



- The share of workers with coverage through their employers—currently accounting for about 60 percent of the non-elderly population—is declining. Between 2000 and 2007, the percentage of companies that offered health insurance dropped from 68 percent to 62 percent, according to the Employee Benefit Research Institute.<sup>4</sup>
- The economic downturn has serious implications for state budgets. According to a National Conference of State Legislatures budget survey, 34 states estimate a total budget shortfall of at least \$28.4 billion for all states since the start of FY 2009. Shortfall estimates for FY 2010 are expected to be at least \$59.3 billion. Medicaid is a counter-cyclical program. As of April 2009, at least 20 states reported FY 2009 budget gaps that were 10 percent of the general fund budget or greater. 13 states reported gaps of between five to 10 percent of the general fund budget. The outlook for 2010 is no better. At least 33 states anticipate budget gaps of at least 10 percent of general fund budgets.<sup>5</sup>
- Of the 26 states that improved access to children’s health coverage, 20 expanded eligibility, according to the Kaiser Commission on Medicaid and the Uninsured. Twelve of those states raised CHIP income limits to 300 percent of the federal poverty guidelines, which more than doubled the number of states with such eligibility levels. (Not all states implemented these expansions.)
- Connecticut, Iowa, Maryland, New Jersey, Oklahoma and Wisconsin expanded health insurance coverage for parents of children enrolled in CHIP or Medicaid.

States also have adopted other strategies, such as developing state-funded health insurance programs, to address gaps in coverage among certain groups. This report which summarizes the state strategies that use public programs or public financing to expand access to health insurance coverage, is organized as follows.

In short, state policymakers face significant challenges. Although states have significantly expanded access to health care for the uninsured during the last several years, the current downturn in national and state economies is expected to slow the pace.

### **Using Public Programs to Expand Access to Coverage**

Concerned about the lack of insurance coverage, states have taken a number of steps to expand access to coverage. States frequently rely upon existing programs, such as Medicaid and CHIP, to cover additional children and adults. Specifically, between 2006 and 2008, states expanded Medicaid and CHIP in the following ways, according to a 2008 survey by the Kaiser Commission on Medicaid and the Uninsured.

- Almost two-thirds of the states (32 and the District of Columbia) increased access to health coverage for “low-income children, pregnant women and parents.”<sup>6</sup>
- Twenty-six states expanded income eligibility, and seven states reduced financial barriers to Medicaid and CHIP by reducing premiums or cost-sharing requirements.
- **Expand Public Programs.** This section examines state approaches that expand Medicaid and CHIP eligibility through increased income eligibility levels and strategies that make additional groups eligible for coverage. It also describes state outreach and enrollment strategies to expand enrollment in public programs.
- **Implement Public-Private Partnerships.** Some states subsidize the cost of private insurance through Medicaid and CHIP premium assistance or CHIP buy-in programs. This section examines these approaches and state strategies that subsidize the cost of private insurance through publicly funded reinsurance and tax incentives for coverage.
- **Establish or Expand State-Only Programs.** This section describes state approaches to expand access to health insurance coverage through state high-risk pools and state-only health insurance programs.

## PUBLIC PROGRAM EXPANSIONS

Among the entire national population, public programs are a significant source of coverage for non-elderly adults and children, accounting for about 29 percent of health coverage for children and 11 percent for adults. The importance of public coverage is even more pronounced among people at or below 100 percent of the federal poverty guidelines. For families with incomes below the federal poverty guidelines (\$10,830 for a single person; \$22,050 for a family of four in 2009), government health insurance programs are the main source of coverage. In 2007, 45 percent of non-elderly people whose incomes were below 100 percent of the federal poverty guidelines were covered by Medicaid, the Children’s Health Insurance Program (CHIP), Medicare or some other public health insurance program. The balance had either private coverage (20 percent) or were uninsured (35 percent).<sup>7</sup> Figure 2 illustrates the source of insurance coverage for adults and children in the United States.

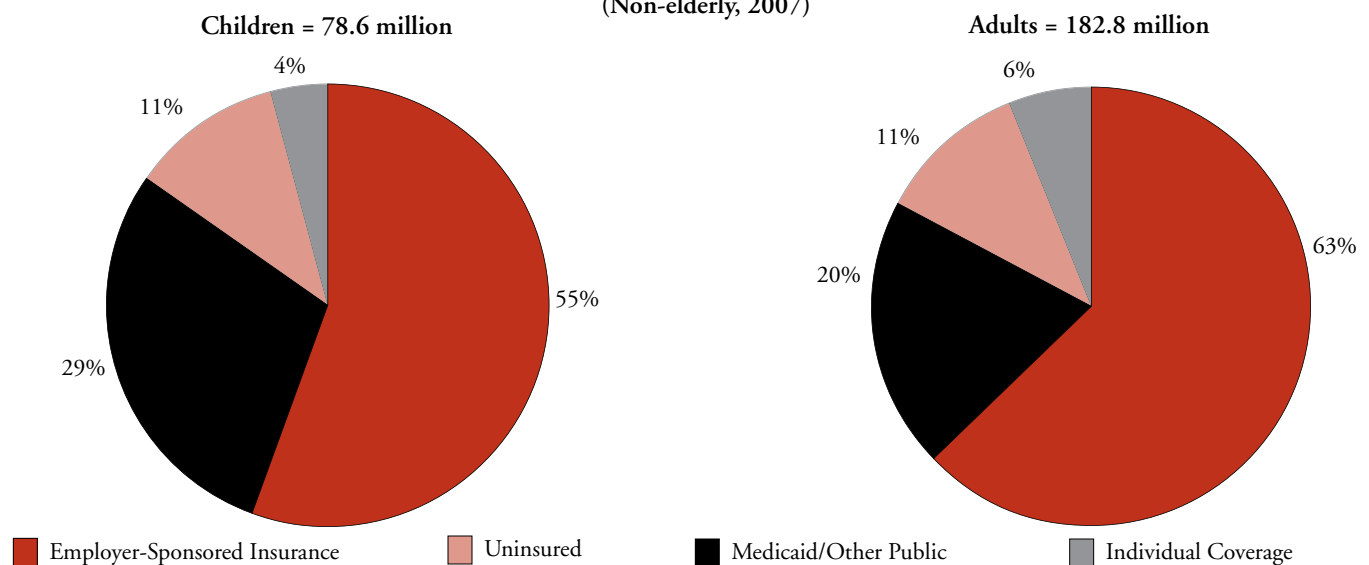
Expanding existing programs often is an appealing strategy because the infrastructure is in place and programs already focus on low-income people. A recent survey of state Medicaid directors found that states have implemented an array of changes for Medicaid. The changes include increasing the provider payment rates, expanding and simplifying eligibility, and improving certain benefits.<sup>8</sup>

Medicaid and CHIP expansions have increased health insurance coverage rates among low-income populations,

especially children. According to the Kaiser Commission on Medicaid and the Uninsured, public program expansions between 2006 and 2007 “largely accounted for a 1.5 million decrease in the number of uninsured, while job-based coverage rates idled.”<sup>9</sup> Although such expansions are popular, the economic realities facing states and differences about how to prioritize state expansions—a daunting task amid constrained budgets—present significant hurdles for state policymakers.

In addition to a challenging economic situation, federal actions in 2007 slowed state expansions. On Aug. 17, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a federal directive that required states to meet certain criteria when using federal funds to cover children in families with incomes above 250 percent of the federal poverty guidelines. President Obama rescinded that directive on Feb. 4, 2009, the same day he signed legislation to reauthorize CHIP. States that enacted legislation to cover children beyond 250 percent of the federal poverty guidelines, but did not implement or were denied approval for the expansion because of the August 17 directive—now have the option of covering kids at a higher income level. The new Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gives every state the flexibility and additional federal funding to expand CHIP eligibility, although the present budget crisis may prevent them from doing so in the near future. Table 1 provides an overview of public programs funded jointly by the federal and state governments.

Figure 2. Public Programs’ Coverage Role Today  
(Non-elderly, 2007)



Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2008 ASEC Supplement to the CPS.

