Efforts to Expand Coverage to the Uninsured: Program Design Challenges and Tradeoffs in Six States

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Executive Summary

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, contracted with AcademyHealth to study the practical experiences of a select group of states that have implemented affordable private and public coverage insurance products for low-income workers. AcademyHealth partnered with the Center for Health Program Development and Management (the Center) at the University of Maryland, Baltimore County to conduct the study.

The study included an in-depth assessment of programs in six states—Arizona, Michigan, New Mexico, New York, Oklahoma, and Utah—to gain a better understanding of the design elements associated with successful programs. Design elements include population targeting criteria; service delivery system; program financing; benefit design, including cost-sharing; and program administration. The study also looks at how the HRSA State Planning Grant (SPG) program assisted states in developing strategies to improve insurance coverage.

Each of the states studied had implemented a public or private program to provide affordable insurance coverage for low-income workers. The numerous variations in program design between the states highlight the challenges and tradeoffs that policymakers must consider when expanding health care coverage. This paper compares and contrasts the different approaches that states take to address this issue in four broad areas.

1. **Program Design** - how states targeted their programs in terms of size of employers, income eligibility standards, and type of delivery system (e.g., managed care)
2. **Program Financing** - the variation in the relative roles of states, employers, and employees in paying for the products and the constraints that Medicaid funding introduces into program operations
3. **Methods to Keep the Program Affordable** - how programs control costs by limiting the services or implementing co-pays and other cost sharing provisions
4. **Program Administration** - the different approaches states have taken to manage and promote these programs

The main body of the report concludes with a section on lessons learned. As the number of uninsured continues to grow and as employer-sponsored insurance rates decline, individual states have stepped in to help improve access to insurance. Most of the states studied developed program design elements with the help of HRSA SPGs. Most of the states in the study decided to build on employment-based coverage, generally through publicly funded premium subsidies.

Since these pilot initiatives were established, several states have announced their intentions to develop state-wide programs. Attention has been drawn to these proposals due to their use of legal requirements for mandatory coverage and substantial public subsidies. However, even with

significant subsidies and mandates, all states must confront the trade-offs analyzed in this paper and the lessons will be helpful as they move forward.

1. **Make realistic enrollment goals** – Programs targeted at small businesses have a long take-up process in part because states not only have to implement these complex programs but they and their partners also have to sell them to a skeptical audience.
2. **Pay attention to the whole package** – Premiums have to be affordable and benefit packages have to be meaningful for small employers to participate in the programs.
3. **Carefully consider the employee cost sharing requirements** – Affordability is key as most of the programs studied targeted low-wage workers with little disposable income.
4. **Making it easy for the employer/employee does not translate into making it easy for the state** – States need to carefully plan for expansions and build an infrastructure that allows for a smooth implementation.
5. **Marketing is critical** – States must develop strategic plans and have adequate funding for marketing to employers, employees/ individuals and to health plans/ insurers.
6. **Individual means testing is a significant administration burden and barrier to enrolling members quickly in the program.**
7. **Plan on the program costing more than expected per member due to pent up demand for services.**
8. **Appreciate the tension between adding benefits and keeping program costs low –** States have found that they need to be cautious in making changes to benefit packages because they may result in large increases in premium costs. At the same time, benefits need to be at an acceptable level to attract buyers.
9. **States without premium subsidies or with small subsidies must be extremely creative in developing affordable benefit packages.**
10. **Know your target population –** Each of the lessons learned illustrates the importance of knowing the target populations of the state initiatives.

Each state program included in the study developed administrative procedures that work within their individual health care environments. The programs are incremental attempts to address the serious problem of many uninsured workers. They were developed with limited funds and/or limited political will to address a full-scale state health care reform program. None of the programs feature legislative mandates to require or penalize employers who do not offer health insurance or employees who do not participate in employer-sponsored insurance (ESI) programs. These conditions have been prevalent in most states in the country, so other states embarking on new initiatives, including those with legislative mandates, can learn from these states. A case study describing each of the state programs in more detail can be found at the end of the report.

Introduction

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, contracted with AcademyHealth to study the practical experiences of a select group of states that have implemented affordable private and public coverage insurance products for low-income workers. AcademyHealth partnered with the Center for Health Program Development and Management (the Center) at the University of Maryland, Baltimore County to conduct the study. The analysis documents the design elements that are important for establishing and implementing a workable program. Design elements studied include population targeting criteria; service delivery system; program financing; benefit design, including cost-sharing; and program administration.

The HRSA state planning grant (SPG) program has been an important resource to states and U.S. territories looking to develop strategies to improve insurance coverage. Through its SPG program, HRSA annually awarded grants to states and territories to give them the resources to collect, analyze, and interpret state-level data on the uninsured and to use this information to develop plans for providing access to affordable health insurance. Since 2000, 47 states, the District of Columbia, and four territories have received grants. Beginning in 2004, the SPG funding was expanded to allow states to further refine and plan for implementation of pilot projects. However, funding for the SPG program was eliminated in the federal FY 2006 budget. All of the states included in the study with the exception of New York received a HRSA SPG that helped them move toward implementation of an insurance pilot project.

