STATE PROGRAMS TO COVER THE UNINSURED

Facing continued increases in the number of uninsured, declines in employer-sponsored insurance, and a lack of national consensus on a way forward, states have been taking matters into their own hands. States have enacted a variety of programs to expand coverage to the estimated 47 million Americans without health insurance. While some states are taking incremental approaches such as providing universal coverage for children or establishing public-private partnerships to insure low-income workers, others are attempting comprehensive system reforms. These broad reforms, in addition to trying to increase coverage and access to care, also incorporate initiatives to address health care quality, cost containment, chronic care management and prevention.

The States Respond

Massachusetts: Mandating Coverage

“Massachusetts has a long history of health policy innovation,” said Michael Miller, policy director for Community Catalyst, a Boston-based health policy advocacy group. “That past record provided a substantive foundation for reform.”

But Miller said there was a confluence of other factors that came together to make health reform happen in Massachusetts in 2006. “The more proximal causes included the potential loss of federal Medicaid funds… and the collection of over 100,000 signatures to put a health reform question on the ballot. [Then-]Gov. [Mitt] Romney’s presidential bid also probably played a role. Finally, the investment of a number of foundations—particularly the Blue Cross Foundation—in the process and in convening stakeholders was significant.”

According to a report by the Kaiser Commission on Medicaid and the Uninsured, more than 100,000 people in Massachusetts have gained insurance coverage as a result of the April 2006 legislation aimed at covering 95 percent of residents within three years. The Massachusetts program includes an expansion of the state’s MassHealth program for children with family incomes up to 300 percent of the federal poverty level (FPL). Insurance premiums are subsidized by the state on a sliding scale for individuals with incomes up to 300 percent of FPL. Those individuals with incomes below $9,800 (100 percent FPL) pay no premiums. The state created the Commonwealth Health Insurance Connector to help individuals and small businesses find affordable health coverage. The Connector allows individuals to keep their policy and provider even if they switch employers.

The state’s mandates have received much of the attention, however. Adults who can afford insurance are now required to purchase it, a first for any state. They risk the loss of their personal exemption on their 2007 income taxes if they didn’t obtain insurance by July 1. A monthly fine equaling 50 percent of the monthly cost of health insurance will be imposed in future tax years. The Massachusetts Department of Revenue will assess the penalty for each of the months during which the individual did not have coverage. Beginning in 2009, the insurance individuals obtain will also have to meet Minimal Creditable Coverage standards set by the Connector Board. Coverage will be required to include “preventive and primary care, emergency services, mental health services and prescription drug coverage.”

For employers, there is a mandate as well. Those with 11 or more employees are required to make a per-worker contribution of about $295 annually or demonstrate that at least 25 percent of full-time employees are enrolled in the company’s group plan and the employer contributes toward their premiums. They can also fulfill the requirement by demonstrating they pay at least 33 percent of employee health insurance premiums. Employers with 11 or more workers are required to have so-called “cafeteria plans” that permit workers to purchase health care with pre-tax dollars. That saves employees about 25 percent of the cost of the premium. Employers may be assessed a surcharge if their employees access free care.

Massachusetts was able to move its reforms forward thanks to its ability to leverage $385 million in federal Medicaid funds once used to assist health plans for the uninsured operated by two public hospital systems. The federal government had insisted the state change an existing Medicaid waiver to shift the funds to insurance coverage.
In addition to collecting individual and employer contributions, the state also plans to invest $308 million from the general fund over three years, according to a report produced by the Robert Wood Johnson Foundation’s State Coverage Initiatives program.

Vermont: Chronic Care Management

Just weeks after health reform was passed in Massachusetts, Vermont legislators enacted the Catamount Health plan to provide a low-cost private insurance product to the uninsured. Former state Sen. James Liddy, one of the architects of Catamount Health, said years of state activity on health reform combined with the rising number of uninsured made Vermont’s comprehensive reform effort possible.

“He over the years Vermont has enacted a number of health care reform programs,” he said. “More than 95 percent of Vermont’s children have health insurance and our SCHIP [State Children’s Health Insurance Program] has been a model for a number of states. At the same time, from 1999 through 2004 Vermont’s overall rate of uninsured grew from 7 to 11 percent, almost all of whom were working Vermonters either not offered employer sponsored health insurance or unable to afford it.”

As in Massachusetts, sliding-scale premium subsidies will be provided for individuals with incomes up to 300 percent of the FPL beginning in October 2007. Similar premium assistance will be provided to low-income individuals with access to employer-sponsored insurance who have previously been unable to afford insurance. The Office of Vermont Health Access in the Agency of Human Services will operate the premium assistance program. Employers will pay a $365 annual assessment for each uninsured full-time employee. Vermont has set a goal of insuring 96 percent of residents by 2010.

Chronic care management is a key part of Catamount with the hope of reducing the rise in the cost of care by reducing hospitalizations, complications and visits to specialists. The program focuses on providing the right care at the right time. Studies have shown people with chronic conditions receive the right care at the right time only 55 percent of the time. About 75 percent of all health care spending today is from people with chronic conditions, according to a study in the New England Journal of Medicine.

