



**ASSESSING STATE STRATEGIES
FOR HEALTH COVERAGE EXPANSION:
CASE STUDIES OF OREGON, RHODE ISLAND,
NEW JERSEY, AND GEORGIA**

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FIELD REPORT

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About the Economic and Social Research Institute

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

About the Center for State Health Policy

Rutgers Center for State Health Policy (CSHP) informs, supports, and stimulates sound and creative state health policy in New Jersey and around the nation. CSHP provides impartial policy analysis, research, training, facilitation, and consultation on important state health policy issues. Established in 1999, the Center is the newest research unit within the Institute for Health, Health Care Policy, and Aging Research at Rutgers University, New Brunswick, New Jersey.

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OVERVIEW

The Economic and Social Research Institute (ESRI) and the Center for State Health Policy (CSHP) at Rutgers University examined the experiences of four states—Oregon, Rhode Island, New Jersey, and Georgia—that have made significant progress in health coverage expansion. The main goal of the project was to determine the key factors that appear essential for success. ESRI and CSHP researchers sought to assess the political, economic, and other “ingredients” that facilitated coverage expansion efforts in each of the states, as well as the barriers and mistakes that hampered those efforts.¹ The underlying question was whether common themes and lessons would emerge from a review of the experiences of these states, despite their different circumstances and strategies.

The research did reveal common themes across all or some of the sites studied, as well as lessons that emerge from individual state experiences. These are highlighted below. The overviews of the case studies that follow provide additional information for policymakers and program administrators. The experiences of these states may provide guidance for other states as they consider how to address a growing uninsured population with limited resources and how to prepare for more ambitious initiatives under better economic conditions.

The fiscal crises experienced by states in 2001–02 have led many states to consider cutting back Medicaid, State Children’s Health Insurance Programs (CHIP), and other health coverage programs, as well as to postpone or cancel plans for further coverage expansions. These temporary setbacks should not obscure the fact that some states have made significant progress in access expansion over the past decade, overcoming myriad obstacles along the way, and remain committed to ensuring that people have access to health coverage.

States have pursued multiple strategies to reduce the number of uninsured. These strategies include increasing enrollment of those already eligible for public programs, initiating CHIP for low-income children, expanding eligibility for public programs to include populations that were previously ineligible (e.g., parents of Medicaid or CHIP-eligible children, adults without dependent children), and shoring up employer-sponsored coverage. Frequently, these state initiatives have been implemented in a piecemeal or incremental fashion, without being integrated into a comprehensive strategy. Several states, however, have tried to develop comprehensive approaches that integrate or at least coordinate multiple strategies in an effort to reach diverse uninsured populations.

¹ A subsequent, companion report will present a cross-cutting analysis of access expansion efforts in six additional states and summarize lessons emerging from the HRSA State Planning Grant initiative.

This report presents case studies of four states that have made significant efforts to expand health coverage: Oregon, Rhode Island, New Jersey, and Georgia. For each state, site visits and interviews were conducted with program administrators, policymakers, and representatives from the consumer, business, and health plan/provider communities. The research team identified individuals from both the public and private sectors who have been instrumental in designing and/or implementing their state's coverage strategy, or who have been directly affected by that strategy.

UNIQUE STATE EXPERIENCES

The states selected for this study represent diversity in background, strategies, and experiences. The research confirms that each state must adapt a strategy to its unique character and circumstances. Yet other states can draw important lessons from their successes and challenges.

Oregon

Oregon has been a leader in health reform for many years, beginning with the implementation of the Oregon Health Plan (OHP) more than a decade ago. The OHP approach to broadening health coverage is built on the premise that it is better for a larger number of lower-income people to have good health coverage than for a smaller number of people to have the best possible coverage. When Oregon began OHP, this approach of prioritizing benefits was unique—and looked at with skepticism by many policymakers across the country. Now, however, other states may look to Oregon as they evaluate the trade-off between providing less generous coverage for more people and having a more generous benefit package for a smaller group. Specifically, states may explore the possibility of applying new federal flexibility rules (primarily under the new Health Insurance Flexibility and Accountability Act regulations) to similar types of coverage initiatives.

In addition to OHP, Oregon has developed a public-private partnership, the Family Health Insurance Assistance Program, or FHIAP, that allows people to use state subsidies to purchase employer-sponsored coverage or individual insurance (either through the non-group market or through the state high-risk pool). These coverage programs in Oregon, which address different segments of the uninsured population and include both public and private initiatives, have contributed to a substantial reduction in the number of uninsured, from 16.4 percent of the population in 1990 to 12.3 percent in 2000.

Rhode Island

As a small state, Rhode Island chose an approach involving incremental expansion of one major public program, RItE Care, through central planning and coordination. While this strategy may not be ideal for states with larger or more diverse low-income populations, it

was quite successful in reducing Rhode Island's uninsured rate to one of the lowest in the U.S.: 5.9 percent among all residents in 2000, and 2.4 percent among children. A unique feature of the program is the state's commitment to quality improvement through performance standards, collection and use of data, and a comprehensive approach to health care with a strong emphasis on prevention. This commitment has resulted in improved outcomes and long-term efficiencies. The state also outsourced many administrative tasks, helping to ensure that adequate resources and expertise were devoted to RItE Care.

When faced with budget constraints along with pressure by participating health plans to raise reimbursement rates, RItE Care created "stop-loss" provisions that reduced health plans' risk for certain high-cost services and took responsibility for paying providers directly for other high-cost services. Other states can consider these tactics when facing similar budget pressures. Rhode Island had difficulty convincing small employers to participate in its new premium subsidy program, RItE Share, and subsequently modified the program to allow the state to bypass employers and subsidize employee health insurance directly. States planning similar initiatives might consider building in a direct subsidy to individual workers. Also, the state made RItE Share mandatory for RItE Care applicants and beneficiaries with access to employer-sponsored coverage. Rhode Island's experiences underscore the need for states to be flexible, to continually monitor their programs in light of changing circumstances, and to make adjustments along the way.

New Jersey

New Jersey was one of the first states to introduce comprehensive reforms in the individual and small-group markets to address issues of health insurance affordability and access in the private sector. By initiating market reforms before expanding public coverage, the state stabilized a faltering market, thereby averting an increase in the number of the state's uninsured and positioning itself for subsequent coverage expansions. In particular, the standardization of small-group benefit packages implemented through these reforms helped to simplify the assessment of cost-effectiveness for the state's employer buy-in program. Maintaining stability in these markets while protecting access to affordable private insurance for high-risk individuals continues to be a challenge. But New Jersey's steadfast commitment to regulating these markets, with input from the business and insurance communities, is instructive for other states.

In the latter half of the 1990s, New Jersey concentrated its efforts on expanding state-subsidized coverage for low-income persons. The state first attempted to cover low-income adults and their families through the individual direct purchase market and later focused on a more comprehensive coverage program, targeted primarily at children,

which built on the Medicaid/CHIP platform. Through its experimental foray into subsidized coverage through the individual market, the state learned that existing state platforms offer a more cost-effective approach to public subsidies, providing greater administrative efficiencies, lower per unit costs, and federal matching funds. In expanding coverage to children, New Jersey has found enrollment in general to be lower than expected, particularly in the highest cost-sharing plan, suggesting that other states may want to consider lower cost-sharing requirements to encourage more parents to purchase coverage for their children. In sharp contrast, enrollment by adults has far exceeded expectations and budgetary limits, suggesting a significant pent-up demand for affordable health insurance for adults. New Jersey's experience suggests that other states may wish to take a more gradual approach in order to assess the unmet demand for affordable insurance among the low-income adult population and the capacity of budgetary resources to meet this demand.

Georgia

A national innovator in CHIP enrollment, Georgia established a high CHIP income limit (235% of the federal poverty level) and conducted a vigorous initiative to enroll over 200,000 children in its PeachCare for Kids program. Georgia developed a streamlined application process to facilitate enrollment in both PeachCare for Kids and Medicaid. The state's passive re-determination system, which automatically re-enrolls children unless administrators are informed of changed circumstances, has supported program retention and offers a model for other states seeking continuity of care.

Georgia was the first state to redirect a portion of disproportionate share hospital funds to primary care, fostering prevention and early intervention. The governor's decision to bring several agencies with responsibility for health care under one administrative umbrella has improved program management. Georgia has also opened its state employee benefits program to allow medical staff in critical access hospitals in rural areas to purchase affordable coverage, and used its purchasing leverage to assure that providers contracting with the state employee benefit plan also participate in Medicaid.

COMMON THEMES

Despite the fact that these four states started from different places, pursued different strategies, and enjoyed different levels of progress, some common themes emerged that may provide guidance to other states.

Importance of Political Leadership and a Clearly Defined Mission

It appears critical to have a strong leader, preferably the governor, adopt coverage expansion as a major priority, and "sell" it to the public, legislators, and stakeholders. Each

of the states studied had a strong program champion, at least at the initial stages. Similarly, establishment and acceptance of specific goals regarding health promotion or coverage expansion to certain populations greatly enhances legislators' ability to enact necessary reforms. Georgia, Rhode Island, and New Jersey had a strong commitment to expanding coverage for children; the latter two states opted to expand coverage to parents as well, to promote coverage for the entire family. Oregon embraced the concept of prioritizing benefits to allow coverage for more people.

Public Promotion of Employer-Sponsored Insurance an Uphill Battle

States examined in this study have been searching for ways to promote employer-sponsored insurance through public subsidies. The goal is to leverage state dollars to help sustain employer contributions and prevent erosion of private coverage. This has been an unexpectedly difficult task, however, and the number of people enrolled in these programs is still relatively small, particularly when compared with Medicaid programs (e.g., OHP and RIte Care) that rely on group coverage outside the employer context. This may reveal a discrepancy between what policymakers in Washington see as the potential for public-private partnerships and what the states are actually experiencing when they try to form such partnerships as a vehicle for coverage expansion.

One reason for low enrollment numbers is that businesses have been less-willing partners than initially anticipated by policymakers, leading some programs to instead provide subsidies directly to employees. Rhode Island faced employer resistance to participating in the state's new premium subsidy program because of timing issues, financial difficulties among small firms, misunderstandings about program requirements, fear of administrative burdens, and the perception that different workers would be treated differently. Oregon's state-only FHIAP pays employees their share of the premium directly and does not involve employers. Its limited enrollment is related to lack of sufficient and stable financing.

After consulting with the business community, New Jersey also opted to offer direct subsidies to employees in its Premium Support Program (PSP). However, the state attributes low enrollment to a number of other factors, including delayed program start-up and challenges in meeting the federal waiver cost-effectiveness requirement whereby employers in New Jersey must contribute at least half of the premium to be eligible to participate in the state's PSP. Since the state's small-group reforms only require a minimum 10 percent employer contribution to purchase a small-group plan in the state, many businesses do not qualify for PSP. However, for those that do qualify, New Jersey's required standardization of small-group benefit packages has assisted the state in

conducting a complex benefit-for-benefit cost-effectiveness analysis for small employers, a task that has proved onerous for many other states.

Georgia was unable to get the primary components of its *Business Plan for Health* off the ground due to an inability to design an affordable plan for subsidizing private coverage and diminished interest from the state's top-level leaders.

The findings do not suggest that these types of public-private partnerships cannot work, but rather that states have to pay particular attention to design features and learn from one another about key barriers and successful program elements. As other states learn from the experiences of the case study states, they may benefit from new federal flexibility on expanding employer-based insurance through Medicaid and/or CHIP. They may be well served, however, by not setting their expectations for promoting employer-based coverage too high, or putting all of their coverage "eggs" in the employer-based "basket."

Fostering Dialogue and Input from Stakeholders

While tensions among various interest groups are natural and unavoidable, efforts to reduce the adversarial quality of the relationships among them greatly enhance coverage programs' viability. Programs that require private plan participation, for example, benefited when states sought feedback from and were responsive to the needs of the health plans. Including patient advocacy groups in discussions about the development and implementation of health reform proved to be essential for ensuring adequate consumer protections, developing a program that functions well for participants, and providing critical "buy-in," or participation, among the programs' constituencies. Public forums were a key part of Oregon's process when developing the Oregon Health Plan; consumer advocates in Rhode Island began as adversaries to the state but became partners in promoting RItE Care. Finally, the involvement of a neutral third party to convene meetings among various groups was very helpful in promoting consensus and support for reforms.

Struggle to Avoid Crowd-Out While Promoting Equity

Expansion of eligibility for public programs without simultaneous promotion of private insurance risks substitution of public for private coverage. It is therefore necessary to anticipate this possibility and establish rules to minimize crowd-out, where employers drop health insurance coverage because public coverage is available. Yet anti-crowd-out rules (e.g., "look back" periods) can result in having individuals in the same income category with different levels and types of coverage and subsidies. In New Jersey, much of the early planning decisions focused on the need to treat families in similar economic

situations fairly without giving currently covered individuals or employers incentives to drop private coverage. This concern drove the state's decisions to offer somewhat higher-income enrollees a benefit package comparable to those found in the private sector, as well as to propose a state-subsidized premium support program for low-income families currently insured by their employers. In Rhode Island, expansion of RIte Care eligibility months before a premium subsidy program was implemented led to initial crowd-out that was very difficult to reverse.

Benefits of Building Coverage Under One Umbrella

The states studied for this report anticipated the benefits of expanding coverage under one “umbrella” program. Rhode Island and Georgia found it helpful to focus their efforts on establishing and then expanding a single program, providing “seamless” coverage across different eligibility groups. Similarly, New Jersey's decision to build on the state's Medicaid managed care platform, after a brief experiment with subsidizing coverage in the much more expensive individual market, facilitated a rapid response to CHIP requirements and simplified program administration. Oregon's major reform of the early 1990s, though made up of various components, was presented under one “Oregon Health Plan” banner.

This approach appears to be beneficial for garnering public and legislative support, minimizing administrative complexity, and allowing families to be covered together (thereby encouraging more appropriate use of the health care system). New Jersey and Rhode Island, for example, attributed success in part to developing strategies for children and parents to be covered together under one program. Based on focus groups conducted with New Jersey KidCare, New Jersey discovered that whole-family coverage was preferred to child-only plans, which led the state to develop the FamilyCare model. Oregon accomplished whole-family coverage by allowing individuals eligible for Medicaid or CHIP to be covered under FHIAP.

Managed Care Concerns

When designing public coverage expansions that rely on managed care plans, states need to pay particular attention to attracting and retaining plan participation. States try to use managed care as a way to control costs, while keeping provider and plan payments sufficient to ensure adequate managed care capacity. One way in which states have assured capacity was to partner with safety net health plans. While both Oregon and Rhode Island still have commercial plan participation in their programs, Rhode Island's support for a Community Health Center-based safety net health plan paid off when commercial plans left the market or refused to accept new RIte Care enrollees. Oregon too has developed a

relationship with a safety-net health plan that has stepped in when commercial plans have backed away from serving OHP enrollees.

Economic Conditions Underscore Need for Flexibility and Creativity

A robust economy and state budget surpluses made major access initiatives possible during the mid- to late-1990s. In looking ahead, however, the principal challenge among all states studied is to sustain past gains through times of budget shortfalls. In order to avoid major cutbacks in coverage or eligibility, Rhode Island has imposed modest premiums and Oregon has proposed a leaner benefit package for non-mandatory Medicaid populations. Georgia will likely move forward with belt-tightening in Medicaid and hold off planned expansions, but will try to avoid making fundamental changes in eligibility or benefits. To slow program enrollment in its FamilyCare program, New Jersey first curtailed its advertising campaign and eliminated presumptive eligibility, and later closed enrollment to non-general assistance childless adults. More recently, New Jersey has instituted additional measures in order to control escalating costs and keep the program solvent. These include closing enrollment to parents, ending enrollment of general assistance beneficiaries in FamilyCare managed care plans, making the benefit package of all adults similar to the most widely sold commercial HMO coverage in the state, and increasing cost-sharing for higher-income families. New Jersey is still committed to enrolling children and continues to face difficulties in recruiting and retaining children, especially in higher-income categories.

Finally, states remain interested in reaching out to groups, such as low-income adults without dependent children, who frequently fall into gaps between government programs and employer-based coverage. However, given limited state budgets, this has become a long-term goal.

The case studies that follow outline each state's current coverage expansion program or programs, elements that facilitated development of the initiatives, and obstacles that thwarted their efforts. They also summarize the primary concerns and challenges each state faces as it confronts major budget constraints and offer lessons for other states interested in expanding health coverage.

CASE STUDIES

OREGON

The objective in studying Oregon was to identify the factors that led to the successful implementation of the Oregon Health Plan, a program that uses Medicaid and CHIP funding to cover low-income Oregonians. Other state programs that have contributed to the reduction in the uninsured were examined as well, including the Family Health Insurance Assistance Program (a state-only program providing access to private insurance coverage), the Oregon Medical Insurance Pool (the state high-risk pool), and the Insurance Pool Governing Board (which helps small businesses and the self-employed gain access to coverage). This case study looks at some of the issues that Oregon faced as the state sought to provide a basic level of benefits to a large segment of their low-income population and how they chose to address those issues.

Summary

Oregon has long been a leader in state health reform, as evidenced by the development and implementation of a broad range of public- and private-sector coverage expansion initiatives over the last decade. Oregon's approach to broadening health coverage is built on the premise that it is better for a larger number of lower-income people to have good—though not necessarily the most comprehensive—health coverage than for a smaller number of people to have the best possible coverage. Trimming the benefit package and relying on managed care freed up resources to assist more of the population in need. Also, Oregon has several coverage initiatives that address different segments of the uninsured population, and those efforts include both public and private initiatives. Finally, with new opportunities for federal flexibility around the Medicaid benefit package for optional populations, Oregon's approach to its priority list of services and the development of its basic benefit package offers an interesting option that other states may wish to study and/or pursue (Table 1).

The cornerstone of Oregon's approach has been the Oregon Health Plan (OHP). This plan initially featured an extension of Medicaid to all state residents with incomes below the federal poverty level (FPL), with coverage extended to 133 percent of the FPL for children under the age of six and pregnant women. Pregnant women and their newborns between 133 and 170 percent of the FPL are now also covered. The next piece involved the 1998 implementation of a Medicaid look-alike State Children's Health Insurance Program (CHIP), which used the OHP infrastructure. CHIP was implemented to cover children from birth to six years old between 133 and 170 percent of the FPL and children from six to 19 years old between 100 and 170 percent of the FPL. The Family

Health Insurance Assistance Program (FHIAP) was implemented in 1998 with sliding-scale state-only subsidies to allow people with incomes up to 170 percent of the FPL to gain access to private insurance coverage outside OHP. These programs, along with a strong economy in the late 1990s, have contributed to a substantial reduction in the number of uninsured, from 16.4 percent in 1990 to 12.3 percent in 2000.²

Table 1. Oregon State Profile and Overview, 1999–2000

| Oregon | Number |
|--|---------------|
| Total population | 3,404,950 |
| Nonelderly population (under 65) | 3,004,320 |
| Total population under 100% FPL | 524,270 |
| Total population under 200% FPL | 1,096,000 |
| Insurance status of nonelderly under 100% FPL | |
| Employer-sponsored coverage | 93,294 |
| Medicaid | 187,214 |
| Uninsured | 169,623 |
| Percent of all uninsured | 36% |
| Insurance status of nonelderly under 200% FPL | |
| Employer-sponsored coverage | 291,157 |
| Medicaid | 281,633 |
| Uninsured | 322,916 |
| Percent of all uninsured | 69% |

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (www.statehealthfacts.kff.org).

The underlying philosophy of the Oregon Health Plan is that all Oregonians should have access to a basic level of benefits and there should be equitable and appropriate utilization of services. To achieve this, the state took a comprehensive view and developed a multi-pronged approach to expanding access to different vulnerable populations. In addition to the Medicaid expansion that covered many poor and near-poor people, Oregon established a high-risk pool (Oregon Medical Insurance Pool) and provided small businesses with access to coverage (Insurance Pool Governing Board).³ In order to fund the Medicaid expansion, Oregon received a federal 1115 waiver to extend coverage to the non-categorically eligible groups and enable the state to limit the benefit package and introduce managed care (Table 2).

² Oregon Office of Health Plan Policy and Research, *Oregon HRSA State Planning Grant Final Report to the Secretary*, October 2001. These numbers are from the Oregon Population Survey; to see how these numbers compare with the Current Population Survey, see Oregon Office of Health Plan Policy and Research, *Varying Rates of Uninsurance Among Oregonians: A Critical Comparison of Two Household Surveys*, October 2000.

³ An employer mandate was also passed by the state legislature in 1989 but enabling legislation was not passed in time by the U.S. Congress so the state employer mandate never became law.

Table 2. Oregon Public Program Enrollment

| Oregon | Number |
|---|---------------|
| Total enrolled in Medicaid/Oregon Health Plan (as of 12/01) | 367,069 |
| Total enrolled in CHIP (as of 12/01) | 18,070 |
| Total enrolled in Family Health Insurance Assistance Program (as of 3/02) | 3,795 |
| Total enrolled in Oregon Medical Insurance Pool (as of 10/01) | 7,918 |

Sources: www.omap.hr.state.or.us for OHP enrollment figures; FHIAP staff for FHIAP enrollment numbers; www.cbs.state.or.us/external/omip for OMIP enrollment figures.

Several factors have contributed to the successful implementation of the Oregon Health Plan. First, publicity surrounding the death of a Medicaid-eligible boy who could not obtain an organ transplant because it was not a covered Medicaid service focused public attention on the provision of Medicaid services. Strong leadership in the state senate and later the governor's office helped garner support for a plan based on clearly defined goals and a clearly articulated philosophy. Stakeholder input contributed to the development of a prioritized list of services, a fundamental component of OHP. Growth of managed care capacity beyond the Portland-Salem metropolitan area helped in the implementation of OHP. Finally, FHIAP was successful because it allowed the whole family to be covered by one insurance plan, and it was structured as a public-private partnership supporting the employer-based system and did not carry a public program stigma.

Oregon encountered challenges in implementing OHP. The state has struggled with provider reimbursement, maintenance of its managed care capacity, and retention of support of the business community. FHIAP has a long waiting list for enrollment and has had difficulty attracting enrollees with access to employer-sponsored coverage.

Despite these challenges, Oregon is still committed to expanding coverage. Now, however, like many other states, they are facing a fiscal crisis. As of October 2001, Oregon's general fund revenues were down 9 percent compared with the September 2000 forecast, and personal and corporate income tax collections were down sharply compared with budgeted levels.⁴ One of the largest components of the Oregon state budget is devoted to OHP, and the state believes that existing cost-containment mechanisms (managed care and benefit package limitations) are less effective than they were when OHP began. Compounding state budget issues are concerns about rapidly rising health care costs, particularly for prescription drugs. As a result, Oregon is being forced to find ways to contain, or even lower, costs within OHP.

As of winter 2001, state policymakers, at the urging of the governor, had chosen to reduce costs by coupling a coverage expansion with a reduction in benefits for certain

⁴ National Conference of State Legislatures. *State Fiscal Outlook for FY 2002: October Update*. October 2001.

populations. The idea was that savings generated from the benefit reduction would allow Oregon to expand coverage to everyone under 185 percent of the FPL. In a sense, this was a step away from Oregon's commitment as embodied in OHP to cover people solely on the basis of income. Under the new plan, people with similar incomes but different family status would have different benefits. However, the state believed this was the most viable way of ensuring the long-term survival of OHP. At the end of May 2002, the state submitted waiver applications that, if approved and implemented, would expand coverage to an additional 65,000 people. Further details about the waivers are presented below.

The following case study presents the basic history of the Oregon Health Plan, outlines some of the successful components and obstacles in Oregon's strategy, and explains Oregon's approach to its latest coverage initiative.