**Table 1. Public Programs Defined**

<b>Program</b>	<b>Description</b>
Medicaid	This jointly funded federal-state program provides health insurance for low-income individuals who meet certain income standards and categorical eligibility qualifications (e.g., aged, blind, disabled, members of families with dependent children). All 50 states, the District of Columbia and the U.S. territories have Medicaid programs.
The Children’s Health Insurance Program (CHIP)	This jointly funded federal-state program provides medical insurance coverage for certain low-income uninsured children who are not eligible for Medicaid. A block-grant program, CHIP is administered by the states; each creates its own guidelines regarding eligibility and services within federal parameters. In creating the basic design for the CHIP program, the federal law allowed states to increase the current income limits for Medicaid to cover more children; develop a new, separate health insurance program that may have different rules and benefits from Medicaid; or use a combination of the two.
<b>Program Waivers and Options</b>	<b>Description</b>
Section 1115 Waiver	Section 1115 waivers give the secretary of health and human services broad authority to waive statutory and regulatory provisions of Medicaid and CHIP, allowing states to implement pilot programs or statewide research demonstration programs to test new, innovative ideas that are budget neutral. Some states with Section 1115 waivers cover those who ordinarily would not be covered under a traditional program eligibility. Among other things, such waivers also allow states to modify the services covered under the program. Many such waivers were adopted to move beneficiaries to mandatory managed care. Some Section 1115 waivers target specific services or populations.
Section 1931 Coverage	As part of the 1996 federal welfare reform, Section 1931 was added to Medicaid law and de-linked Medicaid from cash assistance. Section 1931 prohibits states from setting eligibility for Medicaid at levels lower than the pre-Aug. 16, 1996, levels to ensure that people do not lose coverage. States were, however, allowed to use less restrictive eligibility criteria by disregarding a portion of working parents’ income, eliminating an asset test, extending benefits to two-parent families, or raising income limits to adjust for inflation.
Medicaid’s Health Insurance Premium Payment (HIPP) Program	This Medicaid option is authorized by Section 1906 of the Social Security Act. Under the program, states can use Medicaid funds to purchase employer coverage for eligible people when coverage is available and cost effective. States also can cover family members (usually parents) of the eligible person if it is cost effective. The program pays the employee’s share of the premium, deductible and copayments.
The Medically Needy Option	Under this option, states can extend Medicaid eligibility to additional people who have expensive medical needs but otherwise may have too much income to qualify. It allows states to cover such people with high medical needs relative to their income after they “spend down” their resources to a certain level on medical services.
Medicaid buy-in program for working adults with disabilities	This program allows states to offer a Medicaid buy-in option to certain working people with disabilities so they do not lose Medicaid coverage because they earn too much to qualify.

## EXPAND MEDICAID AND CHIP ELIGIBILITY

Policymakers look to Medicaid and CHIP as a partial solution for the uninsured because of their history of serving millions of low-income, uninsured people and their unique characteristics—an existing and flexible infrastructure, significant purchasing power and generous federal matching funds.

Federal law allows states to increase income eligibility levels to allow more people to qualify for coverage. Each state can determine its income eligibility policy but, at the same time, must comply with federal requirements to serve mandatory groups under income guidelines. Many states have taken advantage of Medicaid's flexibility, to increase income levels beyond the minimum set by the federal government. The minimum federal Medicaid income eligibility levels are:

Poverty Guidelines for the 48 Contiguous States and the District of Columbia* – 2009	
People in family	Poverty guideline
1	\$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010

For families with more than eight people, add \$3,740 for each additional person.  
\*Alaska and Hawaii have state-specific guidelines.

- Pregnant women at 133 percent of federal poverty guidelines.
- Children up to age 5 at 133 percent of federal poverty guidelines.
- Children ages 6 to 19 at 100 percent of federal poverty guidelines.
- People with disabilities are most often eligible at 74 percent of federal poverty guidelines. This eligibility is tied to Supplemental Security Income (SSI). There is no federal minimum income eligibility level for this group. Eleven states have more restrictive income eligibility (than 74 percent) criteria (known as 209(b) states).
- Parents of minor children may be eligible for Medicaid. The income eligibility is usually tied to the standard used in a state's Temporary Assistance to Needy Families (TANF).
- There is no Medicaid eligibility category for childless adults.

**The American Recovery and Reinvestment Act of 2009**, signed by President Obama on February 16, creates temporary changes to Medicaid until Dec. 31, 2010. Following are highlights of changes to Medicaid.

The new law provides states with additional federal matching funds (the federal medical assistance percentages or FMAP) to help states maintain their Medicaid programs in the face of recession-driven revenue declines and caseload increases.

- States that would otherwise experience a drop in their FMAP under the normal FMAP formula will be held harmless (i.e., drop would not be implemented) against any decline.
- All states will receive a 6.2 percentage point increase in their FMAP in addition to the existing FMAP, adjusted for the above hold harmless provisions.
- Those states with large increases in unemployment will receive an additional increase in their FMAP directly related to the increase in unemployment rates.
- A state is ineligible for the FMAP increase if eligibility standards, methodologies or procedures under the Medicaid state plan are reduced below those in effect on July 1, 2008. (States can reinstate eligibility levels to receive the increased FMAP.) To be eligible for the increased FMAP, states must also be in compliance with the Medicaid prompt pay requirements and must not deposit any of the increased funding to any reserve or rainy day fund.

Medicaid payments to hospitals that serve a disproportionate number of uninsured and Medicaid eligible clients.

- Medicaid disproportionate share hospital allotments increased by 2.5 percent in fiscal year 2009 and another 2.5 percent in fiscal year 2010.

Changes to certain Medicaid regulations.

- Extends the current law moratorium on six Medicaid regulations through June 30, 2009, including regulations on optional case management services, provider taxes, school-based administration and transportation.
- Imposes a moratorium on the final regulation regarding outpatient hospital facility services through June 30, 2009, and prohibits the health and human services secretary from enforcing the final rule published in the *Federal Register* on Dec. 8, 2008. (On May 6, 2009, the Centers for Medicare and Medicaid Services [CMS] rescinded the school-based services final rule and the outpatient services definition final rule; and partially rescinded the case management services interim final rule)
- Delay enforcement of portions of the Health Care-Related Tax Final Rule
- Urges the HHS secretary not to promulgate final regulations regarding cost limits for certain providers, payments for graduate medical education and rehabilitative services.

### *The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)*

The Children's Health Insurance Program Reauthorization Act of 2009 reauthorized the CHIP program through fiscal year 2013. It became effective as of April 1, 2009. The legislation increases spending by \$31.5 billion between 2009 and 2013. Increased funding is paid for with a 62-cent increase in federal cigarette taxes. The new law also:

- Maintains coverage for all children currently covered by CHIP and expands coverage to an additional 4.1 million children at the option of the states.
- Establishes an upper income limit of 300 percent of the federal poverty guidelines for states to receive the more generous federal CHIP matching rate, with an exception for states that already have permission to cover higher-income children. Provides for a federal match for states offering coverage above 300 percent of the federal poverty guidelines at the Medicaid (not the CHIP) rate.
- Provides additional federal funding in the form of grants and bonus or incentive payments to the states for outreach efforts to enroll more of the lowest-income uninsured children.
- Ends funding for CHIP coverage of non-pregnant childless adults at the close of 2009 and requires states that received federal permission to cover non-pregnant childless adults to phase out that coverage.
- Ends new waivers to allow CHIP coverage of parents and allows states to move existing parent coverage to a lower federal matching rate.
- Gives states the option to cover uninsured pregnant women (who are not eligible for Medicaid) under CHIP at a minimum eligibility of 185 percent of the federal poverty guidelines. Since the law prioritizes coverage for children, states can submit an amendment to cover pregnant women only if the state CHIP eligibility for children is at or above 200 percent of the federal poverty guidelines.
- Gives states the option to cover immigrant children and pregnant women who are lawfully residing in the United States and who meet eligibility requirements so they need not wait five years to receive coverage (revoking a previous requirement that resulted in a five-year delay in coverage).
- Reduces barriers to using CHIP funds for premium assistance programs to help families afford private coverage offered by employers or other sources.
- Requires states to cover dental services and requires parity of mental health services if offered.
- Allows states that face a funding shortfall and meet enrollment goals to receive additional funding in the form of an adjustment payment.

This section describes state activities to expand Medicaid eligibility, including increasing income eligibility levels, making additional groups eligible, and expanding state outreach and enrollment.

### **INCREASE MEDICAID INCOME ELIGIBILITY LEVELS**

State income eligibility requirements vary considerably for adults who apply for Medicaid. They range from 26 percent of federal poverty guidelines in Alabama to 200 percent or more in Arkansas, Indiana, Iowa, Maine, Minnesota, New Mexico, Oklahoma, Pennsylvania, Washington and the District of Columbia.<sup>10</sup> Many states have obtained federal waivers to cover parents; many of these plans offer fewer benefits and more cost-sharing than traditional eligible groups under Medicaid. In 2008, for example, Indiana implemented waiver coverage for parents and childless adults up to 200 percent of the federal poverty guidelines, with monthly premiums and a more limited benefit package than traditional Medicaid. California covers parents who meet certain criteria up to 100 percent of the federal poverty guidelines. There are 51 states that cover children and 45 states cover pregnant women beyond the minimum federal income eligibility. At least 25 states cover parents above 45 percent of the federal poverty guidelines and 20 states have income eligibility criteria for people with disabilities that extends beyond the 74 percent of federal poverty guidelines.

### ***State Examples***<sup>11</sup>

- Forty states and the District of Columbia enrolled infants (to age 1) in families with incomes greater than 133 percent of the federal poverty guidelines.
- Twenty-five states and the District of Columbia have expanded eligibility for children ages 1 to 5.
- Twenty-nine states and the District of Columbia set income standards for children ages 6 to 19 above the federal standard. Maryland and Vermont, for example, enroll children up to age 19 in families with incomes up to 300 percent of federal poverty guidelines.
- Thirty-four states have medically needy programs.<sup>12</sup> The income eligibility policies in states with medically needy programs vary by state. In Vermont, those with incomes at or below 102 percent of federal poverty guidelines qualify, compared to 14 percent of federal poverty guidelines in Louisiana.

