Since the mid-1970’s state governments have experimented with a wide variety of initiatives to expand access to health care for the uninsured. These initiatives build on the many opportunities to expand coverage offered by states’ multiple roles in the health care system—and a single initiative may often combine several approaches.

**States regulate the market.** States establish the requirements that insurers (and the coverage they offer) must meet in order to do business in the state and make sure that insurers meet those requirements through licensing and reporting systems. States also have avenues they can use to establish responsibilities for employers, employees, and individuals in obtaining coverage and for hospitals, physicians and other providers in delivering services.

**States decide what coverage they will offer through public programs,** as well as how these programs will work together and with the private market to expand coverage.

- States administer both **Medicaid** and **State Children’s Health Insurance Programs (SCHIP).** Within federal guidelines states determine who will be covered, what services will be covered, and how services will be delivered to Medicaid beneficiaries and SCHIP enrollees. The federal government pays a portion of states’ costs for operating the programs. The two programs differ in that: Medicaid covers certain low-income individuals and families, while SCHIP covers targeted low-income children who do not qualify for Medicaid. Federal guidelines provide states with more flexibility to design SCHIP programs than Medicaid programs. The federal government also pays a greater share of SCHIP costs than of Medicaid costs—but there is an aggregate limit on the amount of money the federal government will pay for services delivered to SCHIP program participants. There is no aggregate cap on the amount of federal funding available to pay for Medicaid services.1

- States may also create other **state-sponsored coverage** that offers coverage directly to residents, helps employees purchase the coverage offered by employers (e.g., premium assistance), helps contain the cost of private coverage by spreading the cost of services provided to some or all people who need expensive care among all insurer’s or even more broadly (e.g., high risk pools). States also choose whether they will subsidize this type of coverage, how people will learn of the coverage, and how the coverage will be delivered.

**Fast Facts**

- In 2005, 46.1 million non-elderly Americans were uninsured.

- In 2006, Massachusetts and Vermont both enacted comprehensive reform packages that sought to increase access to coverage.

- As of July 1, 2007 all Massachusetts residents age 18 and older must have creditable coverage.

States purchase health care coverage and services for state employees, Medicaid beneficiaries, and SCHIP participants. States are among the largest purchasers of health care in the nation. This situation provides leverage for containing costs and improving quality of care. States may choose to purchase services directly from providers or purchase coverage from insurers. States may also choose to purchase managed care services or services such as disease management that are designed to contain costs by improving the care provided to people with potentially
costly conditions, such as diabetes. States have used their purchasing power to support health care reform by using savings from state purchasing innovations to fund other coverage and creating ways for individuals and employers to join the state purchasing pool.²

Despite state efforts to expand access the US Census Bureau indicates that the number of uninsured non-elderly Americans has increased every year since 2000. In 2005, 46.1 million non-elderly Americans were uninsured.³ (Note that most elderly are covered by Medicare so they are not included in these numbers). Although state reforms have helped temper greater growth in the numbers of the uninsured there is clearly more work to be done to increase access to coverage and keep costs affordable.

**Overview Of Recent State Reform Activity**

In recent years a number of states have once again risen to the challenge of advancing health reform. This section presents a scan of the health reforms states enacted and implemented in 2006. (Note: This information was gathered through a scan of existing resources and may not include all state reform efforts enacted, approved by the federal government, or implemented in 2006.)

**Comprehensive Reforms**

Massachusetts,⁴ Tennessee,⁵ and Vermont⁶ enacted and began to implement comprehensive reform packages that seek to increase access to affordable coverage. All three states expanded existing public coverage, implemented various small and individual market reforms, and created new state-sponsored coverage options. Each also has unique features, including the following: Massachusetts requires all individuals to have health insurance (individual mandate), Vermont’s reforms seek to increase patient safety and improve management of chronic conditions, and Tennessee’s proposal addresses diabetes management and establishes a high-risk pool. At least one of these states used each of the following sources of funding: premiums and assessments paid by employers, premium and penalty payments from employees and individuals, Medicaid and SCHIP funding (including funding for hospitals that serve a disproportionate share of Medicaid beneficiaries and uninsured individuals), tobacco taxes and tobacco settlements. (Massachusetts and Vermont are discussed in more detail later in this brief.)