History of Expansion Strategy

One of the first events that precipitated the development of OHP was publicity surrounding the death of a seven-year-old boy, Coby Howard. Coby Howard had acute lymphocytic leukemia and needed a bone marrow transplant. In response to rapidly increasing Medicaid costs, driven in part by the increasing number of organ transplants, the state legislature had decided to stop Medicaid coverage of such transplants. Coby Howard was unable to get a transplant and subsequently died. His death focused public attention on the pressing question of how best to allocate resources within a limited Medicaid budget.

John Kitzhaber, an emergency room physician and president of the Oregon senate, saw this as an opportunity to address the problem of lack of insurance coverage, particularly among low-income populations. He also saw this as a way to address problems created by a Medicaid benefit package that covered some less-effective treatments for minor conditions while denying potentially life-saving therapies. To explore options, Kitzhaber brought together stakeholders for discussion about how to address the dual problems of uninsurance and misallocation of health care resources. OHP and the concept of a prioritized list of health services resulted from those discussions.

The Oregon Health Plan

Several underlying principles have guided the development of OHP.⁵ The first principle is that eligibility for public coverage should be based on financial need rather than on federally mandated eligibility categories such as family status. To that end, OHP covers all

⁵ These have been outlined by Governor John Kitzhaber in various speeches. For example, see "Summit on the Oregon Health Plan," Eugene, Oregon, September 13, 2000 (www.governor.state.or.us/governor/speeches/s001013.html).

adults up to 100 percent of the FPL, regardless of family status. The second principle is that, because the public dollars that can be spent on health care are limited, these resources need to be rationally, equitably, and thoughtfully allocated. As a result, Oregon has developed a “priority list” of services and only covers services above a specified line, which can be moved up or down depending on available resources.⁶ One important aspect of the prioritized list is the emphasis on primary and preventive care.

The third principle guiding the development of OHP is public accountability for the development of the prioritized list, determination of where to draw the line in coverage, and explicit reasons for both. Therefore, the Health Services Commission (HSC) develops the priority list and the state legislature “draws the line” that determines the benefit package.

Although legislation authorizing the development of OHP passed in 1989, the HSC did not develop the prioritized list and present it to the legislature until 1991. In August 1992, Oregon submitted a Section 1115 waiver to the federal government. The request was turned down by the Department of Health and Human Services on the basis of the Americans with Disabilities Act, because disability advocates did not believe the process or the list sufficiently took their concerns into consideration. The idea of Oregon’s prioritized list also generated national controversy. Many interpreted the list as “rationing” care for low-income people. The Department of Health and Human Services approved the waiver in 1993 and OHP was implemented in 1994. When CHIP was passed by Congress in 1997, Oregon submitted a Title XXI state plan to place the newly eligible children into OHP. The Office of Medical Assistance Programs administers OHP for the state.

Family Health Insurance Assistance Program

The Family Health Insurance Assistance Program (FHIAP), a subsidy program that helps low- and moderate-income individuals purchase private individual or employer-based coverage, functions alongside OHP. It seeks to encourage participation in the private market and leverage employer dollars that are already being spent on health care. It also provides a mechanism for people leaving OHP to access coverage and maintain continuity of care, although this goal has been somewhat frustrated by the program’s long waiting list. Therefore, although the program is run separately from OHP, it is a critical part of the state’s overall strategy of covering the uninsured.

⁶ Initially, the list was to have been used both for the Medicaid benefit package and to define a benefit package for the employer mandate.

FHIAP emerged from a 1996 ballot initiative that increased the state tobacco tax to raise money for tobacco cessation and OHP. Rather than use the money to shore up existing OHP coverage, the state decided to expand coverage through private market mechanisms. One of the primary barriers preventing low-income people from obtaining private coverage (either through their employer or through the individual market) was the high level of workers' contributions to monthly premiums. In 1996 and 1997, policymakers worked with stakeholders to develop FHIAP, a state-funded public-private partnership that would provide public subsidies toward the purchase of private health insurance.

FHIAP offers state subsidies to people with incomes below 170 percent of the FPL. The subsidies pay between 70 and 95 percent of the worker's share of the premium cost for employer-sponsored plans or non-group coverage purchased in the private market. If the employer offers coverage and pays some portion of the premium, the employee must enroll in his or her employer's plan to receive the FHIAP subsidy. Once the employee has been accepted into FHIAP, he or she must fill out an employer verification form that indicates the employer's contribution amount and the employee's share of the premium. The employer deducts the full amount of the employee's share of the premium through a payroll deduction, and the employee must send in the pay stub each month to show the deduction and be eligible to receive the premium subsidy. To ensure that the employee does not have cash-flow problems because of premium withholding, FHIAP sends the first subsidy payment out as soon as the employer verification form is received and before the first premium amount is withheld.

If the employer does not offer coverage or contribute to the premium, the employee may sign up for a private plan offered by one of the carriers participating in FHIAP, including the Oregon Medical Insurance Pool (OMIP), if the employee cannot obtain commercial insurance. Nonworking FHIAP-eligible individuals may also sign up for one of these plans or enroll in OMIP. Once enrolled, FHIAP pays the insurance carrier directly for the full cost of the premium and the enrollee pays FHIAP for his or her share of the premium. Most FHIAP participants (about 85 percent) are enrolled in individual insurance, including OMIP. Although the state believes that FHIAP has demonstrated it can work well for employer-sponsored coverage, it is important to note that employer coverage is only a small portion of FHIAP at present. Whether enrolled in employer-sponsored coverage or through the individual market, all dependent children must be covered by some form of health insurance before the adults in the family are eligible for the FHIAP subsidy.

Table 3. Oregon Current Major Access Programs (OHP, FHIAP)

| Program aspect | Medicaid (OHP) | CHIP (OHP) | FHIAP |
|------------------------------|--|--|--|
| Waivers/legislation required | Section 1115 waiver | Title XXI state plan | Passed by state legislature July 1997 |
| Time frame | March 1993 waiver approved February 1994 began enrollment | June 1998 CHIP plan approved | July 1998 began enrollment |
| Enrollment | Total enrolled: 367,069 Enrolled in fully capitated health plans: 234,939 (as of December 1, 2001) | Total enrolled: 18,070 Enrolled in fully capitated health plans: 12,715 (as of December 1, 2001) | <ul style="list-style-type: none"> • 3,795 enrolled • 2,212 in individual coverage • 985 in OMIP • 598 in employer-sponsored • 12 approved for enrollment • 26,406 on reservation list (as of March 19, 2002) |
| Eligibility criteria | <ul style="list-style-type: none"> • Oregonians < 100% FPL • Children birth to 6 < 133% FPL • Pregnant women < 133% FPL • Pregnant women and their newborns between 133% and 170% FPL | <ul style="list-style-type: none"> • Children birth to 6 between 133% and 170% FPL • Children 6–19 between 100% and 170% FPL | <ul style="list-style-type: none"> • Oregon resident • U.S. citizen or legal noncitizen • No health insurance for past 6 months (unless coming from OHP) • Income < 170% FPL • Assets/savings < \$10,000 • All eligible children must have coverage before adults get subsidy • Not Medicare-eligible |
| Benefits/subsidies | Comprehensive inpatient and outpatient benefits Sliding-scale premium for adult, nonpregnant “expansion” eligibles | Comprehensive inpatient and outpatient benefit package (same as Medicaid) No enrollee premiums | Sliding-scale subsidy of private insurance premium cost <ul style="list-style-type: none"> • Income < 126% FPL—95% • 126% to 150% FPL—90% • 151% to 170% FPL—70% Commercially available benefit packages |
| Financing | Federal share: 59.20% State share: 40.80% Member premiums as noted above | Federal share: 71.44% State share: 28.56% | State-only program |

Sources: www.omap.hr.state.or.us for OHP enrollment figures; FHIAP staff for FHIAP enrollment numbers.

Other Access Programs

Oregon Medical Insurance Pool

The Oregon Medical Insurance Pool (OMIP), a high-risk pool, is part of OHP and was established by the state legislature in 1987.⁷ The goal of OMIP is to provide insurance coverage for all Oregonians, including FHIAP enrollees, who are unable to obtain health coverage because of medical conditions. OMIP also provides health coverage to Oregonians who have exhausted COBRA benefits and have no other portability options available to them. As of October 2001, there were 7,918 total OMIP enrollees; about 80 percent of them were enrolled in OMIP for medical reasons and the remaining 20 percent were enrolled for portability reasons. OMIP is subsidized through an assessment on insurers and reinsurers; the premium is capped at 125 percent of the premium for a comparable commercial plan for enrollees eligible for medical reasons, and at 100 percent for enrollees eligible for portability reasons. Regence Blue Cross Blue Shield of Oregon administers OMIP.

Insurance Pool Governing Board

The Insurance Pool Governing Board (IPGB), also created by the state legislature in 1987, is a small state agency that helps Oregonians obtain health coverage.⁸ In 1989, the IPGB began certifying low-cost health insurance plans for small businesses and the self-employed. However, as small businesses began to find plans in the small employer health insurance market that fit their needs, the need for these IPGB-certified specialized plans decreased. As a result, the IPGB stopped certifying plans in 1999 and now concentrates on helping small businesses and the self-employed obtain coverage for themselves, their employees, and their employees' dependents. For example, the IPGB runs an agent referral program that links small businesses interested in purchasing health insurance with local brokers who can help them find affordable coverage that matches their insurance needs. IPGB also provides training for agents and community partners about the Oregon health insurance market and about health insurance legislation. In addition, IPGB conducts outreach and marketing regarding the importance of having health coverage.

Small-Market Reforms

The final component of OHP is a series of small-market reforms enacted by the state legislature in 1993 and 1995 and implemented for the most part by 1996. These laws include provisions for guaranteed-issue and renewability, preexisting condition clause restrictions, minimum benefit package requirements, modified community rating,

⁷ For more information, see www.cbs.state.or.us/external/omip.

⁸ For more information, see www.ipgb.state.or.us.

portability requirements, and the extension of small employer reforms to the individual market.⁹

Elements that Facilitated Development: Oregon Health Plan

Importance of Publicity in Spurring Action

The death of Coby Howard was instrumental in focusing attention on the provision of health care within the Medicaid program. More important to long-term change, however, was that the public discussion moved beyond a simple question of whether organ transplants should be covered by Medicaid to a drive for an overall improvement of the health care system in Oregon. This eventually led to the passage of OHP.

Program Champion

When serious reform debate began in 1987, John Kitzhaber was president of the state senate in a legislature where the Democrats controlled both chambers. His leadership and support of the program was instrumental in passing OHP. In 1994, Kitzhaber ran for governor just as the program was being implemented, and his role in developing OHP greatly contributed to the success of his campaign. As governor, he spent much time and energy working with the media to encourage support of OHP and was the most vocal champion of the program. He has served as governor since 1994 and is scheduled to leave office in January 2003. One of the reasons that policymakers are working so hard to strengthen OHP now is a fear that, when Governor Kitzhaber leaves office, there will be less support in the governor's office to ensure that the overall health reform program can survive the downturn in state revenues.

Clearly Defined Goal and Strong Local Support

From the beginning, OHP has had a clearly articulated philosophy: more people should have some level of basic coverage instead of a smaller number of people having a very generous benefit package. Therefore, the result of OHP has been to move some resources from those who have been determined by federal legislation to be "more entitled" to those who are "less entitled," but—in the eyes of the state—equally in need of assistance. Drawing the line initially at 100 percent of the FPL was somewhat arbitrary, and the state has planned to continue to expand coverage up the income scale, introducing sliding-scale premium contributions as appropriate.

The overt statement of purpose behind OHP has made it easier to gather support. While much of the rest of the country was critical of Oregon's attempt to "ration care"

⁹ *The Oregon Health Plan and Oregon's Health Care Market*, a report to the 71st Legislative Assembly. Prepared by the Office for Oregon Health Plan Policy and Research, August 2000.

for the poor, the state's policymakers pulled together in defense of their strategy. In addition, many people were able to voice their concerns and many of those concerns were addressed as the plan was developed. Oregon has a relatively small population, making it possible for state policymakers to elicit opinions from their constituents.

The Prioritized List and Stakeholder Input

In the development of both the prioritized list and OHP, the inclusion of stakeholders was viewed by the state as a key ingredient in the successful implementation of the plan. To obtain stakeholder input, between January and March 1990, a group called Oregon Health Decisions conducted a series of community meetings on behalf of the HSC. A total of 47 meetings were held across the state, with a combined attendance of 1,048. Of those who attended, 9.4 percent were uninsured, 4.4 percent were Medicaid recipients, and 69.2 percent were health care workers. The process resulted in a list of 13 values (e.g., prevention, quality of life, effectiveness of treatment) that were forwarded to the HSC for consideration in prioritizing health services. The HSC used these values to construct and prioritize the 17 categories of care that, along with health outcomes information gathered from the literature and health care providers, determined the ordering of the May 1991 prioritized list of health services. As subsequent issues related to OHP have arisen, the infrastructure for community input created for OHP has served as a forum that can be used to discuss changes to the plan.

As other states explore the possibility of participating in the new Health Insurance Flexibility and Accountability demonstration initiative, they may look to Oregon's experience with the prioritized list as a model. Only certain aspects of Oregon's approach may be relevant to other states, however. Interviewees believed that Oregon's approach to covering the uninsured and the prioritized list reflect particular public values in Oregon. Other states could not take the list as developed by Oregon and implement it as is; the process of developing the list appears to be as important as the list itself.

Development of Managed Care

The implementation of OHP catalyzed managed care in Oregon as plans came together to serve the Medicaid population. Some managed care plans offered better coverage for certain services (e.g., adult dental health) under OHP than under traditional Medicaid plans. Managed care was phased in, first with the Aid to Families with Dependent Children (now Temporary Assistance for Needy Families) population and the noncategorically eligible population (e.g., those who qualified for OHP based solely on income). After the first year, the elderly, blind, and disabled populations and foster children were added. Again, the state worked with advocates, hoping to ensure that the transition to managed care for these special populations was smooth.

Elements that Facilitated Development: Family Health Insurance Assistance Program

As described earlier, FHIAP offers low-income individuals subsidies to help pay either a portion of a worker's share of the premium for employer-sponsored plans or coverage purchased in the private market or through OMIP.

Public-Private Partnership Supporting the Employer-Based System

Although FHIAP was developed later and covers far fewer people than OHP, FHIAP has become an important model for other states looking for ways to build up private, employer-based, or individual coverage. The public-private partnership aspect of FHIAP and the idea that it was supporting the employer-based system made FHIAP politically appealing. Another selling point was that the program does not require the employer to get involved in administering the subsidy. Employers deduct the full amount of the employee's share of the premium through a payroll deduction, as they would for any other employee, and the FHIAP-subsidized enrollee is reimbursed directly by the state for his/her share of the premium. Finally, having a third-party (nongovernmental) administrator was a big selling point in FHIAP's early stages, before the Insurance Pool Governing Board assumed administration of the program.

Family Covered Together

Another popular aspect of FHIAP is its subsidizing of family coverage through a single insurer. For adults to be eligible for the premium subsidy, all children in the household must also be covered (either through OHP or FHIAP). There is no wraparound coverage in FHIAP, so that the OHP benefit package is generally more generous than a FHIAP plan.¹⁰ Yet, many parents want to enroll themselves and their children in FHIAP so that the entire family is covered by the same insurer. Currently, about one-third of FHIAP enrollees are children and about one-fifth are Medicaid-eligible. In addition to providing family coverage, FHIAP offers a choice of plans to those purchasing in the individual insurance market and can offer plans with different delivery systems and different incentives and disincentives for seeking various kinds of care. These aspects of FHIAP can result in better access to care than would be available through a Medicaid plan.

Not a "Public Program"

According to program administrators, FHIAP enrollees appreciate that they are not enrolled in an overtly public program and do not have a Medicaid card. Thus, no one knows that they are receiving a state subsidy. As noted above, many people enrolled in

¹⁰ In fact, one reason that the FHIAP program is not eligible for a federal match is because the state does not want to add wraparound coverage to the program.

FHIAP are eligible for OHP. Their choice of a plan with less generous benefits and higher copayments shows the appeal of FHIAP and may reflect enrollees' desire to distance themselves from public programs. As changes are made to FHIAP, state policymakers recognize the need to maintain an identity for FHIAP distinct from that of Medicaid.

Obstacles and Issues: Oregon Health Plan

Provider Reimbursement Issues

Some principles were envisioned originally as part of OHP but not incorporated fully into the plan. For example, the state made an initial commitment to pay providers fairly and to avoid shifting costs to providers as a way of balancing the budget. For a variety of reasons, following through on this principle has become increasingly difficult as the plan has grown. The general feeling is now that physicians are not being paid fairly and that payments cannot be further reduced. Hospitals appear to be doing better than physicians, but still claim to be losing money on Medicaid patients. There are some physician reimbursement issues, but physicians generally tend to support OHP because it has increased access to care for many patients. OHP also means that, while there is less reimbursement for some patients, there are more patients with at least some degree of coverage.

Business Case

To gain support for OHP within the business community, the state presented the program in terms of an "investment" that would lead to financial benefits. The state argued that OHP would leverage federal funds to finance care for the poor and medically needy rather than just shift costs to private payers. However, businesses did not experience actual reductions in private insurance premiums. As a result, businesses may be wary of supporting new public coverage expansions, although a state purchaser coalition still supports the concept of OHP.

Managed Care Issues

Although OHP further encouraged the development of managed care in Oregon (particularly in expanding managed care outside the Portland/Salem area), at least initially, the delivery system relied too heavily on the willingness of managed care companies to expand outside metropolitan areas. Managed care plans did at first expand across the state, but they soon started to pull out of less-populated areas. Initially, managed care rates paid by the state for OHP members were set based on cost, and that policy helped ensure plan participation. However, over time, plans have begun to conclude that reimbursement rates are no longer sufficient because of the rising costs of providing care. This has contributed to the withdrawal of several plans from OHP. For example, Regence Blue Cross Blue Shield withdrew in May 2001, Kaiser has only limited enrollment, and Providence withdrew for a period, although they now are preparing to reenter OHP.

CareOregon has now absorbed many OHP patients who were enrolled in the other plans, particularly in the Portland/Salem area. CareOregon, a fully capitated managed care plan, began in 1994 as a collaborative partnership between the Multnomah County Health Department, Oregon Health Sciences University, the Clackamas County Health Department, and private nonprofit community and migrant health centers across Oregon. Initially, the Multnomah County Health Department administered the plan, but since 1997, CareOregon has operated as an independent nonprofit organization. Although state policymakers originally thought that the need for CareOregon would disappear as commercial plans developed Medicaid managed care capacity, CareOregon has grown as other plans have pulled out and has developed a collaborative relationship with the state. In addition to CareOregon, the state relies heavily on locally organized and locally controlled Independent Physician Associations (IPAs), and more and more physicians are forming IPAs to meet the increasing demand. In addition, commercial plans do still participate in OHP, although in a more limited way than they did initially.

Employer Mandate

When OHP was first conceived in the late 1980s, it included an employers' mandate to provide health coverage to their workers. At that time, the primary focus was on large- and medium-sized employer groups. However, by the time Oregon had received a federal waiver and set out to implement the plan, the focus had shifted to smaller employers who were concerned about the prospect of an employer mandate. There were also concerns that the mandate would violate the federal Employee Retirement Income Security Act (ERISA).¹¹ The composition of the state legislature had also changed. The house was now controlled by Republicans, the Democrats had only a narrow margin in the senate, and, perhaps most important, John Kitzhaber was no longer president of the senate. President Clinton's health plan was also on the horizon. The legislature decided to delay implementation of the employer mandate until 1996 and make it contingent on obtaining a waiver from the federal ERISA laws. When the state failed to obtain the exemption, the employer mandate was subject to a sunset provision.

Although the employer mandate was never implemented, there was still support for employers voluntarily providing access to coverage. Small businesses were resistant to the mandate, but appreciated the willingness of the state to help their employees afford coverage. Out of this, in part, came FHIAP.

¹¹ ERISA, enacted in 1974 to protect workers' pensions, gave employers the right to self-insure and be free of state insurance regulations.

Obstacles and Issues: Family Health Insurance Assistance Program

Waiting List

One of the critical distinctions between OHP and FHIAP is that, because FHIAP is entirely state-funded and there is limited money available, FHIAP is a “capped” program and can only provide subsidies for a limited number of people. (OHP is now an entitlement program that covers anyone who is eligible.) Because of the program’s popularity, over 26,000 people were on the FHIAP waiting list as of March 2002. Although marketing of the program ended in 1998 because of the large demand, the state still receives between 1,000 and 1,500 applications per month.

In addition to being unable to meet demand and leaving people without coverage, the long waiting list means that FHIAP cannot be a vehicle to provide continuous coverage for people leaving OHP. When FHIAP was initially conceived, it was intended to provide a smooth transition for people who lose their OHP eligibility, allowing them to maintain continuous coverage. Although people generally must be uninsured for six months before they can apply for FHIAP, this waiting period is waived for those who have been enrolled in OHP. When OHP enrollees are about to lose eligibility, they receive a letter notifying them of their change in status and telling them about FHIAP. However, when they sign up for FHIAP, on average, there is about a 12-month waiting period before people who apply can enroll.

Market Split

FHIAP has been struggling to attract enrollees who have access to employer-sponsored coverage. One FHIAP requirement is that, if an applicant is offered employer coverage with the employer contributing some portion of the premium cost, the applicant must participate in that coverage to be eligible for the subsidy. Thus, subsidizing people who have access to employer-sponsored insurance is more cost-effective than covering those without such coverage. However, about 85 percent of FHIAP enrollees purchase coverage in the individual market and only about 15 percent have state-subsidized employer-sponsored coverage.

Family Health Insurance Program/Oregon Medical Insurance Pool Enrollees

Another issue facing FHIAP is that about one-quarter of FHIAP enrollees are enrolled in OMIP. These enrollees are high-risk individuals who are unable to obtain insurance in the private market and who use their FHIAP subsidy to participate in an OMIP plan. Because insurers subsidize the high-risk pool through an insurer assessment and pay based on a certain number of enrollees, their assessment increases as more individuals are enrolled in OMIP. As a result, insurers believe the state is shirking its responsibility to high-risk

FHIAP enrollees and forcing the private sector to absorb some of that cost of care, which insurers believe should be wholly covered by the state. This situation has created insurance industry opposition to further expansion of FHIAP.

Looking Ahead: A New Approach

The Oregon Health Plan—Current Initiative

Oregon is now in a bind. State policymakers have committed philosophically to covering people based on income and have developed a process to do so using the prioritized list, which they initially believed could be used as a tool to control costs. However, the federal government has been reluctant to allow the state to reduce the benefit package. As a result, Oregon believes that using a prioritized list has ceased to be a meaningful way to control costs in the current OHP. It also appears, in light of the state's current fiscal situation, that OHP is not sustainable in its current form. In response, the legislature passed House Bill 2519 in the 2001 legislative session. House Bill 2519 outlines several major changes to OHP that would expand coverage to more people but reduce the benefit package for certain groups to generate savings to fund that coverage expansion and to ensure the long-term survival of OHP. To implement these changes, in May 2002 the state submitted an amendment to their current Section 1115 waiver as well as a Health Insurance Flexibility and Accountability (HIFA) waiver application.

Because federal law has less flexibility regarding the federally mandated eligibility categories (pregnant women, children, elderly, blind, and disabled populations), the new waiver applications divide the current OHP population into several subgroups (Table 4). Categorically eligible populations will now be enrolled in OHP Plus and retain the same set of benefits that they currently have. All adults who qualified for OHP on the basis of income only will be switched into OHP Standard, which has a less generous benefit package. Oregon estimates that about 130,000 current OHP enrollees—nondisabled adults—will be switched from OHP to OHP Standard. In addition, the waivers expand coverage in OHP Standard to people with incomes between 100 percent and 185 percent of the FPL. The state is estimating that an additional 65,000 people will be newly eligible for coverage under the two waivers when they are fully implemented.

