

## State Health Care Reform Initiatives

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### Group 1. “Comprehensive Reform” Programs

**Maine:** adopted 2003: goal universal coverage by 2009.

- Dirigo Health Reform Act.
- DirigoChoice available to small business, self-employed and eligible individuals without access to employer sponsored insurance.
- Available only through Antham (largest carrier in Maine.)
- Program offers discounts on monthly premiums and reductions in deductibles and out of pocket maximums on sliding scale to enrollees with incomes below 300 percent FPL.
- Cost containment: rate regulation small group market and voluntary caps on cost and operating margins insurers, hospitals and practitioners.
- Funding: employer contributions, individual contributions, state general funds, and federal Medicaid matching funds for eligible individuals. Major source “**Savings Offset Payment**” generated through recovery of bad debt, charity care and other voluntary savings targets set by state.
- Ongoing lawsuit: State and Antham disagree as to extent of savings offset, and how “savings offset payments” should be shared.
- Currently state is examining option of DirigoChoice self-insuring as means of achieving greater efficiency.
- Currently only 12,000 enrolled. Most low-income individuals.
- In 2006, the Governor appointed a new blue ribbon commission charged with making recommendations with respect to long term funding and cost containment. The commission will consider various funding alternatives including the “savings offset payment” strategy.

**Massachusetts:** adopted 2006: goal cover 95% of state’s uninsured within 3 years.

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- Massachusetts-Commonwealth Care.
- Individual mandate: all individuals who can afford health insurance must purchase it. If they do not, they will lose personal exemption on 2007 income tax, and in future years will face additional fines of 50% of the monthly cost of health insurance for each month without insurance.
- Employers with 11 or more full-time employees that do not make a “fair and reasonable” contribution to employee’s health insurance will be required to make a per-worker contribution not to exceed \$295 annually. Employers will pass the “fair and reasonable” test if at least 25% of full time employees are enrolled in the company’s group health plan and the employer contributes toward the premium.
- By January 1, 2007, all employers with 11 or more full-time employees must adopt a Section 125 “cafeteria plan” that permits workers to purchase health care with pre-tax dollars. (This saves about 25% on the cost of premiums.) If these employers do not offer to contribute toward or arrange for the purchase of health insurance, they may be charged a “free rider” surcharge, if their employees or employees’ dependents access free care. The surcharge will exempt the first \$50,000 of free care that the employees use. The employer will be responsible for from 10 to 100% of the state’s cost for free care above this amount, as determined by The Division of Health Care Finance and Policy.
- The Commonwealth Health Insurance Connector is a vehicle to help individuals and small business find affordable health coverage. Part time and seasonal workers can combine employer contributions in the Connector. The Connector allows individuals to keep their policy even if they switch employers.
- The Commonwealth Care Health Insurance Program will provide sliding scale subsidies to individuals with incomes below 300 percent FPL. No premiums will be charged to those at or below 100% FPL. The average monthly premium for products offered through the Connector will range between \$276 and \$391 before the subsidies are applied.
- Insurance market reforms include a merger of the non group and small group markets by July 2007. This should result in premium reductions for those in the individual market by 25%. It will also allow HMO’s to offer coverage plans linked Health Savings accounts and HMO products with co-insurance. Young adults can remain on parent’s policy for two years beyond loss of dependent status, or through age 25 whichever occurs first.
- The reform will be financed via several sources. \$385 million in federal matching funds used for the “safety net” will be redirected to cover the subsidies. \$308 million in state general fund revenues will be invested over three years. Individual and employer contributions will also be added.
- Implementation will take place in three phases. In October 2006, enrollment began for the nearly 62,000 residents requiring a full subsidy. In January 2007, the state began enrolling residents with annual incomes between 100 and 300 percent of FPL. The third phase will begin in July 2007 when the individual mandate becomes effective.

