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FROM NEW ENGLAND TO THE GOLDEN GATE BRIDGE: A LOOK AT CREATIVE COVERAGE EXPANSIONS AT THE STATE AND LOCAL LEVELS

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EXECUTIVE SUMMARY

Frustrated by the lack of action or even attention at the federal level, states and local governments are looking for creative ways to expand programs to reach the 47 million Americans without health insurance. There have already been a number of creative initiatives by states and localities over the last five years to cover more of the uninsured, which deserve our review.

Massachusetts recently passed major health care reform, which has widely been reported as an innovative way to provide for universal health coverage. The Massachusetts reform has grabbed the nation's attention and spurred a great deal of discussion about what states can do to try to expand coverage. Massachusetts' success story has served as a catalyst for discussion of creative expansion options at both the state and federal levels.

But Massachusetts is not alone. Several states and localities have started with small program expansions; a few have passed large scale reform. States and local governments are reaching out to assist small businesses, or finding ways to expand coverage to those too poor to afford health insurance but not poor enough to qualify for Medicaid. Many expansions offer limited benefit packages, or implement policy changes that are designed to increase affordability. The tools used to finance expansions vary widely, including using federal funds or dedicating specific state funds.

This paper highlights many of these states and a few local areas—and the various tools they are using to reach the uninsured. These are all programs that have passed state legislatures and are either being implemented, or are moving into implementation in the next year. However, it is important to note that many more state legislatures and Governors had proposals that were debated in the statehouses this year—and we would expect to see more of that during next year's legislative sessions—as more states evaluate policy tools that can be duplicated or adapted back at home.

COVERAGE EXPANSIONS

Covering everyone (or nearly so): Massachusetts

The most unique aspect of the [Massachusetts](#) reform effort is that it strives to cover virtually everyone through a combination of requirements and opportunities, including a re-shaped insurance market, an individual mandate with state subsidies, and an employer contribution requirement. The greatest “exportable” from Massachusetts, however, is political: *bipartisan solutions leading to universal*

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coverage are possible, if the willingness to compromise while pursuing common goals is strong enough to stare down the extremes in both parties.

Universal Goals with Voluntary Means: Maine and Vermont

Both [Maine](#) and [Vermont](#) have passed health care coverage expansions that aim for universal coverage in their states, but stop short of requiring individuals to purchase insurance. Both states have creatively re-shaped the insurance market for those lacking employer coverage, offering subsidies for those who can not afford to purchase coverage, and in the case of Vermont, include an employer contribution requirement.

Covering all children: a place to start

[Illinois](#), [Tennessee](#), and [Pennsylvania](#) are implementing programs to enable all children to have health insurance. By expanding Medicaid and SCHIP, many states are finding it possible to increase the number of children who are insured.

NARROWER TARGETS

Most states have been less ambitious politically and financially, but are trying to offer creative incremental coverage expansions to certain subsets of their population. These states mostly focus on small businesses and their workers, or provide subsidies for the working poor to afford health insurance for their families. The following are some examples of coverage expansions that states are offering.

Encouraging small employers to offer insurance to their workers and their families

One trend is for states to find ways to expand coverage by providing subsidies to enable small employers to offer insurance to their workers and their families. [Arkansas](#), [New Mexico](#), [Oklahoma](#), [West Virginia](#), [Montana](#), [Tennessee](#) and [Rhode Island](#) have all passed or implemented programs targeted at small businesses and their workers.

Expansions to those without employer based coverage

Some states have set up programs specifically for individuals lacking access to employer based insurance. These include [Utah](#), [Pennsylvania](#), [Oklahoma](#), and [Wyoming](#).

Subsidies for individuals to purchase employer sponsored insurance

Another trend in coverage expansion is for states to subsidize individuals wishing to purchase the insurance their employers currently offer. [Massachusetts](#), [Vermont](#), [Illinois](#), [Utah](#) and [Wyoming](#) all have premium assistance programs offered as part of their expansion efforts.

Extending family coverage to young adults

Many states are looking for ways to target coverage for young adults, who are less likely to be insured than other age groups. To combat the loss of insurance to these young adults, many states have implemented requirements that insurance companies extend coverage to older dependents, regardless of their education status.

PRAGMATIC VARIANTS

Limited benefit packages

The expansions **Wyoming, Arkansas, Tennessee, New Mexico, Utah, and Pennsylvania** have passed all offer some type of limited benefit package to make coverage more affordable to enrollees, and to reduce the burden on the state's budget. In addition, [West Virginia](#) recently passed legislation that will allow insurance companies or provider groups to sell limited benefit plans to the uninsured.

States Bearing the Risk of Offering the New Insurance Product

Although most states are partnering with private insurance companies to offer tailored products for their expansions, some states are designing and selling (with subsidies) their own insurance products for targeted expansion groups. The health plans offered by **Illinois, Utah, Wyoming, Pennsylvania, and Oklahoma** are all underwritten by the state.

Another tool tried by [New York](#) is designing a state program using a state subsidized reinsurance mechanism to reimburse private insurance plans for a percentage of the claims paid above a certain level. New York's reinsurance program has piqued the interest of several states, many who have proposed offering similar programs.

High Risk Pools are another tool that 34 states have used to help those who cannot find insurance obtain it. High risk pools are typically state-created, non-profit associations that offer comprehensive health insurance to individuals who have conditions that make them uninsurable in the commercial non-group market. Most states cap enrollment, and use a variety of funding mechanisms to cover the costs.¹

FINANCING MECHANISMS

States are looking at creative financing mechanisms in order to afford to provide coverage expansions. Using federal dollars is the most popular way to enable states to cover more adults, families and children. These include Medicaid 1115 waivers (used by **Massachusetts, Utah, and Vermont**), Health Insurance Flexibility and Accountability (HIFA) waivers (**Arkansas, New Mexico, and Wyoming**) and State Children's Health Insurance Program (SCHIP) expansions (**Illinois, Pennsylvania, and Tennessee**), all of which require federal approval.