Oregon wants OHP Standard to be similar to private commercial plans. As expected, the discussions about which services should be in the benefit package have been lively. The benefit package outlined in the waivers introduces varied levels of copayments and coinsurance intended to encourage primary and preventive care and to discourage the inappropriate use of other services. In addition, there will be some reductions in covered services, such as nonemergency transport. The state is also trying to encourage more

effective treatments and is covering potentially expensive regular costs (for example, introducing lower copayments in OHP Standard for recurrent durable medical equipment costs such as oxygen or diabetic supplies than for one-time expenses such as crutches). Part of the state's philosophy is to focus OHP Standard on "access promotion" rather than "asset protection." Access promotion would structure the coverage to encourage the use of primary and preventive care services, rather than protect the enrollees' assets in the case of severe illness or a catastrophic event.

Policymakers in Oregon worked with stakeholders to determine where the line should be drawn for the OHP Standard benefit package. They estimated that the actuarial value of the OHP Standard package should be equivalent to about 78 percent of the actuarial value of OHP Plus. The waiver steering committee recommended where to draw the line, with final approval needed from the emergency board (a representative group from the legislature). Following this step, the state has submitted two federal waiver requests to allow them to implement the plan. Under these waivers, in addition to the changes to OHP, the state is hoping to obtain a federal match for FHIAP.

Table 4. Proposed Changes to OHP from May 2002 Waiver Applications

| Current Eligibility Categories | Current Program/ Benefit Package | Proposed Eligibility Categories | Proposed Benefit Package |
|--|-------------------------------------|---|--|
| Oregonians < 100% FPL | OHP (Medicaid) | “Vulnerable populations”—mandatory federal categories (children, pregnant women, categorically eligible adults) | OHP Plus—entitlement |
| Children birth to 6 < 133% FPL | OHP (Medicaid) | “Adult population”—adults who qualify based on income only | OHP Standard—capped |
| Pregnant women < 170% FPL | OHP (Medicaid) | Same | OHP Plus—entitlement |
| Children birth to 6 between 133% and 170% FPL* | OHP (CHIP) | Same | OHP Plus—entitlement |
| Children 6–19 between 100% and 170% FPL | OHP (CHIP) | Same | OHP Plus—entitlement |
| Pregnant women & their newborns 170%–185% FPL | Not eligible | OHP Plus (1115 Waiver) | OHP Plus—entitlement |
| Children birth to 19 170%–185% FPL | Not eligible | OHP Plus (HIFA) | OHP Plus—entitlement |
| Oregonians < 170% FPL | FHIAP | “New eligibles” | OHP Standard—capped** |
| Oregonians between 170% and 185% FPL | Not eligible | | <i>or</i> FHIAP (up to 170% FPL)*** |

* Newborns in this income group are funded through Medicaid.

** OHP standard enrollment will be expanded initially up to 110% of the FPL, then moved up by 15% income bands as budget allows, giving priority to parents of CHIP and poverty-level Medicaid children and current clients moving over the upper-income limit of the OHP standard.

*** FHIAP will expand by about 9,500 in the group insurance market and then will open individual insurance. At that time, enrollment in individual insurance will be restricted to keep it approximately equal, from a State General Fund perspective, with group expansion.

Sources: Oregon HIFA application submitted May 31, 2002 and Oregon Section 1115 Waiver Amendment Application submitted May 31, 2002.

Consumer advocates were concerned that the coverage expansion initiative meant that there was less stakeholder and public involvement in the initiative than when OHP was first introduced. This may prove to be problematic if the waivers are approved and Oregon must rely on those same stakeholders to implement it. For example, one of the features of OHP Standard is a \$250 deductible on inpatient hospital stays. However, many of these low-income OHP Standard enrollees will not be able to afford this deductible, and many hospitals have informally agreed to charity care policies that would waive the deductible anyway.¹² As a result, the hospitals view some of the recommended cost-sharing provisions as merely a way of shifting costs to them. If providers believe that unreasonable cost-sharing has been imposed, they may be less willing to see OHP Standard patients for nonemergent care. Adding a new population of enrollees may also shift the risk profile of OHP enrollees, affecting managed care reimbursement rates in a situation in which providers (safety net providers and others) already are concerned they are not compensated adequately.

In addition to concern on the part of providers that the copayments represent a shifting of costs to them, there is a concern among some policymakers that high copayments will discourage people from seeking necessary care. About 60 percent of adults now qualify for OHP based solely on income, and many of those adults have incomes below 50 percent of the poverty line. It may be unreasonable to expect any level of cost-sharing from these enrollees. Other policymakers, worried about some of the cuts in benefits, believe there should have been a broader benefit package with even higher copayments. Another issue that worries consumer advocates and managed care plans is managed care capacity, particularly in the Portland area. As discussed above, most health plans have withdrawn from the OHP market, although both commercial and safety net plans do still participate in OHP. As OHP prepares to expand, it is unclear whether the remaining plans can absorb the new enrollees, particularly because most of the burden will fall on CareOregon, which has just jumped from about 40,000 enrollees to close to 90,000 in the wake of Regence pulling out of the market. Portland/Salem is not currently a mandatory managed care area for OHP enrollees; there are about 30,000 “open card,” or fee-for-service enrollees. These enrollees need to be absorbed into managed care before newly eligible persons are enrolled. If managed care plans are not able to enroll the newly eligible individuals, this group will not have access to primary care providers and be forced to seek care at emergency rooms or find providers willing to see them at Medicaid fee-for-service rates. Now, about 72 percent of OHP enrollees are in managed care (including fully capitated health plans and primary care case management); the goal is to reach 82 percent.

¹² For example, many hospitals write off all charges for people with incomes below 150 percent of the FPL, and only charge 50 percent for people with incomes between 150 percent and 200 percent of the FPL.

To accomplish this, the state plans to increase managed care enrollment through the following steps: identifying individuals who are not enrolled in managed care and should be enrolled; modifying the state's information system to allow members to remain in a plan when they move to a new area served by that plan; providing technical assistance and expansion assistance; holding regional meetings around the state with plans and caseworkers; and sending notices to all field staff about the benefits of managed care. Other strategies include continued work on administrative streamlining and adequate capitation rates for the plans and the introduction of copayments for the fee-for-service population, which the state expects will serve as an incentive for members to join managed care organizations.

Although many advocates are angry at the idea that benefits will be reduced for a subset of OHP population, the state still strongly believes in OHP's original philosophy of giving a greater number of people some basic level of benefits. The state argues that no one is advocating on behalf of the uninsured. The question, given the concerns about managed care capacity, is whether the state will actually be able to expand coverage to the newly eligible population or, instead, if benefits for the currently insured will be reduced with no concurrent coverage expansion.

Health plans are also concerned about how to handle the two benefit packages, OHP Standard and OHP Plus, and how to educate providers and enrollees about the two packages. The state will need to strike a balance between keeping things administratively simple and ensuring that enrollees are in the right plan. Equity issues also arise; under OHP, some groups have less generous coverage than others with higher incomes (e.g., a childless adult at 10 percent of the FPL has a less generous package than a pregnant woman at 125 percent of the FPL). Much change occurs in the OHP population as personal incomes fluctuate and people gain or lose eligibility for assistance or access to employer-sponsored coverage. Adding a new benefit package may make tracking these enrollees even more complicated. Finally, OHP Standard will now be a capped program; some who qualify for coverage may not be enrolled in the plan.

Primary Challenges and Lessons for Other States

In considering Oregon as a model for other states, it is important to remember that many of the hard choices the state must now make are direct results of choices that were made when the plan was established.

All states have only limited ways to finance coverage expansions without introducing new resources from outside the health care system (e.g., new taxes or tobacco settlement funds). States can trim the benefit package, raise cost-sharing, cut payments to

health plans and providers, search for efficiencies through better managed care, pull in more matching funds, or redirect existing subsidies such as disproportionate share hospital payments. In their most recent coverage initiative, Oregon decided to remain focused on trimming benefits, giving some attention to introducing more managed care and increasing copayments. Payment rates have been left mostly untouched out of concern for exacerbating the problem of plan withdrawals. Oregon initially had a rich benefit package under OHP (amendable as needed), but it is now limited in what it can do by federal law and is locked into a benefit package that it no longer believes is affordable.

The state believes that OHP never really rationed care: one-third of the services excluded from the benefit package are common exclusions in commercially available policies; one-third are commonly denied because insurance companies believe they are not medically necessary services; and the remaining third, the state maintains, are for services that are ineffective (for example, treating viral infections). While some are concerned that the discussions about the benefit package resemble discussions about commercial insurance rather than about the most appropriate public benefit package for low-income enrollees, the state believes it is not unreasonable to use the private group market as a model. Oregon also believes that, because a program like FHIAP relies on the private market to provide benefit packages, the state should be able to continue this arrangement, rather than be forced to amend the FHIAP benefit package to receive a federal match.

The state also has committed to a coverage expansion. However, by one account, OHP was 18,000 people over its limit three months into a two-year budget. Some argue that funding must be stabilized for the current program before further expansion. Others argue that it would make sense to evaluate what benefits could be reduced and what cost-sharing could be imposed without doing any harm, and then see how many additional people could be covered. Some believe that the state has decided instead that it wants to cover a certain number of additional people and then determine what benefits to cut to fund the expansion. Either way, it appears that as long as Oregon is interested in amending the generosity of benefits to generate additional revenue, and as long as the current federal guidelines apply, Oregon has little choice but to couple a coverage expansion with a benefits reduction for noncategorical populations. In the context of OHP, a coverage expansion that involves introducing capped enrollment for the noncategorical population is a significant change.

In addition to the decisions related to OHP, state budget characteristics also exacerbate Oregon's current fiscal situation. First, the state has no sales tax. Second, the legislature is bound by a law preventing the state from having more than a 2 percent

budget surplus; additional revenue must be returned to the taxpayers. As a result, even though until recently Oregon had a booming economy, the state has few reserves to sustain itself in an economic downturn. If Oregon does not want to change state law to generate additional revenue (and there is little or no discussion about doing so), few options exist to pay for programs such as OHP.

In conclusion, several things can be learned from Oregon's experience in attempting to extend coverage while limiting benefits. First, the process hinged on a public and transparent discussion of priorities. This took a great deal of time and investment and is ongoing. In the end, this public discussion might be unsustainable because of the effort involved and the political capital expended to implement the program "democratically." Second, federal structures have not historically been flexible in accommodating this sort of approach. Finally, the evidence-based benefits list may be of only limited value in reining in costs over time. Even with the list, Oregon is experiencing the same upward trends in costs experienced by other states. Oregon may now be reverting to a more categorical approach, in part because of what the state perceives has been a lack of federal flexibility toward further benefit reductions (although that may be less true under the new HIFA initiative), but also because it may be difficult to get additional cost savings through this approach and the state is concerned about increasing costs in OHP.

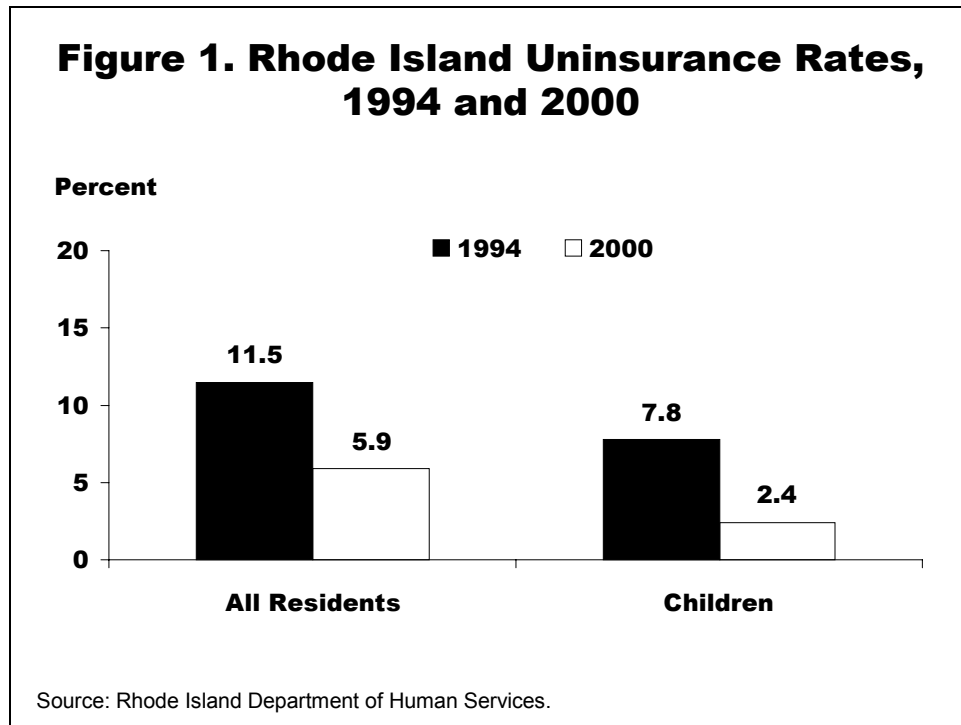
It appears there will be a budget crisis unless action is taken quickly. Governor John Kitzhaber appeared committed to having a five-year waiver in place that would implement the proposed changes to benefits and eligibility before he leaves office. However, the proposed changes cannot be implemented until the federal government approves the two waiver requests. It remains to be seen how the many issues raised above will be resolved to maintain one of the most concerted, sustained efforts by any state to provide their uninsured population with much-needed health care coverage.

RHODE ISLAND

The objective in studying Rhode Island was to determine the underlying forces that led to the development and successful multi-phase expansion of RItE Care, a joint Medicaid and CHIP program for low-income children, parents, and pregnant women. A specific goal was to examine the state's relatively new premium assistance program, RItE Share, to inform others about the impetus behind the program, its struggles, and how the state is addressing the difficulties of promoting private employer-based health coverage.

Summary

Rhode Island has achieved one of the lowest uninsurance rates in the U.S.: 5.9 percent in 2000 among all residents, and 2.4 percent among children. This is due primarily to the development and expansion of RItE Care, a combined Medicaid/CHIP managed care program that began in 1994 and has expanded incrementally to reach an enrollment that now exceeds 100,000 people. When the program was instituted in 1994, Rhode Island's rate of uninsurance was 7.8 percent for children, and 11.5 percent statewide (Figure 1, Table 5). Rhode Island was also selected because it is a small, New England state, contributing to geographic diversity among case studies, and a prime example of a state that has pursued access expansion within one major public program, with central planning and coordination. While this is certainly not the only path to success, it provides other states with a blueprint for a centralized approach.



The case study's main findings involved the identification of certain essential elements that contributed to RItE Care's significant progress. Other states should seriously consider these elements as basic requirements, regardless of the precise model of access expansion they pursue. Among the key "ingredients" are a series of policy initiatives that were built around a clear mission: to improve the health of the population through major public policy reform. Political leadership from the top, backed by a staff with considerable expertise, helped translate the mission into workable programs. The use of data and outside experts strengthened the effort, while the inclusion of consumers, health plans, and other stakeholders in the design and implementation of the new programs helped to build

consensus and support. State support for a Community Health Center–based safety net health plan paid off when commercial plans left the market or refused to accept new RItE Care enrollees. Also, a willingness to make mid–course corrections helped the state government overcome obstacles and address new challenges. Finally, a strong economy in the late 1990s provided a favorable climate for coverage expansion.

The state did face a number of obstacles and unintended consequences, including early opposition by consumer advocates and health care providers, deterioration of the small–group insurance market, and a budget crisis resulting from soaring RItE Care enrollment. The ways that state officials addressed these issues—by creating a structure for input by various interest groups, implementing insurance market reforms, creating a stop–loss feature in contract arrangements with health plans, and instituting modest premiums—provide important lessons for other states.

But the greatest challenge lies ahead, with severe budget constraints threatening the state’s ability not only to expand access further, but also to maintain the gains achieved to date. An important part of this challenge involves shoring up employment–based coverage through the RItE Share premium assistance program. RItE Share pays all or part of low–income employees’ share of the premium under employer–sponsored health coverage. Overcoming administrative difficulties and addressing employer concerns (particularly during a recession) have already led to adjustments in design, including one provision to bypass the employer entirely and another to make RItE Share participation mandatory. Nevertheless, officials acknowledge that this program remains a “work in progress.”

Table 5. Rhode Island State Profile and Overview, 1999–2000

| Rhode Island | |
|-------------------------------------|---------|
| Total Population | 958,440 |
| Nonelderly Population (Under 65) | 813,690 |
| Total Population under 200% FPL | 288,030 |
| Uninsured Nonelderly under 200% FPL | 42,472 |
| Percent of uninsured | 74% |

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (www.statehealthfacts.kff.org).

Background

In 1994, Rhode Island implemented RItE Care, a fully capitated Medicaid managed care program for “Family Independence Program” families (former AFDC families) and certain low–income women and children. The goal was to increase access to and delivery of

primary and preventive health care for low-income populations while slowing the annual escalation of costs for these populations.

An important element of the Rite Care system was that it permitted the gradual expansion of eligibility for the program. Originally enacted in 1994 under a Medicaid Section 1115 Demonstration waiver, Rite Care since has expanded eligibility through several amendments to include pregnant women and children up to age 19 in families with income up to 250 percent of the federal poverty level (FPL) and parents with income up to 185 percent of the FPL. Care for portions of this population (children ages 8–18, parents between 100 and 185 percent of the FPL, and pregnant women between 185 and 250 percent of the FPL) is funded through the Title XXI State Children’s Health Insurance Program (CHIP).

The 1995–97 period was focused on shoring up the program. This included gaining the trust and support of consumers and advocates, adjusting the rate structure to reflect more accurately costs and secure provider participation, broadening benefits, instituting performance standards and an evaluation component to measure improvement in health outcomes, passing administrative reforms that would streamline the enrollment process (e.g., removing face-to-face interviews, allowing mail-in applications), and making other efforts to stabilize Rite Care.

This period was followed by several years dedicated to expanding access (1997–99). The state expanded coverage for parents through a Section 1931 Medicaid State Plan Amendment, incrementally expanded eligibility to children up to age 19 and up to 250 percent of the FPL, and implemented a major enrollment drive facilitated by federal funds dedicated to outreach.

By 1999–2000, however, a number of factors combined to bring Rite Care to the brink of crisis. The successes of the expansion efforts resulted in the swelling of the Rite Care rolls and budget well beyond projections (this was complicated by increasing Medicaid costs for the elderly and disabled). There were complaints that some of the new enrollment in Rite Care represented “crowd-out,” or substitution of public coverage for private insurance, as low-income workers dropped their employer-sponsored coverage to enroll in Rite Care.¹³ There was also major instability in the commercial insurance market. Double-digit premium increases in 1999 and 2000 threatened the continuation of employer-sponsored insurance, particularly for small businesses and low-wage workers.

¹³ One health plan estimated that 20 percent of its new Rite Care enrollees previously had private coverage.

Two of the five existing health plans in Rhode Island abruptly left the state in 1999, leaving 150,000 residents without coverage, including 7,000 RItE Care enrollees.¹⁴ Two other health plans stopped taking new RItE Care enrollees, leaving a sole remaining health plan (a community health center-affiliated, Medicaid-only health plan) to absorb new enrollees.

In response to the impending crisis, Governor Lincoln Almond convened a health care working group that resulted in the enactment of Health Reform Rhode Island 2000 in July of that year. This legislation, intended to make the private insurance market a more viable option for low-income people (and in essence relieving some state budgetary pressures), included: 1) creating RItE Share, a combined Medicaid/CHIP premium assistance program for RItE Care-eligible people who had access to employer-sponsored health coverage; 2) introducing cost-sharing for RItE Care and RItE Share enrollees with incomes above 150 percent of the FPL; 3) reforming the small-group insurance market, including rate stabilization; and 4) creating stronger financial solvency accountability standards for health insurers.¹⁵

Developed as a “marriage between employer-sponsored coverage and publicly sponsored coverage,” RItE Share was intended to reverse crowd-out, save the state money by tapping employer contributions, and promote private, employment-based insurance. RItE Share was implemented in February 2001, but early enrollment had been very slow. The state responded by making some administrative and design changes that have increased participation by low-income working families. State officials and others acknowledge, however, that this important component of Rhode Island’s access initiative presents significant challenges.

Whereas Rhode Island was approved (through a Medicaid Section 1115 waiver) to impose both copayments and premiums on enrollees with incomes above 110 percent of the FPL, it chose to implement only premiums (\$43 to \$58 per month) for enrollees above 150 percent of the FPL. State officials preferred not to erect a financial barrier at the time a health service was needed; they also viewed premiums as a more dependable, quantifiable source of revenue for the program. Consumer advocates are concerned, however, that even this modest cost-sharing may be overly burdensome to some people

¹⁴ The two health plans that left are Harvard Pilgrim Health Care of New England and Tufts Health Plan of New England.

¹⁵ Waiting periods before enrollment into RItE Care were passed but not implemented. Waiting periods are regarded as a last resort because they are seen as forcing families without access to affordable coverage into periods of uninsurance before they can get public coverage or subsidies for commercial coverage.

and lead to disenrollment. The state is monitoring the impact of the premiums, which began in January 2002.

The small-group insurance market reforms included adjusted community rating intended to reduce variability in premiums. As a result, some small businesses face higher premiums while others are better off than they were before, generating pressure from business and the insurance industry to retract the changes. Again, the state is conducting sample audits to assess the impact.

The final piece of the 2000 health reform legislation was to ensure the financial accountability of the health plans operating in the state. Rhode Island adopted stronger financial solvency standards, based on National Association of Insurance Commissioners (NAIC) recommendations, for all licensed health plans.

At about the same time, RIte Care increased reimbursement rates to adjust for the recent influx of parents, an older and more expensive population than children, and to encourage all plans to open their rolls to new enrollees to meet federal requirements regarding member choice.

Rhode Island is currently involved in a project to design an effective and comprehensive plan—building on the RIte Care/RIte Share base but not bound by it—to ensure access to health care coverage for all Rhode Islanders. This initiative, funded by two separate grants from private foundations, provides state officials with flexibility to think creatively about possible ways to reach the remaining 65,000 uninsured Rhode Islanders.¹⁶ Administrators hope to halve Rhode Island’s already low uninsurance rate by 2004. The major obstacle to achieving this goal, as well as the primary challenge to Rhode Island’s progress in expansion of access to date, is maintaining funding during an economic slowdown. Table 6 summarizes the current RIte Care and RIte Share programs.

¹⁶ Funded by grants from the Rhode Island Foundation and the Robert Wood Johnson Foundation (RWJF) under State Initiatives in Health Care Reform (from January 2000 to December 2002) and from RWJF’s State Coverage Initiatives Health Care Program (from January 2002 to December 2004).