## INCREASE CHIP INCOME ELIGIBILITY LEVELS

In 1997, federal law established the Children's Health Insurance Program, which gives states financial support to expand publicly funded coverage to uninsured children who are not eligible for Medicaid. CHIP provides health insurance coverage for uninsured children in families with incomes between the state Medicaid income eligibility levels and 300 percent of the federal poverty guidelines. Before enactment of the federal CHIPRA, the upper eligibility limit that qualified for the federal match was 200 percent of the federal poverty guidelines or 50 percent above the states current eligibility level but many states obtained a waiver from the Centers for Medicare and Medicaid Services to expand CHIP eligibility beyond that limit.

As of January 2009, CHIP eligibility levels in 10 states and the District of Columbia were greater than 250 percent of the federal poverty guidelines according to a survey by the Kaiser Family Foundation. In 33 states the eligibility levels were between 200 and 250 percent of the guidelines. Seven states have set eligibility levels below 200 percent of the federal poverty guidelines. Figure 4 shows Medicaid/CHIP eligibility levels for children.

Federal guidelines also allow states to disregard assets—not counting certain income or resources—when they determine eligibility for CHIP. In 2008, 45 states and the District of Columbia, disregarded assets in determining eligibility for children's health coverage.<sup>13</sup>

Unlike Medicaid, CHIP is a block grant program that provides states with a set amount of funding that is limited both nationally and by state. Medicaid funding has no pre-set limits. Thus, if a state CHIP program is not part of the Medicaid program, the children eligible for the program are not entitled to coverage. If funding runs out, then the states can start waiting lists or control CHIP spending by capping enrollment. This is not permitted under Medicaid. The Children's Health Insurance Program Reauthorization Act of 2009, however, allows states that face a funding shortfall and meet enrollment goals to receive an adjustment payment. However, this does not create an entitlement to the program nor does it guarantee the elimination of waiting list.

### State Examples

As of April 2009, 13 states and the District of Columbia enacted eligibility levels that raised the CHIP income limits to 300 percent of the federal poverty guidelines or higher (some have not implemented these expansions). Among the states are Connecticut, Hawaii, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey and New York in addition to the District of Columbia.<sup>14</sup>

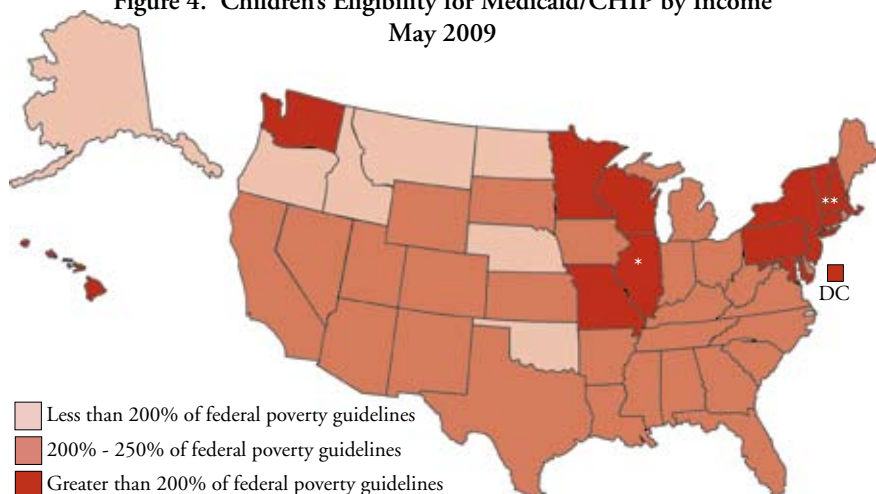
### Evidence of Effectiveness: Medicaid and CHIP Eligibility Expansions

**Medicaid.** Increasing Medicaid income eligibility levels appears to be particularly effective in reducing the number of uninsured. Of all people enrolled in Medicaid, about 29 percent qualify because they are part of an optional eligibility group created at the state's discretion.

Medicaid also is cost-effective compared to private health insurance. After controlling for health status (since Medicaid enrollees tend to have greater health care needs), it costs more than 20 percent less to cover low-income people in Medicaid than it does to cover them in private health insurance.<sup>15</sup>

**CHIP.** Raising CHIP eligibility levels appears to have a significant positive effect on children's insurance coverage rates. Increases in Medicaid and CHIP coverage, according to the Kaiser Commission on Medicaid and the Uninsured, "...have outpaced the erosion of employer-sponsored coverage, resulting in the percentage of low-income children

Figure 4. Children's Eligibility for Medicaid/CHIP by Income May 2009



The federal poverty line (FPL) for a family of three in 2008 was \$17,600 per year.

\*Illinois uses state funds to cover children above 200% of FPL.

\*\*Massachusetts uses state funds to cover children above 300% of FPL.

Source: Kaiser Commission on Medicaid and the Uninsured/CBPP annual survey of state eligibility and enrollment policies, 2009.

who were uninsured declining by one-third over the last decade.” The percentage of uninsured children below 200 percent of federal poverty guidelines dropped from 23 percent in 1997 to 14 percent in 2006.

Another study confirmed that public program expansion reduced the number of uninsured children. “At a time when health insurance coverage was declining for adults, significant progress was made in reducing the number of uninsured children. CHIP and public program expansions were key to preventing a similar increase in the number of uninsured children.”<sup>16</sup>

**MAKE ADDITIONAL GROUPS ELIGIBLE FOR MEDICAID AND CHIP**

In addition to raising the income ceiling for eligibility, states are expanding the reach of their public programs by permitting additional (i.e., non-mandatory) groups to enroll. In many cases, these groups do not enjoy the same benefit levels as the mandatory groups, and they can have additional cost-sharing requirements. States have found that expanding to new categories of people effectively improves access to coverage.

**MAKE ADDITIONAL GROUPS ELIGIBLE FOR MEDICAID**

Federal law requires states that participate in Medicaid to enroll certain groups. It also allows states to cover certain optional groups, with the same financial contribution from

the federal government (may require a waiver). Mandatory groups (also known as “categorically eligible” groups) include certain low-income children, pregnant women, adults in families with dependent children, elderly people and people with disabilities. Many states have expanded eligibility for additional groups, such as pregnant women and children with higher incomes, parents of eligible children, childless adults, certain women diagnosed with breast or cervical cancer, people diagnosed with HIV/AIDS and people with tuberculosis (Table 3).

The Deficit Reduction Act of 2005 allowed states to make changes to eligibility through a state plan amendment, rather than through a federal waiver. It gave states the option (among many other things) of allowing parents of certain children to buy into the state Medicaid program if their family income is at or below 300 percent of the federal poverty guidelines. The act also allowed states the option of tailoring or limiting benefits for specific populations.

*State Examples*

**Working Adults with Disabilities.** As of 2006, 32 states operated a Medicaid buy-in program for working adults with disabilities. Many of these adults would otherwise be unable to work because they would not be covered through their employer, nor would they be eligible for Medicaid because of their income. With buy-in programs,

**Table 3. Medicaid Eligibility Groups<sup>17</sup>**

<b>Mandatory Populations</b>	<b>Optional Populations</b>
Children under age 6 below 133 percent of the federal poverty guidelines	Low-income parents with incomes above state’s 1996 Aid to Families with Dependent Children level
Children age 6 and older below 100 percent of the federal poverty guidelines	Low-income children above 100 percent of the federal poverty guidelines who are not mandatory by age
Parents below a state’s Aid to Families with Dependent Children cutoffs as of July 1996 (median = 42 percent of the federal poverty guidelines)	Pregnant women above 133 percent of the federal poverty guidelines
Pregnant women with incomes below 133 percent of the federal poverty guidelines	People with disabilities and elderly people below 100 percent of the federal poverty guidelines but above Supplemental Security Income level
Supplemental Security Income beneficiaries with incomes below 74 percent of the federal poverty guidelines	Those who are at risk of needing nursing facility or intermediate care facilities for the mentally retarded (ICF-MR) under the Home and Community-Based Services waiver
Certain working people with disabilities	Certain working people with disabilities (above SSI levels)
Medicare buy-in groups	Medically needy

**Source:** The Henry J. Kaiser Family Foundation, Medicaid Enrollment and Spending by “Mandatory” and “Optional” Eligibility and Benefit Categories, June 2005.

adults with disabilities can participate in the Medicaid program by paying premiums on a sliding scale based on their income. According to Mathematica Policy Research Inc., in 2006 more than 97,000 people were enrolled in these programs.<sup>18</sup> Typically, states offer the traditional Medicaid benefit but some states have altered their benefit package to meet the needs of this group. Kansas, for example, received approval from CMS in 2006 to establish a benchmark benefit for its Working Healthy program, the state's Medicaid buy-in program. Under this program, working adults with disabilities who have incomes below 300 percent of federal poverty guidelines can buy into the program and obtain additional services—such as personal assistance and independent living counseling—that are not available to other enrollees.