States have also considered the use of dedicated funding streams, such as tobacco tax revenue and funds received from the tobacco settlement of 1998. **Vermont** and **Oklahoma's** expansions are financed partially with tobacco taxes, while **Arkansas** and **Pennsylvania** have funded their programs partially using the 1998 national tobacco settlement funds. A few states also include state-only general revenue dollars to help fund their expansions.

CREATIVE LOCAL EXPANSION EFFORTS

This paper also explores three local expansion efforts that have garnered a great deal of attention:

- [Muskegon County](#), Michigan's Access Health program;
- [Santa Clara County](#), California's Children's Health Initiative (CHI); and
- [San Francisco](#), California's recently passed Health Care Security Ordinance.

CONCLUSION

From New England to the Golden Gate Bridge, state and local governments are acting as laboratories for the rest of the country, and more importantly, they are yielding results. Many state legislatures have been able to work cooperatively across party lines to develop creative ways to cover more of the uninsured, while federal officials continue to posture, with legislation from both parties stalled by partisan politics.

While the Massachusetts, and to a lesser degree the Vermont and Maine reforms, have been extensive, most states will not be able to replicate what those states have done. Most of the expansions explored in this paper, while well intentioned and well designed, are small. State and local governments are doing what they can with the limited resources they have available—but they need help at the federal level.

Congress should be examining what is going on at the state and local levels and keeping an eye on the results. But states cannot do this alone. While such state experimentation is both helpful and hopeful, national reform should not be done piecemeal at the state and local levels. Rather any reforms done at the state level should help inform Congress about what works best so that national reform can occur expeditiously and without false starts. State reforms should be catalytic and exemplary to, not substitutes for, national reform.

INTRODUCTION

Frustrated by the lack of action or even attention at the federal level, states and local governments are looking for creative ways to expand programs to reach the 47 million Americans without health insurance. There have already been a number of creative initiatives by states and localities over the last five years to cover more of the uninsured, which deserve our review.

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But Massachusetts is not alone. Several states and localities have started with small program expansions; a few have passed large scale reform. States and local governments are reaching out to assist small businesses, or finding ways to expand coverage to those too poor to afford health insurance but not poor enough to qualify for Medicaid. Many expansions offer limited benefit packages, or implement policy changes that are designed to increase affordability. The tools used to finance expansions vary widely, including using federal funds or dedicating specific state funds.

This paper highlights many of these states and a few local areas—and the various tools they are using to reach the uninsured. These are all programs that have passed state legislatures and are either being implemented, or are moving into implementation in the next year.

However, it is important to note that many more state legislatures and Governors had proposals that were debated in the state Houses this year. And five states—Illinois, Colorado, Maryland, New Mexico and Washington State—have active commissions charged with coming back to the legislature next year with a plan for coverage expansion and health system reform. As the frustration with the lack of movement at the federal level grows, it is expected that more states will evaluate and implement policy tools that can be duplicated or adapted back at home in the years to come.

COVERAGE EXPANSIONS

Massachusetts' recently passed legislation, which includes an individual mandate for all citizens in the state to have health insurance, is the most comprehensive coverage expansion to date. Two states, Maine and Vermont, also strive for universal coverage, but do not require individuals to assume responsibility for themselves even when subsidized. Illinois commenced with universal coverage for children, and several other states are looking at how to follow in their footsteps.

Covering everyone (or nearly so): Massachusetts

The most unique aspect of the **Massachusetts [Health Care Reform Plan](#)** is that it strives to cover virtually everyone through a creative combination of requirements and opportunities. Massachusetts has decided to attempt to get at universal coverage through a re-shaped insurance market, an individual mandate with state subsidies, and an employer contribution requirement. To reshape the market, Massachusetts will create the Commonwealth Insurance Connector. The Connector, which will merge the existing small group and individual insurance markets, will enable individuals to purchase various products offered by private insurance companies. Small businesses (those with 50 or fewer employees) and individuals lacking health insurance (including the unemployed, self-employed, those whose employers don't offer insurance, and those ineligible for their employer-based insurance) will be able to purchase fully portable

insurance through the Connector. Policies sold through the Connector will include all current mandates (except for those offered to 19–26 year olds, as explained below).²

The state will provide sliding scale subsidies to help pay for premium and deductible costs for those earning between 100% and 300% of the federal poverty level (FPL). Individuals who earn less than 100% FPL will not be required to pay premiums or deductibles for a plan approved by the Commonwealth Health Insurance Connector Board.³

To insure that the 460,000 currently uninsured in the state are covered, and to lower the average price of coverage for all by bringing in more healthy people, Massachusetts will begin to enforce the requirement that all individuals have a health insurance plan on July 1, 2007. This mandate will be enforceable if the Connector Board determines that “affordable” plans are available. Defining “affordable” is, therefore, clearly a key political and financial issue as yet unresolved.⁴

Modest employer obligations are a key part of the legislation. Any employer with more than 10 employees who doesn’t offer coverage has to pay a “fair share” contribution, or assessment capped at \$295 per employee per year.⁵ Employers also risk a large assessment unless they offer a Section 125, or “cafeteria plan,” to their employees, allowing them to purchase health insurance with pre-tax dollars and linking them to the Connector.⁶

Many questions will need to be answered before the Massachusetts plan is fully operational. While many are hopeful this will be achieved, some remain skeptical of its outcome. For now, perhaps the greatest “exportable” from Massachusetts is *political: bipartisan solutions leading to universal coverage are possible, if the willingness to compromise while pursuing common goals is strong enough to stare down the extremes in both parties*. Such a broad reform at the state level has definitely spurred a great deal of discussion about states’ ability to expand coverage. Massachusetts’ success story has served as a catalyst for dialogue about additional creative expansion options at both the state and federal levels.

Universal Goals with Voluntary Means: Maine and Vermont

Both **Maine** and **Vermont** have passed health care coverage expansions that aim for universal coverage in their states, but stop short of requiring individuals to purchase insurance. Both states have creatively reshaped the insurance market for those lacking employer coverage, offering subsidies for those who can’t afford to purchase coverage, and in the case of Vermont, include an employer contribution requirement.