**Reforms to Help Small Businesses Cover Employees**

Arkansas and New Mexico implemented and Rhode Island enacted and began to implement reforms targeted to small businesses.

- The *Arkansas* program is designed for businesses that have not offered health insurance in the past twelve months. The coverage is not comprehensive but rather a “safety-net” package of benefits. Only employers with 2-500 employees that have at least one employee with an income below 200% of the Federal Poverty Level (FPL)² may participate. All employees of participating employers who do not have other group coverage must participate in the program—and the program is not open to individuals. Employers pay a monthly per-employee payment and employee premiums range from $30-$300 based on age, gender, and family income. The program is operated with a federal 1115 waiver⁴ that provides Medicaid funding for participants with incomes of no more than 200% FPL. Other funding sources are tobacco settlement funds and payments from employers and employees.⁹

- *New Mexico’s* reform was an expansion of the state’s Medicaid program targeted to small employers under a waiver from the federal government. New Mexico contracted with three health plans to provide services through the program to adults with incomes of 200% FPL or less who do not otherwise qualify for Medicaid. Employers with 50 or fewer employees may opt to offer the coverage. In that case: employers pay $75 per employee per month, employees pay a premium of $0-35 based on income, and the remainder is funded by Medicaid using state and federal funding. Individuals may also opt to enroll in the program if they are self-employed or their employer does not participate—in those cases the participant pays both the employer and employee share.¹⁰

- *Rhode Island’s* reform package was designed to lower health insurance premiums for small-business owners and their employees. The reform features a requirement for insurers doing business with the state to offer, beginning in May 2007, and a ‘wellness benefit’ to small-business owners that meets certain cost and coverage criteria. The package also envisions the creation of a reinsurance fund for some employers, a ban of sodas and sugary snacks from public and private elementary, middle and junior high schools; requiring health insurers to cover counseling and prescription drugs for individuals trying to quit smoking; and providing price information to health care consumers.¹¹

**Reforms to Cover All Children**

*Illinois* launched and Pennsylvania enacted programs to cover all children.¹²

- *Illinois’* program offers comprehensive coverage to children, including those previously served by the Medicaid and SCHIP programs. Children from lower-income families may join the program at any time (e.g., the limit for a three-person family is $33,000/year); those from families with higher incomes must also meet a 1-year waiting period requirement and pay premiums and cost-sharing. In 2006, the premium amounts varied from $15 to $300 per child based on family income.¹³

- *Pennsylvania’s* program is an expansion of the state’s SCHIP program to cover all uninsured children. Children from families...
with incomes over 200% FPL must pay premiums and co-pays that vary depending on family income. Those with incomes over 300% FPL must pay the full cost of coverage and meet certain other conditions. The program also requires a waiting period of six months for most children over age 2. This program will be launched in early 2007.  

Incremental Approaches
A number of states also made more incremental efforts to expand access to coverage in 2006, including the following:

- Six states considered legislation related to universal coverage and seven studied the possibility of establishing such a system.  
- Some states, in addition to those previously mentioned, used federal waivers to:
  - expand their comprehensive Medicaid and SCHIP programs (Hawaii),
  - expand Medicaid to provide family planning services to higher income women of child-bearing age (Louisiana and Texas),
  - expand premium assistance programs for employees of small businesses and individuals (Oklahoma),
  - Offer subsidies of up to $100/qualified participant/month to purchase qualified employer coverage (Nevada and Virginia); or
  - Restructure their Medicaid programs (Florida).  
- Idaho, Kansas, Kentucky, and West Virginia received approval from the federal government to restructure their Medicaid programs as permitted under the federal Deficit Reduction Act of 2005 (DRA).  