**Pregnant Women.** Nineteen states have authorized Medicaid eligibility for pregnant women with family incomes of 185 percent of the federal poverty guidelines, and another 21 states approved or adopted expansions for pregnant women with incomes above 185 percent of the federal poverty guidelines. Between 2006 and 2008, Arizona, Connecticut, Indiana, Louisiana, Montana, Tennessee, Virginia, Wisconsin and the District of Columbia increased eligibility for pregnant women by expanding income eligibility or by covering the unborn children under CHIP. As discussed in the next section on expanding eligibility for CHIP, the Children's Health Insurance Program Reauthorization Act of 2009 allows states to cover low-income pregnant women under CHIP through a state plan amendment if they meet certain conditions (e.g., the state already covers pregnant women with incomes up to 185 percent of federal poverty guidelines under Medicaid).

**Young Adults age 19 and 20.** Young adults have a higher risk of being uninsured than any other age group. Eligibility for coverage as a child under Medicaid and CHIP ends when the child reaches age 19. To remain covered by either of these public programs, children must meet the more restrictive eligibility standards for an adult that, in most states, is limited to very low-income parents, or qualify as a pregnant women or an adult with disabilities. As a result, most young adults are dropped from public coverage when they reach age 19.

In 2006, Medically Needy programs in 16 states covered 19- and 20-year-olds who met categorical requirements. States with these programs can cover certain young adults who meet state income eligibility standards (tied to July

1996 AFDC payment levels). States with Medically Needy programs provide coverage to categorically eligible people with high medical expenses who “spend down” (i.e., medical expenses that an individual incurs are deducted from their income, making them eligible for a public program) for the remainder of the period the person is eligible for Medicaid. The benefit package for medically needy people may be more limited than for other beneficiaries, however.

Some states have taken advantage of federal flexibility that allows them to cover some additional young adults. Fifteen states have used the so-called “Ribicoff eligibility” option to cover certain young adults (ages 19 and 20) who meet the financial requirements for Medicaid. Young adults who age out of foster care may be eligible for Medicaid through the Chafee option, which is specifically designed to cover those who previously were in foster care.

In addition, young adults may be eligible for coverage in some states with Section 1115 waiver programs that cover low-income childless adults who meet program eligibility requirements.

In March 2009, Arkansas enacted legislation (HB 1700) requesting the Department of Human Services to apply to the Center for Medicare and Medicaid Services for approval to extend CHIP coverage to people between the ages of 19 and 25 who do not have health care coverage, who are full-time students in an institution of higher education located in the state, who are members of a family with a gross income up to 250 percent of the federal poverty guidelines, and who were enrolled in the program before a specified age.

**People with HIV/AIDS.** Maine, Massachusetts and the District of Columbia have federal approval to expand Medicaid eligibility for people with HIV through Section 1115 waiver programs. Another pathway of eligibility exists through the Ticket to Work/Work Incentives Improvement Act of 1999 that expanded state options under Medicaid by creating new Medicaid buy-in options for working individuals with disabilities. The act authorized state demonstration programs to provide Medicaid to workers with potentially severe disabilities, including HIV/AIDS, who are not yet disabled but whose health conditions could be expected to cause disability. Mississippi and the District of Columbia have demonstration programs under this authority.<sup>19</sup>

## **MAKE ADDITIONAL GROUPS ELIGIBLE FOR CHIP**

The CHIP law allows the secretary of health and human services to grant waivers to the states that help advance program objectives. Before the Children's Health Insurance Program Reauthorization Act of 2009 became effective April 1, 2009, CHIP Section 1115 waivers allowed states to use funds in ways that were otherwise not allowed by the law, such as enrolling other populations (in addition to children) in CHIP programs.

The Children's Health Insurance Program Reauthorization Act of 2009 makes several significant changes, such as phasing out adults and removing a five-year waiting period for legally residing immigrant children and pregnant women. Some key changes are summarized below.

- According to the new law, states must phase-out coverage for parents of enrolled children, new waivers cannot be approved for such coverage. States that have received waivers to cover low-income parents under CHIP will be allowed to move these parents into a separate block grant. The federal match for services to parents covered through CHIP will be reduced to the state's regular federal Medicaid matching rate.
- The reauthorization act also phases out coverage for non-pregnant childless adults for the few states that had received federal permission to cover this population. For those states, waivers will be terminated on Dec. 31, 2009. Instead, states receive temporary Medicaid funding for already enrolled adults and can apply for a Medicaid waiver for any further coverage.
- States already had the authority to cover low-income pregnant women who are not eligible for Medicaid through a CHIP Section 1115 waiver or they could include unborn children in the state plan definition of "child." The new law allows states to cover low-income pregnant women through a state plan amendment if the state covers children in families with incomes at a minimum of 200 percent of the federal poverty guidelines and covers pregnant women at a minimum of 185 percent of the federal poverty guidelines under Medicaid.
- The CHIPRA allows states to cover immigrant children and pregnant women who are lawfully residing in the United States who otherwise meet state Medicaid or CHIP eligibility requirements. If the state meets certain requirements, children and pregnant women need not wait five years for needed health care.

## *State Examples*

According to the Centers for Medicare and Medicaid Services, 11 states cover parents, adults or caretakers through CHIP Section 1115 waivers, including the Health Insurance Flexibility and Accountability (HIFA) initiative. Given the changes in CHIPRA, parents and adults will no longer qualify for CHIP coverage.

## *Evidence of Effectiveness: Expanding Access for New Populations*

Making additional groups eligible for Medicaid appears to be particularly effective to increase insurance coverage rates, especially among the very poor. State Medicaid programs that serve childless adults often enroll the maximum number of people allowed and have waiting lists for coverage because the programs are capped based on the financing that is available to maintain budget neutrality. Utah has seen a steady increase in enrollment since its program began in July 2002. Oregon's Family Health Insurance Assistance Program, which started with only state funds, recently was converted to Medicaid; it has a waiting list of eligible people. New Jersey's experience was similar when the state increased the size of the program for childless adults.

A 2005 evaluation of the Arkansas Medicaid expansion program for pregnant women and older Medicare beneficiaries found that the program—which receives money through tobacco settlement funds—increased Medicaid enrollment. The study found that the programs were not reaching all eligible populations, in part because people did not know about the programs or did not understand what services are covered. Despite steady enrollment increases among pregnant women, for example, the program reached only 47 percent of its enrollment targets for this group. The study recommended improved education and outreach in the enrollment process.<sup>20</sup>

## **STRENGTHEN MEDICAID AND CHIP OUTREACH AND ENROLLMENT**

In 2007, Medicaid provided coverage for 28 million children, and CHIP covered another 6 million. Still, 9 million children were uninsured. Nearly three-quarters of them were eligible for CHIP or Medicaid, but were not enrolled.<sup>21</sup> Policymakers at the federal and state levels are concerned about the failure to enroll eligible children. Outreach and enrollment efforts received enhanced financial support under the Children's Health Insurance Program Reauthorization Act of 2009. The act provided states with \$90 million in grants to improve outreach

and enrollment activities. It also provides states with bonus payments, in addition to the grant funding, if they implement five out of eight measures for simplifying enrollment and renewal—such as implementing 12-month continuous eligibility, eliminating asset tests and in-person interviews, and exercising the option to use presumptive eligibility—and if they exceed target enrollment rates.

Research shows that uninsured children, compared to Medicaid or CHIP-enrolled children, are less likely to have a regular source of health care, are significantly more likely to delay care because of cost, and have unmet health care needs.<sup>22</sup> Among the reasons these eligible children do not enroll are lack of knowledge about the programs, administrative obstacles, and lack of desire to enroll in a public program (because of the perceived social stigma or a feeling that insurance is not needed).<sup>23</sup> This failure to enroll in and retain public coverage also applies to adults. In 2006, two-thirds of uninsured, poor parents were eligible for public coverage but were not enrolled.<sup>24</sup>

Once children are enrolled, retaining them in the program while they are eligible continues to be a challenge. One study found that a significant number of children were enrolled in CHIP at the two-year anniversary of their initial enrollment, but many children were disenrolled from the program at least once during that time.<sup>25</sup> This reflects the emphasis states have placed on simplifying the initial application procedures but have not applied to renewal procedures. One way to avoid disenrollment is to implement a paperless verification policy. This refers to a redetermination process in which families need not return a renewal form unless changes have occurred that might affect eligibility and states verify ongoing eligibility through other means. Two other strategies that states have pursued are simplifying enrollment procedures and intensifying outreach efforts.

### *State Examples*

Examples of simplification procedures include using joint Medicaid/CHIP applications, eliminating asset tests, eliminating face-to-face interviews, reviewing eligibility at 12 months instead of monthly or quarterly intervals, implementing presumptive eligibility, implementing continuous eligibility, and allowing self-declaration of income. According to a 2006 survey, states took the following actions to simplify enrollment and renewal in their children's health insurance programs:<sup>26</sup>

- Forty-six states do not require an interview at the initial application, and 48 states do not require an interview at renewal time.

- Forty-six states do not have an assets test for families with children enrolling in CHIP.
- Forty-four states have a 12-month renewal period.
- Sixteen states have continuous eligibility.
- Nine states have presumptive eligibility in Medicaid.
- Because of confusion about rule differences between Medicaid and CHIP, some states have implemented a single application form that screens for both programs.

Examples of outreach efforts include the following.