Maine

Maine passed [Dirigo Health Reform](#) in 2003. The goal of Dirigo was to establish universal coverage within six years, by 2009. The legislation expanded coverage by offering the DirigoChoice health plan to small businesses (defined as at least 2 but less than 50 employees) whether they had previously provided employer-sponsored insurance or not. The plan is also open to individuals who are either unemployed, self-employed or who work for a small business that does not offer health insurance. Similar to Massachusetts, Maine provides subsidies for premiums and deductibles to individuals on a sliding scale up to 300% FPL.⁷

Although the plan has been offered since January 2005, approximately 15,000 have enrolled, and of those, only 5,000 previously did not have health care insurance. Therefore, the state is nowhere near providing coverage to the 130,000 uninsured individuals it was expected to enroll.⁸ In addition, efforts to sign small businesses onto the plan have not gone as well as expected. Because only 2,000 businesses have signed up, most of the members of DirigoChoice are individuals, many of whom (four out of five)

receive subsidies to help afford their coverage. As a result, the cost of the subsidies to make the premiums affordable has been higher than hoped.⁹

The financing of Maine's reform is contingent upon the savings captured by the reform itself. To get Dirigo started, the state dedicated \$53 million in state funds in the first year. But Maine is relying on what the program terms as "savings offset payments" (SOP) to help fund the program for the subsequent years. The SOP are savings that the state identifies as the result of the Dirigo reforms. For example, because additional uninsured would be covered under Dirigo, the state assumed increases in cheaper preventative care and decreases in more expensive care. Maine planned to capture the savings that private insurance companies and the self-insured would reap from this shift. In addition, the state expected savings through Dirigo cost controls, including an assessment placed on the insurers' revenue. The money the state collects from the assessment—or fee payments—would then be applied to provide affordable coverage to additional uninsured and underinsured citizens.¹⁰

The state's insurance commissioner ruled that Dirigo had generated \$44 million in savings in the first year. However, the process of collection of the SOP has not gone smoothly. There has been much disagreement over how much cost savings there has actually been, with many insurers arguing that there have neither been large nor quick reductions in uncompensated care, and that any existing reductions have not resulted in savings to their companies. A recent court challenge brought to Maine's Superior Court upheld the savings offset payment, but it is expected that the decision will be appealed to the Maine Supreme Judicial Court.¹¹

Due to state lawmaker initiatives to make changes to the program's financing and structure, the Governor decided this summer to create a Blue Ribbon Commission on Dirigo Health. The Commission's work will be to examine why there has been lower than expected enrollment and to study optional funding mechanisms for the program. The commission has been tasked with reporting back to the Governor by December 2006. In the meantime, the Dirigo Health Agency Board of Directors has deferred accepting the insurance commissioner's projected SOP for the second year of operation, an estimated \$34 million, until the Blue Ribbon Commission report.¹²

Vermont

Vermont passed its [Health Care Affordability Act](#) in spring 2006. Under the legislation, Vermont will create the "Catamount Health" plan, which will be sold by private insurance companies to individuals lacking in employer-based coverage. Individuals who have been uninsured for 12 months or more are eligible, as are those who have lost coverage for reasons including job loss, divorce, death of the primary policy holder, etc.¹³ Those under 300% FPL will be eligible for premium subsidies on a sliding scale basis, while those with higher incomes will pay the full cost. Vermont expects that 25,000 of the state's 60,000 uninsured will sign up for Catamount Health.¹⁴

To help offset Vermont's costs, employers will pay a quarterly assessment of \$1 per day per total of full time employees (FTEs) if the employer:

- does not offer health insurance,
- only offers health insurance to some employees, or
- has uninsured employees.¹⁵

However, the first eight FTEs are excluded from the calculation of the assessment in 2007 and 2008, which is adjusted to six FTEs in 2009 and four FTEs in 2010.¹⁶

Although Vermont's legislation differs from Massachusetts in that it does not require its citizens to purchase health insurance, the bill does include a provision which would require the state to consider an individual mandate if the goal of 96% coverage is not achieved by 2010.¹⁷

Covering all children: a place to start

Several states are considering ways to expand health care coverage to all children. By expanding Medicaid and SCHIP, many states are finding it possible to increase the number of children who are insured.

This year, **Illinois** began implementing the [Covering All Kids Health Insurance Act](#), which strives to cover all children in the state. All Kids allows parents to buy into the state's SCHIP program if they have children who have been uninsured for six months or more this year. (Starting in 2007, children must be uninsured for 12 months or more).¹⁸

The monthly premiums and co-payments for parents above 200% FPL (the level up to which the state's SCHIP program covers) are based on a family's income and are charged on a sliding scale basis.¹⁹ Copays start at \$2 a doctor visit, with maximum per year copayments based on a family's income. There are no co-pays for well-baby and well-child visits. All Kids offers the same benefits as the state's KidCare program (Illinois' combined Medicaid and SCHIP program) offers, except it excludes coverage for non-emergency transportation.²⁰ Illinois hopes to reach its 250,000 uninsured, and expect 50,000 to sign up this year at a cost of \$45 million to the state.²¹

Tennessee passed legislation this year, called [Cover Tennessee](#), which is designed to help increase the number of insured in the state. The three programs the legislation enacts, CoverKids, AccessTN and CoverTN, are estimated to cost a total of \$225 million over three years and provide coverage to approximately 190,000 people.²² CoverKids creates the state's SCHIP program for all children from families up to 250% FPL. It also allows for families above that income threshold to buy into the program. The benefit structure is comprehensive and is modeled on the State Employee Health Plan.²³ The state expects to enroll 25,000 children in the first year, and has projected the cost to be \$63 million over the first three years.²⁴

Pennsylvania's Governor also just signed into law legislation that will help Pennsylvania to provide all children in the state with health coverage. The state budget, passed in July, included \$4.5 million in state funding for the Governor's [Cover All Kids](#) program.²⁵ Cover All Kids expands on the state's current SCHIP program by offering health coverage to families making between 200% and 300% FPL for a reduced rate (families at or below 200% FPL receive free coverage). Those families pay premiums on a sliding scale based on the families' income.²⁶

For families with certain conditions that earn above 300% FPL, there will be an option to purchase the state's health insurance through the SCHIP program. Those conditions include if the family was denied coverage because of a pre-existing condition, if the cost of private insurance is more than 10% of the family's income, or if the cost is at least 150% more than the state monthly premium of \$143 per child. In addition, if a family is offered employer-sponsored coverage but cannot afford the full premium, then the state will help the family purchase their employer's coverage. To receive assistance, the parents must prove that their children have not had health insurance for at least six months.²⁷

NARROWER TARGETS

Most states have been less ambitious politically and financially than those above. However, some states are trying to offer creative incremental coverage expansions to certain subsets of their population. These include:

- providing subsidies for employees of small firms to afford coverage, often requiring participating employers to make financial contributions;
- expanding coverage to some of the lowest income individuals who are not usually eligible for public insurance programs like Medicaid;
- providing subsidies for individuals to afford their share of employer sponsored insurance; and
- extending family coverage to young adults.