**Vermont:** adopted 2006: goal to cover 96% Vermont population by 2010.

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- Catamount Health
- Catamount Health Product for those uninsured for 12 months. Based on typical non-group market product offered in state , but with much less cost sharing by individual or family.
- Sets specific service and cost benefits that must be included-e.g. for individual coverage the plan cannot have more than a \$250 deductible, 20 percent coinsurance, \$10 office visit co-pay, no prescription drug deductible, no out-of-pocket for preventative and chronic care, and an out-of-pocket maximum of \$800 per year.
- Subsidies will be provided for uninsured individuals and families with incomes up to 300 percent FPL.
- State will provide similar premium assistance to low-income individuals with access to employer sponsored insurance who have been unable to afford it.
- Employers will pay a \$365 per FTE annual assessment with increases allowed as premiums change.
- Employers without a plan that pays some part of the cost of insurance of employees must pay the health care assessment on all employees.
- Employers who have coverage must pay the assessment on workers who are ineligible to participate in the plan and workers who refuse the employers coverage and do not have coverage from some other source.
- The assessment exempts eight FTE's in 2007 and 2008, six in 2009, and four thereafter.
- Provision for developing and implementing chronic care initiatives involving patient self management, incentives for healthy life styles, support for physical activities, etc. (See Vermont's Blueprint for Health)
- Funding: Increased tobacco products tax, federal matching funds through Global Commitment to Health waiver approved by CMS in 2005. this waiver allows the state to use Medicaid funds for health care investments, in exchange for a cap on Medicaid growth. Employer assessments and enrollee premiums will also be used to finance subsidies.
- State commission on health care reform can deem that rates offered by carriers are not cost effective—allowing the state to pursue self-insuring.

## **Group 2. Pending “Comprehensive Reform” Programs**

**California:** Two plans under consideration (sources: California Healthline, LA Times)

- Single payer state self-insured plan passed both houses in 2006, vetoed by Governor. Reintroduced 2007 by Senator Sheila Kuehl.
- Governor's plan closely resembles Massachusetts, including multiple insurers, mandatory insurance and demonstration of insurance with income tax filing. Fines of \$100 per month for those who do not provide proof, paid into fund for uninsured.

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**Pennsylvania:** details not yet available

**Group 3. Public-Private Partnerships**

**Tennessee:** adopted 2006, goal fill existing coverage gaps for 600,000 uninsured

- Cover Tennessee: includes
- CoverKids: stand-alone health care SCHIP program for all children 18 and under.
- CoverTN: new, portable affordable coverage for working uninsured (less than \$41,000 per year) and small firms unable to afford insurance. Limited benefit plan covering physician, outpatient, mental health, lab and hospital services, and generic drugs. For first three years premiums limited to 10% annual increase. State, employer and employee each contribute 1/3 of premium. State contracts with statewide carriers to offer two products averaging \$150 premium per month.
- AccessTN: High risk pool. Funded by combination of premiums, assessment on carriers and third party administrators, state appropriations and federal funds. Premiums charged to enrollees will be between 150 and 200 percent of commercial benchmark plan. State will subsidize those who cannot afford premiums.
- Appropriation bill for CoverTN also continues funding for affordable drugs, with focus on population suffering chronic diseases. Available to those earning less than 250 percent FPL.

**Rhode Island:** adopted 2006: (several initiatives) goal premium relief small business

- Wellness Health Benefit Plan.
- Target premium is 10 percent of wages.
- Benefits to include promotion of primary care, prevention and wellness. Active management chronically ill. Promoting the use of least costly, most appropriate setting and use of evidence-based quality care.
- Expected to reduce premiums for small business by 25 percent below market rates.
- Businesses with average wages in the bottom quartile could save additional 10 percent of premium through state sponsored reinsurance plan, which is still contingent on finding new funding source.
- Massachusetts Reform Review panel will explore potential of transferring Massachusetts comprehensive plan to Rhode Island.
- Wellness: legislation restricted the sale of sweetened beverages in school vending machines, created an adult flu vaccination program, and encouraged insurance coverage of tobacco cessation products.
- Transparency: legislation expands quality and cost data reporting to all licensed health facilities to enable patients with deductibles and co-insurance to make informed decisions.

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**Montana:** implemented 2006: goal cover employees of small business

- Insure Montana
- Offered to businesses with 2 to 9 employees.
- Tax credits. Qualifying small businesses that are currently providing health insurance are eligible for refundable tax credits. Approximately 600 businesses will receive relief, which will require about 40 percent of the Insure Montana funding.
- Purchasing Pool. Offered to small businesses that have been unable to afford insurance for their employees. Insure Montana provides monthly assistance payment for both employers and employees portion of the health insurance premium. Available to employers who have not offered insurance for past 24 months. Employer must pay at least 50 percent of employee policy, and program pays employer up to 50 percent of the employers contribution for each covered employee. Employees also receive Premium Assistance Payments ranging from 20 to 90 percent based on sliding scale and tied to employee's annual family income.
- Insurance product under this program is available through one of the two Blue Cross Blue Shield of Montana plans offered by the State Health Insurance Purchasing Pool or through a qualified Association Plan.