An increase in the tax on tobacco products is helping fund Catamount Health. The state also hopes to tap federal matching funds to support the provinces for their employees are not charged a fine.

“The political environment was different in 2002-2003 when we were just starting,” Riley remembers. “We had really wanted to do … an employer pay-on-play and a mandate, but dearly people were not ready to talk about that then. So we started a more voluntary way.”

DirigoChoice—the insurance product made available to small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance—is offered exclusively by the state’s largest insurance carrier, Anthem. DirigoChoice offers sliding-scale discounts on monthly premiums and reductions in deductibles and out-of-pocket maximums to enrollees with incomes below 300 percent of the federal poverty level. Employers pay 60 percent of employee only costs and are required to offer family coverage. The state has set the goal of expanding coverage to all uninsured citizens by 2009.

To date, the program has enrolled 12,000 Mainers, fewer than the state had anticipated. The state is working to improve outreach and marketing strategies to increase enrollment. A number of cost-containment measures and an initiative to help residents make informed health care choices are also key parts of Maine’s approach. Dirigo funding comes from a combination of employer premium and individual contributions, state general funds and federal Medicaid matching funds for eligible individuals.

Maine’s reform effort, which has been around since 2003, has already proved hugely influential on other state plans that have followed.

“All the states that have done things have certainly been actively engaged with us and talked with us and learned both from our successes and our mistakes,” Riley said. “It’s interesting that the sliding scale subsidies to reduce private insurance up to 300 percent of [FPL] has pretty much been echoed in all the other plans.”
Illinois: Covering All Kids

Illinois’ effort to make insurance coverage available to all uninsured children has served as a catalyst to other states that are moving forward with similar programs. These states have discovered it’s a relatively inexpensive action they can take to lower the overall number of uninsured and benefit families.

Gov. Rod Blagojevich signed the Covering All Kids Health Insurance Act in November 2005. A recent case study by the Kaiser Commission on Medicaid and the Uninsured credited the initiative’s passage to the strong leadership of the governor, who was the principle architect of the effort, and widespread support from state advocacy groups, health care stakeholders and the legislature.

Any child uninsured for 12 months or more is now eligible for coverage, with the cost to the family determined on a sliding-scale basis. In addition to enrollee premiums, funding comes from cost-sharing (deductibles for services) and projected savings from two new managed care initiatives. No cost-sharing is imposed for preventive care regardless of income. This was done to emphasize the importance of preventive care and make it affordable for low-income families.

The program has already surpassed state enrollment targets and many attribute that to the state’s extensive outreach effort, which includes assistance in filling out the All Kids application offered by community organizations, medical providers and insurance agents. The All Kids expansion has provided coverage to 50,000 previously ineligible children. The state continues to seek federal assistance for children eligible for the state’s SCHIP program KidCare and Medicaid, which are both now part of All Kids.

New Mexico: Public-Private Partnership

New Mexico had the second highest percentage of uninsured individuals in the country in 2004-05—21 percent or 399,000 New Mexicans. Fortunately the state is employing numerous strategies aimed at expanding coverage.

In 2005, the state launched a public-private partnership called State Coverage Insurance (NMSCI). Designed for working adults who earn less than 200 percent of the federal poverty level, NMSCI is funded with a combination of state general fund dollars, federal funds and employer/employee premiums. Self-employed workers are required to pay both the employer and employee portion of the premium.

The state legislature appropriated $4 million for the program in FY 2006, which was matched by $16 million in federal money from SCHIP. More than 8,000 New Mexicans are now enrolled.

New Mexico has also lowered the premiums for its Health Insurance Alliance, a high risk pool for individuals and small employers. The state created the Small Employer Insurance Program, targeted toward nonprofits and small employers. In addition, unmarried dependents can now stay on their parents’ individual and group health plans until they turn 25. Insurers in the state are now required to offer health plans for part-time employees. And the state has begun a two-year process of expanding Medicaid for adults up to 100 percent of the FPL.

Gov. Bill Richardson and the legislature also appointed members to the Health Coverage for New Mexicans Committee, which recently issued its final report assessing three possible models for achieving universal coverage. Lawmakers will take up the committee’s recommendations in January 2008.

Ruby Ann Esquibel, health policy coordinator for the New Mexico Human Services Department, also serves on the staff of the committee. She said even the states that have accomplished comprehensive reforms began with more incremental ones, something that often gets overlooked.

“That’s usually what has had to occur in all these states is they’ve had to use incremental approaches to sort of get to a certain place and you have either a fund built up like they did in Massachusetts for uncompensated care or you had your numbers so high with Medicaid to where you were already covering adults at a high level,” she said. “So [they] had all these things in place then [took] the leap to doing more universal coverage. I think a lot of the states have done incremental [steps] and I think that doesn’t really come out in the newspaper articles.”

—Sean Slone is a health policy analyst at The Council of State Governments