Encouraging small employers to offer insurance to their workers and their families

One trend in expanding coverage is for states to assist small employers so more firms will offer insurance to their workers and their families. **Arkansas, New Mexico, Oklahoma, West Virginia, Montana, Tennessee and Rhode Island** have all passed or implemented programs with targeted subsidies for small businesses and their workers.

Arkansas' [Safety Net Benefit Program](#) is for small businesses with 2 to 500 employees who have not offered insurance in over 12 months. Employers who sign up are required to guarantee coverage to all workers in the firm, regardless of income. Employees of firms that offer coverage are required to enroll unless they can provide evidence of a major medical policy already in effect.²⁸ The level of required fees for employers and employees are still being worked out, but Arkansas estimates that employers will contribute \$15 per month towards the premiums for employees under 200% FPL, and \$100 a month for higher-income workers.²⁹

Employees will be required to share the costs of insurance, in the form of deductibles, coinsurance and/or copayments, with an out-of-pocket maximum. The state will subsidize premiums for low-income workers. Arkansas will begin to enroll small businesses in October 2006. The program will be limited to 15,000 individuals during the first phase. Depending on evaluation and available funding, the number of enrollees could be expanded to up to 80,000 in the future.³⁰

New Mexico's [State Coverage Insurance](#) (SCI) program is designed for small employers with 50 employees or less who have not provided insurance in the last 12 months. Working adults earning less than 200% FPL are also eligible. Employers pay \$75 towards the premium for each employee enrolled and the employee pays up to \$35 per month on a sliding scale based on family income. For low-income individuals whose employers do not want to offer coverage, individuals can choose to participate and pay the employer portion of \$75.³¹ The SCI program is budgeted at \$32 million for this year (including both the state and federal portion), and \$48 million for next year, based on enrollment. As of August 2006, SCI had approximately 4,900 enrollees.³²

Oklahoma has a program called the Employer/Employee Partnership for Insurance Coverage, or [O-EPIC](#). The program is open now to small businesses with up to 25 employees, although the 2006 Legislature passed an expansion of the program to include businesses with up to 50 employees.³³ The program is for individuals (and their spouses/families) at or below 185% FPL. Small businesses, including those that currently offer insurance, must first apply, and once accepted, employees must qualify separately.³⁴

O-EPIC requires the employer to pay 25% of the premium, the employee to contribute 15% of the premium, and the state to pay the remaining 60% (or 85% for the spouse).³⁵ The program is capped at 70,000 enrollees. As of the end of June 2006 the state had 480 employers and 854 employees and spouses enrolled. The average premium assistance paid by OEPIC, per person per month, was \$244.40.³⁶ The state legislature budgeted \$50 million to help fund the program in the first year, with a federal match of \$100 million (see financing section below).³⁷

West Virginia's [Small Business Plan](#) began in 2005. The plan is a public-private partnership between the state's Public Employees Insurance Agency (PEIA) and Mountain State Blue Cross Blue Shield. There is no cost to the state. An affordable, comprehensive health insurance plan is offered to small businesses with two to 50 employees which currently do not offer insurance. The employees must pay at least 50% of premium costs, and 75% of eligible employees in the business must participate. Mountain State Blue Cross Blue Shield is able to use the PEIA negotiated reimbursement rates for providers and prescription drug prices which results in premiums that are between 17 and 22% lower.³⁸ As of September 2006, there were 230 businesses, with 1,100 individuals enrolled in the program.³⁹

Montana began a program in 2006 called [Insure Montana](#), which provides tax credits and a purchasing pool to small businesses with 2 to 5 employees. The refundable tax credits are intended for small businesses currently providing health insurance to their employees. Approximately 446 businesses were enrolled as of May 2006 under the tax credit, and the average credit is \$5,330 per business.⁴⁰

The purchasing pool is for businesses that haven't provided health insurance in the past. Employees are required to pay at least 50% of the premium, and state assistance ranges from 20 to 90% of the employee's portion, on a sliding scale based on their family income. The state also pays up to 50% of the employer's contribution for each covered employee. Montana had 170 businesses in the purchasing pool as of April 2006 and estimates that it will serve 650 businesses by the end of the first year.⁴¹ The state legislature budgeted \$13 million for the first two years of the Insure Montana program.⁴²

Tennessee's recently passed legislation creates a program called [CoverTN](#). CoverTN is expected to provide subsidized insurance for up to 100,000 uninsured employees of small employers.⁴³ The program targets small businesses (less than 25 employees) who are not currently providing coverage and who employ low-wage workers at or below 250% FPL. Also eligible are low-income workers (below 250% FPL) whose employers do not offer coverage, and who have been uninsured for at least six months.⁴⁴

CoverTN is a "three-share" model, in which the state will subsidize \$50 of the expected \$150 monthly premium, with the rest split between the employee and employer. Individuals have the option of paying the full amount if the employer declines to participate. One unique and beneficial aspect to the program is that the coverage is portable and able to move with the individual if he or she loses or changes jobs.⁴⁵

