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## ***Improving and Increasing Access to Care: State Health Coverage Expansions Since 2004***

### **Summary**

Over the past few years, states have emerged from one of the tightest budget crises in recent history. In 2003, with fiscal pressures among the most prominent of state concerns, many states were forced to develop creative methods of providing health coverage options for those most in need. The NGA issue brief, *Doing More With Less: Recent State Coverage Expansions*, which was first published in November 2003—at the height of the budget crisis for many states—provided state policymakers with innovative ideas for action. Since that time, states have demonstrated a continued commitment to expanding coverage to the uninsured. This updated issue brief explores state progress in expanding coverage programs and highlights the most recent innovations in health coverage expansion.

There were 46.6 million uninsured Americans in 2005,<sup>1</sup> an increase of 1.3 million since 2004.<sup>2</sup> The rate of uninsured has increased by more than 5 million over the last four years due to various factors, including rising health care costs, decreasing employer-based coverage, and only modest increases in publicly funded coverage.<sup>3</sup>

As the number of uninsured Americans increases, the costs of treating them are shifted between individuals, communities, and governments. For the uninsured individual, lack of coverage translates into the likelihood of poorer health and health outcomes and holds the individual responsible for their health care costs, often compromising their financial stability. The problem of uninsurance in communities appears in the form of an overall decrease in access to hospitals, emergency room care, specialty services, and a lack of community wellness. Local and state governments also must bear the cost of uninsurance as they reimburse providers for uncompensated care.<sup>4</sup>

Due to its broad scope and complexity, the lack of health insurance in America does not have a quick fix. However, to address the problem of the uninsured, several states recently enacted plans to increase coverage and access for many Americans. States have expanded and implemented:

- **steps toward universal access to health care coverage**, which combines several initiatives to offer residents access to affordable health care;

**Coverage of the U.S. Population, 2005**

Type of Health Insurance	Coverage Rate (percent)	Percent Point Change from 2004
Employer-based	59.5	- 0.3
Uninsured	15.9	+ 0.3
Medicare	13.7	+ 0.1
Medicaid/ SCHIP	13.0	No change
Direct-purchase private	9.1	- 0.2
Military health care	3.8	+0.1

Source: U.S. Census Bureau, 2006.

- **premium assistance programs**, whereby states provide subsidies to low-income uninsured persons to assist them in purchasing private insurance for themselves and their families;
- **tax credits** for small businesses who offer health care and paid part of their employees' health insurance expenses;
- **children's health coverage**, through both SCHIP program expansions and innovative 1115 waivers; and
- **access to community health centers** as an alternative, non-emergent care option for uninsured populations to receive primary care services.

### Who are the Uninsured?

The uninsured do not fit neatly into one category. While adults age 65 and older are eligible for health coverage through the Medicare program, many nonelderly adults and children go without health insurance for a variety of reasons. Many cannot afford private insurance, do not have access to health insurance, and do not qualify for Medicaid, the State Children's Health Insurance Program (SCHIP), or other government insurance programs.<sup>5</sup>

- **Low-income working individuals** with family incomes below 200 percent of poverty make up approximately 65 percent of the uninsured.<sup>6</sup> Employees of small businesses, the service or retail industry, and laborers are less likely to have health coverage through their employer or their spouse's employer.
- **Racial and ethnic minorities** account for half of the uninsured in America.<sup>7</sup> Compared to 11 percent of non-Hispanic whites, 33 percent of the Hispanic population, 20 percent of African Americans and 18 percent of Asian Americans are uninsured.<sup>8</sup>
- **Working families** make up over 80 percent of the uninsured children and nonelderly adults in the U.S.<sup>9</sup> Nearly 70 percent of the uninsured come from families with one or more full-time workers.<sup>10</sup> Among the poor, those with incomes less than 100 percent of the federal poverty level (FPL), 55 percent have at least one worker in the family.<sup>11</sup>
- **Childless, poor adults** make up 47 percent of the nonelderly uninsured.<sup>12</sup> Though Medicaid and SCHIP may have filled in the gap for some who have lost private insurance, public coverage for childless adults has not been able to offset the continued loss of employer-based coverage for many individuals.<sup>13</sup>

### The Consequences of Lacking Health Insurance

Lack of health insurance coverage impacts individuals, communities, and states alike. Individuals who are unable to pay for health care or choose to forego insurance available to them place a burden on the state through over-utilization of emergency services and uncompensated care in their communities.

