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State Experimentation with Reforms to Expand Access to Health Care

American College of Physicians

A White Paper

2007

A Summary of State Efforts to Reform Health Care and Recommendations from the American College of Physicians on Key Elements That Should Be Included In Any Reform

A White Paper of the
American College of Physicians

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Executive Summary

The American College of Physicians has a long-standing commitment to making affordable health insurance available to all Americans. In previous papers, the College has documented the cost of lack of health insurance and the impact of lack of health insurance coverage on health outcomes and proposed core principles for evaluating proposals to expand coverage[1, 2].

In 2002, the College outlined a national framework to achieve universal coverage that includes a combination of premium subsidies, tax credits, purchasing groups, insurance market reforms, and expansion of Medicaid and the State Children's Health Insurance Program (SCHIP). The plan also includes a state opt-out program that allows states to opt out of the national framework and establish their own programs for universal coverage. While little progress has been made to address the uninsured in a comprehensive way at the national level, state policymakers across the country are proposing ambitious and innovative reforms to expand health insurance coverage to individuals in their states. The President and Congress have also announced proposals to support states as they pilot new health reforms.

This paper examines various state initiatives to expand access to health insurance, as well as proposals by the President and Congress in support of state efforts. This paper also identifies key elements that should be a part of any state-based reform. The College recognizes that all states cannot use the same framework to achieve universal coverage and that experimentation with various models is desirable. The College offers the following recommendations to states as they develop models to expand access to care for their residents:

1. **State-based health plans should either achieve universal coverage, or should at a minimum result in measurable and substantial reductions in the number of uninsured within the next 5 years.**
2. **State-based health plans should ensure that all individuals participate in the coverage plan, by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches.**
3. **State-based health plans should at a minimum provide coverage for a core package of preventive and primary care services and for catastrophic expenses.**
4. **States should ensure adequate and stable funding for their state-based health programs by broadly sharing responsibility with the federal government, employers, and individuals within the state.**
5. **State-based health programs should include incentives to ensure a better balance of primary care physicians to specialists and an adequate supply of primary care physicians.**
6. **State-based health plans should give individuals the ability to obtain care from a qualified patient-centered medical home.**
7. **State-based health plans should include reimbursement reforms to support the value of patient-centered care managed by a primary or principal care physician.**
8. **State-based health programs should include incentives for health information exchange and physicians' adoption of Health Information Technology (HIT) to support patient-centered care.**
9. **State-based health programs should not reduce existing benefits for current Medicaid and SCHIP recipients.**
10. **State-based programs should not penalize patients for engaging in unhealthy lifestyles but should include positive incentives for well-being and prevention.**

Introduction

There were roughly 44.8 million Americans without health insurance in 2005 (15.3%), up from roughly 43.5 million (14.9 % of the population) in 2004. The number of uninsured has exceeded the cumulative population of 24 states plus the District of Columbia. While the uninsured rate climbed, the percentage of Americans with employer-based health coverage dropped slightly—to 60.2 percent in 2005 from 60.5 percent in 2004—continuing a recent trend[3]. As the numbers rise, lack of health insurance is beginning to affect middle- and higher-income Americans[4]. Over the past few years, the increase in uninsured has been primarily among young adults, whites, and native-born Americans, demonstrating that uninsurance is not exclusively affecting racial and ethnic minorities or noncitizens, as previously thought[5].

The situation looks even worse in light of a 2005 study by The Commonwealth Fund that found that nearly 16 million Americans are underinsured, meaning their insurance did not adequately protect them from catastrophic health care expenses[6]. Underinsured adults are almost as likely to go without necessary medical care or to take on medical debt as those who are uninsured.

The U.S. has historically tolerated having large numbers of people without health insurance. This is in stark contrast to virtually every other developed country, where guaranteed health insurance is provided either by the state or through employers, with government backup for the unemployed. Options for decreasing the number of uninsured continue to be debated in the U.S. with little consensus on the best and most affordable strategy. Proposals at both national and state levels emphasize making the individual insurance market more affordable. Some would expand eligibility for public programs, and others propose a combination of private and public approaches. Difficult economic times and soaring health care costs have further compromised significant health care reform.

The American College of Physicians has a long-standing commitment to making affordable health insurance available to all Americans. In previous papers, the College has documented the cost of lack of health insurance and the impact of lack of health insurance coverage on health outcomes, and proposed core principles for evaluating proposals to expand coverage.

In 2002, the College developed a sequential series of steps to achive universal coverage[7]. The plan outlines a national framework for coverage that includes a combination of premium subsidies, tax credits, purchasing groups, insurance market reforms, and expansion of Medicaid and the State Children's Health Insurance Program (SCHIP) to ensure coverage of all Americans. The plan also includes a state opt-out program that allows states to opt out of the national framework for coverage that the College proposes and establish their own programs for universal coverage with dedicated and guaranteed federal funding to supplement each state's contribution.

While Congress and the Administration have not been able to come together at the federal level, many states have put partisanship aside and are working on developing creative initiatives to cover their uninsured residents. States are attempting a variety of new approaches for expanding coverage to the uninsured, including new mechanisms to subsidize coverage for low-income individuals and families, new strategies to ease the purchase of health insurance for small employers and individuals without access to employer-sponsored coverage, and new variations of employer and personal responsibility for insurance coverage[8]. Several states are attempting comprehensive reform, attempting to reach near-universal coverage, while others are proposing incremental approaches such as universal coverage for children or public–private partnerships to encourage small businesses to offer insurance. Although comprehensive reform at the national level is ideal, the College feels that these states can act as laboratories for the rest of the country and serve as a catalyst for broad based reform.

Support for State Reform Efforts

Federal Support

In 2007, state efforts received the attention of the Administration and Congress, both of which have announced proposals for supporting states. Congress has also encouraged state initiatives for innovations in the Medicaid program through the Health Insurance Flexibility and Accountability Act (HIFA) of 2006.

President

In his January 2007 State of the Union Address, the President proposed sending federal money to states that form plans to provide lower-cost basic insurance plans to all citizens. States would be free to come up with their own plans as long as they met certain standards.

The grants would be used to help states that are experimenting with innovative ways to cover the uninsured. The White House plan would take federal money being used for charity care at hospitals and redirect it to fund the state initiatives. Under the initiative, the federal government could reallocate up to $40 billion a year that currently goes to hospitals and other providers that treat large numbers of uninsured and low-income patients. Instead, funds would be used to provide basic health insurance coverage for low-income individuals. Hospital groups have expressed concern that the administration's proposal could undermine existing programs by redirecting federal funds[9].

The President has also proposed federal tax credits for individuals and families to purchase insurance, favors expanded use of tax-free heath savings accounts (HSAs), and advocates federal legislation to permit Association Health Plans that would be available nationwide and would not be subject to state insurance regulations.

Congress

On January 17, 2007, a bipartisan group of lawmakers introduced legislation to provide federal grants to states to reduce the number of individuals without health insurance coverage. The Health Partnership Act (S. 325), was introduced by Senators Jeff Bingaman (D-N.M.) and George Voinovich (R-Ohio). The Health Partnership Through Creative Federalism Act (H.R. 506) was introduced by Reps. Tammy Baldwin (D-Wis.), John Tierney (D-Mass.), and Tom Price (R-Ga.). These bills were also introduced in the 109th Congress.

The bills would establish a "State Health Innovation Commission," charged with reviewing state health reform proposals. Once reviewed, the proposals would be subject to approval by Congress. The review process is estimated to take about 6 months. The legislation would provide grants to individual states, groups of states, and portions of states to test various health reform strategies. The amount of funding available to states would depend on the type and scope of plans submitted. Grants could fund initiatives including health savings accounts, tax credits, and Medicaid or SCHIP expansions. Under the legislation, states would be able to ask for relief from federal laws that they think complicate their efforts, such as tax law or the 1974 Employee Retirement Income Security Act (ERISA). After 5 years, the commission would deliver a report to Congress on the effectiveness of the programs[10].

On April 19, 2007, Senator Russell Feingold introduced the State-Based Health Care Reform Act (S. 1169), legislation that calls for state health care coverage pilot projects that would expand coverage and access and improve

quality and efficiency in the health care system. To participate in the pilot projects, states must submit a 5-year plan that identifies the managing organization of the program, specifies target dates for decreasing the number of uninsured within the state, and describes minimum benefits for all who will be covered, which must be comparable to those laid out in the SCHIP statute.

The legislation would also establish a Health Care Coverage Task Force that would be responsible for establishing performance measures and standards regarding the coverage, quality, and cost of state programs. Based on these criteria, the Task Force would review applications and ultimately accept or reject state proposals. States would have flexibility in developing proposals and would be provided with options, including expansion of SCHIP/Medicaid, health savings accounts, pooling arrangements, private insurance expansion, single-payer systems, tax credits, and any other combination of these reforms or other options submitted in a state application and approved by the Task Force.

On April 24, 2007, Senators Gordon Smith and Ron Wyden introduced the Catastrophic Health Coverage Promotion Act (S. 1198), which would establish 4 to 6 pilot programs to which states could apply through the Department of Health and Human Services. Two of the programs would help states offer health plans that combine primary, preventive care and catastrophic coverage. Two other pilot programs would provide assistance to state residents who have heath insurance with annual out-of-pocket costs in excess of $10,500. The programs would first be launched in Oregon and a minimum of 3 other states[11].

Coalition Support

Health Coverage Coalition for the Uninsured

On Jan. 18, 2007, a coalition of 16 health care organizations unveiled a 2-phase proposal to cover half of uninsured Americans by increasing enrollment in public programs and providing tax credits. The Health Coverage Coalition for the Uninsured proposal involves 2 "phases" for providing health care coverage to low-income Americans, the first for children and the second for adults. If fully enacted, the proposal would cover up to one half of the country's uninsured residents. Coalition members include the American Association of Retired Persons, American Hospital Association, American Medical Association, America's Health Insurance Plans, Families USA, Pfizer Inc., Johnson & Johnson, U.S. Chamber of Commerce, and the United Health Foundation.

A key element of the coalition's proposal is a competitive grant program which would enable states to experiment with new, innovative approaches to expand health coverage. States awarded the grant would receive new funding, over and above federal funds currently given to the states for Medicaid and SCHIP. The second phase of the proposal would allow states to expand Medicaid eligibility to cover all adults with incomes below the federal poverty level (FPL). Family status would be eliminated as an eligibility requirement, and coverage decisions would be based solely on financial need. .Additionally, adults with incomes between 100% and 300% of the FPL would receive a tax credit to help them buy insurance, either through an employer-sponsored or state-sponsored insurance system. The proposal would also provide federal grants to states to cover high-risk populations[12].