- Involving health care providers in identifying and enrolling eligible children.
- Stationing outreach workers in convenient locations.
- Developing partnerships with important stakeholders such as tribal leaders, community health centers, Head Start centers, WIC, health departments and community action agencies.
- Developing program materials that are simple and understandable to people of different cultural backgrounds, different education levels and different languages.
- Initiating media campaigns that include newspaper, radio and TV ads and slides in movie theaters.
- Creating toll-free numbers that applicants can call to obtain information. Many states allow applicants to submit information online, and the state uses the single application to determine eligibility for various public programs.
- Implementing “express lane eligibility”—enrolling children who are already eligible for public assistance programs, such as TANF or free and reduced school lunch, into CHIP programs. This approach to eligibility and enrollment gives school districts and counties the authority to bypass paperwork requirements and more easily enroll children.

### *Evidence of Effectiveness: Expanding Outreach and Enrollment Activities*

The evidence to date suggests that states can significantly increase enrollment rates among the uninsured by intensifying outreach efforts and simplifying enrollment procedures for Medicaid and CHIP. Many widely adopted changes do not always achieve intended results, however. A 2004 study published in *Health Affairs* found that presumptive eligibility and self-declaration of income increased enrollment more than other strategies such as continuous eligibility. The study also underscored the importance of human contact in enrollment and retention. Strategies that seek to ease the enrollee burden—through mail-in applications, for example—eliminate personal contact, which can negatively affect enrollment. “Facing

a series of complex programs without personal assistance reduces a recipient's ability to learn about the programs, they fail to obtain forms, and fail to complete them."<sup>27</sup> The enrollment partners mentioned earlier—health care professionals, community activists and day care providers, among others—can serve as the human contact for enrollment.

In 2009, the National Academy for State Health Policy reviewed state actions designed to maximize enrollment in public programs and identified the most successful strategies (summarized below).<sup>28</sup>

Many states are attempting to retain current enrollees as long as they are eligible and to reduce disenrollment among eligible individuals. A 2008 survey of CHIP enrollees in Kansas and New York suggests that certain state strategies positively affect retention. More than 75 percent of children enrolled in CHIP were publicly insured

one year after enrollment (through CHIP or Medicaid). The rest either became uninsured, or moved to private insurance. Simplified renewal policies (with automatic re-enrollment) boosted CHIP retention, according to the study.<sup>29</sup> Active enrollment policies that require parents to inform the state periodically about their child's eligibility, on the other hand, had the opposite effect.

New York City, for example, reverted to an active renewal process in 2002. As a result, "CHIP enrollees were more than three times more likely to disenroll from CHIP than they were under the simplified renewal process (58 percent versus 17 percent)." According to the report, "...states' CHIP renewal policies are critical to ensuring continuous insurance coverage for enrollees, because many low-income children become uninsured during the renewal process and may return to CHIP shortly after disenrollment."

#### **Maximizing Kids' Enrollment in Medicaid and CHIP**

- Keep enrollment and renewal procedures simple.
- Use community-based outreach; it is key to increasing enrollment.
- Use technology to coordinate programs and reduce administrative barriers.
- Change state agency culture to promote enrollment goals.
- Engage leaders (e.g., governors, state legislators, and Medicaid/CHIP directors) who champion the goal of covering kids.
- Engage partners to help achieve coverage goals.
- Use marketing to promote enrollment in public programs (e.g., media campaigns and targeted outreach to specific populations).

Source: National Academy for State Health Policy, "Maximizing Kids' Enrollment in Medicaid and SCHIP," February 2009.

## IMPLEMENT PUBLIC-PRIVATE PARTNERSHIP INITIATIVES

With the budget pressures facing the public and private sectors, it is increasingly difficult for either to alone cover the cost of health insurance. As a result, states are adopting strategies that help the private sector—primarily employers and insurers—provide insurance benefits to their employees. Over the years, states have implemented and sought ways to better coordinate public and private coverage; premium assistance (when a state subsidizes employer coverage with public dollars) is the most common approach.

### PREMIUM ASSISTANCE PROGRAMS

Premium assistance programs use public dollars, predominantly Medicaid and CHIP funds, to purchase private insurance coverage. Through premium assistance, states can subsidize employer-sponsored coverage for workers who are eligible for Medicaid or CHIP or who have eligible family members. The state pays part of the premiums for group employer health insurance coverage of eligible children. In some cases when the state subsidizes a family premium to cover the children, the state can also cover their parents.

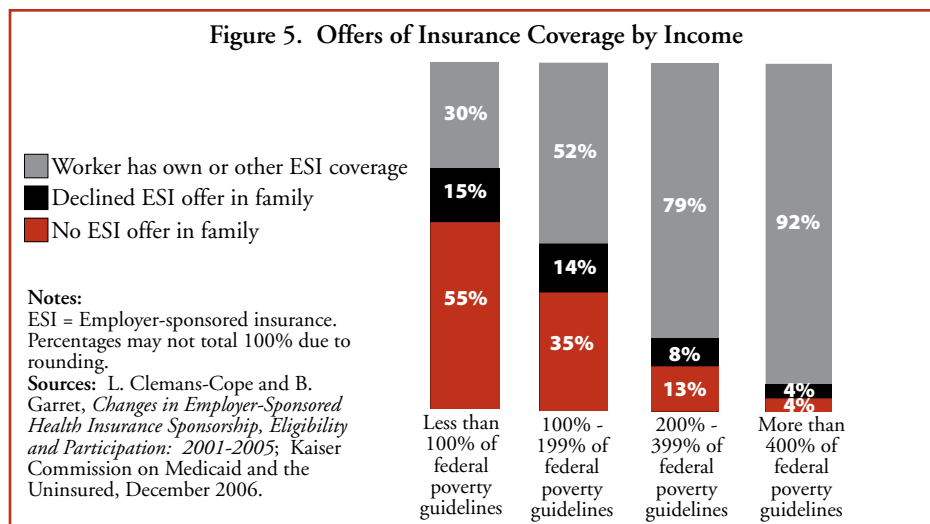
This approach encourages low-income families' participation in private coverage, may help to shore up the private coverage market, and has the potential to achieve cost savings by bringing in employer contributions to help offset the cost of coverage for the public program. Some also believe this approach helps prevent “crowd out” of private coverage by providing a public-private blend of coverage to individuals at the upper end of the low-income spectrum. Figure 5 summarizes insurance coverage according to income. Workers with incomes below 100

percent of federal poverty guidelines are the least likely to have insurance through their employer or through someone else in the family.

States are interested in premium assistance programs for the following reasons.

- Low-income families may have access to employer-sponsored insurance but cannot afford their share of the premium. In 2005, for example, 45 percent of uninsured parents with incomes below 100 percent of federal poverty guidelines had access to insurance through their employer, and 65 percent of workers with family incomes between 100 percent and 200 percent of federal poverty guidelines were offered insurance by their employer.<sup>30</sup>
- Premium assistance programs allow the state to expand access to health insurance by leveraging private health coverage funds.
- Premium assistance programs can help stabilize the private health insurance market.
- New federal government flexibility makes it easier to create programs and apply for the necessary waivers.

These programs also can prevent Medicaid and CHIP from crowding out private health insurance coverage. The Children's Health Insurance Program Reauthorization Act of 2009 reduces barriers for states to provide subsidies for the purchase of employer-sponsored coverage, outlines the conditions that must be met by the employer's insurance, and amends the federal Employee Retirement Income Security Act (ERISA) to promote easier coordination between public and private coverage.<sup>31</sup>



States have pursued premium assistance programs through traditional section 1115 research and demonstration waivers or Medicaid's Health Insurance Premium Payment (HIPP) program. Despite the advantages of this approach for the state (predominately sharing the cost of the insurance with the employer), enrollment in employer-sponsored insurance programs remains low. Less than 1 percent of the total Medicaid population is enrolled in employer-sponsored health insurance versus Medicaid,<sup>32</sup> and even the largest programs have less than 4 percent of the Medicaid population.<sup>33</sup> The primary reason for low enrollment is that fewer than half of families at or below 100 percent of the federal poverty guidelines are offered employer-sponsored coverage. Also, when private insurance is available for this population, it often is very expensive with lower employer financial participation. The relatively low enrollment in the programs can result in high per-person administrative costs.

#### *State Examples of Premium Assistance Programs*

As of 2006, at least 15 states—Idaho, Illinois, Iowa, Oklahoma, Oregon, Maine, Massachusetts, New Jersey, New Mexico, Pennsylvania, Rhode Island, Texas, Utah, Virginia and Wisconsin—sponsored Medicaid and/or CHIP premium assistance programs. These programs vary in size. The smallest has only 61 people enrolled, and the largest—Pennsylvania and Massachusetts—have 23,000 and 33,000 enrollees, respectively.<sup>34</sup> Rhode Island's RIte Share Program, which began in 2002, covered more than 5,000 people in 2006. Enrollment in the RIte Share program is mandatory if it is more cost-effective to enroll the beneficiary in his or her employer's plan than to provide coverage through the state.

A 2004 analysis of Rhode Island's combined Medicaid/CHIP RIte Care program and its premium assistance RIte Share program showed a major difference between expenditures in public funds for members enrolled in the programs. Whereas RIte Care cost \$156 per member per month (in combined state and federal dollars), RIte Share cost taxpayers half that—\$78 per person per month. The balance of the cost is supported by the employer's contribution for coverage.