The **Rhode Island** Legislature passed [legislation](#) this year proposed by the Governor to develop a new, affordable product for small businesses with premiums approximately 25 percent below the small group market rate. This will only be the development phase since the legislation merely authorizes the state health commissioner to work with insurance providers, businesses and other stakeholders to come up with the plan, to be called "Select Care." They are expected to use state mandated benefit flexibility, premium rating restrictions and consumer cost sharing to help lower costs. The Governor has proposed that insurance companies that want to compete for contracts to insure the state's work force must offer the plan that will be developed.⁴⁶

Expansions to those lacking employer based coverage

Some states have set up programs specifically for individuals lacking access to employer based insurance. These include **Utah, Pennsylvania, Oklahoma, and Wyoming.**

- **Utah's** [Primary Care Network](#) covers low-income uninsured parents and adults below 150% FPL who were previously ineligible for Medicaid. When the network was first offered in 2003, individuals were charged a \$50 annual enrollment fee. However, many of those eligible found this option unaffordable. In response, the state reduced it to \$15 per year for adults receiving General Assistance, and \$25 per year for those with incomes below 50% FPL. In addition, enrollees are required to pay \$5 to \$30 co-payments and up to 10% coinsurance for some services. The program reached its enrollment cap of 19,000 adults in November of 2003, and has remained at around 18,000 adults since then.⁴⁷
- **Pennsylvania** started a program in 2002 called [adultBasic](#). The program offers a limited benefit package for low-income adults below 200% FPL, who have not had health insurance for 90 days or more.⁴⁸ Enrollees in the program pay monthly premiums and co-pays for doctor visits and emergency room care.⁴⁹ In the program's first year, demand was two to three times higher than the state could afford and the state had to create a waiting list.⁵⁰ However, the state has been able to address the waiting list with additional funding from state's four Blue Cross Blue Shield plans, which is discussed further in the Financing Mechanisms section below.
- **Oklahoma** will be offering a new O-EPIC program in the fall of 2006, called the [O-EPIC Individual Plan](#). The program is designed as a "fall-back" for individuals whose employers are not eligible to participate in O-EPIC, or who cannot get insurance through their employer because they are either self-employed, unemployed and looking for work, ineligible for small group coverage, or working with a disability. The O-EPIC Individual Plan is being designed to be a state-funded managed care plan with a limited benefit package and a lifetime benefit maximum. Premiums will be assessed based on income, and participants will be required to pay copays, without a deductible.⁵¹
- **Wyoming** has passed legislation allowing the state to apply for a Health Insurance Flexibility and Accountability (HIFA) waiver, which would expand coverage to the parents of children who are enrolled in the state's SCHIP program. Eligible families will have incomes up to 200% FPL. The [Kid Care CHIP Parent Plan](#) will be offered by the state, and if approved by the federal government, would be up and running by 2007.⁵²

Subsidies for individuals to purchase employer sponsored insurance

Another trend in coverage expansion is for states to subsidize individuals wishing to purchase employer based insurance. The **Massachusetts** health reform legislation includes an expansion of the state's already existing premium assistance program, Insurance Partnership, which helps low-income workers purchase their employer sponsored insurance. In the recently passed legislation, Massachusetts raised the eligibility for individual employee participation from 200% FPL to 300% FPL.⁵³

Vermont's new legislation will also allow low-income workers with access to employer sponsored insurance to receive premium subsidies to help pay for their premiums, as long as the employer's plan is equivalent to the Catamount Health plan.⁵⁴

In addition, **Illinois'** new All Kids program offers the All Kids Rebate, for a very few families at very low-income levels. The All Kids Rebate reimburses parents for a portion of the premium they pay for private or employer-sponsored health insurance, up to \$75 per child per month, as long as it covers doctor and inpatient hospital care.⁵⁵

Utah and Wyoming are offer premium assistance programs. **Utah's** Primary Care Network offers a [Covered at Work](#) program designed for individuals unable to afford employer based coverage. Individuals are eligible for a state subsidy if the employer's insurance cost is greater than 5% of their income. The employer must pay more than 50% of the premium cost. The state then directly reimburses the insurer or employer up to \$50 for the employee's portion of the premium per month, or \$100 for the employee and family. Individuals are only eligible for five years and the subsidy decreases over the last three years. Enrollment in the Covered at Work program has been limited, with only 72 adults enrolled as of May 2005.⁵⁶

Wyoming's planned expansion to the parents of children in their SCHIP program includes premium assistance to help parents up to 200% FPL participate in their employers' health insurance plan. Employers are required to cover at least half of the worker's premium, and the state helps subsidize the remaining amount. For parents between 133–200% FPL, the state charges a sliding scale participation fee. If the employer is not willing to cover these costs, an employee may cover the employer's share from a Health Savings Account, third party or other source.⁵⁷

Extending family coverage to young adults

Many states are looking for ways to target coverage for young adults, who are less likely to be insured than other age groups. Typically, most children become ineligible for their parent or caregiver's coverage at age 19, unless they are enrolled as a full time student. To address this issue, states are requiring insurers to extend dependent benefits to older children.⁵⁸

At least seven states have required insurance companies in their state to raise the age limits of dependents eligible for coverage under their parents' plan, regardless of whether they are enrolled in school or not. Most states have raised the age to 24, 25 or 26. However, [New Jersey](#), has expanded coverage for dependents up to age 30, the highest in the nation. These expansions help to cover those young adults who are uninsured and are unmarried with no dependents of their own. States either allow the benefit to be structured as a rider with a supplemental premium or a simple extension of the family's policy.⁵⁹

In addition, **Massachusetts'** recently passed health care reform legislation allows insurance companies to develop a plan specifically geared towards 19–26 year olds. The plans will offer low cost products, with fewer state mandates, through the Connector.⁶⁰

PRAGMATIC VARIANTS

Limited benefit packages

Many of the state reforms offer limited benefit packages in order to make coverage more affordable to enrollees, and reduce the costly burden on the state's budget.