State Reform Efforts and Proposals

Below is a summary of state efforts to expand coverage to their uninsured residents. Many of these proposals have already been signed into law and are in various stages of implementation. Others are proposals by state legislatures and Governors that are currently being debated.

Signed Into Law/Implementation Stage

Arkansas

In March 2006, Arkansas received approval for a HIFA waiver that allows it to use federal Medicaid funds to provide low-cost health coverage to small businesses. In December 2006, then-Governor Mike Huckabee announced the establishment of ARHealthNet, a new program that offers affordable medical benefits to working adults employed by small businesses that have not been able to offer health care coverage. ARHealthNet, which began enrollment in December 2006 and started offering benefits to enrollees in January 2007, is open to employers with 2 to 500 full-time employees who have not offered health insurance to their employees for the past 12 months. The program requires employers who participate to guarantee coverage for all workers, regardless of income. While participation in the program is voluntary for employers, should an employer choose to participate, all employees are required to enroll in the program unless they can prove coverage under another program.

ARHealthNet's benefit plan is best described as a safety-net benefit design. It offers limited coverage compared to what is typically available through Medicaid or through commercial plans. It includes 6 physician visits, 7 hospital days, and 2 outpatient procedures or emergency room visits per year, as well as 2 prescriptions per month[13]. Monthly premiums will range from approximately $30 to $300 based on gender, age, and annual household income. Premium assistance subsidies are only available to employees with family incomes below 200% of the FPL[14].

Funding for ARHealthNet comes from federal Medicaid matching funds, the state Tobacco Settlement funds and employer and employee contributions. The program is being implemented in sequential phases during a 5-year demonstration period. Phase I is currently operating for a period of 12 to 24 months with an enrollment cap of 15,000. Phase II will operate for the remainder of the demonstration with an enrollment cap based on the availability of funding[15].

Kansas

On May 10, 2007, Governor Kathleen Sebelius approved a bipartisan measure that sets the course for reforming and expanding the state's health care system[16]. The bill directs the Kansas Health Policy Authority to research, evaluate, and present Medicaid reform options to the Legislature (by November 1, 2007) for enactment during the 2008 legislative session. The bill also requests the Insurance Commissioner to assess the impact of extending the continuation of state Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits from 6 months to 18 months.

To help low-income Kansans afford health insurance, the bill creates plan to provide premium assistance for adults who earn at or below 100% of the FPL. By 2011, up to $77 million in premium assistance will be provided to help 24,000 residents purchase either employer-sponsored health insurance or coverage from new state health plans to be competitively bid. The program will

be phased in, starting with those earning less than 37% of the FPL in 2008 and increasing to 100% of the FPL by 2011.

In addition, the measure provides up to $15 million in loan guarantees for safety net health clinics for capacity expansion, and facilities upgrades. To qualify for these loans, the clinic must offer a sliding fee discount for health care and other services and must serve all persons regardless of ability to pay. The law also creates a fund through which up to $500,000 will be granted to help create association health plans targeted to groups such as small businesses.

Maine

In 2003, Maine passed the Dirigo Health Act, a law that aims to significantly expand insurance coverage to all Maine residents by 2009, control health care costs and improve the quality of health care services. DirigoChoice, Maine's state coverage program, run exclusively by Anthem Blue Cross and Blue Shield, competes with existing health plans to offer coverage to employees who work at least 20 hours per week. DirigoChoice is available to small businesses, the self-employed and eligible individuals without access to employer-sponsored insurance. The program offers discounts on monthly premiums, reduced deductibles and out-of-pocket maximums on a sliding scale to enrollees with incomes below 300% of the FPL.

DirigoChoice provides full coverage for preventive and wellness health care. DirigoChoice's *Healthy ME* program provides financial incentives to both individuals and small business employers for selecting a primary care physician during enrollment and for taking a health and wellness assessment. Included in the core benefits package is a provision for all enrollees to have a medical home. Accordingly, negotiations with Anthem resulted in allowing and encouraging members to select a primary care physician, although preferred provider organization (PPO) models do not traditionally adhere to this strategy[17].

Maine has implemented several cost-containment measures, including rate regulation in the small group market; voluntary caps on cost; and operating margin of insurers, hospitals, and practitioners. Funding for DirigoChoice coverage, cost, and quality initiatives comes from a combination of employer and individual contributions, state general funds and federal Medicaid matching funds for individuals who are eligible. The original reform envisioned that future premium subsidies would be funded through the "savings offset payment" which is generated through the recovery of bad debt and charity care and other voluntary savings targets set by the state. However, in its second year of operation, DirigoChoice faced a lawsuit that challenged the savings offset payment. Although the savings offset payments were designed to recapture savings to the health system from the Dirigo reforms, insurance companies and Dirigo officials disagreed about how much savings the program generated and whether offset payments were the best way to finance the program. The court dismissed the lawsuit; however, it is currently under appeal. Following the dismissal, the Dirigo Board of Directors voted to table any action to assess year 2 offset payments and instead charged the Governor's Blue Ribbon Commission with developing an alternative funding plan[18].

Although Maine has saved $78 million over 2 years under the Dirigo Health plan[19], its universal coverage plan has not lived up to expectations. The state had hoped to sign up 30,000 individuals by the end of 2005 and has an ambitious goal of expanding coverage to all state residents by 2009, but as of December 2006 only 13,290 have enrolled in DirigoChoice[20]. Unlike other states with comprehensive reforms, Maine does not have individual mandates for coverage nor does it collect assessments on employers who do not provide coverage for employees.

In early April 2007, Governor Baldacci introduced a series of proposals to overhaul the DirigoChoice program. The Governor's plan includes the following proposals:

- Enabling DirigoChoice to market its own insurance policies.
- Ensuring DirigoChoice is made more affordable for small businesses and is refocused on the uninsured and underinsured.
- Introducing a 2% tax on health maintenance organization (HMO) premiums for insurers to help pay for DirigoChoice.
- Pulling the sickest Maine residents out of the individual market and insuring them separately to cut costs for others.
- Implementing new rate regulations for the insurance industry.
- Instituting market reforms, including a reinsurance plan, to increase competition and provide consumers with more choices.
- Requiring insurers to provide discounts for nonsmokers and worksite wellness programs.
- Implementing a 'play or pay' system once steps have begun to increase competition and make insurance more affordable. Employers that do not offer coverage to their employees would be assessed and individuals would be required to have coverage. The requirement would take effect in July 2008 for employers and January 2009 for individuals[21, 22].

The state legislature is expected to debate the Governor's proposal during the remaining months of the 2007 legislative session.

Massachusetts

In April 2006, Massachusetts became the first state to enact legislation requiring all state residents to have coverage. The bill, which was signed by a Republican governor with the overwhelming support of the Democratic-controlled legislature, mandates individual coverage by July 1, 2007. Individuals who can afford private insurance yet do not purchase it will be penalized on their state income taxes. Through government subsidies to private insurance plans the number of children who are eligible for free coverage will be expanded, and more of the working poor will be able to purchase insurance. Businesses with 10 or more employees that do not provide insurance will be assessed up to $295 per employee per year. This funding will be used to support the state-subsidized low-cost plans. The new law also includes pay-for-performance measures and establishes a Cost and Quality Council that is charged with implementing quality and cost metrics and making information about providers publicly available on a Web site.

The proposal is based on the idea of an "individual mandate," requiring individuals who can afford insurance to purchase it based on a sliding scale of affordability. It is anticipated that about 95 percent of the state's uninsured population (approximately 515,000 individuals) will be covered within three years, leaving less than 1 percent without coverage[23]. By allowing individuals and businesses with 50 or fewer employees to purchase insurance with pretax dollars, and by provide insurance companies with incentives to offer stripped-down plans at a lower cost, approximately 215,000 individuals will be covered. Individuals between the ages of 19 to 26 will be offered lower-cost basic plans and individuals with incomes at or below 300% of the poverty level will be offered subsidies for other private plans. Children in those families will be eligible for free coverage through Medicaid.

The Commonwealth Health Insurance Connector is responsible for helping individuals and small businesses find affordable health coverage. Plans participating in the Connector negotiate with the state to develop new benefit packages that make coverage affordable. On March 8, 2007, the Commonwealth Health Insurance Connector Authority Board of Directors endorsed coverage plans from 7 Massachusetts insurance carriers. The approved plans offer a choice of deductibles ranging from $0 to $2,000 with prescription drug coverage. Plans may cost as little as $137 per month or as much as $335 per month, depending on the specifics of coverage and the region of the state. The 3 levels of plans vary by price and cost sharing, but all offer comprehensive coverage, including in- and outpatient care, emergency care, mental health services, and vision care[24].

The Connector is financed through several sources. First, $385 million in federal matching funds previously used to fund the safety net and uncompensated care has been redirected to cover the subsidies. Additionally, the state has invested $308 million in general fund revenues over 3 years and will collect individual and employer contributions as well.

The law is seen as a "mix and match" compromise by those favoring government solutions and those favoring private sector solutions to the issue. Proponents of the Massachusetts law say it proves that health insurance for all is possible without raising taxes and without a government takeover. Critics of the law argue that the mandate is unworkable because the subsidies will not be enough to ensure low-income individuals' access to low-cost coverage. Critics also point out that the law may not be applicable to other states, or the nation as a whole, because Massachusetts has a lower percentage of its population without insurance and had available funding for the initiative via its uncompensated care fund.

Minnesota

In May 2007, Minnesota set universal affordable coverage for all Minnesotans by 2011 as a goal and enacted several provisions to expand coverage to uninsured residents. These included the creation of a new Health Care Transformation Task Force to develop health care reform recommendations for the 2008 legislative session, the reduction or elimination of barriers to coverage for children by addressing complex enrollment applications and waiting periods and implementing cost sharing increases to cover an estimated 30,000 to 40,000 children[25], the mandating of health insurance coverage for dependents up to age 25 regardless of whether they are full-time students or not, and the institution of a health insurance exchange to allow state residents to purchase insurance tax-free. Military families will be able get coverage from MinnesotaCare, which provides subsidized health coverage for eligible Minnesotans, without paying premiums during the first 12 months home from active duty; MinnesotaCare will also become more accessible to self-employed farmers[26], and Minnesota Care's benefits have been expanded to resemble those of private insurance policies.

Funding has also been provided for several pilot programs to explore ways to lower health care costs, including reimbursement reform and the expansion of a statewide pediatrics medical home pilot project.

Montana

In 2005, Montana implemented a joint initiative of Governor Brian Schweitzer and former State Auditor John Morrison aimed at reaching the growing number of uninsured employees working in small businesses. The initiative, Insure Montana, is administered by the State Auditor's Office. It is a 2-part program designed to assist small businesses with the cost of health insurance, whether

they have provided health insurance previously or not. Small businesses with 2 to 9 employees that are currently providing health insurance to their employees are eligible for refundable tax credits in the amount of $100 per employee per month. Forty percent of the annual Insure Montana budget is designated for the employer tax credit.

