 2004; and www.statecoverage.net

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Retaining and Expanding Employer Participation: Leveraging Public Coverage

- Minnesota
  - Launched Smart-Buy Alliance in 11/04 – coalition of purchasers covering 70% of state residents
- Connecticut
  - Nonprofit organizations contracting with state can buy coverage through municipal employees health benefit plan; 14,000 enrolled; savings of 3.75%
- West Virginia
  - Small business insurance pays providers at same rates negotiated by the state public employees plan; savings of 20%; began 1/05

Retaining and Expanding Employer Participation: Pay or Play

- Maryland legislature passed bill requiring employers with 10,000+ workers spend 8% of payroll on health benefits, or contribute to state program
  - Governor not yet responded
- California S.B. 2: employers with 50+ workers provide health insurance or pay into a pool, potentially covering 1 million people
  - Repealed in a ballot initiative
- Other states working on designing new pay or play legislation that can withstand ERISA challenge

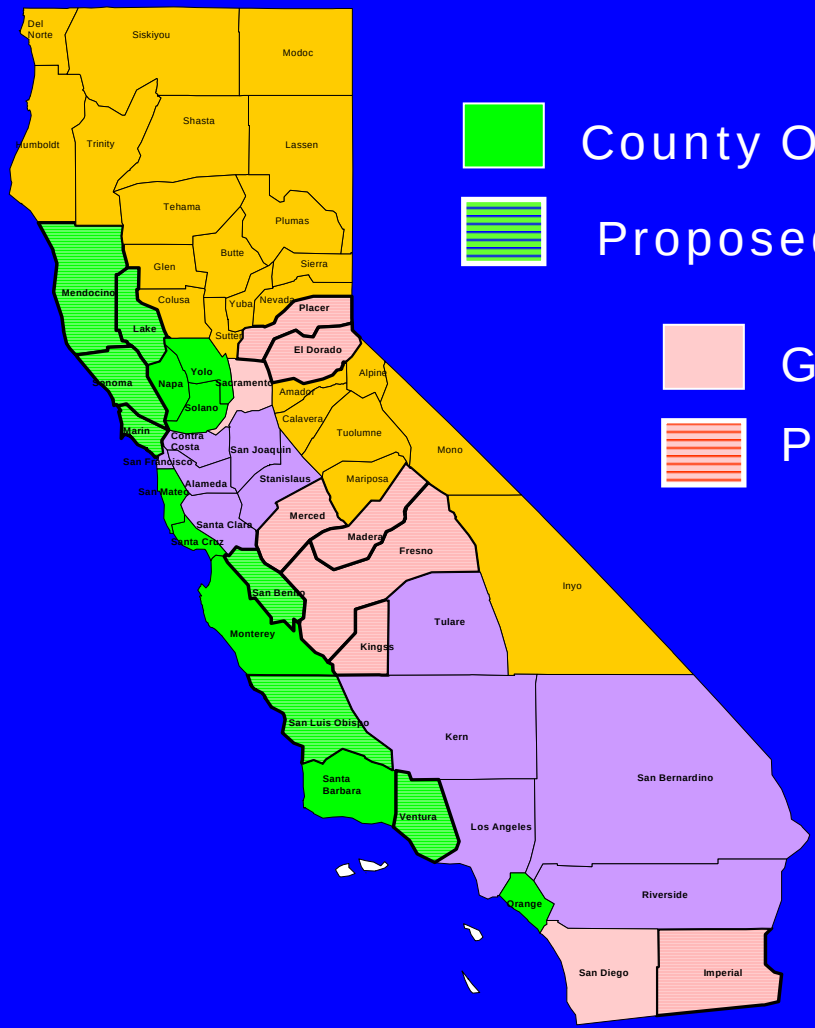
Leveraging Federal Matching Funds

- Illinois CHIP Expansions
  - Children up to 200% of poverty, with presumptive eligibility; parents up to 133% of poverty; 320,000 new eligibles
- Iowa Pilots Medicaid-like coverage
  - New law creates modified Medicaid program for 30,000 residents. Charity care dollars draw federal match, plus some existing Medicaid funds. Reduced benefit package.
- States Use Disproportionate Share Hospital (DSH), Uncompensated Care Funds
  - DSH funds targeted on access to primary and preventive care to reduce emergency room and inpatient hospital use by the uninsured
  - Wisconsin, Georgia, Massachusetts, Michigan, and Maine have programs serving 1,000 to 15,000 enrollees each