Table 6. Rhode Island Current Access Programs

| | RItE Care | RItE Share |
|-------------------------------|--|---|
| Program type | Managed care Medicaid and CHIP combination | Premium assistance program for Medicaid and CHIP-eligible individuals and families with access to employer-sponsored health insurance; mandatory enrollment |
| Waivers, legislation required | State legislation and amendments Medicaid 1115 Demonstration approved in 11/93, extension approved 9/98 Medicaid Section 1931 State Plan Amendment in 1998 Title XXI CHIP 1115 waiver 1/01 | State legislation: Health Reform Rhode Island 2000 1906 Medicaid State Plan Amendment |
| Time frame | Began enrollment in 1994; federal waiver expires in 7/02, but program is expected to continue | Began 5/01, expected to continue |
| Enrollment (as of 8/31/02) | 116,778 enrollees (including 1,989 substitute/foster care children) | 2,148 enrollees |
| Eligibility Criteria | Uninsured parents with children under age 19 up to 185% FPL Uninsured pregnant women and children under 19 from families with incomes up to 250% FPL Licensed family child care providers who care for children enrolled in DHS's subsidized child care program, and their children under age 19 | Meets RItE Care income criteria (parents to 185% FPL, children and pregnant women to 250% FPL) and has access to employer-sponsored health insurance |
| Benefits and/or Subsidies | Comprehensive medical and mental health coverage plus enhanced services such as home visits, nutrition counseling, and smoking cessation classes Services in prior FFS Medicaid plan that are not included in the prepaid RItE Care plan (e.g., long-term care, dental care) are provided and reimbursed on a FFS basis Window replacement to reduce exposure to lead is provided on an out-of-plan basis for lead-poisoned children | State pays the employee's share of family coverage, copays, and wrap-around coverage for Medicaid benefits not in employer's health plan |
| Financing | Federal Medicaid and CHIP funds, state Medicaid and CHIP contributions, state-only funds (for undocumented children and others who do not meet federal criteria) 1/02 began charging premiums to members above 150% FPL | Federal Medicaid & CHIP funds, state Medicaid & CHIP contributions 1/02 began charging premiums to members above 150% FPL |

Elements that Facilitated Development

Rhode Island's approach to increasing access to health care can be viewed as a planned incremental strategy combining expansion of public and private coverage with initiatives to improve direct access to primary care services and a corresponding attempt to reduce inappropriate care. To implement this multifaceted strategy in a cost-effective manner, the state relied on a managed care model and integrated the activities of various state departments and agencies. The state's relative success in reducing the number of uninsured and improving health-related outcomes can be attributed to the following factors.

Political Leadership and Expertise

Strong leadership in the governor's office, the legislature, and the state agency that administers the program has been critical to RItE Care's implementation and success.

RItE Care was first introduced under Democratic Governor Bruce Sundlun's administration in the early 1990s. Considered by many to be visionary, Sundlun championed the program and fostered a coordinated effort between the governor's office and the legislature, where there was considerable support for initiatives for children's health among both Democrats and Republicans. It has been noted that the "far right," which sometimes fights the expansion of public programs, has not been an influential player in Rhode Island. When Republican Governor Almond was elected in 1994, the implementation of RItE Care was well under way. The new governor was fully supportive of the program and continued its implementation.

Strong leadership also was evident at the State Department of Human Services (DHS), which was ultimately named the agency responsible for the RItE Care program. Christine Ferguson, Governor Almond's appointee for director of the DHS, was widely viewed as a politically savvy, extremely effective administrator and advocate of RItE Care throughout her six-year tenure. Similarly, Tricia Leddy, the administrator for DHS's Center for Child and Family Health, which directly administers RItE Care, is widely praised for her knowledge and administrative expertise—another key factor in the program's success.

Strong leadership also was credited with the decision to convert fully from fee-for-service Medicaid to managed care in one step, rather than moving incrementally to a primary care case management model. The risk of the latter approach was that the state could have gotten "stuck" at that interim stage because of political or financial pressures. In addition, the many expansions of RItE Care and the development of RItE Share depended on political leadership and solid knowledge of the federal waiver process.

Clearly Defined Mission

The development and implementation of RItE Care were facilitated by the state's clearly defined goal that children should enter school ready to learn and leave school ready to become active and productive members of society. In this framework, access to health coverage and appropriate health services for children, like a good education, is central to the development of "human capital." Expanding health care coverage to lower-income children and their parents was viewed as an "investment" that would pay subsequent social "dividends."

Placing RItE Care in this framework helped build bipartisan support for the program. Aided by seed money from private foundations to bring various players together, collaboration on RItE Care was achieved around a common goal. The effort led to the development of a number of public programs in other agencies and departments as well. In the same spirit, the state formed a "Children's Cabinet" in the early 1990s. This cabinet still meets regularly, and includes the governor, directors of all departments that are related to children's well-being (Human Services; Education; Children, Youth and Families; Mental Health Retardation and Hospitals; Health; and Administration), and representatives from both houses of the legislature. The cabinet helped establish common goals while acknowledging that incremental steps were needed to reach those goals. This effort was successful in building support among policymakers as well as the public.

Good Economic Climate

The economic boom of the 1990s was a necessary factor in the implementation and expansion of Rhode Island's health care access programs. State budget surpluses gave planners and legislators the latitude to experiment with new approaches and focus on expanding access and improving outcomes, rather than solely on containing costs. Leaders of the effort acknowledged that they would not have been able to implement and expand RItE Care during an economic downturn. In fact, there is widespread concern about Rhode Island's ability to sustain the significant gains achieved as budgets become tighter.

Expertise of Consultants and Management Firm

Both the use of consultants while developing RItE Care and RItE Share and the ongoing contracts with a management firm to perform many administrative functions are viewed by administrators, in retrospect, as being invaluable to RItE Care's success.

A Health Care Financing Administration (HCFA)—now Centers for Medicare and Medicaid Services (CMS)—Section 1115 waiver approval requirement that the state engage in a management contract resulted in DHS contracting with a consulting firm to

help administer RIte Care.¹⁷ Officials suggested that this requirement ensured that adequate resources were relegated to key management functions. They have been very pleased with the firm's expertise in developing rates and contracting with health plans, providing oversight and monitoring of health plan contracts, monitoring utilization and expenditures, coordinating federal matching funds, and other administrative tasks. The consultants are integrated into DHS's operations and even occupy offices in DHS buildings.

DHS also contracted with a local health services research firm to conduct research and evaluation activities required under the waiver.¹⁸ Program evaluation studies are conducted in close partnership with health service researchers at Brown University.

Additional technical assistance was obtained when developing Health Reform Rhode Island 2000 (under a State Initiatives in Health Care Reform grant) and specifically in the implementation of RIte Share.^{19,20}

Apparently "Simple" Structure

Rhode Island expanded state health care coverage through a joint Medicaid/CHIP program, and this concentrated focus contributed to its success, according to the program's administrator. Such an approach contrasts with the multilayered strategies taken by many other states that involve a combination of high-risk pools, premium subsidies, Medicaid expansion, separate CHIP programs, and other initiatives. Rhode Island officials did not dismiss the latter approach as being ineffective, but preferred a more consolidated effort.

Moreover, RIte Care—by design—appears to be one uniform program to the public. Consumers are blind to the complex and multiple financing sources and to the fact that many categories of enrollees are approved under various waivers, amendments, or legislation. There is one application form, regardless of whether the applicant meets criteria for Medicaid, Medicaid-expansion, CHIP, CHIP waiver, or none of these categories. Each population must be tracked separately "behind the scenes" for the state to obtain appropriate federal funding. Depending on the category, the federal government contributes at the regular Medicaid matching rate, the enhanced CHIP matching rate, or not at all, as in the case of undocumented immigrants who are financed by state-only dollars. Rhode Island is one of the few states that has attempted to enroll undocumented immigrants, who are normally left without coverage options. This illustrates the state's

¹⁷ The firm is Birch & Davis/ACS.

¹⁸ MCH Evaluation, Inc.

¹⁹ A Robert Wood Johnson Foundation-funded initiative administered by the Academy for Health Services Research and Health Policy.

²⁰ Among the consultants that provided technical assistance were the Institute for Health Policy Solutions and the Center for Studying Health System Change, both based in Washington, D.C.

commitment to reach hard-to-serve groups even when no federal financial assistance is available.

Unlike RItE Care, the RItE Share program has been perceived as overly complex, contributing, at least in part, to the low participation rates by employers. The state is trying to address this problem in a number of ways, discussed below.

Involvement of Consumers and Consumer Advocates

When RItE Care was first designed in the early 1990s, consumer advocates were very resistant to the managed care aspect of the program, fearing problems such as inadequate access to services, bureaucratic hassles and denials of care. Community members got together and requested the establishment of a consumer advisory group. DHS, aware of both significant public concern about RItE Care and a perception that DHS did not “listen” to its constituents, established a Consumer Advisory Committee in 1995 and invited public participation in the meetings. Both consumers and consumer advocates have been attending the meetings and continue to be actively involved. It was important that state officials made great efforts to listen carefully and respond to the concerns voiced by consumers.

This advisory process was instrumental in transforming consumer advocates from opponents of the public program to partners with DHS in determining the program’s evolution. When it was clear that managed care was inevitable, for example, advocates worked with the state to establish some patient safeguards. By 1996–97, consumer advocates were asking the legislature to expand RItE Care coverage to parents and child care providers.

Consumer advocates continue to be concerned about various aspects of and changes in the program. For example, they are currently apprehensive about the level of premium contributions required from RItE Care enrollees (\$43 per month). They see their role as raising unvoiced issues and concerns with the state.

In addition to the Consumer Advisory Committee, the RItE Share Business Advisory Committee is intended to provide the state with feedback from the business community and involve employers in the process of shaping RItE Share. Unlike the consumer group, however, some of these committee members perceive that their concerns are not being adequately addressed.

Incorporation of Safety Net

The fact that the state incorporated community health centers (CHCs) into the Medicaid managed care program appears to be another important factor in RIte Care's success. It also was critical to the survival of an integral part of the safety net in Rhode Island.

Rhode Island's CHCs were doing well under the fee-for-service Medicaid program. When RIte Care was being developed, the CHCs understood that they needed to be involved as managed care providers to remain viable and to continue serving low-income and uninsured clients. With the support and encouragement of DHS, the CHCs formed the Neighborhood Health Plan of Rhode Island (NHPRI), the only provider-sponsored health plan in the state. NHPRI serves the Medicaid population almost exclusively and currently covers about 60 percent of RIte Care enrollees.

The state entered into a risk-sharing agreement with NHPRI, thus protecting the plan from potential collapse when it was in financial crisis in 1997. An advantageous outcome of this arrangement was that the state gained access to additional information about costs, utilization, and other aspects of health care. NHPRI also works with the state to serve hard-to-reach populations; for example, NHPRI enrolled 2,000 foster children who had been on fee-for-service Medicaid and is working effectively in partnership with the state to address and meet the special needs of this population.

There are mixed views about maintaining a CHC-based health plan. Some private primary care physicians view the CHCs as giving lower-quality care than private practices, and object to the high incidence of self-referral within the safety net network that prevents effective mainstreaming of the RIte Care population. Others, however, cite the advantage of enabling much of the target population to maintain their regular source of care while opening up new private options as well. Supporters also note the CHCs' long experience working with low-income populations. In fact, Rhode Island's CHCs have a better record than private practices of providing lead screening and timely childhood immunizations to RIte Care children.²¹ NHPRI is rated "Excellent" by the National Committee for Quality Assurance, its highest rating for quality.

Finally, NHPRI was always "open" when other health plans either permanently or temporarily closed their doors to RIte Care enrollees because they considered the

²¹ Vivier, Patrick M., et al., "A statewide assessment of lead screening histories of preschool children enrolled in a Medicaid managed care program," *Journal of Pediatrics*, August 2001; and Vivier, Patrick et. al., "An analysis of the immunization status of preschool children enrolled in a statewide Medicaid managed care program," *Journal of Pediatrics*, November 2001.

reimbursement rates to be inadequate. Having NHPRI as a strong partner with the state was essential for the survival of the program.

Dedication to Improving Health

A key to Rhode Island's health care access expansion strategy was the state's dedication not merely to reducing the number of uninsured but also to improving health care. The state set performance standards for health plans serving RItE Care enrollees, collected data through ongoing evaluation studies, and took an interdisciplinary, comprehensive view of health care.

Setting Performance Standards

According to state officials, a turning point in the RItE Care program was when the state "took control" of quality of care by switching from a "passive" request for proposal (RFP) process to setting "bid specifications" with performance goals and incentives. The state defined what it wanted to purchase rather than just buying what the health plans chose to offer. For example, the state built into its contracts with health plans a performance award for certain outcomes, with the provision that a certain portion of the award must be passed on to physicians to encourage high-quality care. The performance measures included administrative, access, and clinical measures. The state also offers partial awards to health plans that display improvements on certain measures.

Initially, RItE Care set five specific health improvement goals that were selected as indicators of the program's success in improving access and quality (improved prenatal care, improved birth outcomes, increased inter-pregnancy intervals, increased childhood immunization rates, and decreased lead poisoning). These indicators are continually measured at the program level, often using public data. Contract-based performance measures brought quality improvement to a new level. With the use of health plan-specific encounter data and administrative data, the state could evaluate 25 measures of health quality and access at the individual plan level and focus effort and improvement on key areas. Further, because all of Rhode Island's health plans participate in RItE Care, it is assumed that the resulting improvement in quality care transfers to private patients as well.

One of the state's initial requirements of health plans participating in RItE Care was that the provider network must be the same as the network for private employer health plans. In that way, the state ensured that any physician taking private patients was required to take RItE Care patients as well. Although health plans initially balked at this requirement, and some physicians reportedly "get around" this rule and continue to discriminate against public enrollees, the precedent has been established and, overall,

Medicaid patients have had access to many more practitioners since RItE Care was enacted. Virtually all primary care physicians participate in RItE Care, whereas only one-third participated in pre-RItE Care Medicaid.

Collection and Use of Data

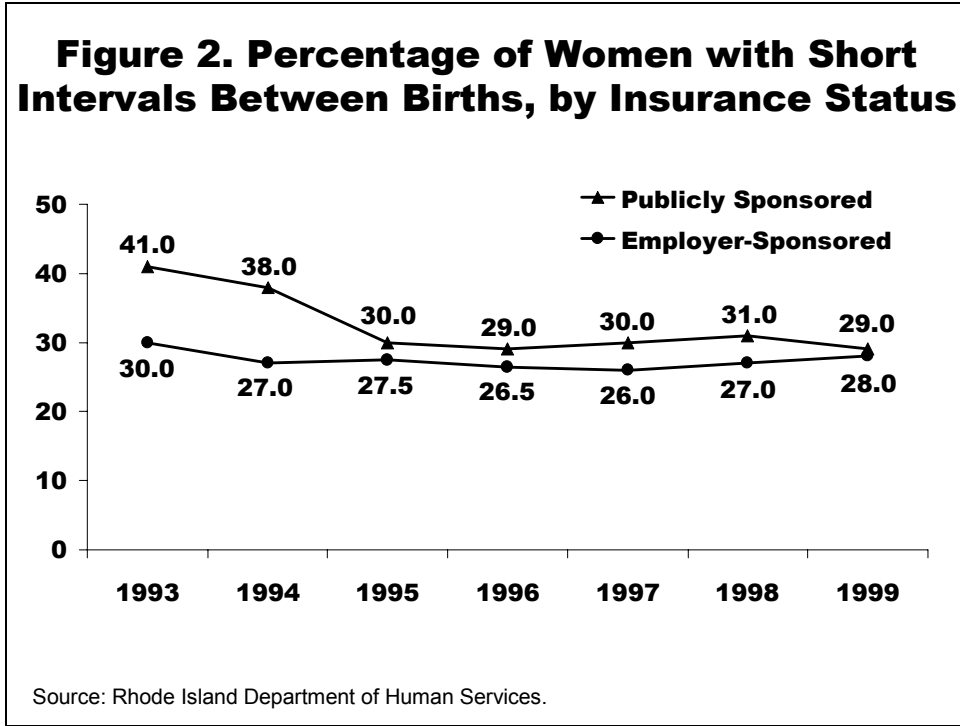
Rhode Island has been a leader among states in using data to monitor and improve health care as well as to publicize and build support for its access expansion program. Outcomes research was built into Rhode Island's initial Medicaid waiver. The state began collecting data in 1995–96 and had documented improved outcomes measured by consumer satisfaction by 1997. Since then, improvements have been demonstrated in many areas including prenatal care, birth outcomes, inter-birth intervals, lead screening, pediatric preventive care, and decreased emergency room use and hospital utilization.

There is a strong willingness to use data to inform key program decisions. For example, when data indicated very high neonatal intensive care unit (NICU) utilization, the state investigated and found that many babies who were not appropriate candidates for NICUs were nonetheless admitted to the units and remained in NICUs for long periods of time. In response, the state decided to carve this benefit out of those covered by the participating health plans, manage it by placing a staff person directly in the primary NICU in the state, and change the reimbursement structure. Although NICU admission rates have remained fairly constant, the length of stay has declined since these changes were made.

This example demonstrates how Rhode Island studied patterns of care, found overuse or underuse of services, and responded. Rather than accepting the status quo of the health care delivery system, they seek out ways to make the system more cost-effective and to improve outcomes.

Members of an interdepartmental evaluation team similarly use public health data to identify and solve problems and publish articles documenting research results. These data are being converted into a user-friendly format for “marketing” the program to potential enrollees, state legislators, and federal agencies. For example, Rhode Island has documented and publicized a marked reduction in the proportion of RItE Care women with short intervals (e.g., less than 18 months) between giving birth. An emphasis on family planning helped close the gap between publicly sponsored RItE Care enrollees and employer-sponsored insurance enrollees (Figure 2).

Consumer advocates now are concerned that, with people moving into employer-sponsored plans through RItE Share (from the RItE Care managed care plans), the state will lose its ability to track their health status and utilization patterns.



Comprehensive Approach to Health Care

RItE Care has been successful in large part because it looks beyond insurance to focus on the overall health of its target population. This philosophy emerges from the program’s early history. Planning for Rhode Island’s Medicaid managed care plan began as a partnership between the state’s Department of Health (DOH), which was interested in the expansion of coverage to uninsured children, and the Department of Human Services (DHS), which was interested in improving access to primary care for its existing Medicaid/AFDC families and decreasing the high use of emergency departments for routine care. When it was decided to house the program at DHS, many DOH public health officials transferred to DHS to administer the program. The two departments continue to have a collaborative relationship through the evaluation team, the Children’s Cabinet, and other joint projects. For example, the departments share data to facilitate DOH’s focus on the continuing gaps in access, such as in oral health care, despite enrollment in Medicaid.

The state’s comprehensive approach also is exemplified in its efforts to control lead-based paint. If a RItE Care child is diagnosed with lead poisoning, the state conducts a lead abatement intervention in the family’s apartment. This includes cleaning walls,

purifying air, and, in a unique program, replacing windows using state and federal Medicaid funds.²²

RItE Care administrators have generated research findings associating health coverage with better health outcomes, and those outcomes, in turn, with lower costs. The state's own research has revealed that if low-income people get health coverage, better patterns of care follow. The state has learned that inappropriate patterns of care are the real "cost drivers," as opposed to a generous benefit package.

State Flexibility

According to state officials, there is a commitment to continuous quality improvement within state government that parallels what the state expects of health plans. This is manifested in the state's willingness to make mid-course corrections. Incorporation of performance standards, changes in reimbursement and risk relationships with health plans, and the implementation of and modifications to RItE Share exemplify the state's flexibility.

Nonadversarial Relationship with Health Plans

Whereas the relationship between Rhode Island's health plans and state government has been difficult at times,²³ DHS officials attributed RItE Care's success in part to the department's nonadversarial approach to the insurance industry. The health plans were actively informed of the RItE Care strategy as it was developing and were given the opportunity to provide feedback even before the initial RFPs were sent out. The state also has learned that the health plans must receive fair compensation if they are to participate in state programs.

When RItE Care began, the capitated reimbursement rates offered were admittedly inadequate, resulting in health plans declining to participate until the state increased its offer. As costs increased, complaints of inadequate reimbursement resurfaced in 1995–96, and after listening to providers and consumers, the state changed its contracts. Although budget constraints prevented the state from significantly increasing its payments to health plans, it renegotiated the risk arrangements and "took back" some services to allow for improved compensation to providers. Specifically, the state reduced the health plans' risk by creating stop-loss provisions for certain potentially high-cost services and offering to remove some high-cost services (e.g., NICU services) and to substitute direct state

²² Landlords are required to pay the state back when they sell the apartment, unless they choose to pay back earlier.

²³ According to some, the relationship between the insurers and the legislature has been fairly adversarial over the years.

control. Similarly, state officials have learned that it is worthwhile to pay primary care providers sufficiently to spend more time on office visits, which will decrease inappropriate care in the long run. That is, it is not cost effective to skimp on primary care.

These measures helped temporarily. In 2000, however, of the four plans originally participating in RItE Care, one left the state and two others were no longer accepting new RItE Care patients (one of these considered leaving the program permanently). Only NHPRI accepted new enrollees until the state was able to increase rates in the spring of 2001. The three health plans that are still operating in Rhode Island enroll RItE Care members.

“Safe Place” for Dialogue

To achieve the shared goals and collaboration discussed above, it was necessary to have a “safe place” to bring together the various constituents (the health care industry, consumers, and state agencies). This was accomplished with the help of committed local entities that offered funds, neutrality, and a conference room.

The Rhode Island Foundation, in conjunction with the Kids Count project (funded by the Annie E. Casey Foundation) provided a place for various players to come together and “roll up their sleeves.” The foundation arranged the Leadership Roundtable on the Uninsured in 1998, bringing together the top leadership in the state to address the issue of the uninsured, and facilitated the governor’s working groups, which led to Health Reform Rhode Island 2000. The local foundations also leveraged additional funds from out-of-state foundations for improved access and children’s causes.

Advantages of a Small State

According to numerous respondents, the small size of the state has been an important ingredient that has facilitated health care reform over the past decade. When legislators, administrators, and interest group representatives live and work within a relatively small geographic area, both unplanned and planned meetings occur frequently and communication is facilitated. For consumer advocates, for example, Rhode Island offers unusual access to DHS officials.

Obstacles and Issues

The current success of Rhode Island’s comprehensive health care access program masks the fact that there were serious challenges that needed to be addressed, obstacles that needed to be overcome, and mistakes that might have been avoided. Below we delineate some of these challenges and the lessons learned.

Initial Disorganization

An initial plan to share RItE Care administration between two state departments (DOH and DHS) is viewed by some as a mistake that fueled disorganization and rivalry between the agencies. Anchoring the program in one agency that took ownership and ultimate responsibility, while encouraging interdepartmental cooperation and collaboration, was deemed critical for the emergence of a strong program.

Underpayments to Health Plans and Providers

As described above, there were a few periods when state reimbursement rates under RItE Care were deemed insufficient by health plans and/or practitioners, placing their continued participation—and RItE Care’s viability—at risk. Primary care physicians, for example, were paid well below market rates, and two health plans stopped accepting new RItE Care enrollees in 2000, generating a crisis point in the program. There has been some criticism that the state should have been more closely in touch with the concerns of health plans so that it could have acted early and averted a crisis. Although the state has responded over the years by changing risk arrangements and increasing rates, many physicians believe that rates should increase further.

Even though state officials understand the need to compensate health plans fairly, they are currently faced with escalating health care costs and tightening budgets. Exacerbating the problem is the fact that health plans are currently at a different stage than they were in the early 1990s. According to industry representatives, health plans were “burned” by Medicare because they were induced to participate in Medicare+Choice (Medicare’s managed care program) and then squeezed by relatively low reimbursement rates. This experience makes some plans reluctant to take on public enrollees and unwilling to take a gamble on a relationship that may not be profitable.

Unstable Insurance Market

Rhode Island’s small and unstable insurance market posed challenges to access expansion initiatives. In addition to trying to get RItE Care up and running, Rhode Island was faced with the sudden departure of two of the five health plans from the state and from the Medicaid program. There are complaints that the governor and the insurance department should have done more to prevent this occurrence. Although the state has since made efforts to stabilize rates and strengthen financial solvency standards, there has been strong resistance to some of these measures.

Further, with only two commercial health plans remaining in the state, there are complaints that these plans hold a disproportionate amount of influence and have

successfully blocked additional access expansion efforts, such as allowing employers to buy in to RItE Care.

Undeveloped Managed Care Market

The state of Rhode Island was challenged with imposing a Medicaid managed care program on an undeveloped managed care market. There was much resistance by consumer advocates, who feared that access would decline because of “gatekeeping.” Primary care physicians, who were not accustomed to being true care managers, also were initially resistant. RItE Care took the brunt of provider resistance to basic managed care practices as the first purchaser in the state to require that every member have a primary care provider available 24 hours a day, seven days a week (through cross-coverage arrangements), and who would coordinate all of the member’s care, including authorizing specialty care visits and nonemergency treatment in a hospital emergency department.