New Mexico's State Coverage Insurance program provides benefits similar to a comprehensive commercial plan, but more limited than the full New Mexico Medicaid benefit package. In addition, it has a restrictive \$100,000 annual benefit limit.⁶¹

Utah's Primary Care Network offers basic primary care benefits, but no coverage for hospital care (except for emergency room visits), specialty or mental health care. There is also a limit on some of the covered benefits, including a limit of four prescription drugs per month. One unique feature is that the state made an informal agreement with its hospitals to provide a dedicated amount of charity care to PCN enrollees, which amounted to \$10 million in the first year. In addition, the state provides enrollees with assistance in connecting to specialists willing to provide them with free care.⁶²

Pennsylvania's adultBasic program is designed to provide basic benefits, including preventative care, inpatient hospitalization, physician services, diagnosis and treatment of illness or injury, out-patient hospital services and emergency care.⁶³

For some of the newest state expansions, although the packages are still in the development process, the intention is to offer limited benefits. **Wyoming's** program for parents of SCHIP kids under 200% FPL will offer limited benefit packages for enrollees.⁶⁴

Arkansas' Safety Net Benefit Program will offer a benefit package that includes 6 clinician visits, 7 inpatient hospital days per year, 2 outpatient hospital services (including outpatient surgery, radiology and emergency room visit) per year, and two prescriptions per month from a tiered formulary. Although no catastrophic coverage is provided, individuals will still be able to access catastrophic care as uncompensated care.⁶⁵

Tennessee's CoverTN will offer a benefit package limited to what the planned premium of \$150 per month will buy. The state expects this package will offer basic coverage, including primary care, some basic emergency and hospital coverage, and prescription drugs. The state anticipates there will be no or low deductibles, and co-pays of \$25 for doctor visits and \$10 for prescription drugs. The plan that is under development will be exempt from state laws requiring certain benefits be offered.⁶⁶

In addition, **West Virginia's** recently passed [Affordable Health Insurance Act](#) included the ability for the insurance industry to sell affordable health plans, with less protection than typical plans, to individuals who have been uninsured for at least 12 months. The plans, which will be sold in the non-group market, will focus on primary and preventative services, with limited access to specialist or hospital care.⁶⁷

West Virginia's legislation also includes a three year pilot project allowing up to eight clinics or private physician offices to sell prepaid primary and preventative care to uninsured individuals or businesses not offering employee coverage. The coverage does not include specialist or hospital services.⁶⁸

States Bearing the Risk of Offering the New Insurance Product

Plans offered by state

Although most states are partnering with private insurance companies to offer tailored products for their expansions, some states are designing and selling (with subsidies) their own insurance product for the targeted expansion groups. The health plans offered by **Illinois' Cover All Kids**, **Oklahoma's OEPIC Individual Plan**, **Pennsylvania's adultBasic program**, **Utah's Primary Care Network**, and **Wyoming's planned Kid Care CHIP Parent Plan** are all underwritten by the state.

This was an interesting debate in the final package that the **Vermont** legislature passed. The Governor wanted to be sure that the state did not take on the public risk of providing the Catamount Health plan; therefore the legislation includes provisions compelling the state's two major insurance carriers to provide the plan for the first two years. After that time period, the state's Health Care Reform Commission will

determine whether the program being offered is working in the private market, and if not, the entire system will become a public program with the state bearing the risk.⁶⁹

Reinsurance

New York has a program called [Healthy New York](#), which began enrolling people in January 2001. Healthy New York uses a state subsidized reinsurance mechanism reimbursing private insurance plans for 90% of claims paid between \$5000 and \$75,000 per member per year. Originally, the program reimbursed plans for claims between \$30,000 and \$100,000, but because of lower-than-expected claims, the legislature lowered that amount in July 2003. As a result, most HMOs reduced premiums by 17% after 2003.⁷⁰

Small businesses with less than 50 employees who have not offered insurance over the last 12 months are eligible for Healthy New York. The business must have at least 30% of its employees earning no more than \$34,000 (adjusted annually) and at least half of the eligible employees must participate. Sole-proprietors and low-income uninsured workers are also eligible if they earn below 250% FPL and have not had insurance coverage over the last 12 months.⁷¹ As of December 2005, Healthy New York had over 100,000 enrollees.⁷²

All New York HMOs are required to provide a Healthy New York product, which includes a benefits package that must provide: inpatient and outpatient hospital services, primary and preventive care, diagnostic testing, maternity care, emergency services, and therapeutic services. The prescription drug benefit was made optional in 2003 in order to allow companies to offer plans without prescription drug coverage at a lower premium cost. Co-payments range from \$10 to \$500, with a maximum annual prescription drug benefit of \$3,000 after a \$100 deductible.⁷³

Most indications are that New York's reinsurance mechanism has lowered premium costs below what is offered in the individual and small group markets in New York. Several other states have been interested in Healthy New York and have proposed offering similar programs.

High Risk Pools

Tennessee's recently passed legislation also established a program called [AccessTN](#). AccessTN will provide a comprehensive health insurance plan for seriously ill adults who are unable to obtain private insurance.⁷⁴ The pool will offer two benefit packages. One will be modeled on the State Employee Health Plan, and the other will be a high-deductible plan with a health savings account.⁷⁵ The state plans to offer a premium assistance plan to help low-income uninsurable adults to participate in AccessTN.⁷⁶

The AccessTN program is one of the newest [High Risk Pools](#), a tool that 33 other states have utilized to cover citizens who lack insurance. High risk pools are typically state-created, non-profit associations that offer comprehensive health insurance to individuals who have conditions that make them uninsurable in the commercial non-group market. Most states cap enrollment, and use a variety of funding mechanisms to cover the costs.⁷⁷

FINANCING MECHANISMS

Not surprisingly, states are striving to design creative financing mechanisms to fund these coverage expansions. Utilizing federal dollars is the most popular way to enable states to cover more adults, families and children. States must obtain federal approval to use Medicaid and SCHIP funds for expansions, and this is most commonly done using 1115 and HIFA waivers, or getting permission to expand their SCHIP program.

States have also used dedicated funding streams to help fund coverage expansions, such as tobacco tax revenue and funds from the tobacco settlement of 1998. A few states also include state only general revenue dollars to help fund expansions. The sections below provide details about how states are utilizing these funding mechanisms.