- Medical expenditures for uncompensated care in 2004 were estimated to **total over \$40.7 billion**. Of this amount, at least \$34.6 billion, or 85 percent, came from local, state and federal governments.<sup>14</sup>
- Over 40 percent of nonelderly uninsured adults have **no regular source of health care**, compared to nine percent of those with coverage.<sup>15</sup>
- Nearly half (47 percent) of uninsured adults **delayed seeking medical care** due to cost, compared to 15 percent of insured individuals.<sup>16</sup>

- The Institute of Medicine estimates that about **18,000 Americans die prematurely** each year because they lack health insurance.<sup>17</sup>

In all, the rising cost of health insurance has caused more private sector firms to decrease benefits and increase employee contributions to health care costs. This has led to an increased number of uninsured and an increased amount of uncompensated care. In order to reimburse health care providers, the cost of uncompensated care is sometimes shifted to privately insured individuals and employers in the form of increased premiums and cost-sharing. The most recent information on the annual growth in private health insurance premiums as reported by employers shows an increase of 9.2 percent between 2004 and 2005.<sup>18</sup> As such premiums continue to rise, employers are less willing and able to offer coverage to their employees, which in turn drives the cyclic pattern of the uninsurance and increasing premiums. This pattern adds to the growing number of uninsured Americans and highlights the importance of state action against uninsurance.

### **State Efforts to Increase Access to Coverage**

In an effort to increase coverage through employer-based and individual insurance, many states have attempted to make health insurance more accessible and affordable, particularly for small businesses and individual purchasers.

#### ***Steps Toward Universal Coverage***

Many states have taken steps to incrementally increase coverage leading to universal access, and some states are offering multiple coverage initiatives to extend health insurance coverage to uninsured populations. States are offering premium assistance for employer-sponsored insurance, new health insurance options intended to be more affordable for employers, employees, and individuals, along with extensions of Medicaid or SCHIP programs.

#### **Maine**

The Dirigo Health Plan, which began providing coverage January 1, 2005, currently covers more than 15,000 Maine residents.<sup>19</sup> The plan is part of a state act to achieve universal access to coverage within five years of implementation and includes efforts aimed at cost-containment and improving health care quality. Maine contracts with a private insurer to offer coverage to small businesses, self-employed and uninsured individuals.

The plan requires participating employers to cover at least 60 percent of the employee's cost plus a maximum \$300 fee for the Dirigo program.<sup>20</sup> Enrollees with incomes below 300 percent of poverty pay premiums and cost-sharing on a sliding scale.<sup>21</sup> The Dirigo Health Plan has enrolled 8,600 residents and 750 small businesses.<sup>22</sup>

Also under the Dirigo Health Plan, Maine expanded MaineCare (Medicaid) eligibility from 100 percent to 125 percent of FPL for single and married adults without dependent children.<sup>23</sup> The state had authority to expand their Health Insurance Flexibility and Accountability (HIFA) waiver from 100 percent to 125 percent of poverty but reached the federal budget neutrality cap and was unable to do so.<sup>24</sup> Through Dirigo, MaineCare expanded eligibility for parents to 200 percent of FPL and has resulted in 4,000 enrolled adults.<sup>25</sup>

#### **Massachusetts**

In an effort to insure every resident of the state, Massachusetts enacted a groundbreaking law to offer affordable private insurance, premium subsidies, and expansions of the existing SCHIP program. The plan requires individuals, businesses, and the government to take steps to ensure every resident is covered. The plan includes an individual mandate requiring all residents to have health insurance by July 1, 2007.<sup>26</sup> Employers with more than 10 employees must offer

insurance or pay a portion of their employees' health insurance premiums and must also offer its employees the ability to buy health insurance with pre-tax dollars.<sup>27</sup>

The state plan created the Commonwealth Health Insurance Connector, which will offer small businesses and individuals the opportunity to buy affordable health insurance.<sup>28</sup> In addition, the state has created the Commonwealth Care Health Insurance Program, which offers sliding-scale subsidies for individuals with incomes up to 300 percent of poverty to buy health insurance.<sup>29</sup> The plans offered through Commonwealth Care will be those managed care companies used by the Medicaid program.<sup>30</sup> Massachusetts also increased the eligibility levels for the SCHIP program from 200 to 300 percent of poverty.<sup>31</sup>

The Massachusetts plan will use funding from the existing uncompensated care pool, Medicaid funds, general state revenues, and employer contributions.<sup>32</sup> Massachusetts found itself in a unique position with \$385 million in federal Medicaid funds that would have been lost if a plan had not been created.<sup>33</sup> The state does not predict that other state funds will be needed after the first three years of the program.<sup>34</sup>

## **Vermont**

Governor Jim Douglas has signed health care reform legislation that extends affordable insurance coverage while reducing costs through several quality improvement initiatives. The law will provide premium assistance to low-income Vermonters and contains initiatives to make Medicaid more accessible for those that are deemed eligible.