There are complaints that some private primary care physicians find ways to avoid serving RItE Care patients and that there is inadequate policing against these practices. Most agree, however, that the market has adapted to the new model.

Enrollment Crisis

Perhaps the greatest challenge to Rhode Island’s access expansion effort was when RItE Care enrollment soared in 1999–2000. As described earlier, many factors contributed to this situation, including the deterioration of the small-group insurance market, escalating health care costs, expansion of RItE Care eligibility, and enhanced outreach efforts. The governor responded by convening a special health care working group that resulted in significant health care reforms in 2000, including the enactment of the RItE Share premium assistance program.

Failure to Coordinate Premium Assistance with Expansion of Eligibility

In hindsight, state officials learned an important lesson about timing: a new premium assistance program should begin in conjunction with expansion of eligibility to families. Expansion in RItE Care eligibility to parents in 1998 allowed some employees to drop employment-based health insurance to join the public program, providing financial savings to employers. When RItE Share was later implemented, employers naturally would not volunteer to take those employees back into their company’s health plan. This forced the state to modify the program so that RItE Share was not dependent on the voluntary participation of employers.

Lack of Business Support for RIte Share

Bad timing was only one of many factors behind the lack of business community support for RIte Share. Employers who were asked to join the RIte Share Business Advisory Committee to help design the program believed that the state did not address their concerns. (The employers, however, did help develop the program's cost-effectiveness test and other features.) Resistance was also apparently related to misconceptions among employers about the rules and design of the program, reflecting inadequate communication and marketing by the state. About 80 percent of all commercial plans were approved for RIte Share participation. Plans with high up-front deductibles were not approved, and this may be a problem in the future as more employers choose high-deductible plans to address escalating premium costs.

There are even greater concerns among small employers, however, who feel burdened by high costs and low profits during an economic downturn. They view RIte Share as an extra hardship that: 1) asks them to pay their share of 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 administrative costs related to changing the employee payroll deduction for certain workers and keeping track of a new payment source; and 4) may cause cash-flow problems related to waiting for the state to reimburse them for the employee's share of the premium.²⁴

The state is responding to some of these concerns by enhancing employer recruitment efforts, exploring possible incentives to increase participation, and allowing direct premium assistance payments to employees so that employers may be bypassed. Under the latter approach, employers are blind to workers' involvement in RIte Share. With this provision, the program's success will not hinge on employers' willingness to participate. The state also requires eligible enrollees to switch from RIte Care to RIte Share and makes RIte Share mandatory for RIte Care applicants who have access to employer-sponsored insurance. These modifications led to an additional 1,800 RIte Share enrollees in the first half of 2002. Despite these changes, however, representatives of the small business community say they are "not hopeful" about the program.

Looking Ahead: Lessons for Other States and Challenges

Many lessons can be drawn from Rhode Island's experiences in expanding access to health care. A clearly defined mission and strong leadership are critical, and the involvement of consumers, health plans, and other stakeholders is important for building support and

²⁴ Also, the state faced administrative difficulties coordinating wraparound and supplemental benefits with private coverage that involved deductibles.

ensuring protections for enrollees. Incremental expansion of one major program, with centralized administration but coordination with other departments and agencies, was a formula that worked well in this state. Creating a stop-loss provision and taking direct control of potentially high-cost services are examples of creative responses to budget constraints that other states may want to consider. The difficulties in getting Rhode Island's premium subsidy program up to speed point to the need to implement such a program simultaneously with (rather than after) expansion of the public program to ensure ease of administration for employers, educate the business community about the details and benefits of the program, establish direct subsidies to employees, and require participation. The state's emphasis on quality, through performance standards, use of data, and a comprehensive approach to health, has succeeded in terms of improved outcomes and efficiency; other states may want to follow Rhode Island's lead in this area.

Looking ahead, state officials maintain that the primary challenge is to maintain RIte Care in the face of severe budget constraints. Additional challenges involve building up employer-sponsored coverage and expanding access to additional groups of uninsured people.

Sustainability in an Economic Downturn

States are facing budget shortfalls, and Rhode Island is no exception. As a result, RIte Care administrators will be struggling to prevent cutbacks in eligibility and/or benefits. Further, because the program has been associated with improved outcomes, many fear that scaling back coverage will lead to declines in health.

By instituting cost-sharing in the form of premium contributions among a portion of RIte Care beneficiaries, the state hopes to contain costs and thereby prevent cuts in coverage and eligibility. Consumer advocates, however, fear that low-income people will not be able to afford their share and will drop out altogether. Advocates estimate that about 6,000 people will "fall off" the program. Early monitoring indicates that among the 5,200 families newly subjected to monthly cost-sharing in January 1, 2002, 87 percent had paid their premiums as of mid-March 2002. Many of those who had not paid cited availability of other coverage. Clearly, it will be crucial to continue monitoring cost-sharing in the upcoming months and years.

Expanding Employer-Sponsored Insurance

Designing a viable program that encourages private employer-based insurance is a primary—albeit elusive—goal. There is concern that, with escalating premiums, employers will opt out of providing health coverage entirely.

State administrators are making an effort to boost private coverage through RItE Share, but there is widespread acknowledgment that this program will need to evolve to meet changing economic circumstances. Ongoing challenges include administrative complexity, excessive financial burdens on employers, and possible loss of access to utilization data on RItE Share enrollees. Marketing as well as clear communication with the business community and low-income workers are critical.

The state has considered allowing businesses to buy into RItE Care (which could offer coverage with much less premium volatility and perhaps at somewhat lower cost than coverage purchased directly from commercial carriers), but one of the health plans has opposed the proposal, presuming it would lose private business. The state also has considered offering a subsidy to employers to encourage employment-based insurance. This, however, would require significant new funding that is not currently available. Instead, the state has taken an alternate route. By bypassing employers and making participation mandatory, the state has seen RItE Share enrollment soar since January 2002. The state is closely monitoring and evaluating its progress.

Filling Remaining Gaps

A final challenge for the future involves identifying the remaining gaps in coverage and creating a seamless system of care. State officials want to know, and are making efforts to learn, who leaves RItE Care and RItE Share and why, who remains uninsured and why, and how the uninsured obtain access to care. They understand the need to build support for public assistance to adults without dependent children and other uninsured populations (for example, by expanding RItE Care eligibility to these groups), but acknowledge how difficult this will be in a time of fiscal constraints.

In sum, there is much concern about how to sustain Rhode Island's expansion of access to health care in a declining economy. Administrators and legislators stress the need to continue to work collaboratively, to acknowledge that the market is changing, and to continue making mid-course corrections. They suggest using past success as a motivator and making a business case for continuing to expand access to health care, for example, by using "investment" language rather than "entitlement" language. Still, the state sees federal government financing as instrumental. As one state official put it, "We know the experiment works. The question is money."

NEW JERSEY

The objective in studying New Jersey was to explore the factors and challenges related to the state's active involvement in health coverage initiatives. New Jersey has been at the forefront of insurance market reform, public subsidies for private insurance, and expansion of public coverage for children and adults. Some initiatives were more successful than others, but all provide valuable lessons to other states.

Summary

Over more than a decade, New Jersey has sought to expand health insurance affordability and accessibility, first through regulatory reforms in the private market and later through expansions in public coverage and subsidies to low-income families. In the early 1990s, New Jersey was one of the first states to introduce comprehensive reforms in the small-group and individual purchase insurance markets to promote access to affordable coverage regardless of health risk and to encourage price competition among carriers. Since the mid 1990s, the state has also been a leader in expanding publicly subsidized coverage. New Jersey's State Children's Health Insurance Programs (CHIP), including the NJ KidCare program, initiated in 1998, and the NJ FamilyCare program, initiated in 2001, have among the most generous eligibility criteria in the country, with more than 238,000 adults and children enrolled in 2001.²⁵ As a result of these programs, as well as a strong private coverage market, the uninsured rate among the nonelderly in the state declined to 14.4 percent in 2001 from a high of 19.1 percent in 1996 (Table 7).

Table 7. New Jersey State Profile and Overview, 1999–2000

| New Jersey | |
|--|-----------|
| Total population | 8,186,500 |
| Nonelderly population | 7,117,310 |
| Total population under 200% FPL | 2,218,490 |
| Insurance status of nonelderly | |
| Employer | 5,295,890 |
| Individual | 267,430 |
| Medicaid | 562,480 |
| Uninsured | 991,520 |
| Insurance status of nonelderly under 200% FPL | |
| Employer | 639,874 |
| Medicaid | 106,958 |
| Uninsured | 586,190 |
| Percent of All Uninsured | 59% |

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (www.statehealthfacts.kff.org).

²⁵ As of 12/3/01. Office of Statistical Analysis and Managed Care Reimbursement, Department of Human Services.

In contrast to some other states that have initiated comprehensive health care reform, New Jersey's coverage initiatives have been incremental and developed over time. The key features of New Jersey's health care access expansions include:

- a combined focus on stabilizing coverage in the private sector and expanding state-sponsored coverage;
- flexibility in its public coverage expansion in program design, outreach, and administration to improve enrollment of children, including a willingness to shift focus from solely covering children to covering parents and some childless adults; and
- consideration of the relationship of public programs to private coverage and an emphasis on maximizing private coverage through such efforts as an employer buy-in program.

Many factors contributed to the successful enactment of New Jersey's various initiatives. Individual (i.e., non-group) and small-group insurance market reforms were achieved, in large part, as a result of the need to avert collapse of the state's insurer of last resort, Blue Cross Blue Shield. The regulatory culture in the state and its history of engaging stakeholders in shaping policy solutions enabled a broad coalition to reach consensus rapidly on these reforms.

The successful enactment of the NJ KidCare and NJ FamilyCare programs can be attributed to the support of the governor and a favorable fiscal environment, stemming initially from the availability of federal CHIP dollars, a strong economy, and buoyant state tax receipts, and later from tobacco settlement funds. Strong entrepreneurial leadership from the governor's staff and creative state policy officials also contributed greatly to program development and enactment.

New Jersey overcame significant obstacles in creating its policy initiatives that may be instructive for other states considering similar initiatives. The insurance reforms enacted in 1993 and 1994 were among the most inclusive in the nation, with open enrollment and pure community rating.²⁶ However, resistance by small business interests to the breadth of these reforms led to significant softening of the rating regulations in the small-group market. While pure community rating in the individual market initially did not have the feared impact of rapid premium increases, over time prices have risen steadily, making

²⁶ Community rating requires that all purchasers be charged the same premium based on the experience of the entire group; premiums cannot vary by an individual's health status, age, gender, or geographic location.

direct purchase of insurance unaffordable for many. Since 1996, the number of individuals covered in this market has declined by about 3 percent per quarter. The state also learned some important lessons from its initial attempt to subsidize health insurance purchase in the individual market. The insurance reforms included the creation of the ACCESS program, a subsidy program for low-income persons wishing to purchase insurance directly through the individual market, which proved to be administratively complex and a costly mechanism for covering the uninsured. As a result, the ACCESS program was phased out and was eventually replaced by more comprehensive efforts to expand Medicaid and CHIP.

Like CHIP initiatives in most other states, the NJ KidCare program experienced early difficulties reaching enrollment targets. Program managers were quick to respond with aggressive outreach strategies. Enrollment eventually moved closer to expectations, but only after garnering considerable criticism from state legislators and the media. The state's enrollment experience in NJ FamilyCare was very different. After opening CHIP to parents and other adults, program enrollment reached its three-year target in just nine months. The extent of the response of adults to NJ FamilyCare, especially among parents earning between 134 percent and 200 percent FPL, who are required to pay monthly premiums, has been attributed to widespread awareness of the program resulting from a statewide multimedia campaign and the existing KidCare program, as well as to a significant unmet need for affordable health insurance in the adult population. The rapid enrollment of adults in NJ FamilyCare combined with the emergence of a significant state budget shortfall led to the need to control program growth. In response, the state closed enrollment to adults without children (with the exception of general assistance beneficiaries) in September 2001, stopped outreach and marketing, and allocated an additional \$25 million in fiscal year 2001 in order to maintain coverage for parents. Today, applications for NJ FamilyCare are still arriving in large numbers, and the state is considering additional strategies to contain costs. The state has also faced delays in its employer buy-in program under NJ FamilyCare and difficulty in demonstrating cost-effectiveness as defined by the CHIP federal waiver requirements. As a result, it is unlikely to reach its revenue target from this source.

The state faces even greater financial challenges ahead. Unrestrained state spending and tax cuts in recent years positioned New Jersey poorly for the economic shockwaves of September 11 and the national economic downturn. New Jersey faces one of the largest state budget deficits in the country. The slumping economy is likely to increase the number of uninsured in the state, while the capacity of the state to extend or even maintain its current coverage efforts is in doubt.

This case study presents a brief history of New Jersey’s health insurance coverage initiatives over the past decade, describes the elements that facilitated their success and the obstacles they have encountered, and discusses future challenges that the state faces in maintaining one of the most far-reaching coverage expansion programs in the nation.

Background: Development of New Jersey’s Coverage Initiatives

New Jersey’s health insurance coverage initiatives span more than a decade and cross the administrations of opposing political parties. During that time, access to affordable health insurance remained a top priority, although the focus shifted from the general adult population to achieving near-universal coverage for children.

Coverage initiatives in New Jersey generally fall into two periods: insurance market reforms in the early 1990s and child (and later family) subsidized coverage expansions in the late 1990s and early 2000s. These separate initiatives were not designed as a single, comprehensive strategy but instead represent an incremental approach to coverage expansion. In many ways, however, the experiences of earlier initiatives informed and facilitated subsequent coverage programs. The following discussion summarizes the key features of these initiatives.

Insurance Market Reforms of the Early 1990s

Individual and Small-Group Market Reforms

In 1992, the individual (i.e., nongroup) market in New Jersey was on the brink of collapse. Blue Cross Blue Shield (BCBS), which was subsidized by the state as the carrier of last resort, faced looming shortfalls and was near bankruptcy. The courts had ruled that the state’s hospital rate-setting mechanism, which was the primary mechanism for subsidizing BCBS, violated federal law. Although later overturned, the court decision catalyzed a sea change not only in hospital financing but also in the structure of insurance reforms in the state. To preserve the state’s individual market while unburdening BCBS, policymakers crafted a solution with the assistance of key industry and consumer representatives that provided guaranteed-issue, renewability, limits on preexisting conditions, and full community rating. Lauded as one of the most comprehensive reform packages in the country, the reforms included a unique “pay or play” requirement mandating that all health insurance carriers operating in the state either issue individual coverage or pay an assessment to cover a proportionate share of the reimbursable losses of those carriers that did sell in the individual market. Carriers that issued coverage also could choose to seek an “exemption” by agreeing not to seek reimbursement and by writing an assigned target of individuals. The reforms were generated, in large part, by the insurance industry itself. As a result, they included both stricter requirements on carriers and reduced

regulatory burdens. For example, the laws established an independent board to which carriers would submit premium change filings, replacing the existing prior approval required from the Department of Banking and Insurance.²⁷

At the same time as individual market reforms were unfolding, the state also enacted reforms in the small-group market, largely in response to pressure from the business community. Small employers, particularly the smallest firms, were being excluded from the market through medical underwriting practices. Many could not get coverage or were getting limited coverage because of exclusionary riders or preexisting condition exclusions. The difficulties of acquiring and maintaining health coverage in small businesses also were believed to limit job mobility among higher-risk employees. In addition, limitations in the small-group sector were reportedly leading excluded higher-risk workers to seek coverage in the individual market. Based on the same principles as the reforms in the individual market, small-group reforms required guaranteed issuance, guaranteed renewability, and limited exclusions for preexisting conditions in businesses with between two and 49²⁸ full-time employees. To be eligible to purchase the small-group coverage packages, small employers were required to pay at least 10 percent of premiums and achieve a minimum employee participation rate of 75 percent.

The original small-group coverage law also included rating restrictions. Ratings could be based only on age, gender, and geographic classifications and were not permitted to vary by more than a 3:1 ratio, which was to be gradually phased in to full community rating with at least 75 percent of premiums going toward medical expenses.²⁹ Under these rules, many employers experienced significant rate increases, and under political pressure, the state amended the rating reforms in 1996, freezing the premium variation ratio at 2:1, rather than moving to full community rating.

Another important feature of both the individual and small-group coverage reforms was standardization of benefit packages to simplify price comparison for purchasers (Figure 3, Table 8). The new laws required that no plans be sold in the individual market other than those approved by the state-appointed oversight board. This unique approach contrasts with most other states that either do not standardize plans or require that specific standard basic, standard, or catastrophic plans be offered, but permit the sale of other,

²⁷ Swartz, K. and Garnick, D., “Hidden Assets: Health Insurance Reform in New Jersey,” *Health Affairs*, Vol. 18, No. 4, 1999.

²⁸ With the passage of the Health Insurance Portability and Accountability Act, New Jersey modified its definition to two to 50 employees to comply with federal requirements.

²⁹ A 3:1 rating band meant that the highest-cost demographic/geographic rate cell could not be charged more than three times that which the lowest-cost cell is charged for the same product. Pure community rating permits no variation in price whatsoever for a given product.

nonstandard plans as well. Similarly, in the New Jersey small-group market, carriers are permitted to offer only standard benefit plans—including one managed care plan and five indemnity plans that may be offered also as a preferred provider organization or point-of-service plan. To stave off opposition by small employers with existing plans, the state allowed some such plans to be “grandfathered” and made available to new groups, albeit with significant limitations. The state also allowed for riders to add to the benefit package. But, in general, small businesses have bought the standard packages, with only 2 percent of the small-group market currently purchasing pre-reform plans.

Figure 3. New Jersey Individual and Small-Group Market Post-Reform Enrollment, 1993–2001

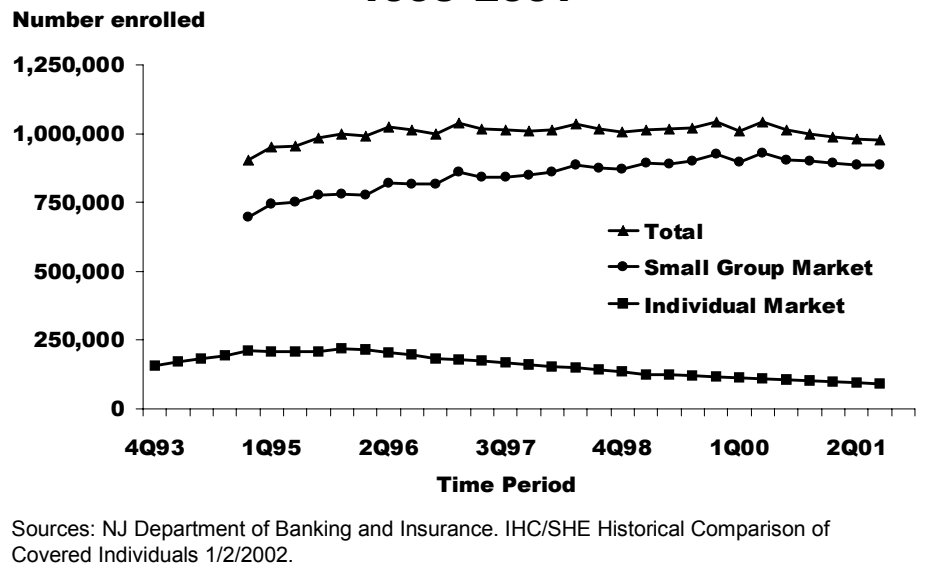


Table 8. New Jersey Standardized Individual Purchase and Small-Group Benefit Plans, 2002

| Individual Plans | Co-insurance | Deductible/Copayment Options | Hospital Confinement Copay | Coverage Benefits |
|------------------|--|---|---|---|
| PLAN A/50 | 50% | \$1,000/\$2,500/\$5,000/ \$10,000 deductible | No | Office visits; hospital care; prenatal and maternity care; immunizations and well-child care; screenings, including mammography, pap smears and prostate examinations; x-ray and laboratory services; certain biologically based mental illness, alcoholism, and substance abuse services; prescription drugs. No deductible or coinsurance for routine physicals and other preventive care — up to \$300 per year per person and up to \$500 for newborns until the end of the calendar year in which the child attains age 1. |
| PLAN B | 40% | \$1,000/\$2,500 deductible | Yes-In addition to deductible \$200 for up to 10 days per year. | Same covered benefits as Plan A/50. |
| PLAN C | 30% | \$1,000/\$2,500 deductible | No | Same covered benefits as Plan A/50 |
| PLAN D | 20% | \$500/\$1,000 deductible | No | Same covered benefits as Plan A/50 |
| HMO | Carriers have the option to cover drugs at 50% | \$10/\$15/\$20/\$30 copays | Yes | Same covered benefits as Plan A/50 |

| Small-Group Plans | Co-insurance | Deductible/Copayment Options | Hospital Confinement Copay | Coverage Benefits |
|--------------------------|--|--|---|--|
| PLAN A | 80% hospital 50% all other | \$250 deductible | \$250 for up to 10 days per year | Up to 30 days hospital, very limited coverage provided out of hospital |
| PLAN B | 40% | \$250/\$500/\$1,000/\$2,500 deductible | Yes-In addition to deductible \$200 for up to 10 days per year. | Office visits; hospital care; prenatal and maternity care; immunizations and well-child care; screenings, including mammographies, pap smears and prostate examinations; x-ray and laboratory services; certain biologically based mental illness, alcoholism, and substance abuse services; prescription drugs. No deductible or coinsurance for routine physicals and other preventive care—up to \$300 per year per person and up to \$500 during the first year of a newborn's life. |
| PLAN C | 30% | \$250/\$500/\$1,000/\$2,500 deductible | No | Same covered benefits as Plan B |
| PLAN D | 20% | \$250/\$500/\$1,000/\$2,500 deductible | No | Same covered benefits as Plan B |
| PLAN E | 10% | \$150 deductible | No | Same covered benefits as Plan B |
| HMO | Carriers have the option to cover drugs at 50% | \$5/\$10/\$15/\$20/\$30 copays | Yes | Same covered benefits as Plan B |

Source: New Jersey Individual Health Coverage Program Board and Small Employer Health Coverage Board, NJ Department of Banking and Insurance.

Following small-group market reforms, enrollment in small-group plans increased continuously over the next six years, from approximately 690,000 individuals in 1994 to more than 930,000 in the second quarter of 2000 (Figure 3). In contrast, enrollment in nongroup plans rose initially fell from a peak of 220,000 in 1996 to only 90,000 in 2002, a steady decline of 3 percent per quarter.

State-Subsidized Coverage

At the same time that the state instituted reforms in the individual and small-group markets to make coverage more accessible for families of modest means, it also made its first foray into subsidizing coverage for low-income non-Medicaid-eligible people through the New Jersey ACCESS program. ACCESS provided sliding-scale subsidies to people with incomes under 250 percent of the federal poverty level, to help them purchase coverage in the individual market. Financed using surplus revenues in the unemployment compensation fund and without any federal financial participation, the program was created both to expand coverage and to provide an influx of covered individuals in a still unstable individual market. It was believed that ACCESS would help attract insurers to offer nongroup plans. The program, which began at the end of Governor James Florio's administration, was never fully funded by the subsequent administration of Governor Christine Todd Whitman, because the new administration felt that the individual market was an expensive vehicle through which to provide insurance coverage. The new administration felt that the Medicaid platform would be a better mechanism on which to base coverage expansions because of potential cost savings from managed care and the availability of federal matching funds. Because of its high per person costs to the state, the ACCESS program was eventually phased out and the remaining enrollees were eventually transferred to the NJ FamilyCare program.