SPG grantees have used grant funds primarily to:

- Collect and analyze data on uninsured individuals, businesses, and the marketplace
- Engage and build consensus among stakeholders
- Study options for expanding coverage

Some of the states that received grants through the SPG program have gone on to implement state coverage initiatives and a number of these programs will be discussed in this study. During the time period of these grants, states were undergoing tremendous budgetary pressures, which were often fueled by large increases in state Medicaid programs. This, combined with the fact that the state-specific studies funded through SPG confirmed that most of the uninsured residents are in families with full-time workers, led many states to implement programs that built on employment-based coverage. States were able to leverage limited public dollars with employer and employee contributions, generally through a publicly funded premium assistance or reinsurance program. In addition to the activities highlighted above, states used grant funds to develop premium and benefit structures, administrative and marketing strategies, and financing mechanisms. These design elements were critical in developing each of the programs.

In this study, we conducted an in-depth assessment of programs in six states—Arizona, Michigan, New Mexico, New York, Oklahoma, and Utah—to gain a better understanding of the design elements associated with successful programs. We focused on these states because each of them had implemented a public or private program to provide affordable insurance coverage

for low-income workers. The programs studied are incremental attempts to address the serious problem of many uninsured workers. They were developed with limited funds and/or limited political will to address a full scale state health care reform program. None of the programs feature legislative mandates to require or penalize employers who do not offer health insurance or employees who do not participate in employer-sponsored insurance (ESI) programs.

In addition, state and program characteristics vary widely among the study group, thereby allowing states across the country to examine program elements and implementation strategies that may pertain to their particular circumstances. The following table illustrates some basic differences in health insurance coverage of the non-elderly populations in these states.[1] Uninsurance rates range from a low of 13 percent in Michigan to a high of 24 percent in New Mexico. In addition, Michigan relies much more heavily on employer-sponsored insurance (67 percent) than New Mexico (50 percent). Utah has the lowest percentage of Medicaid enrollees (11 percent) and New York has the highest (19 percent).

Table 1: Basic Characteristics of Health Insurance Coverage by State

State/Nation	% Uninsured	% Medicaid	% Employer-Sponsored Insurance	% Individual Coverage	% Other Public
Arizona	21	17	53	6	2
Michigan	13	14	67	4	1
New Mexico	24	18	50	5	3
New York	15	19	60	4	1
Oklahoma	22	14	56	5	4
Utah	17	11	63	8	2
United States	18	14	61	5	2

This paper is divided into programmatic sections, each of which will highlight similarities and differences among the six programs. Key sections will include program design, program financing, methods to keep the program affordable, and program administration. This part of the report will end with a lessons learned section. A case study describing each of the state programs in more detail can be found on pages 27 through 69.

To obtain the information necessary to complete the study, the Center first reviewed program literature, including studies, papers, and brochures. To obtain detailed programmatic descriptions, the Center interviewed key program staff and other pertinent stakeholders.

Key informants for all of the programs studied were committed to increasing insurance rates within the state (or in one case, county). In addition, they recognized that the problem has to be addressed at the state or local level because national solutions are not forthcoming. Finally, all of the programs worked with key stakeholders to develop administrative procedures that would work within their individual health care environments. In keeping with their commitment to the uninsured population in their area, programs changed administrative procedures that did not work or were inefficient.

[1] Data from Kaiser and Urban Institute Analysis of Current Population Survey, March 2005 and 2006.

Background

Due to the variation among the six programs presented in this paper, it is necessary to provide a brief overview of each state before presenting an in-depth discussion of findings. There is a great degree of variability with regard to program and benefit design, program funding, and populations targeted. Some states offer multiple programs and products. Because most Americans under the age of 65 receive health insurance through their employer (61 percent in 2005) and most uninsured adults are employed, many of the programs highlighted in this paper build on employer-sponsored insurance (ESI) products. That said, there is a healthy mix of program designs among the six states studied. Programs range from a county-specific and community-based program in Muskegon County, Michigan, to a statewide and self-funded program that offers multiple benefit packages in Arizona. Again, some states offer more than one program and enrollment numbers vary greatly. Half of the states profiled use federal matching funds to partially subsidize their programs and all but one use state funds. A comparison of key program characteristics is presented in Table 2; a more detailed discussion of each state can be found in the Case Study section of this paper.

Arizona – The Healthcare Group of Arizona (HCG) was created in 1985 to provide affordable and accessible health care coverage to sole proprietors, small businesses with 50 or fewer employees, and political subdivisions (cities and towns). The program was initially funded by a grant from the Robert Wood Johnson Foundation. In 1988, small employers in four counties were allowed to participate and the program was launched statewide in 1993. Full-time employees and dependents at qualifying firms are eligible to participate in the program. Employers with fewer than six employees must have 100 percent participation; otherwise 80 percent of employees must enroll in an HCG plan. As of December 2006, there were 24,562 lives covered by HCG. Although few states or programs provide enrollment targets, HCG enrollment in December 2006 was below the July 2006 target of 27,698 and short of the January 2007 target of 43,381. HCG estimates that once enrollment reaches 100,000 the program could afford to provide individual coverage. HCG is state-sponsored public-private partnership that is operated under the Arizona Health Care Cost Containment System (AHCCCS) and is totally separate from the state's Medicaid and SCHIP (State Children's Health Insurance Program). The state contracts with private managed care organizations (MCOs) and a statewide preferred provider organization (PPO) for insurance plans. As of the 2005/2006 budget, HCG is totally self-funded via premiums.