Low-income, uninsured Vermonters with access to an employer-sponsored insurance plan will also be given a subsidy to pay for the insurance plan available to them. Vermonters eligible for the state's Medicaid program with access to approved employer-sponsored insurance also will be offered premium assistance to participate in employer-sponsored insurance.

Those without access to an employer-sponsored insurance plan will be offered a Catamount Health plan, which are provided by private insurers and must offer a standard set of benefits defined by the state. Premiums will range from \$60 per month for individuals with household income of less than 200 percent of FPL to \$135 per month for individuals with household income between 275 and 300 percent of FPL.<sup>35</sup>

In addition, employers are required to pay \$365 annually for full-time employees if the employer does not offer insurance, only offers insurance to some workers, or some employees remain uninsured. This will be required of all employers with nine or more employees in 2007 and increasing to employers with five or more employees starting in 2010.<sup>36</sup>

A chronic care management system will be created to manage the chronic conditions of individuals enrolled in Medicaid and the State Children's Health Insurance Program, Dr. Dynasaur. The new law also proposes steps to control costs and cost shifts within the health care system by promoting healthy behaviors through a grant program to fund community health and wellness programs. In addition, the state will soon adopt rules to permit health insurance companies to offer premium discounts or other incentives—known as a Healthy Choices Discount—to people who participate in health promotion or disease prevention programs such as smoking cessation.<sup>37</sup>

### ***Premium Assistance***

One method of making private insurance more affordable for low-income families is to provide them with subsidies that enable them to purchase coverage – known as premium assistance. To develop such programs, states use Medicaid and SCHIP dollars to pay private insurance premiums for beneficiaries so they may purchase private coverage for themselves. States that

have implemented premium assistance programs have found success—not only because it provides coverage to a substantial portion of low-income families who have access to employer-based insurance and are unable to afford it—but also because it helps stabilize private markets and prevent crowd-out, which occurs when private employers or individuals drop private insurance for public coverage.

In general, states have two main options for implementing premium assistance programs using Medicaid dollars.

- Develop Health Insurance Premium Payment (HIPP) programs, in which the state uses Medicaid funds to purchase employer-based group health insurance on behalf of Medicaid-eligible individuals, if such insurance is available and it is cost-effective to do so.<sup>38</sup> To date, Medicaid HIPP programs have been implemented in at least nine states, including **California, Georgia, Iowa, Missouri, Pennsylvania, Rhode Island, Texas, Virginia, and Wisconsin.**<sup>39</sup>
- Secure a Health Insurance Flexibility and Accountability (HIFA) waiver or another section 1115 waiver from CMS. When coverage is purchased this way, it is not subject to federal Medicaid cost-sharing and benefit standards, which means the money used for premium assistance may go toward insurance that is less comprehensive than traditional Medicaid coverage. Most states that have pursued premium assistance through HIFA waivers have found that the waiver allows them increased flexibility, reduced administrative requirements, and a streamlined application process.<sup>40</sup> More recently, the federal government has encouraged states to use the HIFA waiver to coordinate public and private coverage for SCHIP beneficiaries. States employing waivers in this way in recent years include **Arkansas and New Mexico.**

### **Arkansas**

Arkansas has been an innovator in insurance expansion since 1996, when it started its ARKids program as a precursor to the SCHIP program. More recently, the Arkansas Safety Net Benefit Program, which was approved through a HIFA waiver, will help employers provide limited coverage for their employees through a public/private partnership. Employers will be offered private insurance options chosen by the state.<sup>41</sup> In order to participate in the program, employers cannot have offered group health insurance for the past 12 months prior to program enrollment and must guarantee 100 percent employee participation, unless an employee has other medical coverage.<sup>42</sup> The package for adults will cover two prescriptions per month, six visits to a medical clinic per year, up to two trips to the emergency room per year, up to seven days in the hospital, and includes an out-of-pocket expenditures cap.<sup>43</sup> Enrollees will pay up to a \$15 per month premium and a 15 percent coinsurance for services.<sup>44</sup> Arkansas plans to begin offering benefits to the state's employees and families in early 2007.<sup>45</sup>