Funding and implementation strategies vary considerably among states, as do eligibility requirements. Eligibility is open to all Medicaid-eligible individuals in Texas, Iowa and Pennsylvania; other states target specific income levels. Statutory requirements for benefits and cost-sharing vary based on the program type—CHIP program,

Medicaid Health Insurance Premium Payment Program or Medicaid Section 1115 demonstration waiver. Enrollees in a Medicaid HIPP, for example, must have access to all benefits covered under Medicaid; Section 1115 waiver demonstration projects need not meet any specific standards for optional and expansion populations.

Pennsylvania's Health Insurance Premium Payment Program, implemented in 1994, has more than 23,000 enrollees, making it one of the largest in the nation. The program pays the employee's share of the premium for workers who are eligible for Medicaid and have access to employer-sponsored coverage. According to one analysis, the program saved more than \$76 million in 2003, compared to providing direct Medicaid coverage for these people. Outreach with employers and automated enrollment contributed to program success.<sup>35</sup>

### **MEDICAID BUY-IN PROGRAMS**

States have the option to extend Medicaid coverage to working people with disabilities who otherwise would not be eligible for Medicaid coverage because their income from earnings is too high. Typically, workers with disabilities who have sufficient income share in the cost of the program—they buy into Medicaid through monthly premium payments. States have a great deal of flexibility in designing income and asset limits and cost-sharing requirements under the Balanced Budget Act of 1997 and the Ticket to Work and Work Incentives Act of 1999. The state decides whether to impose cost sharing and the type and amount of payments, within very broad guidelines. Unrelated to the Medicaid buy-in program for workers with disabilities, some states with Section 1115 waivers allow beneficiaries who are not categorically eligible for the program to “buy-in” to Medicaid by paying a monthly premium and other fees. The premiums, which usually vary depending on the beneficiary's income, help offset the cost of expanding Medicaid. If a beneficiary fails to pay the premium, benefits can be denied.

### **CHIP BUY-IN PROGRAMS**

Several states allow families with incomes above the CHIP eligibility levels to purchase coverage in the CHIP program. States design these programs to fill a coverage gap among middle to lower income families who are neither eligible for public coverage through Medicaid or CHIP nor are able to purchase coverage on their own. Families enrolled in buy-in programs pay a portion or the

full cost of the premium and, in exchange, their children have access to comprehensive health insurance benefits offered through the CHIP program.

Several states have had CHIP buy-in programs for more than 10 years, and more states are considering or establishing these programs, since they are administratively straightforward (states typically use the same staff and administrative process for CHIP and for the buy-in program) and cost-effective. On the other hand, current enrollment in these programs is relatively low—in part due to high premiums for families—and, as a result, they have not significantly expanded coverage among eligible uninsured children. Some argue that these programs encourage families to substitute private coverage with public coverage (i.e., crowd-out). A 2008 report by the Urban Institute’s Health Policy Center found that CHIP buy-in programs have had “little impact” on employer-sponsored insurance, however.<sup>36</sup> Others point out that buy-in programs may result in adverse selection, since children enrolling in a relatively expensive and voluntary program could be more likely to have serious health care needs.

States also have a new option for an alternative to a CHIP buy-in program created by the CHIPRA. It gives states the option to establish a purchasing pool for employers with fewer than 250 employees and at least one employee who is CHIP-eligible or has a CHIP-eligible child and/or families wishing to purchase coverage. The purchasing pool must offer at least two CHIP benchmark or benchmark-equivalent products. States can provide CHIP-funded subsidies for premium costs for those eligible for CHIP.

#### *State Examples of Medicaid and CHIP Buy-In Programs*

In 2006, 32 states operated a Medicaid buy-in program for people with disabilities, with total national enrollment of more than 97,000. Although enrollment varies considerably among states, the total enrollment in all states has increased significantly—from 29,398 participants in 2001 to 97,491 in 2006.<sup>37</sup>

Many states operate a CHIP buy-in program. Connecticut, Florida, Maine, North Carolina, New Hampshire, New York and Pennsylvania<sup>38</sup> created some of the first programs. In recent years, other states have considered or adopted such programs. All of the programs are available to families with incomes at 200 percent of the poverty level or higher. Some state examples are summarized below.

- In Florida, families with incomes above 200 percent of the federal poverty guidelines, who are not eligible for public coverage or premium assistance, can buy into Florida KidCare by paying the full cost of premiums and administrative costs. (This is a common requirement. According to the National Academy for State Health Policy, six of the seven states with buy-in programs in 2005 required families to pay the full premium as well as administrative costs.)<sup>39</sup>
- Pennsylvania allows families with incomes above the threshold for public coverage or premium assistance to buy into CHIP if their coverage has been denied due to a preexisting condition, if their private insurance premiums are 150 percent higher than the state’s monthly premium, or if the cost of insurance exceeds 10 percent of the annual family income.
- Tennessee’s Cover Kids program allows families with incomes above 250 percent of the federal poverty guidelines to buy into the program by paying monthly premiums, which totaled about \$225 per month per child in 2008. The benefits of the plan, based on the state employees’ health insurance plan, focus on preventive and well-child care.
- In 2008, Ohio’s Governor signed an executive order establishing the Children’s Buy-In Program for children with complex health conditions who are unable to obtain or afford health insurance on the private market. Families with incomes above 300 percent of the federal poverty guidelines can purchase public coverage for children through the buy-in program as long as they meet specific criteria, such as being ineligible for Medicaid and being younger than age 19.

#### *Evidence of Effectiveness for State Premium Assistance and Buy-In Programs*

##### **Medicaid Premium Assistance and Buy-In Programs.**

It appears that Medicaid premium assistance and buy-in programs have had at least a limited positive effect on coverage rates. Iowa, which operates the oldest premium assistance program, enrolls more than 8,000 people, including more than 2,000 family members who would not qualify for Medicaid. In states that combined implementation of the premium assistance program with a Medicaid expansion—such as Rhode Island and Utah—it is clear that the number of uninsured dropped. It also is clear that some premium assistance programs have saved

states money. For example, New Jersey estimates that the state's cost savings average around \$204 per family per month.<sup>40</sup>

A 2005 report by the Kaiser Commission on Medicaid and the Uninsured examined premium assistance in five states and concluded that the financial success of the programs depends upon an employer contribution to the premium, robust enrollment in the program, and the cost of employer-sponsored insurance. As the cost of health insurance premiums for employers continues to rise, Medicaid premium assistance programs become less cost effective.<sup>41</sup>

For Medicaid buy-in programs for workers with disabilities, states hoped that most buy-in enrollees would enroll in employer-sponsored private health insurance and that Medicaid would supplement coverage for services not covered under employer plans. To date, however, enrollment in private coverage is low, due in part to the fact that many people are working fewer hours than required to qualify for coverage.

**CHIP Premium Assistance Programs and Buy-In Programs.** It does not appear that CHIP premium assistance programs have been particularly effective in expanding health insurance coverage to date. There is a relatively low rate of participation in CHIP premium assistance by states, predominately due to federal regulations. The CHIP Reauthorization Act of 2009 made some changes to the CHIP cost effectiveness tests. However, the federal government still requires that states “wrap around” the private coverage benefits to reach parity with the public sector coverage. Although somewhat simplified by the new law, premium assistance still remains a complicated endeavor for states.

In 2003, a study conducted by the federal government took an in-depth look at the experiences of Massachusetts and Wisconsin programs because, until recently, they were the only states with federally approved programs. According to the report, as of Sept. 30, 2001, 709 children were receiving CHIP premium assistance under the Massachusetts program and, as of Oct. 31, 2001, only 47 families were enrolled in the Wisconsin program. The two major reasons that relatively few states have implemented CHIP premium assistance programs are that “... federal requirements make premium assistance programs administratively burdensome and the fact that a relatively

small number of children are potentially eligible for such programs.”

Oregon's experience, however, demonstrates that premium assistance programs are attractive to consumers and can offer access to health services comparable to CHIP. In 2007, the Child Health Insurance Research Initiative (CHIRI) compared enrollment experiences in Oregon CHIP versus the state's premium assistance program, the Oregon Family Health Insurance Assistance Program (FHIAP). Eligibility requirements are the same for the two programs; thus, eligible families can choose either. The report's findings<sup>42</sup> are summarized below.

- Enrollees in both programs reported similar access to services and program satisfaction. Almost all children in both programs had a regular source of care, and both groups were equally satisfied with benefits. However, CHIP enrollees had higher unmet needs for specialty care than FHIAP enrollees (11 percent versus 4 percent).
- Fifty-two percent of FHIAP families thought they were ineligible for CHIP. Other reasons families chose the premium assistance program over CHIP included preference for private insurance, coverage for the whole family, and the ability to keep their current health plan or doctor.
- Family education level, prior insurance experience and employment influenced program enrollment. Families with more highly educated parents were more likely to enroll in the premium assistance programs, as were families with at least one employed parent.

According to NASHP, enrollment in the seven states with buy-in programs in 2005 totaled about 44,000 (compared to enrollment of nearly 840,000 in those states' CHIP programs). Although these programs provide coverage to children who otherwise may have lacked insurance, they remain relatively small compared to the number of children who are eligible for the programs.