For businesses that were previously unable to afford health insurance for their employees, Insure Montana provides health insurance coverage through a small business purchasing pool[27]. Insure Montana offers monthly assistance payments for both the employer's and the employee's portions of the health insurance premium. This assistance is only available to small employers who have not offered insurance in the past 24 months and the assistance subsidy is based on a sliding scale tied to the employee's annual family income.

Coverage under Insure Montana is available through 1 of 2 Blue Cross Blue Shield of Montana plans offered by the State Health Insurance Purchasing Pool or through a qualified Association Plan. Currently Insure Montana is nearing capacity—approximately 1400 small business are participating—and has begun a waiting list for coverage assistance.

New Mexico

On July 1, 2005, New Mexico launched its new public–private partnership called State Coverage Insurance (NMSCI), under the auspices of the HIFA initiative. This demonstration project uses unspent SCHIP funding to provide managed care coverage for uninsured employed adults with incomes up to 200% of the FPL. New Mexico's blended funding model incorporates employee and employer contributions with state and federal funding to offer managed care coverage provided by plans selected through a competitive bid process, creating a unique public–private partnership. The more commonly used employer-sponsored insurance models were found inappropriate for New Mexico due to its disproportionately large number of small employers and a correspondingly low rate of employer-sponsored coverage. Hence, NMSCI is a unique model of a subsidized commercial product.

Although NMSCI targets uninsured working adults, there is currently no program requirement for individuals to be employed. If an individual wants to participate but the employer is not willing, the individual can enroll in the program as an "individual" rather than as part of an employer group. The participant must then pay the employer portion of the premium as well as the employee portion. An individual who has had access to employer-sponsored commercial insurance but who has not taken it up due to affordability, and who meets all NMSCI eligibility requirements, may participate in the program. If the employer offers insurance and the individual is not eligible for the employer-sponsored insurance, that individual would potentially be eligible for NMSCI. In fact, employees who have been unable to participate in their employer-sponsored health plan because of cost can be covered by the employer through NMSCI if they meet eligibility and crowd-out requirements stipulating that the employee has not recently dropped their private coverage in order to obtain coverage through NMSCI.

NMSCI regulations prohibit NMSCI eligibility if an individual has voluntarily dropped health coverage within the last 6 months. Starting with the first month the insurance was dropped (i.e., the first month of no coverage) they are not eligible for NMSCI. This regulation is aimed at preventing crowd-out. In order for employers to participate, they must not have voluntarily dropped a commercial health insurance product in the past 12 months.

Cost sharing is on a sliding-scale basis, with the premium and copayment amounts corresponding to 3 income groupings (1% to 100% of the FPL, 101%

to 150% of the FPL, and 151% to 200% of the FPL). Employers pay $75 per employee per month, and the employee pays from $0 to $35 per month, depending on income grouping. Individuals not affiliated with an employer pay the $75 employer premium in addition to the employee premium. Sliding-scale copayments, based on the income groupings, are due upon the delivery of medical services. There is an out-of-pocket limit on cost sharing that represents 5% of the program participant's countable income (after all income exclusions and disregards are applied). Benefits are similar to a comprehensive commercial plan with a $100,000 annual benefit limit.

NMSCI implementation was effective July 1, 2005, and the demonstration will last until July 1, 2010. New Mexico expects that 40,000 individuals will be covered over the course of the 5-year demonstration. Although the program intent is to focus on coverage of employed individuals, there are currently no specific goals for covered lives, employer groups, or percentage of enrollees via employer groups. Since the demonstration is new and has limited funding, program participation goals focus on maximization of appropriated funding[28].

Oklahoma

In September 2005, Oklahoma received approval from the Centers for Medicare Medicaid Services (CMS) for the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC), the state's Premium Assistance program for low-wage workers. O-EPIC is funded by state general fund revenues generated by a tobacco tax, along with federal matching funds under Title XIX and employer and employee contributions.

O-EPIC premium assistance has 2 different strategies for covering low-wage workers. The Employer-Sponsored Insurance (O-EPIC ESI) program helps low-wage workers at small firms (fewer than 50 employees) purchase qualified insurance offered by their employer. Employers work with an insurance agent to choose a qualified health plan to offer their employees. Qualified health plans are commercially available plans in the Oklahoma market that meet a minimum standard. O-EPIC ESI then pays 60% of the insurance premium for qualified employees with incomes no greater than 185% of the FPL and 85% of the qualified enrollee spouse's premium. The subsidy is paid prospectively to the employer at the beginning of each month[29].

The Individual Plan (O-EPIC IP) helps qualified individuals with incomes no greater than 185% of the FPL who are ineligible to participate in O-EPIC get health insurance coverage. The Individual Plan includes self-employed individuals not eligible for small group health coverage, workers at small businesses who are either not eligible to participate in their employer's health plan or whose employer does not offer a Qualified Health Plan, and unemployed individuals who are currently seeking work. O-EPIC IP also provides coverage to working individuals with a disability who meet the Ticket-to-Work program requirements and have incomes above the Medicaid level, but no greater than 200% of the FPL.

Enrollment in O-EPIC ESI began in November 2005 and the O-EPIC IP began enrollment in January 2007. As of October 25, 2006, 645 businesses were enrolled in O-EPIC ESI, which represented 1,200 individuals. The goal for overall enrollment in O-EPIC is 50,000 individuals, 25,000 in the Employer-Sponsored Insurance program and 25,000 in the Individual Plan[30].

Rhode Island

In July 2006, Governor Ronald L. Carcieri signed into law a broad package of health care-related bills, including legislation to lower health insurance premiums

for small-business owners and their employees. The legislation created a new commission to develop a health insurance plan that will be exempt from state coverage mandates governing other Rhode Island plans. The Health Insurance Commissioner is tasked with working with business, insurance, and other stakeholders to develop a new, affordable health plan, called The Wellness Health Benefit Plan. The legislation set a target premium of 10% of wages, while at the same time providing benefits that meet the following affordability principles outlined in law: promoting primary care, prevention, and wellness; actively managing the chronically ill; promoting the use of the least costly, most appropriate setting; and use of evidence-based, quality care.

Meeting this legislatively-defined price point is expected to reduce premiums for all small businesses to approximately 25% below market rate through a combination of enhanced negotiating leverage via premium rate controls, administrative cost reductions, and innovative plan design elements. In addition, eligible low-wage small businesses (those with average wages in the bottom quartile) will save an additional 10% on premiums through a state-sponsored reinsurance program. This reinsurance program passed into law during the 2006 legislative session; however, it is contingent upon the identification of a new funding source during 2007.

Other elements of the health reform package include a ban on sodas and sugary snacks in public and private elementary, middle, and junior high schools and the requirements that health insurers cover counseling and prescription drugs for individuals trying to quit smoking and provide price information to health care consumers[31]. It also expands quality and cost data reporting to all licensed health facilities in the state.

Tennessee

In June 2006, Tennessee Governor Phil Bredesen signed a bill creating a program called Cover Tennessee to provide health insurance for working individuals who are uninsured, children, and those with pre-existing medical conditions. The program offers basic health insurance to working individuals who have been uninsured for at least 6 months. Program coverage costs about $150 per month for an individual, with costs divided equally among employers, employees, and the state. Employers with 25 or fewer workers can enroll in the program if at least half of their employees are eligible for enrollment and can pay two-thirds of the cost of coverage. Premiums are adjusted depending on an individual's age, tobacco use, and weight or body mass index. Beneficiaries are expected to make copayments. The program, which began enrollment in March 2007, is expected to cover about 185,000 residents over the next 3 years[32]. Cover Tennessee, which relies on voluntary participation, emphasizes wellness, prevention, and disease management.

The Cover Tennessee program contains several components. The CoverKids Act creates a separate, standalone health care program for all children age 18 and under in Tennessee. This is an SCHIP Program. The CoverTN program aims to provide new, portable, and affordable coverage for the working uninsured who earn less than $41,000 per year, as well as for small firms that do not currently offer insurance. While CoverTN is a limited-benefit plan, covered services include physician services, hospital services, outpatient services, mental health services, lab services, and generic pharmaceuticals at a minimum. During the first 3 years of the program, premium amounts charged to employers, employees, and individuals cannot increase more than 10% per year to maintain affordability. The program is based on the 3-share concept, whereby participating employers, the State of Tennessee, and the individual each contribute one-third of the premium.

AccessTN is the high-risk coverage pool. Tennessee previously operated a high-risk pool, but it was disbanded when the state chose to cover uninsurable individuals under its TennCare waiver. The new pool is funded by a combination of premiums, assessments on carriers and third-party administrators, state appropriations, and possible federal funds pending grant release from CMS. The state has also authorized a premium assistance program to subsidize individuals who cannot afford the premiums.

Utah

In November 2006, Utah announced a revised premium assistance program, the Utah Premium Partnership for Health Insurance (UPP). UPP is a partnership between employees, employers, and the Utah Department of Health that provides workers financial assistance to purchase private health insurance policies through employers. A previous version of the premium assistance program, called Covered at Work, was initially created in 2002 under the state's Primary Care Network program. The peak monthly enrollment under the initial Covered at Work program was 79 individuals. Many attributed this modest number to the $50 subsidy being too low to attract participants. Now, the new UPP program will provide a significantly larger subsidy of up to $150 per adult for low-income workers enrolled in employer-sponsored insurance whose premiums represent more than 5% of their annual income. Subsidies are also available for employees' children at amounts of up to $100. If their children's dental services are covered in their employer-sponsored plan, parents may be eligible to receive an additional $20 per child. Currently, Utah has funding to enroll 1,000 adults and an estimated 250 children; approximately 3% of the 34,000 Utah adults working full-time say they could be covered under their employer's health plan if they felt they could afford the monthly premium payment[33].

Vermont

In May 2006, Vermont passed a far-reaching health reform plan, Catamount Health, with the goal of insuring 96% of Vermont residents by 2010. Catamount Health's coverage is based on the state's standard individual market insurance plan, but with less cost sharing by individuals and families. The program provides coverage for individuals who have been uninsured for 12 months (with some exceptions) and provides new subsidized coverage to uninsured individuals and families with incomes up to 300% of the FPL who do not qualify for other public programs. Premium subsidies will be determined on a sliding scale based on participants' income.