### **New Mexico**

By pooling together federal, state, and employer dollars, New Mexico developed the State Coverage Insurance program (NMSCI), a premium assistance program that provides health insurance to adults with family incomes up to 200 percent of the FPL.<sup>46</sup> Though the state's HIFA waiver was approved in 2002, its implementation was delayed until July 2005 because of state budget pressures and implementation issues.<sup>47</sup> The new program offers employers state-designed private health insurance plans they can offer to their employees.<sup>48</sup> Employers are expected to contribute \$75 per member per month, and employees will pay premiums up to \$35 per month and co-payments based on a sliding scale.<sup>49</sup> There are annual benefit caps, and out-of-pocket

spending is limited to 5 percent of family income.<sup>50</sup> The program, which is funded by unspent SCHIP funds, hoped to provide coverage to 10,000 residents in the first year.<sup>51</sup>

### ***Tax Credits for Small Businesses***

Statistically, almost half of all uninsured workers are self-employed or work for businesses with fewer than 25 employees. To target this population, states have developed tax credits for those employers offering health coverage to their employees. This effort aims to encourage more small businesses to offer coverage and to maintain coverage that is currently offered. Under the Trade Adjustment Assistance Act of 2002, health coverage tax credits (HCTCs) were created to subsidize health coverage for early retirees and workers displaced by international trade.<sup>52,53</sup> In 2005, further progress was made through the President's proposal to include employer tax credits for those employing up to 100 workers. Under such a plan, credits of up to \$200 per individual and \$500 per family could be awarded to small businesses given that such employer contributions were made through a health savings account.<sup>54</sup>

By allowing small business owners to receive tax refunds for dollars spent on employee health care, states can help employers to continue to provide health care coverage. In addition, by expanding the list of health plans employers offer in order to obtain a tax refund, additional employers who would not have offered coverage may find the incentive to do so. **Arizona, Kansas, Montana, and West Virginia** recently have implemented plans that include tax credits for small businesses.

### **Montana**

Montana's Small Business Health Insurance Affordability Act (HB 667) was signed into law in May 2005 as part of the Insure Montana initiative and became effective January 1, 2006.<sup>55</sup> More than half of uninsured Montanans work for small businesses.<sup>56</sup> Under the initiative, tax credits of \$100 per month per employee are available to employers with fewer than 10 employees who currently offer and contribute toward their employees' health insurance.<sup>57</sup> The state hopes to cover 3,500 Montanans with the tax credits.<sup>58</sup>

In addition, premium assistance is available to small businesses with fewer than 10 employees not providing health insurance. In order to receive the assistance, employers are required to provide coverage through two plans offered through the new State Health Insurance Purchasing Pool or another qualified association plan.<sup>59</sup> A portion of the employer and employee premium is covered by the assistance.<sup>60</sup> The Insure Montana purchasing pool has been operating since the beginning of 2006 and is aiming to provide coverage to 4,000 residents.<sup>61</sup>

### **Kansas**

In April 2005, a Kansas law began giving small business employers a tax credit for offering health savings accounts to their employees. Under SB 257, the Small Employer Health Insurance credit, small businesses can receive a tax credit for contributing to health savings accounts for their employees.<sup>62</sup> This legislation helped capture part of the President's tax credit proposal and offers an innovative approach to incentivizing employer-based coverage in the state.

The Small Employer Health Insurance credit also encourages employers by making the credits available to businesses with less than 50 employees that have not contributed to their employees' health insurance over the past two years.<sup>63</sup> The enhanced credit for newly contributing employers is \$70 per member per month in the first year, phasing down to \$35 per member per month in the third year, and ending after the third year.<sup>64</sup> In some instances, this new state income tax credit is double the amount of the previous credit.<sup>65</sup>

### *Children's Health Coverage Expansions*

Despite a recent period of tight state budget revenues, most states are finding ways to expand the State Children's Health Insurance Program (SCHIP) and other public programs for children. In 2004, 35 states experienced increases in SCHIP enrollment.<sup>66</sup> Of those states, 16 had 10 percent or greater increases in enrollment in 2004.<sup>67</sup> As of July 2005, 43 states have expanded coverage to children at or above 200 percent of FPL.<sup>68</sup>

#### **Idaho**

Approved through an 1115 HIFA waiver and an SCHIP state plan amendment in 2004, the SCHIP program expanded eligibility for children with family incomes up to 185 percent of poverty, created the CHIP B program, and created the Idaho Access Card Program.<sup>69</sup> The program divides SCHIP coverage into two categories: CHIP A, the existing Medicaid expansion program, providing coverage for children with family incomes up to 150 percent of the FPL; and CHIP B, a separate child health program covering children from families with incomes from 151 percent to 185 percent of poverty.<sup>70</sup>