Medicaid Expansions

Prior to the State Children's Health Insurance Program, New Jersey's Medicaid income eligibility levels were comparable to or lower than the national average for children,³⁰ although the state did elect to include optional Medicaid services targeted toward children and to expand coverage to optional populations in the late 1980s and early 1990s. In 1991, New Jersey extended coverage for children up to six years of age under 133 percent of the FPL and for pregnant women and children less than one year of age up to 185 percent of the FPL, prior to such coverage being federally mandated. The state also chose to cover the elderly, blind, and disabled populations, which are optional coverage groups under the Medicaid program. Although other states had sought Medicaid Section 1115 waivers to

³⁰ Cornell, E. *Maternal and Child Health Update: States Have Expanded Eligibility and Increased Access to Health Care for Pregnant Women and Children*. Health Policy Studies Division, National Governors Association, February 2001.

expand significantly eligibility in the mid-1990s, New Jersey initially began work in this area but then opted not to pursue this strategy, focusing instead on nonentitlement solutions to expand coverage for children.

Subsidized Expansions of Coverage for Children and Families in the Late 1990s and Early 2000s

Expanding Coverage for Children (NJ KidCare)

During her first campaign for governor in 1993, considerably before the passage of federal legislation creating the Children's Health Insurance Program, Governor Whitman made expansion of health insurance coverage for New Jersey's children a priority. In 1997, the growing national debate over coverage for children also advanced the issue in the state, particularly in a gubernatorial election year. Once elected, the governor established an interdepartmental working group to prepare a plan for covering all children in the state. Led by a senior policy adviser in the governor's office, the working group met on a weekly basis for many months.

The interagency group worked out myriad design details for a new child coverage strategy that would build on the existing Medicaid managed care program. After rejecting an initial proposal to subsidize child coverage through the individual market, Governor Whitman seized on the enactment of the federal CHIP legislation in 1997 to move ahead with implementation of the NJ KidCare program. NJ KidCare was financed with federal matching funds through Title XXI (Plans B and C, and later Plan D) and a Medicaid Section 1931 waiver (Plan A).³¹ The advanced planning that the state had already undertaken considerably shortened the waiver application and approval period.

The NJ KidCare program was designed with the philosophy that all children should have health insurance coverage but that higher-income families should bear some responsibility for the cost of coverage. Program design was premised on the theory that children in the lowest income group should receive the most comprehensive benefits because they are most likely to need services that their families cannot afford. Families with more resources should have benefits that more closely resemble plans available through employers. Thus, the state developed a tiered benefit approach that provided different levels of benefits to different income groups and imposed cost-sharing for the

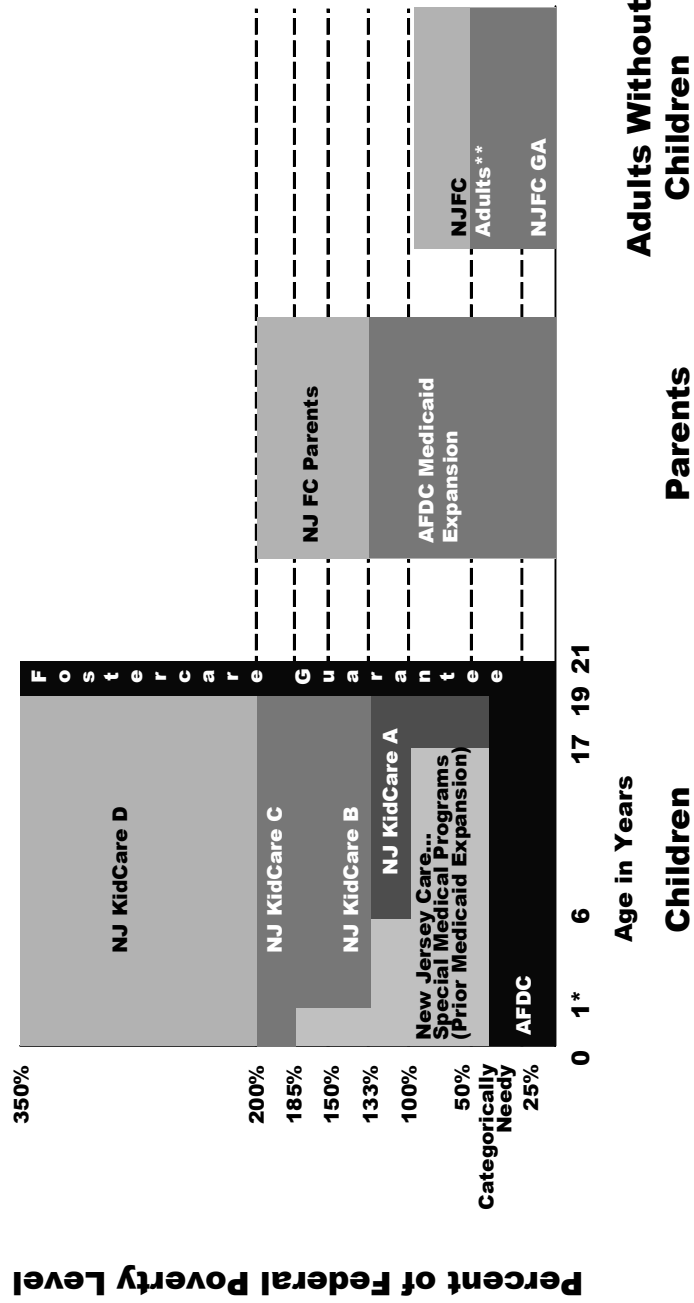
³¹ Section 1931 of the Social Security Act, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, allows states to expand coverage of low-income families through amendments to their Medicaid state plan without obtaining Federal waivers. Under Section 1931, states have great flexibility to cover more low-income families via income disregards, asset disregards, and increasing income and asset limits. (Birnbaum, M, *Expanding Coverage to Parents through Medicaid Section 1931*. State Coverage Initiatives Issue Brief, May 2000.)

highest income group (Figure 4). From the outset, program designers were concerned that publicly subsidized coverage would substitute for private coverage (a phenomenon known as “crowd-out”), and that coworkers of parents of NJ KidCare–eligible children would view a rich package with low cost-sharing as unfair. To address these concerns, the NJ KidCare plan for children in families between 151 percent and 200 percent of FPL was designed much like a standard employment-based plan, with the sole exception that, to promote child development, the state added some preventive and mental health services to the NJ KidCare benefit.

As was true for programs across the country, NJ KidCare experienced lower than expected enrollment and underspent allotted funds in its first year. In response, the state enacted legislation and submitted a series of state plan amendments for a second phase of the program. Through income disregards³² (which New Jersey learned about from Connecticut’s experience), the amended plan effectively expanded coverage under NJ KidCare to 350 percent of the FPL, potentially providing coverage for an additional 60,000 children (Figure 4). Other program amendments submitted and approved included reducing the period that children needed to be uninsured from one year to six months and exempting from the six-month rule children who were covered by COBRA and nongroup health plans or who became uninsured because of their parents’ job loss for families with incomes below 200 percent of FPL. To improve enrollment, the state also submitted an amendment to allow hospitals, federally qualified health centers, and public health clinics to provide services pending actual eligibility determination for children up to 200 percent of the FPL. As a result of these efforts, NJ KidCare enrollment improved significantly, particularly in Plans A and B, which required no participant cost-sharing.

³² Income or earnings disregards are allowed deductions that may be used in calculating income eligibility for applicants or recipients. Earnings disregards are frequently time sensitive, that is, the disregard becomes less generous over time. Income disregards vary significantly across states and are employed by most states that use net income, rather than gross income, to measure income eligibility. New Jersey disregards \$90 of earned income for applicants to its Medicaid and CHIP programs, and \$200 and 20 percent of the remainder for CHIP recipients. (Irvin, C., Czajka, J, *Simulation of Medicaid and SCHIP Eligibility: Implications of Findings from 10 States*. Final Report by Mathematica Policy Research, Inc. to Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, August 2000.

Figure 4. Eligibility for New Jersey Public Health Insurance Programs, 2002



* Includes pregnant women and children under age 1.

** Enrollment of non-General Assistance childless adults closed as of September 2001.

Source: State of New Jersey, Office of the Governor, 2000. Percentages still current for 2002.

In the second program phase, the state also had proposed vehicles for state-subsidized support of low-income families to purchase employer-based coverage. The program had two components. The first, the Partnership Assistance Program (which was later modified as the Premium Support Program) was similar to programs available elsewhere in that it was targeted to low-income individuals potentially eligible for employer-sponsored insurance who were not currently covered. The second component, the Equity Program, was a state-subsidized support program for currently covered low-income families. Under this program, proposed by policy staff within the governor's office, families above 133 percent and under 200 percent of the FPL who currently had a basic benefit package through their employer would be eligible for a state subsidy of up to \$45 per month. To be eligible, the employer would pay at least 50 percent of the premium, the employee would pay \$25 toward dependent coverage (compared with the \$15 per month in KidCare Plan C), and the state would pay the remainder up to \$45 per month. The intent of the program was to provide subsidies for low-income parents who had "done the right thing" in the past by purchasing insurance for their families, potentially at great sacrifice, rather than to extend subsidies only to those who had no coverage. The Equity Program was to be funded by state-only dollars, because no federal match was available, and was estimated to cost the state \$14 million to assist 55,000–57,000 eligible families. Proponents were unable to get sufficient support for the legislation, however. Because the program would not elicit federal matching funds, many felt that the limited state funds available should be targeted to those without insurance.

NJ FamilyCare and the Premium Support Program: Expanding Coverage to Parents and Childless Adults

The NJ FamilyCare initiative was developed in part as a further response to lagging enrollment in NJ KidCare but also as a result of the availability of new state funds through the tobacco settlement. Based on focus groups conducted with NJ KidCare parents, the state discovered that whole family coverage was preferred to child-only plans. State planners also were aware of research showing that children were more likely to get immunizations and regular checkups if their parents also were insured. As a result, the state developed a strategy for extending coverage to parents, with the goal of increasing the enrollment of children along with improving access to care for their parents.

At the same time, some policymakers were concerned that the welfare-to-work requirements under the state's welfare reforms would leave many former beneficiaries medically uninsured and felt that the state should protect single adults from losing health coverage. They argued that this population had the greatest health care needs and that, without coverage, they were relying on emergency rooms for basic health care or on

expensive hospital-based charity care. As a result, the NJ FamilyCare proposal expanded coverage not only to parents up to 200 percent of the FPL but also to the state's General Assistance population and low-income childless adults up to 100 percent of the FPL. The state also opted to use state-only funds to cover documented immigrants.

New Jersey also established the Premium Support Program to help families with incomes up to 200 percent of the FPL purchase employer-sponsored coverage in cases in which it would cost the state less to provide support than if such families were enrolled in FamilyCare. The program is mandatory for FamilyCare and voluntary for KidCare beneficiaries who have access to employer-sponsored coverage when the employer contributes at least 50 percent of the premium cost. This strategy was seen as having several advantages. It would avoid excluding workers from state help with health insurance costs simply because their employer offered health benefits; it would be less costly than providing a NJ FamilyCare plan; and it might reduce the incentive to substitute public for private coverage.

The state financed NJ FamilyCare with a combination of federal funds under a Section 1115 waiver, tobacco settlement funds, and expected employer funds from the Premium Support Program. New Jersey was one of the first states to apply for a Section 1115 waiver under CHIP. NJ FamilyCare enabling legislation, the Family Care Coverage Act, was enacted in July 2000 and called for \$100 million from the tobacco settlement funds, \$48 million from Section 1115 waiver federal matching funds, \$29 million from existing state General Assistance funds, and \$24 million from employer contributions through the Premium Support Program. Enrollment in NJ FamilyCare began in October 2000 and the Section 1115 waiver was approved in January 2001. Table 9 summarizes NJ FamilyCare for children and adults.

Table 9. New Jersey Publicly Subsidized Coverage Programs

| Program Type | NJ FamilyCare for children (previously KidCare)/ Phase I & II | NJ FamilyCare/Premium Support Program for adults (plans A and D only) |
|------------------------------|---|---|
| Waivers/legislation required | Children’s Health Care Coverage Act. 12/97 (P.L.1997, c.272)/ 5 amendments 1999–2001 Medicaid 1931 waiver (Plan A) Title XXI State Plan (Plans B,C,D) | FamilyCare Health Coverage Act 7/00 (P.L.2000, c. 71) 1115 CHIP waiver |
| Time frame | Enrollment began Feb/March 1998 (Plans A, B, and C) Enrollment for Plan D - July 1999 | Family Care Enrollment began October 2000. CHIP 1115 waiver approved 1/2001 Premium Support Enrollment began July 1, 2001/Outreach began in May |
| Benefits/subsidies | Benefits: Plan A—Same as Medicaid managed care Plans B & C—Modified commercial benefit package Plan D—Average commercial HMO benefit Subsidies: Plan A—No premium, no copays Plan B—No premium, copays for some services Plan C—\$15 premium per month, per family; copays \$5–\$10 Plan D—Premium based on sliding-scale ranges from \$30–\$100 per month, copays \$5–\$35 | Family Care Benefits: Plan A—Same as Medicaid managed care Plan D—Average commercial HMO benefit Subsidies: Plan A—No premiums or copayments Plan D—Premium based on sliding-scale ranges from \$30–\$100 per month for families with children. Parents above 150% FPL pay an additional \$25 for one parent or \$35 for two parents. Childless adults pay no premiums, copays \$5–\$35. Premium Assistance Program—wrap around employer benefit to cover all Plan D benefits if deemed cost effective. Premium lower than for FamilyCare. |
| Eligibility Criteria | Children under 19 in families earning less than or equal to 350% FPL: Plan A—133% FPL or less Plan B—134%–150% FPL Plan C—151%–200% FPL Plan D—201%–350% FPL Six-month waiting period for Plans B, C and D. Exceptions allowed for waiting period in some cases. | Plan A: <ul style="list-style-type: none"> • Parents up to 133% FPL • Pregnant women up to 200% FPL • Single adults/childless couples up to 50% FPL • Individuals on General Assistance (GA) Plan D: <ul style="list-style-type: none"> • Parents who do not qualify for Medicaid up to 200% FPL • Single adults/childless couples from 51% to 100% FPL Six month waiting period for Plan D Premium Support Program: <ul style="list-style-type: none"> • FamilyCare eligible whose employer offers health insurance with comparable benefits and pays 50% of the premium. |

| Program Type | NJ FamilyCare for children (previously KidCare)/ Phase I & II | NJ FamilyCare/Premium Support Program for adults (plans A and D only) |
|------------------------|--|--|
| Enrollment as of 12/01 | Plan A—33,855 | Single Adults |
| | Plan B—9,868 | <ul style="list-style-type: none"> GA—24,495 0%–50% FPL—11,396 51%–100% FPL—6,858 |
| | Plan C—27,741 | Parents |
| | Plan D—15,008 | <ul style="list-style-type: none"> TANF 0%–133% FPL—77,398 134%–150% FPL—13,772 151%–200% FPL—12,983 |
| | TOTAL—86,472 | Prior Health Access enrollees—1,306 |
| | | Other restricted aliens—3,616 |
| | | TOTAL FamilyCare Adults—151,824 |
| | | Premium Support Program—115 enrolled and 108 pending open enrollment. |
| Financing | Plan A B, C, and D—65% federal funds, 35% state (CHIP matching rate) | Plan A—50% federal, 50% state funds (Medicaid matching rate) |
| | | Plan D: <ul style="list-style-type: none"> Parents—65% federal, 35% state (CHIP matching rate) GA, restricted aliens, childless adults—100% state funded |

Source: Office of Statistical Analysis and Managed Care Reimbursement, NJ Department of Human Services, Enrollment as of December 2, 2001.

Elements that Facilitated Development

One of the key elements of success shared by all of the coverage initiatives in New Jersey has been the strong role played by the governor’s office. The administration of Democratic Governor Florio brokered the early individual and small-group coverage reforms; and the NJ KidCare and NJ FamilyCare initiatives benefited from the strong leadership of Governor Whitman, a Republican. There are also important differences in the factors that led to the successful implementation of the two waves of reform. The following discussion addresses these differences.

Individual and Small-Group Coverage Reforms

Regulation by Cooperation

The individual and small-group market reforms had significant support from the insurance industry. This reflects the general health policy culture in the state, which had long relied on stakeholder input to shape an active state regulatory role. The state had a history of regulating hospital reimbursement through its all-payer rate-setting system. This system was used not only to limit the growth of hospital expenditures but also to redistribute

resources within the market. Under one such redistributive mechanism, Blue Cross Blue Shield (BCBS) paid discounted rates to hospitals. BCBS was seen as providing a public good because it was the insurer of last resort, but by the early 1990s, the political coalition that supported rate-setting had evaporated, and BCBS was sinking into deep financial trouble. New Jersey responded to this crisis by bringing the insurers and other stakeholders to the table to hammer out a new system. The result was the inclusive regulatory scheme with community rating and guaranteed-issue and with requirements that insurers participate in the risky individual market or share in the losses of carriers that did.

NJ KidCare and NJ FamilyCare

A Program Champion

Even before Governor Whitman took office, she had decided to make near-universal coverage for children a legacy of her administration. In the governor's state-of-the-state messages at the outset of both her terms, the NJ KidCare and NJ FamilyCare programs were highlighted. Many attribute the success of the programs to her strong and consistent leadership. Her stewardship resulted in near-unanimous support from both legislative bodies for NJ KidCare and NJ FamilyCare legislation. The president of the senate was the prime sponsor for NJ KidCare and also testified in support of the bill, which according to at least one official interviewed occurs only rarely.

Program Development Leadership Came from Within Government

As a result of the high priority the governor had given to coverage of children, the state was able to "hit the ground running" when CHIP was enacted in Washington, in 1997. An interdepartmental working group had been developing a program long before the CHIP funds actually became available. The working group met from May to September in 1997. It stimulated cross-pollination of ideas and increased knowledge of and familiarity with issues in the insurance markets and Medicaid for those administering other programs, reducing some of the "silo effect" that plagues many state governments. The state also sought planning grant funds from the Robert Wood Johnson Foundation and assembled considerable data on the number and characteristics of the uninsured in the state, using Current Population Survey data and focus groups. Unlike many other states that relied heavily on external consultants, New Jersey relied largely on a homegrown plan created by a core group of state leaders. It appears that the principles and strategies developed by the working group were important to successful program start-up.

Decision to Build on Existing Infrastructure

Many state officials attributed the early successes of NJ KidCare and later NJ FamilyCare to the decision to build the programs on the state's Medicaid managed care platform.

Initially, some within the working group had proposed a program to cover children through the individual market, building on the ACCESS program and funding the initiative through assessments on insurers. Early in the process, however, this proposal was abandoned by the group because participants agreed that expanding coverage through the individual market would be too costly and too hard to control. The strategy of building on the Medicaid platform facilitated a rapid response to CHIP requirements and simplified program administration. For example, amending current Medicaid managed care plan contracts to include the NJ KidCare population eliminated a potentially lengthy procurement process.

Although the success of the state's Premium Support Program is far from assured, its initial design was facilitated by the earlier small-group market reforms. As in all states with similar programs, covering services not included in employer plans but covered by NJ FamilyCare (referred to as "wraparound" benefits) and assessing the cost effectiveness of doing so can be extremely complex. Although this was also true in New Jersey, the standardization of small-group benefit packages that was part of earlier small-group reforms significantly simplified the process. In fact, one official observed that without standardization in the small-group market, the wraparound would have been impossible.

Emphasis on Equity and Minimized Crowd-Out

Much of the early planning discussions focused on the need to treat families in similar economic situations fairly while avoiding giving currently covered individuals or employers incentives to drop private coverage. Program planners felt that if the state's coverage initiatives were seen as unfair or poorly targeted, it would lose political support from business. These concerns drove the decision to offer a benefit package for families above 133 percent of the FPL that was similar to the most widely sold policy in the private sector (then a U.S. Healthcare managed care product) rather than the Medicaid benefit package. Given the lack of discretionary funds in this income bracket, however, the state added some additional services that it believed would support child development, including preventive health, hearing, dental, vision, and some mental health services but excluding transportation, case management, and other benefits covered by the Medicaid program. These additional services were made available to children but not to adults in NJ FamilyCare. In addition, the decision to cap parental coverage at 200 percent of the FPL was driven by both crowd-out and budgetary concerns. As noted above, a separate policy initiative, called the Equity Program, would have offered state subsidies to families with access to private coverage but for whom the premiums were unaffordable. This program was driven by equity concerns, but it was not approved by the legislature.

Working with Stakeholders

State program planners working with key stakeholders contributed to successes in both the enactment and early implementation of NJ KidCare and NJ FamilyCare. From the outset, the state worked with children's advocacy groups and other groups in shaping NJ KidCare. This helped create a broad constituency for the program. Although local providers initially were not actively engaged in program design, over time the state developed strong working relationships with both the hospital association and community-based providers to help New Jersey respond rapidly to boost lagging enrollment (a problem that was experienced early on in CHIP programs across the country). Utilizing outreach funds from welfare reform, the state provided three-year, performance-based grants to community-based organizations [e.g., Federally Qualified Health Centers and Women, Infants, and Children program sites] to enroll low-income children. In addition to appropriating additional state funds for outreach, the state also sought private funding, in collaboration with the New Jersey Hospital Association, through Robert Wood Johnson's Covering Kids initiative.

Because Governor Whitman wanted to use tobacco settlement funds to support the NJ FamilyCare expansion, program planners had to negotiate with others who staked claims on that funding stream. The hospitals in the state, whose uncompensated care fund for charity cases had been cut substantially after earlier reforms abolished the hospital rate-setting system, were eager to use tobacco funds to restore charity care funding. To gain hospital support for the FamilyCare program, the state both earmarked some tobacco settlement funds for charity care and also extended presumptive eligibility under NJ FamilyCare for two years. Presumptive eligibility allowed hospitals and federally qualified health centers to receive reimbursement for adults before being deemed fully eligible, guaranteeing cash flow. Given the slow enrollment experience under NJ KidCare, the state also saw presumptive eligibility as a means of encouraging rapid take-up of NJ FamilyCare. (As discussed above, the rate of enrollment in NJ FamilyCare was much more rapid than anticipated, potentially because of the statewide multimedia outreach campaign and a ready market of adults seeking affordable health insurance coverage. Thus, presumptive eligibility was ended after just nine months.)

State planners also worked with the business community in developing coverage subsidy initiatives, including the Premium Support Program. Concerns of the business community encouraged a strong emphasis on equity and anti-crowd-out provisions in all the state's coverage initiatives.

Availability of New Funds

The healthy fiscal environment of New Jersey and the availability of federal CHIP dollars and tobacco settlement funds also were important catalytic factors in the enactment of both NJ KidCare and NJ FamilyCare. Indeed, many officials interviewed indicated that the replicability of New Jersey's programs is contingent on new funding streams becoming available, especially expansion of funds funneled through Title XXI or similar federal mechanisms.

Obstacles and Challenges: Individual and Small-Group Coverage Reforms

Rising Premiums and Declining Enrollment in the Individual Market

Initially, the individual market reforms had a positive effect on the market.³³ The number of carriers offering individual products rose from only one to more than 20 and by the fourth quarter of 1995, enrollment in the individual market had increased by 63 percent from the pre-reform period, covering over 220,000 individuals. In the first few years of operation, increases in the rates for the most popular individual plans remained consistent with medical inflation, and median rates for HMO coverage did not increase at all.³⁴ Individual reforms also introduced managed care into this market, which initially lowered the cost of coverage; however, over time, the prices of coverage in this market have risen dramatically. As of March 2002, the lowest cost for an HMO plan with a \$30 copayment was \$338 per month for single coverage and \$1,011 for family coverage. As discussed above, the number of individuals covered in this market has declined since 1996 by about 3 percent per quarter. By the third quarter of 2001, enrollment had declined to 91,433, a 32 percent decrease from the prereform period. Although some of this decline may have been caused by economic growth during this period and by people becoming eligible for employer-sponsored coverage, insurers attributed the decline to adverse selection and concomitant price increases resulting from pure community rating and guaranteed-issue. Community rating in the individual market is currently being reassessed and proposals have been introduced to allow modified community rating.