Catamount Health has a standard of care for all policies offered to the uninsured, including comprehensive coverage for primary and preventive care and chronic care management programs; provides incentives for healthy lifestyles and participation in wellness programs; and has programs to track and manage hospital infections. Vermont's "Blueprint for Health" includes reimbursement for providers that encourage chronic care management and quality (versus quantity) health care[34]. The Vermont Informational Technology Leaders (VITL) is a public–private partnership charged with developing the state's HIT and Health Information Exchange (HIE) plan, which will include incentives for physicians to adopt HIT.

Funding for Catamount Health comes from federal matching funds expected from CMS's Global Commitment to Health waiver, a 60-cent-per-pack increase in the state's tobacco tax, payments that tobacco manufacturers will make to the state beginning in 2008, enrollee premiums, and employer assessments. Employers are required to pay a $365 annual assessment for each full-time

employee that is not insured. Employers will be allowed some exceptions to the assessment during the first 4 years of the program. If private insurers fail to voluntarily offer the new insurance program, state regulators could require them to offer it. After 2 years, a Commission on Health Care Reform will determine whether having the program offered through the private market is cost-effective[35].

Virginia

On June 20, 2006, Governor Tim Kaine signed legislation into law that allows small businesses that employ 50 or fewer workers to join together to form health insurance purchasing pools[36]. Through these purchasing pools, small businesses are able to purchase or facilitate providing insurance to employees (and dependents of employees) who work more than 30 hours per week. They are also able to negotiate premiums for their members. The legislation, which had bipartisan support and went into effect on July 1, 2006, also allows small businesses that previously have provided coverage to increase the health insurance options offered to their employees. Regulatory guidance is expected to be issued by the state Insurance Commission in 2007[37].

West Virginia

In April 2006, Governor Joe Manchin III signed state legislation that "seeks to guarantee all West Virginians access to health care by 2010."[38] One provision encourages 8 health clinics across the state to launch a pilot program offering basic health care services to uninsured state residents for a low monthly fee. Another provision launches the Appalachian State Health Plan, which will allow private insurers to provide low-cost, "no-frills coverage policies to the working poor." The proposal also creates the West Virginia Health Information Network, under which public and private entities can collaborate to build a statewide electronic health records system. A new state government office, as well as a 16-person oversight commission, will also be formed to regulate the new programs and develop proposals for providing lower-cost medical care.

Additionally, West Virginia currently operates a public–private partnership between insurance companies and the West Virginia Public Employees Insurance Agency (PEIA) that allows small businesses (i.e., firms with 2 to 50 employees who have not previously offered coverage for 1 year) to access PEIA's reimbursement rates and drug purchasing power. The state predicts the program will generate a 20% to 25% discount below market rate for small businesses. West Virginia used State Coverage Initiatives grant funds to help fund the program development, which began in 2005. West Virginia officials estimate the program will have provided health insurance to 8,000 previously uninsured small business employees after 5 years[39].

Proposals Recently Introduced or Being Debated

Alabama

In January 2007, Governor Bob Riley announced his health reform proposal designed to increase the number of Alabamians with health insurance by allowing small employers with 25 or fewer workers to deduct twice the amount they pay for health insurance premiums from their state income taxes. In order to encourage the employees of these small businesses to participate in their employer's health insurance plans, employees with incomes of up to $50,000 would be also able to deduct the twice the amount they pay for health insurance from their individual income taxes. If approved by the state legislature, the tax incentive would take effect Jan. 1, 2008[40].

California

In January 2007, Governor Arnold Schwarzenegger proposed extending health care coverage to all of California's 36 million residents as part of a sweeping package of changes to the state's troubled health care system. A total of 6.5 million people, one-fifth of the state's population, do not have health insurance, far more than any other state. At least 1 million of the uninsured are illegal immigrants.

Under the Governor's plan, all individuals would be required to secure insurance for themselves and their dependents at a level that would protect them against catastrophic costs and minimize the shifting of costs to those with insurance. The poorest Californians would gain access to insurance through expansion of the Medicaid and State Children's Health Insurance programs, known as Medi-Cal and Healthy Families, respectively. The 1.1 million residents with incomes between 100% and 250% of the FPL would be eligible for coverage through a state purchasing pool run by the Managed Risk Medical Insurance Board, and would make premium contributions toward their Medi-Cal coverage of between 3% and 6% of gross income. Most of these individuals are expected to use the pool to secure insurance, but about 200,000 are likely to get insurance through their employers.

Under the Governor's plan, employers of 10 or more workers would be required to provide coverage to their workers or pay 4% of their payroll into the state's purchasing pool so their workers could buy insurance on their own. The Governor also called for changes to state tax laws that would allow employers to set up cafeteria plans, so that workers could make tax-sheltered contributions to health insurance premiums and save employers additional Social Security contributions. He also said the state should adopt federal tax provisions for health savings accounts, which allow individuals to use pretax income toward health care costs. Schwarzenegger also proposed to increase Medi-Cal reimbursement rates for health care providers and hospitals by a total of $4 billion, in an acknowledgement that the current rates are far too low. In exchange, physicians and hospitals would pay a "dividend" to the state to help fund the state-run purchasing pool. The dividend or user fee would be 2% of revenue for physicians and 4% of revenue for hospitals. Overall, the plan would redistribute $10 billion to $15 billion to health care providers, and they would pay back $3.5 billion of that in the form of dividends.

The plan would tie future reimbursement rate increases to specific performance measures, such as reporting quality-of-care information and adopting new health information technology. It would also promote patient safety through a mandate that health facilities reduce medical errors and hospital-acquired infections by 10% over 4 years, technical assistance to implement evidence-based safety measures, and the creation of a "reengineering" curriculum to improve safety and streamline costs[41]. Additionally, the plan would require hospitals and health plans to spend 85% of all premiums on direct patient care, not administrative costs or profits. Health plans would be required to cover everyone who applied for coverage in the individual market, regardless of their age or health status. Plans would also be required to offer reward packages and incentives, including enhanced benefits and/or reduced premiums, to enrollees who engaged in healthy practices such as exercise or losing weight.

Overall, the $12 billion cost of the Governor's plan would be covered with $5.4 billion in new federal funds, $3.5 billion in dividends from providers and hospitals, $2 billion in a shifting of funds now used to pay disproportionate share hospitals, $1 billion in employer fees, and $203 million in other funding sources. Much of the new federal funding would come as a result of expanding Medi-Cal and Healthy Families, which would make the state eligible for more federal matching funds that come with more enrollees.

On March 13, 2007, Governor Schwarzenegger signed an Executive Order establishing a Cabinet-level public–private sector workgroup to develop a strategy to increase quality, strengthen health care transparency, and increase accountability in health care delivery. It directs that performance metrics for public and private sector transparency and accountability implementation activities be developed by December 31, 2007; expands the Office of Statewide Health Planning and Development's ability to collect data on health outcomes, costs, and pricing for consumers, purchasers, health plans, and providers; and promotes ways to align incentives between health plans and providers to improve the quality and efficiency of health care[42].

Connecticut

In March 2007, Governor Jodi Rell announced 2 proposals to provide all residents in the state with access to health coverage. The Healthcare for UninSured Kids and Youth (HUSKY) Health 2007 initiative targets uninsured newborns and school-age children. Currently, the state's HUSKY plan serves children based on a sliding fee scale, and is open to uninsured newborns. The new initiative would waive premiums for the first 2 months following birth. In addition, the initiative would require parents to inform schools at the start of every school year whether their children have health insurance to assist school systems in referring parents to the HUSKY Plan.

The Charter Oak Health Plan would benefit uninsured adults who do not have insurance through their employers by providing basic health insurance coverage to adults 19 to 64 years of age regardless of income or preexisting conditions. Premiums would be community-rated and not exceed $250 per person per month. In addition, cost sharing would be structured to encourage primary and preventive care. Maintaining affordable rates would be contingent upon broad enrollment, including large numbers of healthy members. In February 2007, through her 2008–10 budget recommendations, Governor Rell announced a premium assistance component to the Charter Oak Health Plan. The subsidy would be available to the lowest-income participants, those who do not qualify for Medicaid or the HUSKY program due to income, do not have children, or both. The subsidy would drop low-income participants' monthly premium to as low as $75[43].

The Connecticut State Senate has also considered comprehensive health reform bills, one calling for a single-payer health system and the other establishing a state-run purchasing pool for small employers and uninsured individuals. Senate Bill 1371, the Connecticut Saves Health Care program, would create a single health insurer in Connecticut to ensure coverage for all residents not on Medicare. The bill passed the Senate Committee on Insurance and Real Estate but will not likely pass the full Senate due to strong opposition to replacing the current system of employer-based and individually purchased policies overseen largely by private insurers.

The Senate Insurance and Real Estate Committee also recently passed the Healthy Steps bill, which would create a new Health Care Reform Commission to develop a more affordable health plan for small employers of 50 or fewer employees that relies on a market-based insurance system. Under this proposal, the state would contract with a private nonprofit organization that would serve as an insurance purchasing pool for previously uninsured individuals and small employers to buy coverage. This connector program would offer 3 kinds of health plans, including a high-deductible plan linked with a health savings account. The bill would provide tax credits at varying levels to small employers that provide health insurance that meets or exceeds the standards set for the affordable plan to be developed. It also calls for the expansion of Medicaid/HUSKY and increased reimbursement to doctors, dentists, and hospitals from insurers serving Medicaid members[44].

Delaware

In her FY2008 Budget released in February 2007, Governor Ann Miner introduced proposals for improving and expanding health care access in Delaware. The Governor recommended the creation of the Delaware Healthy Life Fund, to be funded by increasing the state's cigarette tax by $0.45 per pack. The recommended increase is projected to generate an additional $42 million that the Governor plans to use to support programs focusing on the health needs of Delaware's most at-risk populations as well as improving the state's comprehensive system of health services.

The proposed Delaware Healthy Life Fund would support the following health initiatives:

- $5 million recommended for Uninsured/Underinsured initiatives
- $223,700 recommended to create a Medicaid Buy-In Program to assist individuals with disabilities by allowing them to work without losing health benefits
- $1.1 million recommended to expand the Delaware Healthy Children Program (CHIP) to an additional 975 families
- $3 million recommended to continue the creation of the Delaware Health Information Network (DHIN) to improve the exchange of clinical information within Delaware's medical community
- $1 million recommended to support recommendations of the Governor's Task Force on Health Disparities[45]

Illinois

In December 2006, Governor Rod Blagojevich announced a broad plan, Illinois Covered, for bringing universal coverage to Illinois. The proposal calls for an individual mandate requiring every resident to purchase health insurance from either their employer, a public program, or the individual market. Those who do not would face a financial penalty. Similar to other universal coverage proposals, it would require employers to either provide coverage or pay an assessment to a state fund that would assist individuals in purchasing insurance. The proposal was drafted by a state task force created through the Illinois Legislature, with the support of providers, hospitals, labor unions, and consumer groups.