In addition, the Idaho Access Card Program offers premium assistance to children in CHIP A or B for private insurance of the families' choice.<sup>71</sup> The access card provides between a \$100 to \$300 premium subsidy per child per month for the purchase of private insurance.<sup>72</sup> The insurance must be comprehensive and the children must have access to appropriate services. Approximately 1,400 children are expected to use the Access Card Program.<sup>73</sup> This assumes approximately 25 percent of children eligible for CHIP B and less than 1 percent of children eligible for CHIP A will opt for the Access Card over direct coverage under the state plan.<sup>74</sup>

#### **Illinois**

In November 2005, Illinois passed the Covering All Kids Health Insurance Act, which made insurance coverage available to all uninsured children in the state. Participants will be charged premiums and co-pays for doctors' visits and prescriptions based on a sliding scale by family income. Families with incomes of less than \$100,000 will pay premiums ranging from \$40 to \$100 per child per month.<sup>75</sup> Uninsured children in families with higher incomes also will be eligible, but the premiums will be higher.<sup>76</sup> A new case management system in the FamilyCare and All Kids programs is expected to offset the \$45 million cost of the All Kids program in the first year.<sup>77</sup>

Using federal funds and waivers, states also have expanded SCHIP coverage to low-income pregnant women and parents. In June 2004, **Arkansas** became the seventh state (in addition to **Illinois, Massachusetts, Michigan, Minnesota, Rhode Island, and Washington**) to utilize an HHS regulation allowing states to expand SCHIP coverage to unborn children in order to provide prenatal services to pregnant women. Rather than requiring states to apply for a waiver, the regulation permits states to offer prenatal care as a state option to pregnant women who have family incomes up to 200 percent of FPL and would otherwise be ineligible for coverage before their child was born. States can access the option by filing an SCHIP state plan amendment.

### *Expanding Access to Community Health Centers*

Rather than leaving the uninsured with costly emergency room visits as their only option for care, states have recognized community health centers (CHCs) for the integral role they play in the health care safety net. Community health centers provide high-quality, affordable primary care and preventive services, as well as on-site dental, pharmaceutical, and mental health and substance abuse services. Often located in areas where care is needed but scarce, they improve

access to care for millions of Americans regardless of their insurance status or ability to pay. Their costs of care rank among the lowest, and in many cases, CHCs reduce the need for more expensive inpatient and specialty care.<sup>78</sup>

Announced in 2002, the President's Initiative for the Uninsured created new service sites in the nation's network of community health centers and expanded the range of health care services offered at existing health centers. The initiative hoped to add 1,200 new and expanded CHC sites and increase the number of people served annually from nearly 10 million in 2001 to 16 million in 2006.

### **Colorado**

Colorado has been a leader in adopting the Presidential initiative to address health disparities and provide primary care through CHCs. In 2002, Colorado received over \$6 million from the initiative, which it used to fund 60 health center expansions and new center sites, serving at least 195,000 patients. Research has shown Colorado communities with CHCs have lower emergency room usage rates for Medicaid and uninsured patients than those communities without CHCs.<sup>79</sup> Additionally, they have higher immunization rates for children compared to Colorado HMOs.<sup>80</sup> Through their chronic disease collaborative, Colorado CHCs have developed systems to improve patients' health status and monitor change over time.<sup>81</sup>

### **Wisconsin**

Wisconsin developed the State Community Health Center Grant Program, utilizing a federal-state partnership in expanding access for the uninsured. The grant program was an annual state investment that supported the primary care network of 330 federally funded health centers in Wisconsin. Between 2001 and 2002, \$3 million in state funds was budgeted to supplement federal funds for community health centers. The state investment allowed health centers to increase dental services, expand facilities and hire dozens of providers. Without these state funds, services would have been reduced drastically and thousands would have found it more difficult to receive the medical and dental care they needed.<sup>82</sup>

### **Conclusion**

Increased pressure on state budgets, along with rising health insurance costs and a decrease in employer-based coverage, have led many states to develop innovative strategies to expand coverage to the uninsured. In recent years, many states have begun to build on the existing employer-based and individual insurance markets to expand coverage through premium assistance programs, tax credits, and other programs that provide private insurance coverage to small business and low-income individuals. Other states have extended eligibility for existing programs, such as SCHIP and Medicaid; implemented HIFA waivers that provide coverage to parents, children, and childless adults beyond the states' eligibility guidelines; expanded coverage to unborn children through an SCHIP plan amendment; and expanded the network of CHCs across the country. Over time, expanding coverage for uninsured individuals can significantly reduce state allocations for uncompensated care and improve the quality of life and productivity of many states' uninsured residents.

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