In 2008, the Urban Institute's Health Policy Center found that take-up rates among eligible children were relatively low, with between 8 percent and 11 percent of eligible children enrolling in the programs. The high price of premiums is partly to blame, as are other factors, such as lack of awareness or lack of interest in enrolling in the

program. “Many uninsured families eligible for the buy-in may find the premiums unaffordable relative to their income.”

As economic conditions worsen, some anticipate these programs will become an important source of coverage for families with moderate- to higher-incomes; however, the high cost of premiums may continue to thwart enrollment. The Children’s Health Insurance Program Reauthorization Act of 2009 mandates the Government Accountability Office to conduct a study on state premium assistance programs by January 2010.

## **SUBSIDIZE THE COST OF PRIVATE INSURANCE**

Work-based enrollment is one of the most effective tools to insure people. Only those programs where coverage is essentially automatic, such as Medicare, enroll higher proportions of eligible people. Most Americans receive insurance through their employer. According to the Economic Policy Institute, between 2000 and 2007, 41 states experienced “significant losses in coverage.” Maryland, Missouri, North Carolina and South Carolina experienced declines of employer-sponsored coverage in excess of 7 percent.<sup>43</sup> In 2008 and 2009, employer-sponsored coverage continued to decline as unemployment rose.

To address this trend, some states have implemented programs to increase private health insurance coverage. This section examines other approaches that use state funds to subsidize the cost of private insurance. In addition to the premium assistance and buy-in programs described earlier, states also use state-funded reinsurance and tax credits to expand access to health insurance coverage. Although these strategies have advantages, state experience shows that significant subsidies are needed to decrease the number of uninsured.

### **MAKE PUBLICLY FUNDED REINSURANCE AVAILABLE FOR PRIVATE COVERAGE**

State-funded reinsurance is a mechanism for reducing the price of private health insurance by having the state cover (i.e., reinsure) a portion of health insurers’ high-cost health claims. Under this approach, a state can cover all mid-level claims (e.g., amounts between \$30,000 and \$100,000 per claim) or all claims above a certain threshold (e.g., exceeding \$25,000). Because the state picks up a portion

of the cost of catastrophic claims, the price insurers charge for plans with state-funded reinsurance is lower. Availability of state-funded

reinsurance generally is linked to state-approved plans for low-income, uninsured people and small employers. The intent of state-funded reinsurance is to expand coverage by making insurance more affordable.

### *State Examples*

Connecticut, Idaho, Massachusetts, New Hampshire, New Mexico, New York, Utah and Washington are among the state that have established reinsurance programs to expand access to health insurance coverage among small groups and individuals. All but the New York program operate without a state subsidy.

New York’s state-funded reinsurance program, Healthy NY, was established in 2001. Under Healthy NY, all health maintenance organizations (HMOs) are required to offer a standard benefit plan that, when sold to eligible small employers, is partially subsidized through a state-supported reinsurance fund. Major sources of funding are state tobacco tax revenues and tobacco settlement money. The program reimburses health plans for 90 percent of claims between \$5,000 and \$75,000.

Small employers can enroll in a Healthy NY HMO plan if they have not offered coverage for the past 12 months and no more than one-third of their employees earned more than \$36,500 per year in 2007. Employers must pay at least half the premium, and at least half of all employees must participate or already have coverage through another source. Uninsured sole proprietors and uninsured people who are not eligible for other programs also can enroll if their family income does not exceed 250 percent of federal poverty guidelines. In 2007, Healthy NY plans were required to offer a high-deductible health plan option, with or without prescription drug coverage.<sup>44</sup>

### **Reinsurance Defined**

“State government provided reinsurance—essentially, insurance for insurance companies—can relieve health insurers of the risk of ‘adverse selection’ (disproportionate enrollments of individuals with extraordinarily high medical costs), particularly in the small group and individual markets.”

*Source:* The Commonwealth Fund, *Reinsurance: How States Can Make Health Coverage More Affordable for Employers and Workers?* July 2005.

### *Evidence of Effectiveness for Publicly Funded Reinsurance*

Enrollment in the New York program has increased rapidly since 2001, and premiums have remained relatively low. The program currently provides benefits to nearly 150,000 New York residents; enrollment in 2007 increased by 14 percent, according to a 2007 report by the New York Insurance Department. To attract additional enrollees, New York made several changes to the program in 2003. These changes included lowering the reinsurance threshold to \$5,000, broadening eligibility guidelines, adding a second standardized plan that does not cover prescription drugs, and easing employer contribution requirements. Today, 53 percent of enrollees are classified as individuals (not covered by an employer), 31 percent are small business employees, and 16 percent are sole proprietors.

Interest in reinsurance programs remains high in other states. The Reinsurance Institute of the Urban Institute developed quantitative models to help state policymakers in Rhode Island, Washington and Wisconsin examine how reinsurance would affect premiums, employer offer and employee take-up of coverage, and state costs. A 2008 Reinsurance Institute report, *Reinsurance in State Health Reform*, found that state reinsurance subsidies—from general funds or special funds—expanded coverage among the previously uninsured. “How much reinsurance reduced premiums and hence increased coverage was a function of how much state funding was hypothesized.” In other words, higher state investments were linked to lower premiums and increased coverage.

The study found that reinsurance did not affect everyone equally and, in fact, benefited workers with higher incomes more than those with lower incomes because higher-income workers were likely more able to afford coverage. The report also found that broad reinsurance—programs that target broad segments of the population, such as workers in small firms—“is not cost-effective relative to more targeted subsidies, if considered solely as a tool for increasing coverage.”<sup>45</sup> States still can choose these approaches, however, if they have other goals such as helping small firms afford coverage or stabilizing the insurance markets. “Reinsurance is better seen as a complement to other reforms than as a stand-alone reform.”

#### **PROVIDE TAX INCENTIVES FOR COVERAGE**

A health insurance tax incentive is a credit or deduction for purchase of health insurance that reduces an individual's

or employer's tax burden. Tax incentives are designed to encourage employers and individuals to have health insurance by lowering the effective price of coverage. A health insurance deduction or credit can be capped, limited to certain categories of tax filers (e.g., small business, previously uninsured individuals, etc.) or made available for purchase of particular types of coverage only (e.g., comprehensive benefit plans). Tax credits can be given directly to employers, especially small employers, to help them provide coverage to their employees. Tax credits provided to individuals subsidize the cost of purchasing insurance in either the employer or the individual market. Although these approaches have been popular recently, they also are controversial because of cost and concerns about who benefits.

States are experimenting with requiring employers to offer a “Section 125 cafeteria plan to their employees as a means of lowering costs for both employees and their employers. Section 125 cafeteria plans were created by a 1978 federal law that amended the Internal Revenue Code. Designed as an optional feature for employers, cafeteria plans allow employees to pay for a variety of health care expenses without paying any federal tax on those charges. The result can be a savings of between 25 percent and 40 percent of every \$1 the employee contributes to his or her plan. The employer also realizes savings on FICA withholding tax for each participating employee, typically around \$160 per year. It costs about \$100 per year per employee to create and administer a health-only cafeteria plan, and several national companies compete for this business.

#### *State Examples*

Some states, such as Arkansas, Minnesota and South Carolina, allow self-employed individuals to deduct the full amount of their health insurance premium payments when calculating their state income tax.

In Colorado, certain people can claim a credit against personal income tax for health insurance expenses. The credit—a maximum of \$500 per year—is available to those whose incomes do not exceed \$35,000 for individuals with dependents or \$25,000 for individuals with no dependents.<sup>46</sup>

Oklahoma allows eligible employers to take a refundable tax credit for premiums paid on behalf of eligible employees who elect to participate in a state-certified basic health benefit plan. The credit, equal to \$15 per month per eligible employee, is allowed for two consecutive years.

Maine employers with fewer than five employees are eligible for a corporate income tax credit if they make qualifying health benefit plan contributions for low-income employees and their covered dependents. The credit is equal to either 20 percent of the dependent benefit or \$125 per employee. To qualify, an employer must pay at least 80 percent of the premium for each low-income employee and 60 percent of dependent coverage. Coverage also must be available to all low-income employees who have been employed for 30 days or more and work more than 25 hours per week or 1,000 hours annually.

Some states encourage employers to offer coverage by conditioning receipt of tax credits for new jobs created in enterprise zones on, among other things, provision of employer-sponsored health coverage. Arizona provides that an enterprise zone tax credit can be taken for each new “qualified employment position” if the position includes health insurance coverage and the employer pays at least 50 percent of the premium. Massachusetts allows certain businesses to take a \$200 tax credit for each “enterprise zone new business facility employee” in excess of the number employed during any prior tax year if the employee is insured under an employer-provided health insurance plan.

As of April 2009, at least 13 states adopted laws requiring or encouraging employers to offer a cafeteria plan, with a dual goal of keeping coverage available and affordable and expanding the numbers of those using commercial health insurance. A cafeteria plan allows an employee to

purchase health insurance with pre-tax dollars, even if the employer does not contribute to the plan. Connecticut, Florida, Indiana, Iowa, Kansas, Maryland, Massachusetts, Minnesota, Missouri, Rhode Island, Tennessee, Utah and Washington enacted laws that either require or encourage employers to create cafeteria plans.