Small Employers Seeking Better Deals Challenge Stability of Small-Group Market

The small-group market has not exhibited the erosion in the number of covered individuals seen in the individual market, but attempts to avoid the regulations have challenged the stability of the reforms. After implementation of the regulations, insurance

³³ Swartz, K. and Garnick, D., "Lessons from New Jersey," *Journal of Health Politics, Policy and Law*, Vol. 25, No. 1, February 2000.

³⁴ New Jersey Small Employer Health Benefits Program Board. *The Effects on the Individual and Small Employer Health Coverage Markets of Permitting Individuals to Purchase Small Employer Health Benefits Plans*. September 1996.

carriers began offering stop-loss plans with low “attachment points”³⁵ that resembled high deductibles under traditional health insurance policies. For example, some stop-loss policies set the attachment point at \$1,000, reimbursing employers for claims paid over that amount. Because stop-loss policies were originally designed to reimburse self-funded employers for catastrophic or unexpected expenses, these policies were not considered to be health insurance and were not subject to health insurance reform laws. Policies with low attachment points permitted small businesses to avoid purchasing plans in the state-regulated program and thereby avoid paying higher health insurance rates. The state addressed this problem by increasing the permitted attachment point for stop-loss coverage to \$20,000 per year.³⁶

The small-group market has also been challenged by self-funded multiple employer welfare associations (MEWAs). These are arrangements that provide benefits to the employees of two or more employers. MEWAs were not previously subject to clear state regulatory oversight. Recently, the state enacted P.L. 2001, c. 352, which permits the establishment of MEWAs and provides for state oversight of the financial solvency of these entities. Although MEWAs may lower the price of coverage for small businesses, they may adversely affect the cost of coverage in the small-group marketplace to the extent that they offer different benefit packages or allow for rating of coverage that differs from the small-group market. Further, MEWAs are not subject to state guarantee funds. One recent high-profile MEWA failure highlighted the risks of these arrangements.³⁷ MEWAs also contribute to higher rates in the small-group market because groups with low-risk workers exit the regulated market, leaving higher-risk groups and increasing the overall cost of coverage. Although recent legislation introduced in the state supporting purchasing alliances may reduce the cost of coverage for some groups, such as MEWAs, the new entities also may have the unintended consequence of increasing rates for other groups.

Competition also has come from professional employer organizations (PEOs). These entities generally offer small businesses an array of services, including payroll and human resources administration, and may offer different types of insurance coverage including workers’ compensation and health benefits.

³⁵ An attachment point is the dollar amount of loss when an insurer begins to provide coverage. Stop-loss or excess risk insurance typically has two attachment points: the specific attachment point at which the employer is no longer required to self-fund the claims of an individual, and an aggregate attachment point at which the employer is not required to self-fund the claims for all covered individuals. O’Leary, K., Sanders, W., *Small Employer Health Insurance Reform: New Jersey’s Approach*.

³⁶ 1995 N.J. Laws 340, Section 1, definitions of “health benefits plan” and “stop loss or excess risk insurance.”

³⁷ Fitzgerald, E., “Car dealers’ health insurance trust goes under—Rising costs doomed NJ-CAR’s arrangement, which has \$13 million-plus in unpaid bills.” *Star Ledger*, Newark, N.J., February 24, 2002.

Pay or Play Difficult to Administer

The unique loss-sharing pay or play mechanism in the individual market, which was intended to encourage carriers to enter the market and offer coverage at competitive rates, has proven to be somewhat complicated to administer and has resulted in considerable litigation.

Initial Resistance from Businesses to Benefit Standardization

Because of strong opposition from some businesses that wanted to maintain their existing benefits, the small-group law was amended in 1996 to scale back a mandatory conversion to standard plans, thus allowing insurers to offer riders and grandfathering previously nonstandardized plans. Over time, however, businesses have increasingly opted to purchase one of the five standard plans, which today account for 98 percent of the plans purchased by small businesses.³⁸

Subsidizing Coverage in Individual Market Too Expensive

The ACCESS program, though innovative, proved to be an expensive approach to expanding coverage. The individual market is the most costly market segment because of its higher-risk enrollees and higher administrative costs. In addition, because ACCESS participants were a small fraction of individual market participants, state administrators could not realize economies of scale from negotiating with carriers or implementing cost-containment strategies. With a capped appropriation, the number of people who could enroll was limited. In fact, at its peak the program only enrolled 20,000 people, a tiny proportion of the uninsured. As the individual market became more costly, this strategy became increasingly unaffordable. As discussed above, the initial proposal to expand coverage to low-income children through ACCESS was abandoned by state officials when they saw the prospect of federal matching funds through CHIP. They also felt that it would be more efficient to manage the program through the existing Medicaid managed care infrastructure.

Small Employers Have Difficulty Meeting Employee Coverage Requirement

One of the requirements of the small-group coverage reform program was that, for a small business to be eligible, a minimum of 75 percent of the employer's workers must sign up for insurance. Business representatives have said that it is difficult to meet this requirement, in part because employees may be covered through other sources. Employees who had coverage through their spouse were counted toward the 75 percent requirement, but until recently other types of coverage were not similarly credited. A recent amendment to the

³⁸ Quarterly enrollment data for third quarter 2001. New Jersey Small Employer Health Benefit Program Historical Comparison of Covered Lives, January 2002.

small-group law, P.L. 2001, c. 346, now provides credit toward the participation requirement for persons covered under most public programs or by other group coverage. Employers still are not permitted to count an employee's participation in NJ FamilyCare toward the minimum participation requirement.

Obstacles and Challenges: NJ KidCare and NJ FamilyCare

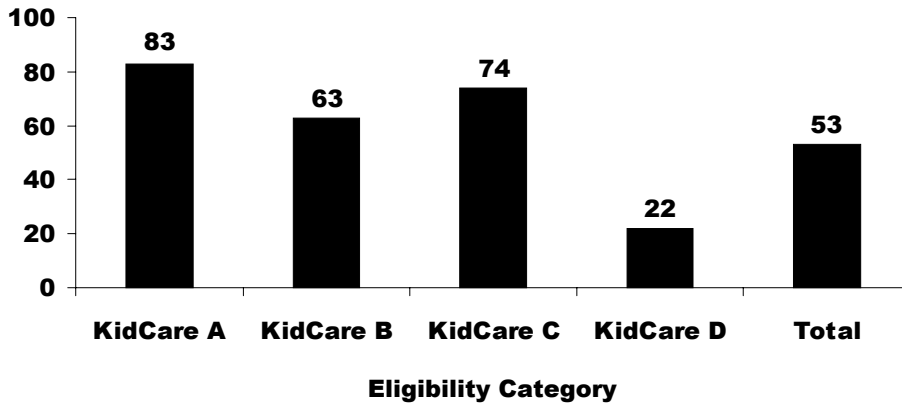
Low Enrollment of Children

As is true of most CHIP programs, NJ KidCare experienced lower than anticipated enrollment. Some attributed this to an unrealistic start-up period that assumed that the target population would be fully enrolled in one year. Others attributed it to the expected period needed to raise awareness of a new program and limited initial marketing of the program. The state has taken a series of steps to improve enrollment, including working with an advertising firm to develop a statewide multimedia outreach campaign to increase visibility, seeking external funding to support greater outreach efforts and engaging community-based organizations and the provider community to assist in enrollment.

After considerable investment in a variety of outreach methods, including grants to community-based providers and presumptive eligibility with respect to hospitals and community health centers, enrollment improved but remained below targets for the higher-income groups for whom premiums are required. Even with the expansion of coverage to parents, which was intended to increase the number of children covered, enrollment of children overall as of December 2001 was still only about half of the target (53%).³⁹ Enrollment varied considerably by type of plan, however. Plans A, B, and C, which were initiated in early 1998, enrolled an estimated 76 percent of eligible children as of December 2001, compared with 22 percent of eligible children enrolled in Plan D, which was initiated in mid-1999 (Figure 5). Plan D also has much higher cost-sharing requirements, with a \$30 to \$100 sliding-scale monthly premium and \$5 to \$35 copayments. Although premiums and cost-sharing are well below market rates, they may be a significant deterrent to enrollment.

³⁹ Office of Statistical Analysis and Managed Care Reimbursement, N.J. Department of Human Services, December 3, 2001.

Figure 5. NJ KidCare Enrollment as a Percentage of Qualifying Uninsured by Eligibility Category, December 2001



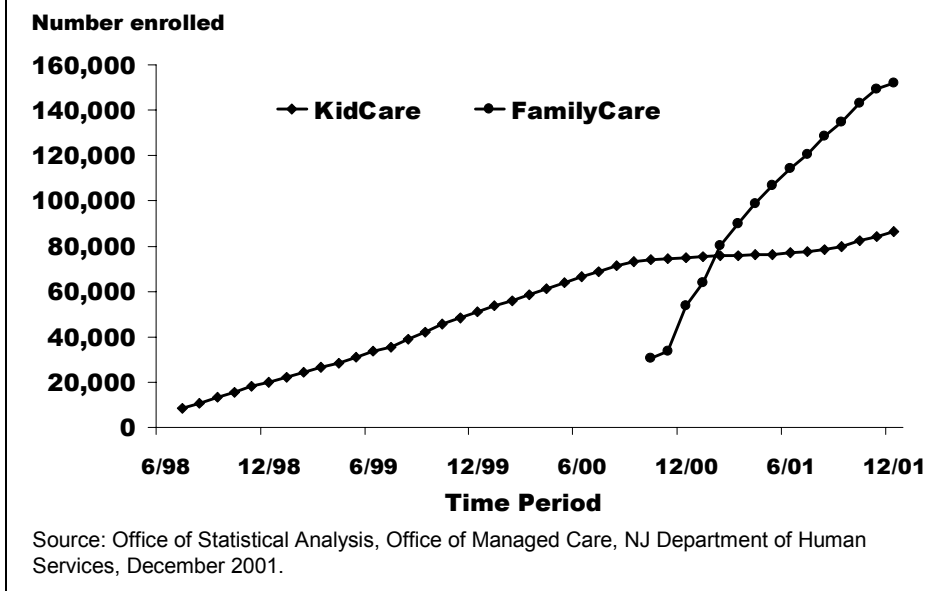
Source: Office of Statistical Analysis and Managed Care Reimbursement, NJ Department of Human Services, 12/3/01.

Faster than Expected Enrollment of Adults

State planners assumed that enrollment would occur more quickly in NJ FamilyCare than in NJ KidCare because of heavy outreach and marketing of NJ KidCare, the availability of contact information for parents of children enrolled in NJ KidCare, and the plan to automatically enroll the General Assistance population. Even so, planners did not anticipate how popular this program would be. In just nine months, NJ FamilyCare reached its three-year enrollment target. High demand led to stresses on the program as state program managers and their enrollment contractor struggled to catch up.

Enrollment of parents, particularly parents earning between 133 and 200 percent of the FPL who were eligible for Plan D, far exceeded expectations (Figure 6). Given the low enrollment of children in similar plans, this suggests that the willingness to pay premiums may differ when coverage is being purchased for adults compared with children.

Figure 6. NJ KidCare and FamilyCare Enrollment Trends, 1998–2001



To slow program enrollment, the state first curtailed its advertising campaign for NJ FamilyCare. In September 2001, it closed enrollment to non-general assistance childless adults and considered further cost-saving measures.

Budget Problems

In March 2001, only three months after NJ FamilyCare was initiated, managers projected a deficit in the program budget driven by greater than expected enrollment and higher than expected costs, particularly in the General Assistance program. This group, which is one of the neediest populations in the program, previously had access to emergency Medicaid and charity care services but had minimal access to preventive and mental health services. In retrospect, program managers felt that this population had pent-up demand for these services. Also, to accommodate quick rollover of this population to NJ FamilyCare, General Assistance recipients were covered on a fee-for-service basis, which also contributed to escalating costs. The state has since revised this policy, allowing a 30 to 60 day window to choose or be assigned to a managed care plan. At the same time, based on actuarial data for NJ FamilyCare single adults, plans are facing significant losses, particularly for adults with a history of chronic illness. Two plans threatened to pull out of the market because of low reimbursement rates. The state has since provided a rate increase from Medicaid surpluses, but plans are still concerned that costs will exceed reimbursement caps. Another step taken to support the program’s growing costs has been an additional one-time allocation of \$25 million that the state was able to redirect from lower expenditures in the Medicaid budget, which was expected to cover 25,000 to 30,000 parents.

More recently, New Jersey has instituted additional measures in the FamilyCare program in order to control escalating costs and keep the program solvent. Before the last budget year expired on June 30, 2002, the state spent \$272 million of its own funds on the program—\$91 million more than had been planned. Facing a large state budget deficit, Governor James McGreevey has mandated that the state's share of spending on FamilyCare be held to \$229 million in fiscal year 2003, or \$43 million less than the state is currently spending.

In anticipation of these budget cuts, in addition to closing enrollment to childless adults in September 2001, the state stopped accepting applications from all parents as of June 15, 2002. This does not affect any current beneficiaries or applications received prior to June 15. NJ FamilyCare remains available to all eligible children with annual family incomes up to 250 percent of FPL and presumptive eligibility is still available for children in families with incomes at or below 200 percent of FPL and for pregnant women.

In addition, effective July 1, 2002, all general assistance beneficiaries are no longer enrolled in FamilyCare managed care plans. They receive a benefit package of community-based services provided on a fee-for-service basis. Hospital services, including hospital-based behavioral health services, are reimbursed through the state's charity care program and substance abuse services are provided through the Substance Abuse Initiative administered by the Division of Family Development.

Finally, in order to preserve the program for children, the state has scaled back the benefit package for some adults. Effective September 1, 2002, parents currently enrolled in Plan A (Medicaid package of services) will receive a benefit package comparable to Plans B and C that mirrors the most widely sold commercial HMO package in the state. For higher-income families who currently share some costs of the program, copayments and premiums increased effective September 2002.

Stumbling Blocks to Employer Initiatives

Governor Whitman's proposed Equity Program, designed to subsidize coverage for NJ KidCare-eligible children who had existing employer coverage, failed to get legislative support. Opponents of the program bill argued that scarce state resources, which would not be matched by federal funds, should be directed to cover those who were uninsured rather than to subsidize those who were already insured.

The Premium Support Program (PSP), which pays the worker's share of employer-sponsored plan premiums for previously uninsured NJ FamilyCare-eligible families with children, was approved by the legislature. However, technical and practical

considerations including contractual problems with managed care companies and a lack of employment information in the NJ FamilyCare database contributed to a six-month delay in the implementation of this initiative. Not wanting to delay enrollment in NJ FamilyCare, the state opted to initiate the program without PSP in place.

To improve participation in PSP, the state has conducted outreach through eligibility files. It also has attempted to identify employers with a number of FamilyCare enrollees to conduct outreach to businesses to encourage participation and assess whether they meet the employer eligibility and cost-effectiveness standards. Insurance underwriters also have marketed the program. Despite these efforts, enrollment has been slow, with only 150 individuals enrolled and 108 pending enrollment six months after the program started. State officials noted that if PSP had been in place when the FamilyCare program was initiated, some of these administrative problems could have been avoided by recording employment information at the time of enrollment.

Meeting federal requirements under the PSP waiver has been very challenging and costly. The state must demonstrate that it is cost effective to pay the employee's share of employer premiums compared with enrolling a family in NJ FamilyCare, and it must ensure that the scope of each subsidized employer plan meets minimum standards. This requires a benefit-for-benefit analysis, which was comparatively simple in the small-group market because of standardization of these plans. But the large-group market benefit plans are not standardized, making the scope-of-plan and cost-effectiveness certifications difficult. Industry representatives also raised concerns about the required 50 percent employer contribution, which is much higher than the minimum 10 percent contribution eligibility requirement in the small-group regulations. (Note that the Centers for Medicare and Medicaid Services originally wanted a 60 percent employer contribution and New Jersey submitted a waiver to require only 50 percent). The release of Health Insurance Flexibility and Accountability demonstration initiative guidelines⁴⁰ may allow states more flexibility in setting the employer contribution than in the past, and state officials are investigating the cost effectiveness of lower employer contribution percentages. Analysis commissioned by the state suggests that a minimum employer contribution of 35 percent would likely be cost effective.

Although business representatives give favorable reviews to PSP, they acknowledge that more needs to be done to promote it. They also report some potential barriers to program expansion. For instance, employers may be reluctant to participate for fear that

⁴⁰ Health Insurance Flexibility and Accountability is a newly developed Medicaid and CHIP Section 1115 waiver designed to encourage new approaches that maximize private health insurance coverage options for individuals below 200 percent of the FPL.

they will be required to pay worker premium shares if employees fail to do so, or because of a program requirement that employers inform the state if an employee receives reimbursement under PSP but does not purchase the company plan. Now that the initial administrative problems have been solved, the state has expanded program outreach. Managers acknowledge, however, that the potential pool of enrollees may be declining because of the softening economy.

Looking Ahead: Primary Challenges

New Jersey has been at the forefront of health care reform for over a decade. The state has not pursued a fully unified, comprehensive approach, but it has incrementally developed an integrated series of programs that build on each other and collectively form one of the broadest coverage programs in the country. Despite the fact that the state has developed strong platforms for both regulation of the private market and subsidies for low-income coverage, both policy arenas face significant challenges in the future.

In the private market, centrifugal forces threaten to undermine broad risk pooling in individual and small-group markets. Insurance carriers argue that the individual market, with open enrollment and pure community rating, is subject to cycles of serious adverse selection. Evidence on declining enrollment in the individual market supports this argument.

After six years of stability and steady growth, signs are appearing that New Jersey's small-group market may have begun to erode. Carriers in that market, which has been relatively stable, reported double-digit rate increases and declining enrollment as of 2000. These recent trends may be attributable to broader forces affecting all employer-based insurance, including the economic downturn and the general inflation of health care costs, but they will increase pressures to dismantle or modify the small-group market reforms. Even if the regulations are not changed, many small employers may leave the state-regulated system by forming self-funded Multiple Employer Welfare Associations or other kinds of group purchasing arrangements. Whatever the underlying forces, sustaining New Jersey's inclusive risk pooling in individual and small-group markets will become increasingly difficult in the coming years.

New Jersey has raised the bar for what states can do to cover the uninsured through public subsidies, but these initiatives also face serious challenges. NJ FamilyCare is threatened by the state's recent budget woes. As of February 2002, the state was predicting a budget deficit of nearly \$6 billion and the newly elected governor had already imposed 5 percent across-the-board spending reductions as well as additional cuts to some specific

health programs, including reductions in Medicaid reimbursement.⁴¹ NJ FamilyCare program officials are looking for ways to reduce costs; the state first will seek to save dollars without reducing program eligibility, but it might ultimately have to close enrollment for some eligibility categories (enrollment for adults not on General Assistance and without children has already been closed). By the end of the last gubernatorial administration, state officials were considering a number of cost-saving options including case management programs for high-cost enrollees, premium or copayment hikes, cuts in dental services in Plan D, prior authorization of some services, and closing enrollment for some groups. The new administration will face the same kinds of options. Even if the state fiscal environment improves, it is doubtful that New Jersey will be able to expand its CHIP initiatives to new populations unless the federal government significantly increases funding to states.

The coverage initiatives also face other ongoing challenges. NJ FamilyCare has experienced continuing problems recruiting and retaining children, especially in income categories in which families have to pay premiums. In contrast, adult enrollment, particularly among parents in eligibility categories in which family premiums are required, has been considerably higher than expected, suggesting that willingness to pay differs significantly when coverage is being purchased for adults rather than for children. Program managers are devoting considerable effort to enrolling and retaining children in the program even as they have reduced outreach to enroll parents.

Integrating public insurance with employer-sponsored coverage in ways that encourage a continued or even expanded private-sector role is another major challenge. Although the Premium Support Program is small, strategies like these theoretically offer considerable promise with respect to leveraging private funds. Recruiting and enrolling participants has been difficult, however. In a slumping economy, more workers, particularly those who qualify for PSP, are likely to lose coverage, and fewer employers may be willing or able to afford to buy in. It is too soon to tell whether these barriers will ultimately mean that this program cannot be brought to scale. Potentially greater flexibility in federal oversight of these strategies and state refinements in program design hold promise. In any case, if states are to attack the problem of the uninsured among moderate-income people, finding ways to coordinate with employer coverage without significant crowd-out will be important. New Jersey is a proving ground for employer premium support strategies.

⁴¹ Kocieniewski, D., "McGreevey's Budget Calls for Deep Cuts," *New York Times*, February 12, 2002, p. 6.

Finally, a continuing challenge heard in the political discussion of health coverage in the state is charity care, its interrelationship with coverage initiatives, and the investment required to preserve the safety net. Although coverage initiatives in the state have done a great deal to reach the uninsured, it is not yet known whether the NJ FamilyCare program has resulted in a reduction of charity care cases. The competing priorities of extending coverage while maintaining charity care funding for facilities serving those who do not have coverage will continue to remain in the forefront of political debate, particularly if economic conditions do not improve soon or if proposed federal funding cuts for health care facilities under Medicare and Medicaid are implemented.

Lessons for Other States

New Jersey's comprehensive yet incremental approach to health care coverage, focusing on maximizing access to private insurance while building a base of subsidies for public coverage, offers lessons for other states. By initiating market reforms early in the last decade, the state stabilized a faltering market. This may have resulted in a greater number of uninsured seeking public subsidies. Although the elements of the reforms may require reexamination, the state's initiation of a strategy that was accepted by the business and insurer communities positioned it well for subsequent expansion of public coverage. In particular, the standardization of benefit packages available in various markets helped simplify the establishment of cost effectiveness and of wraparound benefits for the state's employer-buy-in program.

Lessons also may be taken from New Jersey's experience with the expansion of public coverage. Through its experimental foray into subsidized coverage for low-income families through the individual direct purchase market, the state learned that existing state platforms that provide greater administrative efficiencies, lower per unit costs, and federal matching funds offer a more cost-effective public subsidy approach.

In expanding coverage to children, states should anticipate lower enrollment, in part because the perceived need for health care for children may not be as great. Because enrollment in the most expensive cost-sharing plan has been the lowest, other states may want to consider reducing cost-sharing requirements to attract more parents to purchase coverage for their children. Although New Jersey has experienced high demand for subsidized coverage for adults, it is not yet clear whether greater coverage of eligible children will follow.

Based on New Jersey’s experience in expanding coverage to parents and other childless adults, states may wish to take a more gradual approach to assessing the unmet demand for affordable insurance among the low-income adult population and the capacity of budgetary resources to meet this demand.

GEORGIA

The objective in studying Georgia was to identify factors leading to the development of the state’s integrated and flexible approach to child health coverage as implemented through the state’s Medicaid program and its CHIP program, called PeachCare for Kids. Also explored was the state’s experience in leveraging public funds to expand coverage for low-income people and in forging partnerships with business leaders, providers, and community representatives to develop Georgia’s *Business Plan for Health*. The following summary describes the forces and ingredients leading to the development of these efforts and identifies reasons why certain components were successful while others stalled.

Summary

Georgia made a concerted effort to place all of the state’s purchasing—under Medicaid, CHIP, and for its own employees—under one roof. It was successful in developing a streamlined public program enrollment system that substantially reduced the number of uninsured children. Georgia’s consolidation and integration of diverse health programs have enabled the state to leverage its purchasing power to foster improvements in coverage and access in a state with rural access barriers, reluctance by some providers to participate in public programs, and few organized systems of care. State officials have also forged partnerships with business leaders, providers, and community representatives to develop Georgia’s *Business Plan for Health*, a blueprint for coordinated public- and private-sector initiatives to improve access to health care. This plan brought together diverse stakeholders to develop a sweeping package of public, private, and community-based approaches to the problem of the uninsured. Central to the plan is the idea that public-sector expansions must go hand-in-hand with support for private-sector coverage.