Medicaid/CHIP Redesign Can Help Stretch Dollars

- California maintaining recent coverage expansions by moving more enrollees into managed care
  - 262,000 parents and children
  - 554,000 seniors and persons with disabilities
- Utah's Primary Care Network is testing a primary/preventive care benefit to reach more of the uninsured
  - Over 19,000 enrolled
  - Downside – funded out of reduced benefits for poor /near-poor Medicaid beneficiaries
  - New York Child Health Plus and Minnesota care began with primary care; expanded to inpatient care

Existing and Proposed Managed Care Counties



County Organized Health System (COHS)

Proposed COHS

Geographic Managed Care (GMC)

Proposed GMC

Two-Plan Model

Remaining FFS Counties

Source: Sandra Shewry, Director, CA Dept of Health Services. Presentation to the Task Force on the Future of Health Insurance, March 2005.

Simplifying and Streamlining Eligibility and Redetermination

- Minnesota uses single eligibility form for its 3 coverage programs
- Georgia has electronic application and eligibility determination, single application for children
- California has electronic application and express lane eligibility for enrolling children eligible for other public benefits
- Multiple states have gone to passive re-enrollment, longer eligibility periods, and presumptive eligibility

Targeting Special Populations

- High Risk Pools
  - About 32 states have high risk pools, mostly insuring small numbers of residents with high cost illnesses
  - Minnesota is the largest, with 30,000
  - Colorado subsidizes low income enrollees in its ColoradoCare program
- Workers displaced by the Trade Act are eligible for Federal tax credits of 65% of premiums; take up rates greatly influenced by state implementation
  - Low take up so far, with leading states experiencing 8–11% of eligibles enrolling
  - Premiums still unaffordable for most eligibles
- Four states let families with incomes above CHIP income limits buy children in, no state subsidy
  - Connecticut, Florida, New York, North Carolina

Revenue Sources for Coverage Expansions

- Minnesota
  - 2% tax on hospitals (since 1/1/93), and health care providers (since 1/1/94)
- Maine
  - Dirigo includes a 4% surcharge on insurance premiums conditional on reduction of bad debt and charity care from expanded coverage and other savings offsets
- Maryland
  - A new (12/04) 2% tax on HMO premiums helps fund Maryland Health Insurance Program
- Oklahoma, Colorado, and Montana
  - Enacted new tobacco taxes in 2004 earmarked for health care

Outlook

- Difficult for states to find funds, so they need to be creative
- In some states, not cutting Medicaid coverage will be the only progress
- Most expansion states pursuing incremental steps building on employer coverage and Medicaid/CHIP
- Linking quality improvement, cost reduction, and coverage expansions may help states gain support of key stakeholders
- Collaboration between public and private insurers promising, e.g. Minnesota Smart-Buy Alliance

Federal Support for State Experimentation

- HRSA Pilot Project Planning Grants
  - 46 states have state planning grants averaging $1 million each to develop coverage options
  - 9 states received up to $400,000 each to pilot test a coverage expansion this year
  - New funding is available for next year
- IOM recommended state coverage demonstrations with federal funding

Acknowledgements

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  Jennifer Edwards, Senior Program Officer, Director, State Innovations Program, The Commonwealth Fund

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  Alice Ho, Research Associate, The Commonwealth Fund

- Sharon Silow-Carroll et al., *Stretching State Health Care Dollars* (5 Reports), The Commonwealth Fund, October 2004.
- *States in Action: A Quarterly Look at Innovations in Health Policy* – Fund newsletter to be released next week
- More reports on state innovations on the Fund website: Visit www.cmwf.org/tools/tools.htm

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Panel Overview

- Michael Deily, Director, Division of Health Care Financing, Utah State Medicaid Agency
  - Primary Care Network and Covered at Work
- Trisha Leddy, Administrator, Center for Child and Family Health, Rhode Island Department of Human Services
  - RIte Care
- Barbara Brett, Executive Director, CoverColorado
  - CoverColorado
- Karl Ideman, President, Pool Administrators, Inc.
  - Reinsurance