Creating new coverage options: Both Massachusetts and Vermont created new state-sponsored coverage options as part of their health care reforms. Massachusetts also created a new independent authority (the Connector) to administer the newly available plans (select health plans, administer enrollment and payment).

**Table I: State Sponsored Coverage**

<table>
<thead>
<tr>
<th>Administering Agency</th>
<th>Massachusetts</th>
<th>Vermont</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commonwealth Health Insurance Connector Authority</td>
<td>Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)</td>
</tr>
<tr>
<td>• Independent authority</td>
<td>• Existing state agency that regulates health insurance</td>
<td></td>
</tr>
<tr>
<td>• Will offer both Commonwealth Care and Commonwealth Choice to uninsured</td>
<td>• Coverage will be offered through existing channels by private insurers as part of the small group market (uninsured individuals may join)</td>
<td></td>
</tr>
<tr>
<td>• Non-working people, employees of large employers who do not have access to employer coverage, and employees of employers with 50 employees or less can purchase coverage Through Connector</td>
<td>• If no insurer voluntarily develops package, BISHCA may require one of two plans doing business in the state to offer the coverage</td>
<td></td>
</tr>
<tr>
<td>• Participants will be able to retain coverage when changing jobs</td>
<td>Reform Commission</td>
<td></td>
</tr>
<tr>
<td>• Will aggregate employer contributions for employees with multiple employers.</td>
<td>• will review for cost-effectiveness in 2009 and may move to self-insured plan</td>
<td></td>
</tr>
</tbody>
</table>

It appears that states will continue to be active in health care reform in 2007. California’s governor has released a plan to insure all Californians, regardless of immigration status, that includes many of the elements discussed here: implement private market reforms, establish state-sponsored insurance, offer premium assistance to lower-income residents, create an individual mandate for coverage, improve patient safety, encourage and support personal responsibility, and offer a wellness benefit, etc.  

**Comprehensive Reform In Massachusetts And Vermont**

In 2006, Massachusetts and Vermont both enacted comprehensive reform packages that sought to increase access to coverage that created new state-sponsored coverage, addressed private and public coverage, and defined employer and employee roles in obtaining coverage. As previously mentioned, each of these reform packages also included unique, innovative elements that other states are now considering. The remainder of this brief describes critical elements of both states’ efforts; however, the reforms were too extensive to be fully captured in this brief.

**Public Coverage**

Both states included three types of public coverage in their reforms: state-sponsored, Medicaid, and SCHIP. See Table 1 below and tables on following pages for details.
Table 1 continued: State Sponsored Coverage

<table>
<thead>
<tr>
<th>Subsidized Coverage</th>
<th>Massachusetts</th>
<th>Vermont</th>
</tr>
</thead>
</table>
| Commonwealth Care   | • Subsidized, comprehensive coverage for uninsured Massachusetts residents who do not qualify for Medicaid and have family incomes of no more than 300% FPL  
• Offered by four health plans selected by state (and currently contracted with Medicaid agency),  
• Enrollment began 10/06 for those w/incomes under 100% FPL  
• Enrollment of those w/incomes of 100-300% FPL will begin 1/07  
• Coverage and cost varies by family income and plan. Participants with family incomes of 100% | Catamount health  
• Comprehensive coverage for uninsured Vermonters  
• Will be offered by at least one private insurer (if no volunteers state will require one to offer)  
• Insurers expected to begin selling policies 10/07  
• Participants pay premiums based on income  
• Participants pay cost-sharing for services |
| Non-subsidized coverage | Commonwealth Choice  
• Non-subsidized, comprehensive coverage for uninsured with incomes over 300% FPL  
• Proposals from health plans due 1/07, enrollment will begin 7/07  
• At least one coverage option will be a policy that offers the “minimum creditable coverage” that meet the requirements of the individual mandate | Catamount Health  
• Identical to subsidized coverage except participants with incomes over 300% FPL pay full cost of coverage |

Private Market

Both states made reforms to private coverage and Vermont has specified some additional changes it will consider based on how their implementation unfolds.