Under the plan, residents would fall into 3 categories: Assist, Choice, and Rebate. The Covered Assist program would be available for childless adults that are ineligible for the state's Medicaid program, do not have access to employer-sponsored insurance, and have incomes below the FPL. The state would pay premiums for individuals who have employer-sponsored coverage. Under the Covered Choice program, the state would require all managed care plans to offer a new affordable and comprehensive insurance product to individuals and small businesses. By reinsuring the product, the state intends to make premiums more affordable. Premiums paid by the consumer would be based on income levels. Those eligible for the Choice plan would include individuals without access to employer-sponsored insurance and small businesses with 25 or fewer employees that contribute at least the minimum required percentage of the premium. The Covered Rebate program would essentially be a premium assistance program subsidizing coverage and providing discounts to everyone who either purchases coverage through Illinois Covered Choice or who has access to an employer-sponsored plan (if the employer contributes at least 70% of the premium for

employees). This program would also cap health insurance premiums for employees by having the state cover the difference between the cost of the full premium and the sliding-scale employee contribution amounts that will be set based on income level[46].

In addition, Governor Blagojevich plans to increase the eligibility level for parents in the FamilyCare and SCHIP programs from 185% to 400% of the FPL. Eligible parents with access to employer-sponsored insurance could also take advantage of the new Rebate program. Governor Blagojevich's proposal would also allow dependents to have access to insurance on their parents' policies up until their 30th birthday.

Additional delivery system improvement and cost-containment provisions include the development of a statewide consensus plan to promote wellness and to manage chronic conditions; the establishment of a guaranteed issue policy, rate increase restrictions, and insurance regulation reforms; improved accountability and transparency and better information to assist consumers in making better choices about their health care; and efforts to improve patient safety, promote electronic medical records, improve information about quality of care, and reduce administrative costs.

While the proposal has found a base of support, there are concerns over the price tag: $3.6 billion a year in state expenditures plus $1.5 billion a year in costs to employers. If implemented, the proposal would cover an estimated 1.5 million residents. The plan would need approval by the state legislature and is envisioned to be implemented in 2008.

Of note is Illinois' new health care program, Illinois Health Connect, run by the state's Department of Healthcare and Family Services. Illinois Health Connect requires all participants (Medicaid and SCHIP beneficiaries) to establish a medical home[47].

Indiana

In November 2006, Governor Mitchell Daniels Jr. unveiled a coverage expansion proposal that would provide insurance for approximately 350,000 potentially-eligible residents and attempt to improve the health of all Indiana residents by reducing tobacco use and increasing immunizations rates for children.

The Governor's plan would provide coverage utilizing the Health Savings Account model combined with catastrophic insurance coverage above the deductible. Individuals would annually receive $500 of predeductible free preventive care and have an $1,100 deductible. All participants would have a POWER (Personal Wellness Responsibility) Account established in their name. The account would contain the monthly contributions made by participants in addition to a State contribution for a combined total of $1,100 per adult. The State's contribution would vary according to a sliding scale based on a participant's financial ability to contribute to the account. The State would subsidize the account to ensure there is a total of $1,100 per adult in the account. Participants would contribute no more than 5% of their gross family income, and would not have any cost sharing once the deductible is met. At the end of the year, participants could have access to funds over $500 in their account, provided they have received their age-, gender-, and disease-specific preventative services. Balances under $500 would be used to offset the following year's contribution. The reasoning behind allowing individuals to access the funding in their account is that it creates an incentive for them to use services in a cost-conscious manner.

Covered services would include physician services, prescriptions, diagnostic exams, disease management, home health services, and inpatient and outpatient hospital eservices. There would be a $300,000 annual limit on coverage.

The target populations for the new coverage expansion include:

- Pregnant women up to 200% of the FPL
- Parents increased from 23% up to 200% of the FPL
- Childless adults from 100% to 200% of the FPL (childless adults are currently not covered at all)

Pregnant women would be covered in the traditional Medicaid program and would not have a POWER Account.

A recipient would need to have been uninsured for at least 6 months, be a U.S. citizen, be a resident of Indiana for at least 6 months, and not have had access to employer-sponsored insurance. If a person voluntarily drops the program, or does not make payments within 30 days, they would become ineligible for the program for 18 months.

Indiana would contract with private insurance companies to administer the program. High-risk individuals would be identified through the enrollment process and be placed in the State's high-risk pool. These individuals would receive enhanced benefits and disease-management services but would still only pay 5% of their income[48]. Funding for the Governor's proposal would come from an increase in the state's cigarette tax[49].

Iowa

In January 2007, in his State of the State address, Governor Chet Culver pledged to significantly increase access to quality health care for all Iowa residents, particularly the 250,000 residents without health coverage. He proposed that an additional $140 million is needed to address the state's health care needs, and charged that a $1 increase in the cigarette tax could generate the funds. On March 15, 2007, the Governor signed the cigarette tax increase into law, following the state legislature's approval. Although Governor Culver has not released his official health reform plan, during his election he ran on the platform of expanding the state's Medicaid/Hawk-I coverage program to families with income up to 200% of the FPL, as well as offering a Hawk-I buy-in program that would allow residents of all income levels to purchase coverage for their children through the program with a sliding-scale premium.

Louisiana

In October 2006, the Louisiana Health Care Redesign Collaborative submitted a concept paper to CMS outlining a proposed redesign of the health care system in New Orleans with the goals of addressing the state's high uninsured rate, improving quality of care, and creating a more stable health care infrastructure in the aftermath of Hurricane Katrina. The most noteworthy recommendation that the Collaborative made was to completely redesign the way care is delivered in Louisiana and adopt a medical home system of care similar to the College's Patient-Centered Medical Home (PC-MH) proposal. Under the medical home provision, most residents who receive public assistance would be enrolled in health care systems with primary care clinics that are linked with a group of specialists and hospitals. To quality as medical homes, facilities would need to meet certain quality measures and have electronic medical records among other criteria.

The proposal would involve pooling resources in the Medicare, Medicaid, and SCHIP programs. As the proposal has both statewide and regional components, a combination of Medicaid state plan and demonstration authorities as well as Medicare demonstration authority will be required for certain aspects of the proposal, including the development of a Health Insurance Connector (HIC)

and the establishment of the Louisiana Health Care Quality Forum (LHCQF). The HIC would serve as an information clearinghouse about insurance options and methods of enrolling for individuals earning a maximum of 300% of the FPL. All uninsured childless adults with incomes up to 200% of the FPL would be covered. Families of uninsured children at 200% to 300% of the FPL would receive a premium subsidy for their children funded through Medicaid. Coverage would also be expanded to pregnant women with incomes up to 200% of the FPL who are not otherwise eligible for Medicaid. The LHCQF would be responsible for developing clinical quality guidelines and collecting, collating and reporting data on the medical home.

The Collaborative also calls for a demonstration project, the Louisiana Health Service Corps (LHSC), for health care workforce recruitment and retention. The LHSC would provide income guarantees for primary care physicians, dentists, registered nurses, and licensed professional staff; annual medical malpractice payments; and incentive payments such as relocation expenses and sign-on bonuses.

In March 2007, U.S. Health and Human Services Secretary Leavitt offered an alternative health care reform plan, stalling negotiations with the state over the waiver proposal. The state estimates that the Secretary's plan will cost an additional $500 million a year (which the Secretary has indicated the federal government will not provide) and will leave 60% of Louisiana residents without health coverage[50].

Maryland

In February 2007, the Maryland state legislature began debating several health care expansion proposals, specifically one that would raise the state's cigarette tax by $1 per pack to support substantial reform. The revenue from the tax would be used to fund expanding Medicaid eligibility for adults up to 116% of the FPL and for children in families with incomes up to 400% of the FPL. The proposal also would allow families above 400% of the FPL to buy into the SCHIP program at full cost. The proposal also calls for small businesses with fewer than 50 employees to receive subsidies in order to provide health benefits. In addition, insurers would be required to offer coverage to dependents until age 25.

The state legislature is also considering Governor Martin O'Malley's Maryland Health Care Access Act, which would also extend dependent coverage until age 25 and expand SCHIP coverage to children in families that earn up to 400% of the FPL; create an insurance pool for small businesses to help them purchase insurance on a pretax basis; establish an Institute for Health Care Quality to promote quality health care in the State; encourage the use of wellness programs to improve preventive care in the State; and set up a Task Force on Expanding Access to Affordable Health Care to examine issues such as the expansion of Medicaid to cover adults, providing incentives to small businesses to provide coverage, incentives for individuals to secure coverage, and developing a cost-effective reinsurance fund[51].

Michigan

In her 2007 State of the State Address, Governor Jennifer Granholm announced a proposal to address the rising cost of health care in Michigan, expand affordable coverage to more than half a million residents who do not have insurance, improve the overall quality and efficiency of health care through improved HIT, and create a culture of health lifestyles. The proposal, Michigan First Healthcare Plan, provides access to affordable coverage through a partnership with the health care industry and the business community and through an expansion of

the state Medicaid program[52]. The 2-tiered plan would provide insurance to uninsured residents who have incomes lower than 200% of the FPL but do not qualify for Medicaid and to uninsured residents with higher incomes, either through employer-sponsored coverage financed with a combination of employer and employee funding or through coverage provided by government-funded programs such as Medicaid or Medicare. Lower-income beneficiaries would pay for low-cost coverage on a sliding payment scale based on income, while higher income beneficiaries would have to pay their own premiums at a reduced group rate. Small businesses would pay less for insuring their workers because costs would be pooled with other companies.

The plan also calls for the development of a statewide health information network to advance the use of information and communication technologies as a means of improving the quality of patient care and reducing health care costs. Although private insurance providers would be responsible for designing their own benefits package, the plan states that a minimum benefits package should include basic preventive and primary care, hospitalization, emergency room services, mental health care and prescription drugs. The plan also has a wellness and disease prevention component.

Funding for the plan would come from a combination of individual and employer contributions and financing from the state's Medicaid waiver[53].

Missouri

On February 15, 2007, Governor Matt Blunt announced his proposal, an endorsement of State Representative Doug Ervin's legislation, House Bill 818, to expand health coverage for Missouri residents. House Bill 818, which was designed primarily for workers at small businesses that provide little or no health care coverage, would allow all Missourians, including the uninsured, to purchase health care with pre-tax dollars, ease the burden on small employers who want to contribute to their employees' health insurance, and allow employees to keep their health care plan if they change jobs. Additionally, the proposal would lower the cost of health insurance by pulling together a wide variety of workers into the insurance pool, providing employers with stable coverage costs, and using state and federal tax benefits to offset part of the costs[54].