#### *Evidence of Effectiveness*

It does not appear that state tax deductions or credits for the purchase of health insurance have increased the number of people with coverage. A review of existing research reveals that tax subsidies have not significantly influenced health insurance coverage rates for people. This is due in part to the fact that the value of state tax incentives relative to the price of coverage is too small. Studies indicate that, to bring the cost of coverage to a level most of those currently uninsured can afford, premium subsidies (including tax incentives) must be substantial (e.g., 60 percent or more). A problem with tax incentives is that those eligible for the incentive (e.g., uninsured small employers and individuals) often owe so little in taxes that a deduction or nonrefundable tax credit is of little value. Studies have shown that, for tax credits to effectively stimulate coverage among the uninsured, they must be available when premium payments are due, and therefore need to be refundable ((the individual receives the full amount of the credit even if his tax liability is lower than this amount) and advanceable (individual does not have to use his own funds first in order to claim the credit later).

## **ESTABLISH OR EXPAND “STATE-ONLY” PROGRAMS**

### **SPONSOR A STATE-ONLY HEALTH INSURANCE PROGRAM**

State-only health insurance programs are funded with state money and usually require some contributions from enrollees and participating employers. The programs make state-subsidized coverage available to uninsured low-income people. State-only programs are designed to help people who cannot afford individual coverage or the employee share of employer-sponsored coverage and who do not qualify for any other fully or partially federally funded insurance program. Some offer comprehensive plans, while others offer limited benefit plans.

Although states have a great deal of latitude to design programs to meet their unique needs, such plans have not been widely adopted, perhaps because of the high cost of operation.

#### *State Examples*

Pennsylvania sponsors adultBasic, a low-cost, state-subsidized health insurance program for uninsured adults between the ages of 19 and 64. The program provides basic health insurance to Pennsylvanians with family incomes below 200 percent of federal poverty guidelines who are not eligible for Medicaid. Eligible individuals pay about \$30 in monthly premiums and copayments for office and emergency room visits. The program covers the balance with funds from the Tobacco Settlement Agreement and the Community Health Reinvestment Agreement, which is funded by annual contributions from four nonprofit Blue Cross/Blue Shield plans. As of April 2009, the program covered 43,615 people, and 212,418 were on a waiting list. Four private health insurers administer the program in different parts of the state.

Washington operates a state-funded health plan, Basic Health. The plan offers subsidized coverage to uninsured adults under age 65 that meet the income guidelines of the program. Benefits include doctor and hospital care, preventive care, emergency services and prescription drugs. Families in Basic Health pay a monthly premium that is based on family size, income, age and the health plan selected. Cigarette and alcohol taxes are the primary sources of funding for the plan. In 2006, the Legislature authorized 6,500 additional slots, bringing total program capacity to 106,500.<sup>47</sup>

#### *Evidence of Effectiveness*

Some state-only health insurance programs have effectively expanded coverage. The Pennsylvania adultBasic program, for example, reached maximum enrollment just eight months after it began and has maintained a long waiting list. As the numbers shown in the previous state examples section indicate, state-only health insurance programs cover hundreds of thousands of people who would otherwise be uninsured. The major concern for states, however, is financing of the program.

### **ESTABLISH OR EXPAND A STATE HIGH-RISK POOL**

High-risk pools are nonprofit organizations created by state law to offer comprehensive health insurance to people who cannot obtain health insurance in the private market due to their health status. In most states, the high-risk pool also provides health insurance for federally eligible people under the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 and for those eligible for the federal Health Coverage Tax Credit Program.

Depending on the state, participants pay a premium based on a formula specified in state law. The typical premium for high-risk pool coverage ranges from 125 percent to 200 percent of standard rates, which are the amounts insurers charge healthy individuals for comparable coverage. Premiums paid by high-risk pool enrollees do not cover the full cost of their care. The balance comes from various sources, including assessments on health insurers, hospital service charges, state general funds, premium taxes and tobacco settlement funds. In addition, in 2006, \$75 million in federal grants helped 31 states cover costs associated with their high-risk pools.<sup>48</sup>

#### *State Examples*

Total national enrollment in the 34 state high-risk pools<sup>49</sup> reached 201,047 in 2007.<sup>50</sup> Typically, state high-risk pools have strict eligibility rules and a relatively small number of enrolled individuals.<sup>51</sup> About two-thirds of high risk pools had less than 4,000 participants in 2006, and just six states had more than 10,000 enrollees.<sup>52</sup>

Funding for high-risk pools comes from a combination of premiums and other sources, such as assessments on insurance companies, assessments on hospitals and other health care providers, allocations from state funds and various other mechanisms. California, Colorado, Idaho, Illinois, Indiana, Kentucky, Louisiana, Nebraska, South

Dakota, Tennessee and Utah allocate funds to help support the high-risk pool.

Minnesota's high-risk pool, the Minnesota Comprehensive Health Association, covered the most people of any state, with a 2006 enrollment of about 31,000. Several other states—such as Alaska, Florida, Louisiana, New Hampshire and South Dakota—had 1,000 or fewer enrollees.<sup>53</sup> Some state pools are set up to encourage as many uninsurable individuals as possible to enroll in the pool, while others restrict eligibility to certain subgroups of the uninsured; they might allow only HIPAA-eligible individuals to enroll. The Idaho Individual High-Risk Reinsurance Pool is unique because the state requires all insurers that offer individual insurance to offer a high-risk pool plan.

#### *Evidence of Effectiveness*

The availability of high-risk pool coverage for uninsurable people has minimally lowered health insurance coverage rates. In 2006, pool premiums averaged about \$5,355 per year. Variation among states ranged from \$1,700 per year in Idaho to \$9,160 per year in South Carolina.<sup>54</sup> In addition, other cost sharing—through coinsurance, copayments and deductibles—results in high costs for enrollees.<sup>55</sup> High-risk pools are not a viable option for most low-income uninsured people because of the expense.

The federal Trade Adjustment Act of 2002 appropriated \$100 million to encourage the start-up or continuation of high-risk pools through grants to help states cover some operating losses. The State High Risk Pool Funding Extension Act of 2006 reauthorized federal grants, including \$15 million in seed grants and \$75 million for operational and bonus grants.<sup>56</sup> In 2006, the Center for Medicare and Medicaid Services awarded a total of \$2.45 million to five applicants for seed grants, \$50 million to 31 states for operational grants, and \$25 million to 25 states in bonus grants.

## CONCLUSION

States have taken numerous actions to expand access to health care coverage. The most significant gains in insuring those who otherwise lack coverage have resulted from expansions of public programs. Even in today's fiscal crisis, states continue to evaluate and discuss ways to expand Medicaid and CHIP to cover additional people. State experiences demonstrate that states are taking a multi-pronged approach to improving coverage and are pooling the resources of all stakeholders—government, employers and individuals. Expanding public programs has been a top priority for states in recent years, and these actions have helped to reduce the number of the uninsured. However, all approaches require significant state investment during a turbulent economic situation.

The future outlook for public expansions and other programs that rely on state funds is uncertain. As state budgets face new challenges, policymakers will face difficult choices about how to finance coverage and how to address current and future problems. According to the Kaiser Family Foundation, "Demand for Medicaid increases when the economy is weak, requiring states to manage the increase in enrollment and program spending just as state budget conditions are most constrained."<sup>57</sup> States are likely to continue to search for cost-effective measures that fill the gaps for the uninsured. Many expect these approaches will spread the burden by requiring more from the public and private sector and increased cost sharing by individuals and employees. States also will keep a close watch on the growing momentum to create national health reform.

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## THE IMPROVING COVERAGE SERIES

In 2004, the National Conference of State Legislatures published *State Options for Expanding Health Care Access* by Barbara Yondorf, Leah Oliver and Laura Tobler, a report that outlined the plethora of state strategies for expanding health care access. Although many of the strategies described in that report remain the same, much has changed at the federal and state levels during the past five years. The *Improving Coverage* briefs provide new data about the uninsured, update information about state approaches, and describes how recent federal and state developments—including a worsening economy and federal policy changes—are expected to affect state programs. The format also has changed. Unlike the original publication, which contained all strategies in one document, this report is presented in two issue briefs that cover specific topics and one web page.

- *Using Public Programs to Expand Health Insurance Coverage* examines state options for increasing health insurance coverage rates by expanding government health programs. It examines options that expand Medicaid and the Children's Health Insurance Program (CHIP); establish or expand state-only health insurance programs; and establish or expand public-private initiatives, such as premium assistance and buy-in programs.
- *Improving Coverage: Strengthening the Health Care Safety Net*, describes strategies that increase access to care through an expanded health care safety net.

In addition to the issue briefs, NCSL has developed an accompanying web page to summarize new programs that address the uninsured. *State Programs to Cover the Uninsured* is a new web page that provides a 50-state description of programs that provide health insurance coverage. These programs change frequently in response to federal policy, economic conditions and state experiences. For state coverage profiles of the 50 states and the District of Columbia, go to [www.ncsl.org/programs/health/statecoverage.htm](http://www.ncsl.org/programs/health/statecoverage.htm).

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