Table 2: Private Market Reforms

<table>
<thead>
<tr>
<th>Massachusetts</th>
<th>Vermont</th>
</tr>
</thead>
</table>
| • Merge individual and group markets  
• Create insurance products for young adults  
• Extend dependent coverage through age 25  
• More flexibility in insurance market, such as permitting deductible levels consistent with federal Health Savings Accounts (HSA) laws  
• Imposes a moratorium on new mandated benefit legislation until at least 1/1/08 | • Provides assistance to insurers in individual market to reduce premiums by 5%  
• Study to determine feasibility of merging the individual and small group markets  
• Allows insurers to offer discounts for ‘healthy lifestyles’  
• Envisions streamlining of administration by establishing common claims and procedures and a common provider credentialing form. |
Expanding Medicaid and SCHIP

Both states also expanded their Medicaid and SCHIP programs as part of their health care reform packages. It is important to note that both states have long operated their Medicaid and SCHIP programs under 1115 waivers which, after approval by the federal government, allow them to operate programs that do not follow standard federal Medicaid or SCHIP rules as long as the programs are ‘budget neutral’ for the federal government. (In other words, the cost to the federal government of operating the program under the waiver may not exceed the cost to the federal government of operating the program without the waiver.)

Table 3: Medicaid and SCHIP

<table>
<thead>
<tr>
<th>1115 waiver name and original approval date</th>
<th>Massachusetts</th>
<th>Vermont</th>
</tr>
</thead>
<tbody>
<tr>
<td>MassHealth</td>
<td>• Originally approved in 1995</td>
<td>Global Commitment to Health</td>
</tr>
<tr>
<td>• Amendment request in 5/06 to support health care reform</td>
<td>• Meets budget neutrality requirements</td>
<td>• Approved 9/05</td>
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<tr>
<td></td>
<td></td>
<td>• Replaced existing 1115 waiver “Vermont Health Access Plan” originally approved in 1995.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Federal funding capped at $4.7 billion over 5 year demonstration period</td>
</tr>
<tr>
<td>Description of coverage</td>
<td>• Eight different eligibility groups that, together, cover</td>
<td>• Covers adults with incomes up to 185% FPL, uninsured children up to 225% FPL, and underinsured children from families with incomes up to 300% FPL</td>
</tr>
<tr>
<td></td>
<td>• Adults, children and pregnant women with family incomes up to 200% FPL. A subgroup of adults is only covered by Medicaid if they have or have access to employer coverage.</td>
<td>• Adults with incomes over 50% FPL and children from families with incomes over 185% pay premiums on sliding scale</td>
</tr>
<tr>
<td></td>
<td>• Certain women diagnosed with breast or cervical cancer with gross family incomes at or below 250% FPL</td>
<td>• Services delivered by Office of Vermont Health Access, which acts as a publicly sponsored MCO</td>
</tr>
<tr>
<td></td>
<td>• Benefits and cost-sharing vary by eligibility group.</td>
<td>• Offers premium assistance that uses Medicaid funding to subsidize qualified employer coverage. The Catamount Health coverage qualifies for the program.</td>
</tr>
<tr>
<td></td>
<td>• Offers premium assistance that uses Medicaid funding to subsidize qualified employer coverage. The Commonwealth Care coverage qualifies for this program.</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Had implemented some innovative financial arrangements to provide funding to two hospitals that had, historically, served a disproportionate share of Medicaid beneficiaries and the uninsured that it was unlikely to be allowed to continue to use. The 1115 waiver amendment enabled the state retain this federal funding and redirect it to provide coverage to individuals.</td>
<td>• Lowered premiums for some participants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Created a chronic care management program in Medicaid</td>
</tr>
</tbody>
</table>
Both of these states reforms define roles for individuals, employers, and employees in paying for coverage.