Federal funding

1115 waivers

A large part of the **Massachusetts** reform was based on the need to come up with a new 1115 waiver application that would satisfy the federal government's request that the state stop subsidizing safety net *institutions* and instead attach federal dollars to people. For Massachusetts there was \$385 million in federal funding at stake.⁷⁸ Therefore, the Massachusetts legislation included shifting the state's existing Safety Net Free Care Pool, which currently reimburses providers for uncompensated care, to a new Safety Net Care Fund, which will combine the state and federal funds to help pay for the subsidies for low-income individuals and families.⁷⁹

In **Utah**, the Primary Care Network (PCN) and PCN Covered at Work programs are both funded through an 1115 waiver that was approved by the federal government in 2002 (and for PCN Covered at Work a year later). Receiving the 1115 waiver allowed the state to receive a federal match of 70% to help fund the program, which was budgeted at \$16 million in 2003. In addition, Utah started offering a reduced benefit package, called "Non-Traditional Medicaid", to current Medicaid recipients who were parents. The resources saved as a result of this shift helped to fund both PCN programs.⁸⁰

Vermont's reform also requires the state to seek permission from the federal government to include subsidies provided for Catamount Health in their existing Medicaid 1115 waiver.⁸¹

HIFA waivers

Arkansas was approved for a HIFA waiver this year to help the state receive federal Medicaid funds to start their Arkansas Safety Net Program.⁸² **Oklahoma's** O-EPIC program is also funded with a HIFA waiver that the state received in September 2005.⁸³

New Mexico's State Coverage Insurance program was started with the approval of a HIFA waiver in 2002. The waiver proposed using unspent federal SCHIP funds to provide managed care coverage for adults up to 200% FPL. The program also uses state general funds, and the combination of premium dollars paid by the employer and employee.⁸⁴

In 2006, **Wyoming's** state legislature passed legislation allowing the state to apply for a HIFA Waiver. If approved, the waiver would allow the state to expand coverage to the parents (with incomes up to 200% FPL) of children currently enrolled in the state's SCHIP program.⁸⁵

SCHIP funds

Illinois and Pennsylvania will fund their expansions to cover all children using federal SCHIP funds. **Illinois'** program will fund all children under the 200% FPL with SCHIP program dollars. Those above 200% FPL who receive subsidies on a sliding fee scale will be funded with state funds. To help pay for the state share, the state is shifting beneficiaries currently in Medicaid and SCHIP into managed care. Anticipated savings in the first year are expected to be \$56 million, which will go to cover the All Kids program, estimated to be \$45 million in 2006.⁸⁶

Pennsylvania's 2006 budget included a commitment of \$4.4 million for the yet to be enacted Cover All Kids program. The program would also be funded with \$10.2 million in SCHIP funds from the federal government, which would still need to approve the proposal once it passes the state legislature.⁸⁷

Dedicated state funds

A few states have financed their coverage expansions with tobacco tax revenue. **Oklahoma's** O-EPIC program is partially funded using revenue collected from tobacco taxes, as well as federal funds from their HIFA waiver.⁸⁸ Subsidies provided under **Vermont's** Health Care Affordability Act will be funded with an increase in the cigarette tax. The state plans to increase the tax on tobacco from \$1.19 to \$1.79 in 2007 and to \$1.99 in 2009.⁸⁹

Arkansas and Pennsylvania have also partially funded their programs using money that the states received from the 1998 national tobacco settlement. **Arkansas** expects to use \$18 million from its tobacco settlement funds to help pay for its Arkansas Safety Net Program over the next five years.⁹⁰

Pennsylvania's adultBasic program is partially funded with a portion of the tobacco settlement money. adultBasic receives approximately \$400 million per year from the settlement fund.⁹¹

One unique aspect of adultBasic's funding was negotiated by Pennsylvania's Governor last year. Governor Rendell negotiated a one-of-a-kind way to help finance adultBasic, as well as other state run programs for the uninsured.⁹² The state's four Blue Cross Blue Shield plans agreed to help finance various state initiatives, including adultBasic, as well as local health care services. The insurance plans appropriate a percentage of their revenue from premiums they receive yearly—based on a formula—to the Annual Community Health Reinvestment Fund. Sixty percent of the Fund will help the state finance its state programs for the uninsured and 40% will go to health care services in local communities. The four plans expect to put over \$1 billion into the Fund over six years. Pennsylvania uses the money from the Fund to increase the number of adults in the adultBasic program, many of whom have been on long waiting lists for the program.⁹³

CREATIVE LOCAL EXPANSION EFFORTS

Muskegon County, Michigan

Access Health is a “three-share” program in Muskegon County, Michigan aimed at increasing health insurance coverage, especially for small and mid-size businesses. The program, established by efforts spearheaded by the [Muskegon County Health Project](#), was established in September 1999.⁹⁴

The annual budget for the program is \$2 million and is financed with a three way split. Employers pay 30% of the cost of health insurance, employees pay 30%, and the community pays 40%. The community's funding comes from local funds, the State of Michigan, and federal Disproportionate Share Hospital (DSH) funds, which the state and local hospitals agreed to let the county use to help finance the program.⁹⁵

Employers can participate in Access Health if they have not offered health benefits for 12 months and the median wage of eligible workers does not exceed \$10 per hour. The program is intended for small and medium sized employers, but there is not an upper limit on the size of the firm.⁹⁶

The Access Health plan covers a variety of services, including: inpatient and outpatient care, primary care, preventative services, emergency room care and prescription drugs. All care must occur within the

county. Premiums have remained low, under \$50 per month for the employee share, and co-pays are kept low to encourage use of primary and preventative care.⁹⁷

Access Health has had over 300 businesses participate in the program, and 1,300 individuals enrolled, approximately one third of the 3,000 eligible uninsured individuals in the county.⁹⁸

Santa Clara County, California

Santa Clara County was the first [Children's Health Initiative](#) (CHI) established in California. Started in 2001 by a public-private partnership, the purpose of the Santa Clara program is to provide health insurance for all children up to 300% of poverty who are not eligible for other public health insurance programs.