Several factors have contributed to the Georgia’s success in developing and expanding public coverage programs for children, leveraging public financing, and developing the state’s *Business Plan for Health*. First, by focusing on children—a vulnerable population that generates public support—the state has maximized political support for comprehensively tackling a single task. Georgia has not only implemented effective outreach and enrollment policies to cover children, but has also created workable strategies to retain coverage for kids. Building on the existing Medicaid infrastructure, CHIP has served as a laboratory for the development of program improvements that are

now used in both Medicaid and CHIP. These improvements have contributed to a children's coverage program that is integrated and user-friendly.

Second, by creatively using its leverage as a major purchaser, the state has undertaken a number of initiatives to foster coverage and improve access with relatively small amounts of funds. For example, the state has made a number of small demonstration grants to localities to assist the uninsured. It has also re-directed a portion of disproportionate share hospital funds from hospital services to primary care and wielded its purchasing leverage to increase provider participation in Medicaid and CHIP. And it has used the forum of stakeholders organized initially to write the *Business Plan for Health* as a sounding board for ongoing discussions about setting priorities during a period of scarce state resources.

To date, few of the initiatives outlined in the *Business Plan for Health* have been implemented. Progress has been greater in the public arena and in developing community approaches than in developing private-sector strategies. While major new developments in all areas are currently on hold because of the state's shaky fiscal outlook, Georgia seems to have taken a pronounced step back from some of the proposed private-sector strategies, such as tax credits for small employers. State officials attribute this retreat to an independent analysis prepared for the state showing a relatively low impact on health coverage per dollar spent on state tax credits (as currently designed), the centerpiece of the private-sector proposals. But they have not responded by trying to redesign the tax credit or develop another approach to promoting coverage among uninsured workers.

In addition, given the costs involved and the political climate in the state, Georgia seems unlikely to pursue Medicaid expansions for adults. As a result, it seems unlikely that the state will embark on any substantial coverage initiatives in the near future, especially for adults who are not targeted for coverage under current programs.

Georgia's state leadership, however, is hopeful that even though the environment is not currently ripe for major coverage expansions or other new initiatives, the infrastructure recently built can serve as a foundation for new programs in the future. This infrastructure includes leadership from the governor and in the Department of Community Health, dialogue and partnerships with a wide variety of stakeholders, and experience developing creative approaches for leveraging the state's purchasing clout (Table 10).

Table 10. Georgia State Profile and Overview, 1999–2000

| Georgia | Number |
|--------------------------------------|---------------|
| Total population | 7,772,210 |
| Total adults 19–64 | 4,874,480 |
| Total children 18 and under | 2,116,080 |
| Total population below 100% FPL | 1,229,930 |
| Adults 19–64 under 100% FPL | 643,400 |
| Children 18 and under below 100% FPL | 471,410 |

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (www.statehealthfacts.kff.org).

Background and History

Georgia has an uninsurance rate among the nonelderly population of about 19 percent, higher than the national average.⁴² As in the rest of the country, workers in small firms, those with low incomes, and people living in rural areas are more likely to be uninsured. While Governor Roy Barnes and a few other health care leaders such as Russ Toal, the former commissioner of the Department of Community Health, have focused attention on broader issues of uninsurance through the development of the *Business Plan for Health* and uninsured grants, momentum has been greatest for children’s health coverage. The state has thrown its energy into developing an innovative and flexible CHIP program, called PeachCare for Kids. In large part because of its success in outreach and enrollment for Medicaid and CHIP, the state now has more than 850,000 enrollees under age 21 in Medicaid and over 190,000 enrollees in PeachCare for Kids (Table 11).⁴³

Georgia clearly has had success with PeachCare for Kids and this new and innovative program has increased enrollment in Medicaid and CHIP. Another, less hopeful, reason for enrollment increases is the downturn in the economy. In November 2001, almost one-third (28%) of parents applying for PeachCare for Kids for their children indicated they had lost their health insurance because they lost their jobs, compared with 6 percent in June 2001.⁴⁴ This trend is expected to continue. The state’s economic situation is likely to erode the base of employer-sponsored coverage, already fragile in this agricultural state, while increasing pressure on public programs and decreasing funding for them. This confluence of factors will create some difficult decisions for the state in the future, as it already has in the 2003 budget cycle.

⁴² Custer, William. *Expanding Health Insurance Coverage in Georgia*. Author’s analysis of 1999 CPS.

⁴³ Governor’s State of the Union Address, January 2002.

⁴⁴ *Florida Times Union*, December 2, 2001.

PeachCare for Kids

PeachCare for Kids is the state’s CHIP plan, designed as a Medicaid look-alike program. PeachCare for Kids covers children from families at the Medicaid income limits up to 235 percent of the federal poverty level (FPL). Families with children over six years of age pay premiums at a rate of \$7.50 per month for individual children to a maximum of \$15 for families with more than one child enrolled. With enrollment in May 2002 of over 190,000, participation in PeachCare for Kids far exceeds the state’s two-year goal of enrolling 60,000 children. Georgia recently ranked fifth in the nation in CHIP enrollment after California, New York, Texas, and Florida.

Table 11. Georgia Public Program Enrollment, 2002*

| Georgia | Number |
|--------------------------------------|---------------|
| Total enrolled in Medicaid | 1,331,110 |
| Adults over 21 | 478,660 |
| Children 21 and under | 852,450 |
| Total enrolled in PeachCare for Kids | 190,377 |
| Total enrolled in public programs | 1,521,487 |

* 2002 year-to-date numbers; unduplicated numbers computed as of 5/02.

Source: Georgia Department of Community Health, Office of Communications.

Business Plan for Health

Approved by the state legislature in 2000, the *Business Plan for Health* is an ambitious package of recommendations for expansion in coverage and improvements in three areas: public-sector programs, private-sector interventions, and community initiatives. The *Business Plan for Health* proposed a variety of strategies to increase coverage, including development of a new pared-down essential care insurance product, coverage for parents of Medicaid-enrolled children to 150 percent of the FPL, and tiered tax credits for small businesses. A few, but not all, of these proposed changes have been implemented.

Development of the *Business Plan for Health* was carried out in a very open and participatory manner, resulting in a relatively high degree of buy-in from stakeholders—at least to the notion of a comprehensive plan if not to the details. Respondents described the planning document as a general blueprint and weathervane for future activities rather than an operational plan for expansion of coverage.

The state followed a multistep process to develop the plan. The policy staff in the Department of Community Health first systematically reviewed recent literature on coverage approaches and their effectiveness. Based on this review, a list of suggested strategies was developed and vetted by the governor. This list was shared with three working groups (providers, private employers and insurers, and advocates) for their input

and reaction. After these groups met and discussed the draft plan, the state invited group members to submit written recommendations and suggestions. Many of these recommendations were incorporated into the final version of the plan approved in 2000 by the governor and the legislature.

Uninsured grants

Although many of the more expansive initiatives laid out in the *Business Plan for Health* are on hold in part because of the state’s fiscal situation, the state has awarded nine demonstration grants to statewide and local organizations to implement projects and programs focused on the needs of the uninsured. An estimated \$2.9 million in state resources will be matched by contributions from local communities to finance these activities. Planned activities focus on three areas: private-sector initiatives (most notably development of a proposal to cover high-risk people deemed uninsurable), pharmacy coverage, and community-based initiatives.

Table 12. Georgia Current Access Programs

| | Medicaid | PeachCare for Kids |
|-------------------------------|--|--|
| Program type | Medicaid | Medicaid look-alike CHIP program |
| Waivers, legislation required | None | Legislation passed in 2000 to increase eligibility to 235% the FPL |
| Time frame | | Plan approved in 1998. Eligibility expansion from 200% FPL to 235% FPL in 2001 |
| Enrollment | 1,331,110 | 190,377 |
| Eligibility Criteria | <ul style="list-style-type: none"> • TANF adults 44% FPL • Pregnant women/newborns 200% FPL • Infants 185% FPL • Children 1–5 133% FPL • Children 6–19 100% FPL | <ul style="list-style-type: none"> • Children through age 18 from Medicaid eligibility level up to 235% FPL • Three-month waiting period |
| Benefits and/or Subsidies | Medicaid benefits | Same benefits as Medicaid excluding non-emergency transport and targeted case management |
| Financing | Federal match 59.7% State contribution 40.3% | Federal match 71.8% State contribution 28.2% Most recent expansion funded through tobacco settlement monies Sliding-scale premiums |

Source: Georgia Department of Community Health, Office of Communications.

Elements Facilitating Development and Program Innovations

Making enrollment simple for families of Medicaid or CHIP children

Georgia has worked hard to make its enrollment process simple and easily navigable by families with a minimum of effort and without the need to understand the organization or complexities of the program. Seamlessness of the application process and of coverage, achieved through shared systems, rules, and provider networks, was a principal goal of the state when it decided to pursue a Medicaid look-alike model for CHIP rather than a stand-alone program. This integrated approach has a number of facets:

- The state has a simple, one-page application for children applying to Medicaid or PeachCare for Kids. This application can be filled out and mailed in or completed online (Georgia is the first state to implement an online application that families can complete on their own.)
- Both PeachCare for Kids and Medicaid allow families to self-declare their income on children's applications. Self-declaration minimizes the paperwork families must produce and the effort they must expend applying for coverage.
- Families who apply for coverage through PeachCare for Kids but whose children are found eligible for Medicaid may stay under the PeachCare for Kids umbrella, obtaining a PeachCare for Kids coverage card although technically remaining in the Medicaid program (including Medicaid benefits and cost-sharing). This ability to enter Medicaid coverage through multiple doors is a critical innovation.
- Because of shared systems (including an automated eligibility determination system) and identical rules on income determination, the PeachCare for Kids and Medicaid programs can transfer applications without the need for family involvement.

Increasing continuity of coverage and care for children

In addition to focusing effort on the initial application process, program managers also have developed approaches to maximize retention and continuity of coverage:

- PeachCare for Kids and Medicaid have passive redetermination for enrolled children. This increases retention, because it means that children are automatically reenrolled. Families only need to return paperwork if there has been a change in their income or other factors affecting their eligibility status.
- PeachCare for Kids staff proactively review case files of Medicaid enrollees who remain under the PeachCare for Kids umbrella. If it is anticipated that the family will no longer be eligible for Medicaid based on the age of the child or the income of the

family, but can remain in PeachCare for Kids, the child is automatically rolled over from one program to the other. This promotes continuous coverage for children.

- PeachCare for Kids recently made enrollees eligible for the program in the month in which they apply, essentially replicating the protection provided by presumptive eligibility. In addition, children in PeachCare for Kids are automatically enrolled for one year.
- Families can retain providers as they move between PeachCare for Kids and Medicaid because both programs use the same network.

Leveraging Public Financing for Care and Coverage of the Uninsured

Placing all publicly financed coverage under one organizational roof

Approximately two-and-a-half years ago, the governor reorganized public coverage by bringing together the Medicaid program, the state health planning agency, and the state employee benefit program into a newly formed entity, the Department of Community Health. When PeachCare for Kids was initiated, it too was managed by this new department. The department also was charged with developing solutions to the problem of the uninsured in Georgia. Together, these public programs cover one-quarter of the state's residents. Pooling the enrollees from different programs gives the organization more visibility and leverage. This leverage can be used both to negotiate better coverage terms for Medicaid and public employees and to obtain broader buy-in for new initiatives to cover the uninsured.

Using a variety of regulatory and programmatic levers to create opportunities for coverage and care of the uninsured

The state has made creative use of regulatory authority and private/public partnerships to increase care and coverage for the uninsured and to improve program management.

Examples of this include:

- Allowing critical access hospitals (mostly rural hospitals with 15 beds or fewer) to buy in to the state employee benefit program to provide health benefits to hospital staff and their families. A number of these hospitals do not offer health benefits to dependents, in part because of already high and escalating small-group premiums.
- Requiring hospitals seeking a Certificate of Need (CON) to meet charity care requirements. Providers applying for a CON must demonstrate that 3 percent of revenues are devoted to charity care. In a recent case, a CON application for one of the most prominent hospitals in Atlanta was denied based on failure to meet this

requirement. It was ultimately granted after the hospital agreed to meet the state's threshold for charity care and to ensure that its entire medical staff participated in Medicaid.

- Requiring providers contracting with the state employee plan also to contract with Medicaid.
- Requiring hospitals participating in the state's Indigent Care Trust Fund (ICTF)—the main component of the state's disproportionate share funding to hospitals) to devote 15 percent of their ICTF allocation to primary care. The state is also stepping up monitoring of the ICTF allocation and has published a formula that providers must use to calculate charity care. The state allocates ICTF dollars first to rural hospitals, which are reimbursed for 100 percent of their indigent care costs. The remaining dollars are divided among urban hospitals.
- Simultaneously implementing a Pharmacy Benefit Manager (PBM) for both the state employee plan and Medicaid. The PBM uses a three-tier cost-sharing plan for both programs. This means that enrollees pay a higher copayment for brand-name drugs on the formulary than for generic products and experience a further increase in the copayment for brand-name products that are not on the formulary. The state also plans to develop shared disease management approaches for the two populations using the PBM. These programs would be aimed at managing chronic illness for people with conditions such as asthma, diabetes, and hypertension.

Developing the Business Plan for Health

Bringing diverse stakeholders to the table

The planning process to develop the *Business Plan for Health* included not only advocates and providers, groups that have traditionally contributed to planning and strategizing for Georgia's public programs, but also embraced private-sector representatives, including insurers and employers. This latter group of stakeholders, which had not formerly been involved, brought perspectives and input focused more on the private market than on public-sector programs. The emerging dialogue, spanning public coverage and private-sector issues, is considered a major asset created by the *Business Plan for Health* development process. The state continues to draw on this group of stakeholders for input and suggestions. Faced with the need to cut health program budgets, for instance, state officials contacted the working group participants for their thoughts and recommendations on how to move forward with the proposed reductions.

Leadership by a “Health Care Governor”

Respondents indicated that the governor has a detailed understanding of health care and a strong commitment to improving access. Examples of his leadership include development of the *Business Plan for Health* concept along with restructuring the Department of Community Health to bring together health planning with public coverage (Medicaid and state employer benefit plan) functions.

Obstacles and Issues

Relative absence of managed care

After a brief trial, the state’s Medicaid program backed away from enrolling people in health maintenance organizations and reverted to a traditional fee-for-service program (nationwide, about six of 10 Medicaid enrollees are now in HMOs). The absence of managed care as a cost management tool may have contributed to the state’s recent budget difficulties, although other states that rely heavily on managed care also have had difficulty holding down costs. Georgia is now trying to shift more enrollees out of the straight indemnity program and into preferred provider organizations (PPOs), in which a primary care case management approach is used. Under this approach, primary care physicians receive a small fee for serving as a “medical home” for Medicaid enrollees and guiding them through the health care system.

Recent fiscal challenges

Most respondents pointed to the state’s fiscal situation as the most significant barrier to expansion of coverage. The recent economic slowdown spurred the governor to request budget cuts of 2.5 percent for the 2002 fiscal year with an additional 5 percent planned for the 2003 fiscal year. For Medicaid, the cuts amount to \$80 to \$90 billion for 2002, with twice that amount the following year. In January 2002, the governor presented his 2003 budget outlining cuts to Medicaid. Certain elements of the *Business Plan for Health*, already approved, have been placed on hold in this proposed budget. These include expansion of children’s Medicaid coverage to families at 150 percent of the FPL, most helpful to low-income state employees who, because of federal eligibility rules, cannot enroll in the PeachCare program. Other initiatives included in the *Business Plan for Health* but not yet approved by the legislature are on hold indefinitely. The most significant of these is an ambitious plan to provide tax credits for small employers. In addition, the governor’s budget proposes to eliminate the second year of transitional Medicaid coverage for families leaving welfare.

The governor has announced that there will be no layoffs of state employees resulting from the budget crunch and that some programs, including the recently

developed cancer coalition, will be protected from cuts. The coalition is a major project launched by the governor to improve cancer prevention and treatment and to emphasize training and clinical research.

Difficulty obtaining private funding for new programs

Respondents agreed that using public funds to finance major expansion of coverage through either public programs or private insurance is unlikely in the near future. In the interim, the state has looked for additional sources of funds, including private grant funding, for some smaller initiatives, however, the state has not had a great deal of success obtaining funding from foundations and other grant programs.

Reimbursement rates

Although access to providers for enrollees in public programs remains relatively robust, some respondents indicated that physicians are backing away from participating in Medicaid, complaining that reimbursement levels are well below market rates. These respondents believed that major problems in access may emerge unless rates are increased. Proposed increases in reimbursement rates were scaled back even before the recent budget cuts were announced.

Lack of impetus to move forward

Few of the *Business Plan for Health* program elements have been implemented. One clear barrier is the recent fiscal situation, but other factors also seem to be at play. Some believe the governor is not pursuing coverage efforts as strongly as he did at the beginning of his administration and point to the allocation of the tobacco dollars primarily to programs other than expansion of coverage programs as an indicator of this. Although Georgia's current stasis can be attributed partly to the sluggish economy and dwindling state tax revenues, it also emerges from the inability to maintain momentum following a change in leadership in the health department. The previous director, Russ Toal, was a driving force behind comprehensive reform. He was also a point of connection to the governor's strong support for health care access improvement initiatives, as well as an effective counterweight to stakeholder opposition or hesitancy. Toal's absence left a void in policy leadership and advocacy for comprehensive reform that has not yet been filled.

Barriers to developing insurance market reforms

To be successful, many of the envisioned innovations on the private side would need to be paired with reforms of the small-group and individual insurance markets. These changes are under the purview of the state's insurance commissioner, an elected official. Respondents reported slow progress developing some of these market reforms, especially

in the individual market. A number of reforms focused on the small-group market are already in place. Along with guaranteed-issue and guaranteed renewability, the state limits how much premiums can vary in the small-group market based on health status, risk, or other demographic factors and also limits insurers' ability to deny coverage to individuals based on preexisting conditions.

Dispersed and rural population

The state's demographics and size are viewed as a challenge to developing effective coverage programs and ensuring access. This problem has a number of facets. First, ensuring provider access is inherently difficult in rural areas, which constitute a large portion of the state. Second, the start-up costs for new statewide efforts are high because the state government needs to work and negotiate with 159 different county governments. Third, many of the rural providers, and particularly the critical access hospitals, are at risk of closing because of financial difficulties.

Difficulties putting together a combined public and private approach

Although most respondents supported the notion of private-sector coverage strategies in Georgia, the state has reportedly backed away from the main private-sector initiatives outlined in the *Business Plan for Health*. The mainstay of the plan was an employer tax credit designed to provide tiered benefits to employers and favoring rural employers and those who had not before offered coverage. Officials in the Department of Community Health suggested that the tax credit for uninsured workers was tabled because cost estimates prepared by researchers at Emory University "came back much higher than expected," but the size of the cost estimates reflected the amount of the credit, eligibility standards, and the projected take-up rate. As the recent debate in Congress showed, there is no single version of a tax credit—several different ones are under consideration with widely varying amounts and eligibility criteria. Georgia might consider working with cost estimators to try to identify an affordable yet potentially effective package.

So far, the right combination of public and private programs that is politically as well as financially feasible, and effective, has not emerged. There has been some discussion of developing coverage for the parents of CHIP-covered children using a purchasing pool or premium payment approach, however, there are no concrete plans to move forward with this program.

Looking Ahead: Challenges and Lessons for Other States

Georgia has developed a model program for providing health coverage to children through CHIP and along the way has facilitated enrollment in Medicaid among those

eligible but previously not participating. The state has been innovative in developing a seamless enrollment system with multiple points of entry and the ability to shift families across programs to ensure continuity of coverage without burdensome redeterminations. Enrollment of children surpassed expectations and strong coverage retention policies have minimized disenrollment or lapses in coverage. The state also has supported early intervention, preventive health, and better access to care by reallocating a portion of disproportionate-share hospital dollars to primary care, supporting community programs to provide direct services to the uninsured, and using its purchasing leverage to increase provider participation in Medicaid. Georgia also has consolidated several departments under one agency and set up a working group of diverse stakeholders to provide community input to the state's decision-making process.

A primary challenge in Georgia is to develop a way to support employer-sponsored coverage. Public support for major Medicaid expansions to cover more adults is likely to be weak. Therefore, a breakthrough to reduce the number of uninsured working-age adults will probably require some combination of leveraging public funds to support job-based coverage or introducing insurance market reforms to make coverage in the individual market more affordable.

Georgia also may eventually consider resurrecting its plans for a tax credit, and it could consider less costly ways to implement such a program. It is important to note that no state has found an easy way to bolster employer-sponsored coverage for lower-income workers. The key challenge is finding a subsidy that is big enough to induce a sizable take-up rate, but not so big that it will overtax the state's budget.

The experience in Georgia demonstrates the need for a comprehensive approach to expansion of coverage that blends together efforts to enhance enrollment of those already eligible for public coverage, expansion of eligibility when feasible, and support for private coverage. Getting such a blended, multifaceted approach off the launch pad will require leadership from the top, skilled staff work, and in some cases technical assistance from outside the state government. The stakeholder infrastructure, and a measure of goodwill, are still in place from the prior attempt at health care reform. An important question is whether the state will do the technical and political work needed to capitalize on previous planning experience and restart its initiative.

RELATED PUBLICATIONS

In the list below, items that begin with a publication number are available from The Commonwealth Fund by calling our toll-free publications line at **1-888-777-2744** and ordering by number. These items can also be found on the Fund's website at **www.cmwf.org**. Other items are available from the authors and/or publishers.

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

#559 *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care* (August 2002). Based on a Commonwealth Fund survey of health insurance in the workplace, this report finds that two of five workers experienced increases in their premiums or cost-sharing, or both, during 2001. Although public support for job-based health insurance remains strong, many workers are not confident that employers will continue to offer coverage to them down the road. Workers are even more uncertain about their ability to get good health care in the future.

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

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

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

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

#518 *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002). Sherry Glied, Cathi Callahan, James Mays, and Jennifer N. Edwards. This issue brief finds that a less-expensive health

insurance product would leave low-income adults at risk for high out-of-pocket costs that could exceed their annual income.

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

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

#512 *Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk* (December 2001). Lisa Duchon, Cathy Schoen, Michelle M. Doty, Karen Davis, Erin Strumpf, and Stephanie Bruegman. This report, based on The Commonwealth Fund 2001 Health Insurance Survey, finds that in the past year one of four Americans ages 19 to 64, some 38 million adults, was uninsured for all or part of the time. Lapses in coverage often restrict people's access to medical care, cause problems in paying medical bills, and even make it difficult to afford basic living costs such as food and rent.

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

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

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

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

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

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

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

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

#493 *Diagnosing Disparities in Health Insurance for Women: A Prescription for Change* (August 2001). Jeanne M. Lambrew, George Washington University. In this report, the author concludes that building on insurance options that currently exist—such as employer-sponsored insurance, the Children’s Health Insurance Program (CHIP), and Medicaid—represents the most targeted and potentially effective approach for increasing access to affordable coverage for the nation’s 15 million uninsured women.

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

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

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

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

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

#476 *“Second-Generation” Medicaid Managed Care: Can It Deliver?* (Winter 2000). Marsha Gold and Jessica Mittler, Mathematica Policy Research, Inc. *Health Care Financing Review*, vol. 22, no. 2.

This study of Medicaid managed care programs in seven states finds that the programs require state policymakers to make difficult tradeoffs among the competing goals of improving Medicaid access, providing care for the uninsured, and serving those with special needs who are dependent on state-funded programs. Available online only at www.cmwf.org.

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

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

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

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

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

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

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

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

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

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

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