### Table 4: Individual, employer and employee responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Massachusetts</th>
<th>Vermont</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>• As of July 1, 2007 all Massachusetts residents age 18 and older must have creditable coverage, those without coverage will lose their personal state income tax exemption—full if filing individually; half if filing jointly • pay a penalty for each uninsured month, starting 1/08. • Individuals may be exempted from the requirement due to religion or if they do not have access to affordable coverage through the Connector. • The Connector will establish an appeal process.</td>
<td>• Uninsured may join Catamount Health • Legislature may implement individual mandate if insured rate is less than 96% in 2010.</td>
</tr>
<tr>
<td>Employer and employee</td>
<td>• Small employers may obtain coverage through the connector • Requires employers with more than 10 full-time employees to create “cafeteria plans”, that enable employees to use pre-tax dollars to pay health insurance premiums • Employers with more than 10 employees that do not offer minimum creditable coverage will pay a ‘fair share’ assessment of $295/employee/year unless they insure at least 25% of employees or contribute 33% of an employee’s individual premium • Employers whose employees do not take up coverage and who incur a predetermined cost of care will pay a ‘free rider’ penalty.</td>
<td>• Employers with uninsured employees pay assessment based on number of uninsured FTEs (phased in by 2010) • For employees who qualify for Medicaid • State pays employee share to bring premium and cost-sharing down to Medicaid levels • State provides wrap-around benefits that cover any Medicaid-covered services not covered by employer’s insurance. • For employees with incomes up to 300% FPL who do not qualify for Medicaid • State pays difference between Catamount premium and employer coverage • State pays part of employee cost-sharing for chronic care services</td>
</tr>
</tbody>
</table>
References

1. These are very simple descriptions of complex programs. For more information please refer to the Centers for Medicare & Medicaid (CMS) website at www.cms.gov.


7. The Federal Register publishes poverty guidelines that establish the federal poverty level (FPL) for Medicaid and SCHIP each year. The FPL varies by family size and residency. In 2006 a family of three living in one of the 48 contiguous states with an income of $16,600/year was considered to have an income of 100% of the federal poverty level. Federal Register: January 24, 2006 (Vol. 71, No. 15) Page 3848-3849. Retrieved 10 January 2007. http://asp.ehhs.gov/poverty/06fedreg.htm

8. As previously discussed states must operate their Medicaid and SCHIP programs within federal guidelines. Section 1115 of the Social Security Act (SSA), however, provides the Secretary with the authority to waive most of these requirements under certain circumstances—thus enabling states to implement Medicaid and SCHIP program policies that do not comply with the standard federal guidelines. 1115 waivers must be “budget neutral” to the federal government (i.e., not cost the federal government more to operate the program with the waiver than to operate the program without the waiver). These waivers usually expire after five years, although states may request renewals. Please refer to the CMS website for more information: http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/9. Arkansas Center for Health Improvement. Health Insurance Initiative—Health Care Financing, website. Retrieved 8 January 2007. http://www.achi.net/current_initiatives/health.asp and Arkansas HealthNet. What is ARHealthNet?, website. Retrieved 8 January 2007. http://www.arhealthnet.com/10. New Mexico Human Services Department. New Mexico State Coverage Insurance, website. Retrieved 8 January 2007. http://nmisci.state.nm.us/NmSCHIPHome.aspx


12. Other states, such as Wisconsin engaged in planning efforts to cover all children that have not yet been enacted or implemented. Wisconsin Department of Health and Family Services, BadgerCare, website. Retrieved 9 January 2007. http://www.dhs.wisconsin.gov/badgercareplus/index.htm


17. The Deficit Reduction Act of 2005 (DRA), was signed into law in January 2006. It made extensive changes to Medicaid, including authorizing states to offer different benefit packages for different groups of beneficiaries and increase the use of cost-sharing (including premiums) without an 1115 waiver. Please refer to the Deficit Reduction Act pages on the CMS website for more information: http://www.cms.hhs.gov/DeficitReductionAct/


20. Most of the information in this section about Vermont’s reforms is drawn from two sources: CMS. Vermont Global Commitment To Health Section 1115 Demonstration Fact Sheet. Updated 11/05, and Vermont Legislature. Catamount Health: The 2006 Health Care Affordability Act, website.