The proposal would establish a state agency to act as a clearinghouse through which insurers could offer health plans. When an employer signs up with the agency, the employees would contact the agency to receive information about the available plans. Each employer would determine a flat per-employee amount that he or she would be willing to contribute towards the cost of health coverage and would send the contribution to the agency. Each employee would be responsible for the remainder of the premium.

The proposal would also allow workers to choose the plan with the providers and services they want at the price they are willing to pay. If workers lose or quit their jobs, they would not automatically lose their coverage; instead, they would then be responsible for the entire premium but could maintain part of the tax benefit by deducting the premiums from their income. Additionally, low-wage couples would be able to combine their employers' contributions for use toward a less expensive family insurance policy[55].

A cornerstone of Governor Blunt's health reform plan is the promotion and establishment "health care homes." Currently, Federally Qualified Health Centers serves as the health care home for nearly 300,000 Missouri residents. In January 2007, Governor Blunt announced his intention to expand the number of health centers in an effort to increase residents' selection of health care homes[56].

New York

On April 1, 2007, the New York State Legislature approved Governor Eliot Spitzer's FY2008 state budget proposal, which includes several initiatives to expand access to health care coverage and reduce health care costs. The approved budget includes a measure to raise the eligibility requirement for Child Health Plus, the state's SCHIP program, from 250% to 400% of the FPL, creating the nation's highest ceiling for SCHIP eligibility. This measure will make the majority of New York's 400,000 uninsured children eligible for Child Health Plus[57]. The budget also simplifies the enrollment process to help some 900,000 uninsured adults and children obtain and retain Medicaid coverage and significantly reduces the growth rate of Medicaid spending by redirecting more Medicaid dollars to Medicaid patients. New York will distribute more than $600 million based on services to Medicaid patients, more than $100 million of which go to hospitals in every region of the state serving the largest number of Medicaid patients[58].

In line with Governor Spitzer's stated goal of ensuring a "health care system based on a principle of patient-centered care," the budget also provides $200 million in investments in 2007–08 in a multiyear effort to focus attention and resources on disease prevention and primary care. Measures include investments in comprehensive diabetes, cancer, obesity, and asthma prevention programs; smoking cessation treatment; expanded access to the cervical cancer vaccine for uninsured young women; and other public health initiatives.

Funding for the budget's health initiatives will come from the anticipated $1 billion in savings in 2007–08 that would result from restructuring the state health care system. The approved budget reduces the state's Medicaid growth rate from an average of 8% a year for the past 5 years to 1% from year to year. The approved budget also includes $82 million funding cuts to hospitals and nursing homes and more than $372 million savings by reducing Medicaid payments to pharmacists for prescription drugs and by freezing the premiums the state pays to insurance companies that enroll Medicaid patients. Additionally, New York is anticipating $132 million in savings from improved efforts to fight Medicaid fraud and abuse[59].

North Carolina

On March 28, 2007, North Carolina State Senator Walter Dalton introduced a bill to create the "Healthy NC" program, which would facilitate the availability of affordable health coverage for small businesses, the self-employed and uninsured workers and would establish a health insurance pool for uninsured state residents with high-risk conditions[60]. Under the proposal, every insurer that offers individual or group benefit plans and is among the 15 insurers with the highest health benefit plan market share shall offer qualifying individual and group insurance contracts. These contracts would be subject to preexisting condition limitations. Small businesses with less than 25 eligible employees who have not provided health coverage during the past 12 months would be eligible for the Healthy NC program. Small businesses would be required to contribute at least 50% of the insurance contract's premium on behalf of their employees. Self-employed and low-income individuals with family incomes at or below 250% of the FPL who have not had health insurance during the past 12 months would be eligible for the program.

State residents with high-risk conditions would have to meet certain preconditions to be eligible for the Healthy NC program, including having been rejected by at least 2 insurers because of health reasons or quoted a premium that would exceed the cost of a similar policy offered under the pool. Under the

proposal, insurance policies would cost no less than 150% but no more than 200% of the price a healthy individual would pay for comparable coverage. Each insurer in the state would be assessed a fee of no more than $2 per covered individual in order to subsidize the pool.

The core benefits package for the Healthy NC program would be comparable to other small group or nongroup market plans in North Carolina, with the addition of mental health and prescription coverage. Coverage premiums would be community-rated and include rate tiers for individuals, individual and spouse, and at least 1 other family tier. Funding for the Healthy NC program would come from the newly created, tax-exempt North Carolina Health Insurance Risk Pool Trust Fund.

Oregon

In March 2007, at the request of Governor Theodore Kulongoski, the Oregon Health Policy Commission submitted its draft road map for health reform for the Governor's approval. The goal of the road map is to achieve universal health coverage for all Oregonians in an affordable health care system that offers high-quality health care, ensures positive outcomes, and promotes healthy lives[61]. The Commission's road map provides 8 recommendations for improving the quality of and access to health coverage. The Commission calls for universal health coverage for all children by improving and expanding access to Medicaid and SCHIP programs; by giving parents with moderate family incomes the opportunity to buy affordable, state subsidized group coverage for their children; and by continuing the expansion of school-based health centers. The Commission supports mandating health coverage for all state residents and creating a Health Insurance Exchange, similar to Massachusetts' Health Insurance Connector, to operate as a central forum for individuals and small businesses to buy affordable health coverage. The road map also calls for publicly-financed subsidies for low-income residents. Subsidies would be available on a sliding scale for all residents at or below 300% of the FPL.

Regarding efforts to improve the quality, safety and efficiency of Oregon's health system, the Commission recommends creating an independent institute that will develop and promote methods for improving quality information collection, measurement, and reporting; providing leadership and support to further the development of widespread and shared electronic health records; assuring a workforce that can capitalize on health information technology; and encouraging purchasers, providers, and state agencies to improve system transparency and public understanding of quality in health care[62]. Most notably, the Commission recommends the promotion of the primary care medical home model.

Funding for the Commission's health reform road map would come from federal Medicaid matching funds, other state funds, and a broad-based employment payroll assessment. Other potential sources of funding discussed in the road map include a retail sales tax, an increased tobacco tax, an increased beer tax, an increased wine tax, a medical luxury tax, and a provider tax.

Pennsylvania

In January 2007, Governor Edward G. Rendell proposed Prescription for Pennsylvania, a health care reform plan intended to reduce costs and improve health care access and quality through a variety of initiatives.

A major component of Rendell's proposal is Cover All Pennsylvanians (CAP), a program that would offer state-subsidized basic health insurance coverage through the private insurance market in order to reduce the cost of

coverage for individuals and small businesses. Businesses would be expected to pay about $130 per employee per month for coverage while their employees would pay an estimated $10 to $70 per month based on an income-based sliding scale. Businesses that employ fewer than 50 people and whose employees earn less than the state average annual wage would be eligible to purchase CAP coverage for their employees. Businesses that do not insure their employees would be assessed a percentage of their payroll, with the proceeds to be used to help fund CAP program costs; however, businesses with fewer than 50 employees would be exempt from the assessment for the first year of the program.

Another element of the proposal is a mandate that all state residents with incomes greater than 300% of the FPL and all full-time, 4-year college students and graduate students obtain health insurance coverage. Uninsured adults would be able to buy into CAP on a sliding scale that would top out at $280 a month for adults who earn more than 300% of the FPL. Adults who earn less than 300% of the FPL would not be required to purchase insurance, but would be offered discounts and subsidies.

The Governor's plan also includes several cost containment and quality improvement measures, including providing incentives to hospitals to devise less costly procedures for treating patients with nonemergency health problems who appear for care in emergency rooms; providing financial incentives for providers who offer services in the evening and on weekends, to discourage the use of emergency rooms for nonemergency care; encouraging investment by providers in health information technology; and promoting healthy lifestyles through wellness education in public schools. The plan would eliminate legal and regulatory barriers that limit nurse practitioners, midwives, and other licensed health care providers from practicing to the fullest extent of their training, including taking medical histories and providing physical examinations. Dental hygienists would also be allowed to practice in schools and clinics without a dentist's supervision. The plan would also limit premium increases, establish a standard basic health care package for individuals and small businesses, and limit the ability of health insurers to consider certain factors such as health history in setting rates for plans offered to individuals and small businesses[63].

Other proposed initiatives to improve quality include a requirement for hospitals to implement systemwide quality management and error-reduction systems to ensure accurate reporting of problems; the establishment of a pay-for-performance initiative to be developed in conjunction with other major health care purchasers; and the establishment of payment systems that promotes the use of a model program to manage treatment for chronic diseases, including heart disease, diabetes, and asthma.

Washington

On February 6, 2007, building on the foundation of the recommendations put forth by the Blue Ribbon Commission on Health Care Costs and Access, Governor Chris Gregoire introduced the "Healthy Washington Initiative," which includes several elements with the goals of granting access to health coverage for Washington children by 2010 and all residents by 2012 and the slowing the state's rate of increase in total health care spending to match the growth rate of personal income. The Governor's proposal calls for:

- Covering all young adults between the ages of 19–25 by extending the age of dependent coverage and requiring insurers to implement other strategies to address the gap in coverage for this population
- Creating the Washington Health Insurance Connector to facilitate individual and small business purchases of health insurance in the nonlarge group markets

- Establishing a grant program for community health centers to work on reducing unnecessary emergency room visits
- Designing a state-supported reinsurance program for high-cost enrollees to improve the affordability of premiums in the nonlarge group markets
- Exploring opportunities to partner with the federal government to expand coverage in Medicaid and the state's Basic Health program and piloting a Health Opportunity Accounts program to encourage personal responsibility[64]

The Governor's proposal also calls for investments in health information technology to give patients and providers better access to medical records, funding for better care management programs to help people struggling with chronic diseases, and increased reimbursement rates for physicians treating SCHIP children.

Details regarding the sources of funding—which is estimated at $142 million—for the Governor's proposal have not yet been announced[65].

Wisconsin

In July 2006, Governor Jim Doyle launched the Healthy Wisconsin Council, which was tasked with developing an action plan to reduce Wisconsin's uninsured rate by 50%; reduce health insurance premiums for individuals and small businesses by 30%; strengthen Wisconsin's private insurance market; and encourage more employers to offer comprehensive, affordable health coverage to their employees. The Council released its final recommendations in January 2007, and many of its proposed solutions concur with the Governor's health policy plan[66].