The insurance product Santa Clara offers is known as Healthy Kids, which provides a comprehensive list of services similar to California's SCHIP program. Children are covered from birth to age 19, regardless of their immigration status. Families pay a very modest premium of \$4 to \$6 per month, per child, with a maximum of \$18 per family.⁹⁹

Healthy Kids is a locally funded program. Funding comes from a variety of sources, including foundations, state, and local (city and county) contributions. As of June 2006, the Santa Clara CHI had received 114,000 applications for health insurance coverage, including for California's Medi-Cal (California's Medicaid program) and Healthy Families (California's SCHIP program) programs. A waiting list exists for the Healthy Kids program, which currently enrolls approximately 14,000 children.¹⁰⁰

Since Santa Clara started their program, a number of counties in California have implemented CHIs. As of May 2006, 18 counties had implemented and 12 were planning on forming CHIs.¹⁰¹ All of the CHIs conduct outreach to enroll eligible children not only in their own Healthy Kids plans, but also in the state's Medi-Cal and Healthy Families programs. A statewide coalition of advocates, founded to create universal access to health care for all children in California, is working to find a permanent source of public funding for all the Healthy Kids programs in the state.¹⁰²

San Francisco City, California

San Francisco is the first city in the country that has passed a proposal to provide access to health care for all of its citizens. The San Francisco Board of Supervisors passed, and the Mayor signed into law, the [San Francisco Health Care Security Ordinance](#) this summer. The ordinance establishes the San Francisco Health Access Program, which will cost about \$200 million a year to enroll approximately 82,000 uninsured adults currently living in the city.¹⁰³ The City plans to put in \$104 million, which it currently spends on the uninsured, to help finance the program. The rest of the funding will come from premiums paid by individuals and employers, an employer minimum spending requirement, and from federal funds.¹⁰⁴

City residents will be covered, regardless of pre-existing conditions, immigration status or employment—but only within the city limits. This is because the program is not health insurance, but rather health coverage which acts like insurance with a limited network, assigned gatekeeper and 100% copay outside of network, and no coverage outside of the city limits. Those enrolled in the program will receive preventive care, hospitalization services, specialty care and prescription drugs, all coordinated and provided through the city's Department of Public Health, non-profit clinics, and non-profit hospitals.¹⁰⁵ Individuals will be assigned a medical home and assigned to a primary care physician who will coordinate their care. Vision, dental, infertility and cosmetic services will not be covered.¹⁰⁶

Individual city residents who do not have insurance will be able to enroll in the San Francisco Health Access Program, and pay a premium based on a sliding scale on their income. Individual premiums will start at \$3 a month and go up to more than \$200 per month for those with the highest incomes. Employers can also enroll their employees as a group and pay for their premiums.¹⁰⁷ The city will implement the employer program during two separate phases. First, employers with 50 or more employees will be able to sign up for the program starting on July 1, 2007. Second, employers with 20–49 employees will be able to enroll starting in March 2008.¹⁰⁸

To discourage employers from dropping current coverage for their employees, the ordinance sets a minimum spending requirement for medium-sized and large employers, based on a minimum amount they must spend per hour on health care for their employees. For example, companies with more than 100 workers will be required to spend \$1.60 an hour per employee on health care services. Medium-sized employers, those with 20–99 employees, must spend \$1.06 per hour per employee on health care. Companies with less than 20 workers are exempt. This amount can be spent by the employer by purchasing health insurance, contributing to the Health Access Program, contributing to health savings accounts, or directly reimbursing employees for their health expenses.¹⁰⁹ The minimum spending requirement for employers is intended to help finance the Health Access Program, however a legal challenge based on ERISA is likely.¹¹⁰

CONCLUSION

State and local governments are acting as laboratories for the rest of the country, and more importantly, they are yielding results. From New England to the Golden Gate Bridge, state and local policymakers are using various tools to increase the number of insured in their states, including providing subsidies for small businesses and individuals, and using expansions of public assistance programs, such as Medicaid and SCHIP.

Many state legislatures have been able to work cooperatively across party lines to develop creative ways to cover more of the uninsured, while federal officials continue to posture, with legislation from both parties stalled by partisan politics. Congress should take a cue from Massachusetts, where a Republican governor and a Democratic legislature worked together to lay out a fairly ambitious plan—one developed with common goals of improving the health, and sense of community responsibility, for the citizens of Massachusetts.

The bi-partisan reform package that Massachusetts passed has created increased interest across the political spectrum in universal coverage through an individual mandate. And while the Massachusetts, and to a lesser degree the Vermont and Maine reforms, have been extensive, most states will not be able to replicate what those states have done. Most of the expansions explored above, while well intentioned and well designed, are small. State and local governments are doing what they can with the limited resources they have available—but they need help at the federal level.

Congress should be examining what is going on at the state and local levels and keeping an eye on the results. There has been legislation introduced this Congress (S. 2772, HR 5864, and S. 3776), that would provide federal support through grants to states and local governments that want to try to expand coverage to more of their citizens. By providing such support to spur experimentation and then forcing Congress to examine the results—perhaps states and local governments can be the catalysts for reform at the federal level.

But states cannot do this alone. While such state experimentation is both helpful and hopeful, national reform should not be done piecemeal at the state and local levels. Rather any reforms done at the state level should help inform Congress about what works best so that national reform can occur expeditiously

and without false starts. State reforms should be catalytic and exemplary to, not substitutes for, national reform.

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- ¹⁰³ Cecilia M. Vega, “San Francisco Supes give final OK to health care coverage,” *San Francisco (CA) Chronicle*, July 26, 2006.
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- ¹⁰⁵ Ibid.
- ¹⁰⁶ Academy Health State Coverage Initiatives, “San Francisco Approves Universal Access Bill,” St@teside newsletter, July 26, 2006, <http://www.statecoverage.net/stateside0706.htm>.
- ¹⁰⁷ California HealthCare Foundation, “San Francisco Moves Forward with Health Access Plan,” *California Healthline*, August 9, 2006, <http://www.CaliforniaHealthline.org>.
- ¹⁰⁸ Academy Health, “San Francisco Approves Universal Access Bill.”
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- ¹¹⁰ For more information about ERISA, please see: <http://www.chcf.org/topics/healthinsurance/index.cfm?itemID=109413>.