**Utah:** adopted 2006: goal premium assistance program.

- Premium Partnership for Health Insurance
- Offers up to \$150 per adult for low income workers enrolled in employer-sponsored insurance whose premiums represent more than 5 percent of their annual income.
- Subsidies of up to \$100 are also available for employee's children.
- Currently state has funding to enroll 1,000 adults and 250 children.
- (Note: previous program that provided \$50 per month had a peak monthly enrollment of 79 individuals)

**New Mexico:** adopted 2005: goal expand coverage to low-income uninsured workers

- State Coverage Insurance
- Program available to low-income, uninsured, working adults with family income below 200 percent FPL.
- Premiums paid by employer and employee contributions in combination with state and federal funds.
- Individuals may enroll through employer or as self-employed individual. Self employed pay both employer and employee portions of premium.
- Benefit package comprehensive with annual maximum of \$100,000.
- Services provided through managed care organizations.
- 4,400 workers currently enrolled.

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**Oklahoma:** 2005: goal to provide coverage to 50,000 low-wage working adults.

- Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)
- Funded by state general fund, tobacco tax and federal matching funds.
- Offered to qualified employees in small business (less than 50) to assist in buying insurance through employer.
- Employers work with agents to find private health plan to offer employees.
- O-EPIC pays 60 percent of the health premium for qualified employees with income below 185 percent FPL, and 85 percent of the premium of qualified employee's spouse.
- Employers expected to contribute 25 percent of the employee's premium.
- Employees contribute up to 15 percent of own premium and 15 percent for their spouses.
- Individual plan is expected shortly that will assist individuals with less than 185 percent FPL income, and who are ineligible for their employer's health plan, self employed, or employed by small firms that do not offer insurance.
- Individual plan will provide coverage through managed care plans that also serve the Medicaid program.

**Arkansas:** approved 2006: goal low-cost health coverage for small business

- ARHealthNet
- Open to all employers who have not offered group health insurance to employees in the preceding 12 month period.
- Requires employers to guarantee coverage for all full-time employees regardless of income.
- All employees eligible to enroll, but subsidies offered only to those with annual incomes below 200 percent FPL.
- Limited coverage with six clinician visits, seven hospital days, two out-patient or emergency room visits per year. Limits include two prescriptions per month.
- State has contracted with commercial third-party administrator to administer program.
- Program will be implemented in sequential phases over five years. First 12-24 months will have enrollment cap of 15,000. Enrollment capped in remaining period by available funds.

#### **Group 4. Covering Children**

**Illinois:** 2005: goal to cover all uninsured children

- Cover All Kids Health Insurance Act
- Program is open to all children regardless of income, who have been without insurance for 12 months.

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- Program hopes to cover 50 percent of those uninsured children whose family income exceeds 200 percent of FPL.
- Program funded through enrollee premiums and cost sharing and savings from care management.
- State continues to seek federal funding for the SCHIP program, and links with other public programs such as Family Care (coverage for parents up to 185 percent FPL)

### **Other Cover All Kids Programs**

**Pennsylvania:** 2006: allows families to purchase health insurance on a sliding scale based on income.

**Tennessee:** 2006: see earlier: (SCHIP for children in families up to 250 percent FPL.)

**Connecticut:** Husky B program. SCHIP allows uninsured children in families above 300 percent the opportunity to buy into program. (adopted 1997, total enrollment 800 individuals in autumn 2006)

### **Proposed and Pending Kids Programs:**

Oregon  
Wisconsin  
Washington  
New Mexico details unavailable at this time.

### **Group 5. Medicaid Deficit Reduction Act, Redesign and Financing 2006**

#### **West Virginia:**

- Moved healthy children and parents into one of two plans.
- Basic Plan: covers all mandatory and some optional services, but benefits more limited than under previous Medicaid package.
- Enhanced Plan: For individuals who have signed the member agreement. This plan covers all items in Basic health plus mental health services, diabetes care, and prescription drugs above the four drug limit of the basic plan. This plan is comparable to the previous Medicaid benefits package.
- Membership agreement includes a 'personal responsibility contract' involving a Healthy Rewards pilot program. Members earn 'credits' that can be used to cover co-pays, and bonus credits are added for meeting health goals. Individuals who do not meet responsibilities are moved to the Basic Plan.