Building on the success of the BadgerCare Program, Wisconsin's SCHIP program that covers children and parents to 185% of the FPL, Governor Doyle has proposed merging Family Medicaid, BadgerCare, and Healthy Start into BadgerCare Plus to cover the following populations:

- All children (currently, BadgerCare covers children up to 185% of the FPL; the new proposal would expand benefits above the previous income ceiling and create a sliding scale so all children would have access to insurance)
- Pregnant women (eligibility increased from 185% to 300% of the FPL)
- Parents and caretaker relatives up to 200% of the FPL
- Youth (ages 18–20) aging out of foster care regardless of income
- Parents with children in foster care up to 200% of the FPL
- Farmers and other self-employed parents up to 200% of the FPL

Simplification is a key component of the proposal. BadgerCare Plus would simplify eligibility by switching to a gross income test with 2 deductions, using presumptive eligibility for certain children and pregnant women and replacing the current multitude of coverage groups with only 3 groups: children, pregnant women, and adults.

Covered individuals who earn less than 200% of the FPL would receive the current Medicaid benefit package. For those individuals who earn above 200% of the FPL, the state would develop a benchmark plan based on the largest low-cost commercial plan available in the state plus additional wraparound benefits such as early childhood development services. Premiums and copays would apply for some populations subject to the 5% of family income rule.

Like many other states, Wisconsin's employer-sponsored insurance rate has dropped. In 2001, 76% of Wisconsin residents received insurance through their employers; by 2004, that figure had declined to 69%. The drop in employer-sponsored coverage has been particularly acute for firms that employ less than 50 workers. To attempt to stabilize the small group market, the Healthy Wisconsin Council has recommended establishing a state-subsidized reinsurance pool for the entire small group market and health insurance purchasing cooperatives but targeting the subsidy to the smallest low-wage firms. In addition, the Council has recommended expanding Medicaid to cover childless adults up to 200% of the FPL.

The Healthy Wisconsin Council also recognized that recommendations for important incremental steps should serve as building blocks for future reforms. As such, their final recommendation was to urge the Governor to adopt a comprehensive health care reform to provide broad coverage and lower health care costs[67].

Wyoming

During the 2006 legislative session, the Wyoming state legislature enacted a bill that would allow the state's Department of Health to seek a HIFA waiver from CMS to provide health coverage to parents of children in families with income up to 200% of the FPL and who are enrolled in EqualityCare or Kid Care CHIP. The bill stipulated that enrollment for the program will be capped at 3,720 parents, and any increase in enrollment beyond the capped amount would require action by the state legislature.

The program would have 2 options:

1) Kid Care CHIP "Premium Assistance for Parents": Parents or guardians may participate through their employer's health insurance plan. Employer participation for full-time employees would be at least 50% of the monthly premium of the health insurance plan selected by the parent or guardian. For part-time employees (less than 30 hours per week), the Department of Health may collect an hourly fee from the employer.
2) Kid Care CHIP Parent Plan: A plan offered by the Department of Health, similar to Kid Care CHIP, with a scaled down benefit package developed by the Kid Care CHIP Benefit Committee. This plan would require employers to contribute 50% of the monthly premium with the Department of Health picking up the remaining cost (up to an identified maximum).

In both options, if an employer refuses to participate in the program, the parent or guardian who would qualify may pay the employer's share of the premium from a health savings account, a third party or another source. Parents with incomes above 133% of the FPL will be assessed a participation fee on a sliding scale basis. Wyoming expects the waiver to be implemented in 2007[68].

Recommendations of the American College of Physicians

The College supports state flexibility to investigate different, cost-effective approaches that contribute to the overall goal of providing all Americans with access to affordable coverage. The College recognizes that all states cannot use the same framework to achieve universal coverage and also recognizes the value of experimentation with various models. However, the College has identified key elements that should be a part of any state-based reform. These recommendations are based on the College's Core Principles on Access and policy papers including those on Workforce and the Patient-Centered Medical Home (PC-MH)[69, 70].

The College offers the following recommendations to states as they develop models to expand access to care for their residents:

1. **State-based health plans should either achieve universal coverage, or should at a minimum result in measurable and substantial reductions in the number of uninsured within the next 5 years.**

Access to affordable health care should not be considered a luxury but a right for all. If universal coverage cannot be immediately accomplished, state proposals should apply an incremental approach to providing coverage to residents. These proposals should have an explicit goal of all residents being covered by an adequate health insurance plan within 5 years. Sequential reforms that expand coverage to targeted groups should identify the subsequent steps, targeted populations and financing mechanisms that will result in achieving coverage.

Maine, Massachusetts, and Vermont are all in the process of implementing reforms to achieve universal coverage in their states. A key element shared by all 3 plans is that they subsidize coverage for families with annual incomes up to approximately $53,000 (300% of the FPL for a family of 4).

Universal coverage plans proposed in California, Illinois, and Pennsylvania are also encouraging. All 3 plans call for individual mandates to obtain coverage.

2. **State-based health plans should ensure that all individuals participate in the coverage plan, by applying individual mandates, employer mandates, automatic enrollment in publicly funded plans, or some combination of these approaches.**

Short of a single-payer system sponsored by the state, the only way to cover all residents in a state is by applying individual mandates, employer mandates, or a combination of both. Without mandates, the College believes that achieving universal coverage in a state is unlikely. For example, Maine's DirigoChoice Program, which is voluntary, had a goal to sign up 30,000 individuals by the end of 2005 and cover all state residents by 2009, but has only enrolled 13,290 individuals as of December 2006.

Massachusetts is the first state in the nation to require individuals to purchase health insurance coverage. Individual noncompliance by those who can afford to obtain coverage will result in the loss of personal income tax deductions. In subsequent tax years, the penalty will include a fine equaling 50% of the monthly cost of health insurance for each month without insurance.

Ideally, states, employers, and individuals should share responsibility, but each state must decide the best approach for its residents. Employer mandates could include either requiring employers to provide insurance to their employees or taxing employers who do not provide coverage and having their employees participate in insurance pools or public plans. For example, Massachusetts and Vermont require businesses to pay modest assessments toward state-offered coverage if

they fail to provide insurance for their workers. Similarly, Pennsylvania's proposal includes a "fair share" assessment levied on all companies that do not insure their employees.

Individual mandates should not cause financial hardships to residents. States should supply affordable premiums and adequate public subsidies to offset costs for low-income residents. Purchasing pools may be necessary to dilute the burden for those that have the misfortune to have a chronic or debilitating condition.

3. State-based health plans should at a minimum provide coverage for a core package of preventive and primary care services and for catastrophic expenses.

Individuals who have access to health insurance coverage may still experience barriers to needed services if the covered benefits are inadequate. The College believes that proposals to expand health insurance coverage must also have in place a mechanism to establish an adequate scope of benefits. The goal should be to establish a uniform, evidence based package of benefits that would apply to all state residents. Qualified insurers should be required to offer a basic benefits package, including preventive and screening procedures that have been shown to be effective and a limit on total out-of-pocket costs in a calendar year. Coverage should also be portable so that individuals can keep their coverage if they change jobs or move to another community.

Maine's DirigoChoice plan offers a core benefit structure including prescription drugs and preventive care. The Michigan First Healthcare Plan proposes a minimum benefits package that would include basic preventive and primary care, hospitalization, emergency room services, mental health care, and prescription drugs. The plan also has a wellness and disease prevention component. In Massachusetts, individuals will have the choice of 3 levels of plans that will vary by price and cost sharing but will all offer comprehensive coverage, including in- and outpatient care, emergency care, mental health services, and vision care. A unique feature of the Massachusetts plan is that it allows individuals to keep their policy even if they switch employers.

4. States should ensure adequate and stable funding for their state-based health programs by broadly sharing responsibility with the federal government, employers, and individuals within the state.

Economic difficulties and budget constraints have often forced states to cut back on programs for the uninsured. States must ensure adequate, stable funding to finance their coverage models by sharing the responsibility of funding the program with all stakeholders. Both the federal and state governments should make a fiscal commitment to such programs. All employers and individuals within the state should also contribute to financing state-based health programs, with individuals contributing based on their income.

5. State-based health programs should include incentives to assure a better balance of primary care physicians to specialists and an adequate supply of primary care physicians

There is mounting evidence for the benefit of a balance of primary care physicians to specialists, yet the number of medical students and residents choosing to pursue careers in primary care specialties, including general internal medicine, continues to decline. Studies have shown that primary care has the potential to reduce costs while still maintaining quality[71]. States with higher ratios of primary care physicians to population have better health outcomes,

including reduced mortality from cancer, heart disease or stroke[72, 73]. The supply of primary care physicians is also associated with an increase in life span[74, 75]. The preventive care that general internists provide can help to reduce hospitalization rates[76]. In fact, studies of certain ambulatory care–sensitive conditions have shown that hospitalization rates and expenditures are higher in areas with fewer primary care physicians and limited access to primary care[77, 78].

High levels of student debt coupled with inequitable and dysfunctional payment policies are key drivers behind the decline in the number of physicians going into primary care. States should take immediate steps to reverse the decline in interest in careers in primary care, including general internal medicine, and improve the payment and practice environment of existing primary care physicians.

Connecticut, New York, and Rhode Island are among the states that have proposed plans with an emphasis on primary care. Louisiana's proposal includes a provision that would create the Louisiana Health Service Corps for health care workforce recruitment and retention. The LHSC would provide income guarantees, annual medical malpractice payments, and incentive payments to recruit and retain primary care physicians.

6. State-based health plans should give individuals the ability to obtain care from a qualified patient-centered medical home.

It is widely believed that the current method of health care delivery in the United States, which emphasizes episodic treatment for acute care through private health insurance and governmental programs, is not optimally meeting the health care needs of patients with chronic diseases.

In January 2006, the College proposed a fundamental change in the way that primary care is delivered and financed. The patient-centered medical home (PC-MH) model envisions physicians in practices that provide comprehensive, preventive and coordinated care centered on patients' needs, using health information technology and other process innovations to assure high quality, accessible and efficient care. Practices would also be accountable for results based on quality, efficiency and patient satisfaction measures. In the patient-centered medical home model, patients will have a personal physician working with a team of health care professionals in a practice that is organized according to the principles of the PC-MH. Rather than being a "gatekeeper" who restricts patient access to services, a personal physician leverages the key attributes of the PC-MH to coordinate and facilitate the care of patients and is directly accountable to each patient. Personal physicians advocate for and provide guidance to patients and their families as they negotiate the complex health care system.

Studies of the medical home model indicate that a medical home provides better effectiveness, increased efficiency, and more equitable care to individuals and populations while lowering the overall costs of care[79]. North Carolina, which has implemented a smaller-scale version of the medical home model through its Primary Care Case Management Medicaid program, has already seen cost savings and quality enhancement. The program, in which every patient is matched with and given access to a primary care physician, along with locally based disease management and nurse educator support that is integrated with the physician practice, has improved the outcomes of diabetes and asthma care while achieving cost savings to the state of between $200 million and $220 million per year[80].

Illinois, Louisiana, Missouri, and Oregon are among the states that have included a medical home component in their health reform proposals.

7. State-based health plans should include reimbursement reforms to support the value of patient-centered care managed by a primary or principal care physician.

The College's PC-MH model includes a series of recommendations for reforming payment policies, including new models for paying physicians for the coordination of care for patients with chronic diseases; increased payment for office visits and other evaluation and management services; separate payment for e-mail consultations for nonurgent health issues, to reduce the need for face-to-face visits; and additional payments to physicians who use electronic health records to improve quality.

States should ensure that payments to primary or principal care physicians appropriately recognize the added value provided to patients who have a patient-centered medical home. Reimbursement methodologies should move away from paying physicians based on the volume of episodic services (with per-visit and per-procedure codes) to one that creates incentives for care management, team-based care, and practice redesign.

Inequitable and dysfunctional payment policies are key drivers behind the decline in the number of physicians going into primary care, and will result in major barriers to access unless states take action to ensure that physicians engaging in primary care can receive reimbursement commensurate with the value of their contributions. Adequate payment to all physicians, including primary care physicians who choose not to practice in a medical home model, is of critical importance.

8. State-based health programs should include incentives for health information exchange and physicians' adoption of Health Information Technology (HIT) to support patient-centered care.

The use of HIT plays an essential role in a successful PC-MH model. Such support systems have been shown to offer the most effective way to keep track of patients' health care needs, communicate with patients effectively and efficiently, and provide evidence-based clinical approaches to medical care. The College strongly believes that linking care coordination and support systems together will result in overall quality improvement and enhanced communication access.

Unfortunately, the costs of acquiring such technologies remain prohibitively expensive for most physician practices. State-based health programs should include incentives for physicians to adopt HIT to support patient-centered care and health information exchange. Recognizing the importance of HIT, Vermont has created the Vermont Informational Technology Leaders (VITL), a public–private partnership charged with developing the state's HIT plan, including the creation of incentives for physicians to adopt HIT.

9. State-based health programs should not reduce existing benefits for current Medicaid and SCHIP recipients.

For many states, expansion of Medicaid and SCHIP may be the most feasible way of extending coverage to the poorest Americans who lack health insurance. States that choose to develop their own programs in place of Medicaid or SCHIP should ensure that benefits are not reduced for current recipients.

10. State-based programs should not penalize patients for engaging in unhealthy lifestyles but should include positive incentives for well-being and prevention.

The College supports a consistent approach to health promotion. State-based programs should include positive incentives to encourage well-being and prevention. Penalizing individuals for engaging in unhealthy lifestyles conflicts with the goal of improving the health status of individuals. States should consider offering education and support to those residents that choose to engage in unhealthy lifestyles to get them on the right track. Such strategies have the potential to lower costs and improve health outcomes.

Vermont's Catamount Health includes a Healthy Lifestyles Insurance Discounts Program, which allows discounts of up to 15% of premiums for compliance with its health promotion program. Catamount Health also waives copayments and deductibles for chronic care management and preventive care.

California's proposal includes "Healthy Actions Incentives/Rewards" programs. These programs, which would be offered in both private and public programs, would provide rewards such as premium reductions and gym memberships for individuals engaging in healthy behaviors.

Conclusion

The College is encouraged to see the innovative approaches that states are taking for covering their uninsured residents, but is cautious to endorse any specific plan at this time. While it is imperative to guarantee coverage to all Americans, it is equally important to consider the type of care that Americans deserve. The College believes that all Americans have the right to affordable, high-quality, patient-centered care in a system that incorporates health information technology and continuous quality improvement innovations that center on each patient's needs.

Although some state proposals do not address the root causes of the nation's most pressing health care issues, they stimulate discussions that could lead the way in addressing the problem of the uninsured on a national basis. With so many other issues continuing to dominate the national agenda, the best that Congress and the Administration may be able to do to expand access is to give states the money they need to support their own reforms. The College recognizes that it is unlikely that states alone will be able to repair the U.S. health care system, but stands ready to assist those states that would like to develop models to provide comprehensive coverage and patient-centered care to their residents.

Key Features of State Reforms

State	Initiative	Key Features
Comprehensive Reforms		
California		• Individual mandate for coverage • Expands Medicaid and SCHIP to poorest Californians • Purchasing pool for individuals with incomes between 100% and 250% of the FPL • Increase in Medicaid reimbursement rates for health care providers • Cost containment measures
Illinois	Illinois Covered	• Individual mandate for coverage • Expands FamilyCare and SCHIP eligibility to 400% of the FPL • Three coverage categories • Medical home component • Employer assessment
*Kansas		• Kansas Health Policy Authority to develop Medicaid reform options by Nov 2007 • Premium assistance for adults at or below 100% of the FPL • $15 million in loans for safety net health clinics' expansion and upgrades
Louisiana		• Redesigns New Orleans health care system • Adopts medical home model system of care • "Louisiana Health Service Corps" demonstration project • Health Insurance Connector • Expands coverage through private insurance
*Maine	DirigoChoice	• Goal of universal coverage by 2009 • Core benefits package • Cost containment measures • Premium discounts and reduced deductibles for enrollees with incomes below 300% of the FPL
*Massachusetts	Commonwealth Care	• Individual mandate for coverage • Pay-for-performance measures • Health Insurance Connector • Employer assessment

*Minnesota		• Goal of universal affordable coverage by 2011 • Health insurance exchange for tax-free purchase of health coverage • Reforms to reduce or eliminate barriers to coverage for children • Free MinnesotaCare coverage for military families during the first 12 months home from active duty
Oregon		• Individual mandate for coverage • Universal coverage for children by expanding access to Medicaid and SCHIP • Health Insurance Connector • Premium subsidies for all residents with incomes below 300% of the FPL • Medical home component
Pennsylvania	Cover All Pennsylvanians	• Mandate for coverage for residents with incomes above 300% of the FPL • State-subsidized health coverage through private insurers • Employer assessment • Expand legal duties of nonphysicians
Washington	Healthy Washington Initiatives	• Extending age of dependent coverage to 25 years • State-sponsored reinsurance program for high-cost enrollees • Health Insurance Connector
*Vermont	Catamount Health	• Goal of nearly universal coverage by 2010 • New subsidized coverage for uninsured individuals and families with incomes up to 300% of the FPL • Comprehensive coverage for primary and preventive care • Employer assessment • Incentives for adoption of HIT

Public/Private Partnerships

*Arkansas		• Open to businesses with 2–500 employees that have not offered insurance • Safety Net benefit package • Provided through private insurers • Subsidy provided for workers with incomes below 200% of the FPL
Connecticut		• Waives CHIP premiums for newborn through age 2 months • Outreach funds to train school staff to educate parents about CHIP program • Encourages private insurers to offer basic coverage regardless of income or health status • Government-sponsored premium assistance • Cost-sharing structured to encourage primary care
Michigan	Michigan First Healthcare Plan	• Expands coverage through partnership with health care industry and business community • Expands Medicaid program • Develops statewide health information network
Montana	Insure Montana	• Refundable tax credits to small business with 2–9 employees that provide health insurance • Purchasing pools and premium assistance to small businesses that do no currently provide health insurance
*New Mexico	State Coverage Insurance	• Uses unspent SCHIP funds to provide managed care coverage to uninsured, employed adults with incomes up to 200% of the FPL • Individuals may enroll through their employer or as self-employed persons • Premiums paid by employer/ employee contributions and state/federal funds
North Carolina	Healthy NC	• Purchasing pools for employees of small businesses and mandatory employer contributions • Purchasing pools for residents with high-risk conditions • Establishes North Carolina Health Insurance Risk Trust Fund

*Oklahoma	O-EPIC	• Premium assistance voucher available for small firms (2–50 employees) that offer a qualified plan and income-eligible employees with incomes below 185% of the FPL • Individual plan available to uninsured workers whose firms do not offer insurance and to self-employed (who earn less than 185% of the FPL)
*Rhode Island	Wellness Health Benefit Plan	• Premiums for all small businesses expected to be reduced by 25% below market rate • Promotes primary care, prevention, and wellness • More transparency of health care costs and quality data
*Tennessee	Cover Tennessee	• New affordable health insurance product for working uninsured and small businesses that do not offer coverage • At least 2 statewide private plans • Cost limited to $150 per month, split by employee, employer and state • High-risk pool
*Utah	Utah Premium Partnership for Health Insurance (UPP)	• New premium assistance program • Partnership between employees, employers and state • $150 subsidies for low-income workers enrolled in employer-sponsored insurance • Subsidies up to $100 for employee's children
*West Virginia		• Goal of universal access to health care by 2010 • Program that allows small businesses with 2–50 employees access to reimbursement rates and drug purchasing power • Program expected to generate 20%–25% discount below market rate for small businesses

Medicaid/SCHIP Expansions		
Maryland		• Expands Medicaid eligibility up to 116% of the FPL for adults and up to 400% of the FPL for children • Allows CHIP buy-in for families above 400% of the FPL • Increases state cigarette tax
New York		• Expands Child Health Plus eligibility to 400% of the FPL • Simplifies Medicaid enrollment process • Significantly reduces Medicaid spending growth rate • Investments for primary care and disease prevention
Wisconsin	BadgerCare Plus	• Expands access to BadgerCare above current income ceiling (185% of the FPL) on a sliding scale • Simplifies eligibility for BadgerCare Plus • State-sponsored reinsurance for small group market
Wyoming		• Provides coverage to parents with children enrolled in EqualityCare or Kid Care CHIP and with incomes up to 200% of the FPL • Two coverage options • Assessment for participation for parents with incomes above 133% of the FPL
Government-Based Reforms		
Delaware		• Creates a Medicaid buy-in program to assist people with disabilities by allowing them to work without losing health benefits • Expands state CHIP program • Creates Delaware Health Information Network • Reforms to be funded by $0.45 state cigarette tax increase
Indiana	POWER (Personal Wellness Responsibility) Accounts	• Uses Health Savings Account model • POWER Accounts of $1,000 include state contributions • Proposal to be funded by cigarette tax increase

Iowa	• $1 increase in state cigarette tax • Expands Medicaid eligibility to 200% of the FPL • Offers CHIP buy-in to all residents with sliding scale premiums
Missouri	• Allows residents to purchase health coverage with pretax dollars • Purchasing pools for wide variety of workers • Health coverage plan transferable, not linked to one's place of employment • Medical home component
Employer-Sponsored Coverage Reforms	
Alabama	• Tax incentives for small businesses with 25 or fewer employees that provide health coverage to employees • Tax incentives for employees of small businesses
*Virginia	• Purchasing pools for small businesses with 50 or fewer employees • Employers can negotiate premiums for their employees

* Denotes states that have already begun implementing their reforms.

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