#### **Kentucky:**

- KyHealth Choices now offers four plans tailored to specific populations.

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- **Global Choices:** designed for pregnant women and working parents up to 68 percent FPL, foster children, medically fragile children, Supplemental Security Income-related groups and women with breast and cervical cancer. Global Choices covers basic medical services with new benefit limits and increased cost sharing. No long term services.
- **Family Choices:** is designed for most children including those enrolled in SCHIP. Offers the same benefit package as Global Choices except there are no prescription drug limits, and higher vision care maximum benefit.
- **Optimum Choices:** For individuals with developmental disabilities and mental retardation in need of long term services. Coverage similar to other plans, but includes long term care.
- **Comprehensive Choices:** For elderly and individuals requiring nursing facility care. Offers all the benefits of Global Choices plus two levels of long term care.
- **KyHealth Choices** also includes an employer-sponsored insurance option. Enrollees can choose to receive a subsidy for private plans that meet the state's employee plan benchmark and certain economy and efficiency criteria.

**Idaho:**

- Idaho is enrolling the Medicaid and SCHIP populations into three major benefit plans.
- **Medicaid Basic:** for low-income children and working-age adults. Covers most primary and acute services. Does not include services not needed by participants with average health needs such as case management, hospice or institutional care.
- **Medicaid Enhanced:** For individuals with disabilities or special health needs. Covers all services Medicaid provided prior to reform.
- **Medicaid-Medicare Coordinated Plan:** serves elders and those eligible for both Medicaid and Medicare. Integrates benefits to improve access. State pays capitated rate per enrollee to Medicare Advantage for integrated services, Medicare-excluded drugs and "wrap around" benefits. Will be implemented mid 2007.

**Kansas:**

- Working Healthy Ticket to Work Medicaid Buy-In program.
- Allows workers with disabilities and incomes below 300 percent FPL to be covered by the State plan Medicaid coverage.
- They also receive additional services including assessments to determine personal service needs, independent living counseling, assistive services like wheelchair ramps.

**Group 6. Other Medicaid Reform Proposals**

**Florida:** initiated 2006 in 2 counties: goals provide choice, increase access, reduce costs

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- Changes program from defined benefits to defined contribution.
- Includes Enhanced benefit Accounts to reward healthy behaviors
- New low-income pool included to pay safety net services for uninsured.
- Initial groups covered, Temporary Assistance for Needy Families and Aged and Disabled eligibility groups.
- Will extend to three additional counties in 2007.

**South Carolina:** approval pending

- Proposal would cover most Medicaid enrollees (except dual eligibles and children in foster care) with a Personal health Account.
- Accounts would be based on current levels of fee-for-service spending and risk adjusted for gender, age and health status.
- Enrollees would receive assistance from counselors in choosing from four options: private insurance, medical homes network, employer-sponsored insurance opt-out, or self-directed opt-out. (opt-outs involve purchasing some level of insurance)

**Wisconsin:** proposed

- BadgerCare Plus
- Would merge Medicaid and SCHIP programs
- Coverage expanded to seven populations
- All children to age 19 with incomes above 185 percent FPL, with cost sharing scaled to family income.
- Pregnant women with incomes between 185 and 300 percent FPL.
- Parents and caretaker relatives with incomes between 185 and 200 percent FPL.
- Caretaker relatives with incomes between 44 and 200 percent FPL.
- Birth parents of children in foster care with incomes up to 200 percent FPL.
- Youth 18 through 20 aging out of foster care.
- Farmers and other self-employed parents with incomes up to 200 percent FPL, contingent on depreciation calculations.

**Other Sources**

In February 2007, The Texas Health and Human Services Commission released a comprehensive study of Medicaid reform strategies. See <http://www.hhsc.state.tx.us/> under “Medicaid Reform Project.”

National Association of Insurance Commissioners, *State Innovations in Modernizing Health Insurance and Extending Coverage to the Uninsured*, April 2007.

Commonwealth Fund resources: <http://www.commonwealthfund.org>