Michigan – Michigan's Access Health, available only in Muskegon County, provides access to a comprehensive array of health care services for uninsured workers of businesses that did not previously provide health insurance coverage. The care must be provided by local county-based providers and the care is paid for on a fee-for-service basis. Certain services, such as routine dental care, vision and hearing exams, neonatal intensive care outside the county, injuries resulting from automobile accidents, workplace injuries, organ transplants, and treatment for serious burns are not covered by the program. Access Health was implemented in 1999 and currently serves approximately 1,200 employees and dependents. It is known as a "three-share

plan" whereby employers and employees each pay approximately 30 percent of the cost of the program and the community pays the remainder. Access Health is overseen by the state treasurer rather than the insurance commission, exempting it from health insurance rules such as state benefit mandates and solvency requirements.

New Mexico – The New Mexico State Coverage Insurance (NMSCI) began enrolling small employers (those with less than 50 employees) and individuals on July 1, 2005. The program provides access to a statewide managed care system primarily targeted to employers and low-wage employees, although low-income uninsured individuals are also allowed to participate in the program. Individuals must have family incomes below 200 percent of the federal poverty level (FPL) to participate in the program. NMSCI is a Medicaid and SCHIP expansion program. It is funded via New Mexico's unspent SCHIP (including the required state match) as well as with employer and employee contributions. The managed care coverage is provided by private plans selected through a competitive bidding process. Because of its low rate of ESI coverage among small businesses, New Mexico opted not to use an ESI model. Although benefits are similar to a comprehensive commercial plan, there is a $100,000 annual benefit limit.

New York – Healthy NY began enrolling individuals in January of 2001 and has three target populations: small business employers and their employees, sole proprietors, and working individuals who cannot obtain insurance through their employers. The program serves approximately 110,000 individuals, 76,500 subscribers, and 34,500 dependents. All health maintenance organizations (HMOs) in the state must participate in the program. Other carriers may also participate. In addition to the HMO products, a few plans offer a PPO. Healthy NY includes a fairly comprehensive benefit package and a reinsurance program that results in lower premiums for employers and employees. Unlike earlier programs in New York, as well as many of the other programs in this study, Healthy NY does not directly provide subsidies to small businesses or low-wage workers. Instead, the subsidy is directed at the insurance product through a reinsurance program, which pays most of the expenses of high-cost people who join the program.

Oklahoma – The Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program assists Oklahoma small businesses and employees in paying health insurance premiums. The target population includes low-income individuals and small employers. O-EPIC consists of two programs: the Premium Assistance Partnership Program (Premium Assistance) and the Premium Assistance Public Program (Individual Plan). Premium Assistance began enrolling beneficiaries in November of 2005. The Individual Plan was implemented in January of 2007. A Health Insurance Flexibility and Accountability (HIFA) waiver program, O-EPIC is funded via federal matching Medicaid funds, state tobacco tax funds, and individual and employer premiums. Premium Assistance utilizes the private insurance market and provides subsidies to employers to pay for employee health insurance premiums. The state's goal is to allow market forces to determine the benefit package and to integrate Premium Assistance workers into the private insurance marketplace rather than have them depend on state health programs. The Individual Plan is being administered by the state Medicaid office and will provide a limited package which includes primary care case management services and a lifetime maximum

benefit. The state Medicaid infrastructure will provide administrative support and Medicaid providers will deliver care.

Utah – The Utah Primary Care Network (PCN) is a fee-for-service state-run Medicaid expansion program operating under a Section 1115 Medicaid waiver. PCN has enrolled approximately 16,000 individuals and provides a limited benefit package of primary care services. The program does not cover specialty physician services and there is no coverage for inpatient hospital care. Utah hospitals agreed, however, to donate $10 million of inpatient care annually to PCN enrollees. This agreement was made easier by Intermountain Healthcare, a nonprofit health care system serving the health care needs for many Utah residents. In November of 2006, the state began another program—Utah's Premium Partnership for Health Insurance (UPP)—to provide subsidies to uninsured employed individuals to help them pay for ESI plans. The program targets low-wage workers regardless of health status and helps them gain entry into the ESI market. Uninsured individuals and families with incomes below 150 percent of the FPL are eligible for PCN and UPP, and children in families below 200 percent of the FPL are eligible for UPP. Employers do not participate in PCN, but in UPP they must cover 50 percent of ESI premiums and offer plans that meet the minimum standards of the program. UPP utilizes existing ESI plans in the Utah market. Both programs are funded through federal funds and state general funds. UPP also receives employee and employer contributions and a limited allocation of tobacco tax revenue for SCHIP allotments. The state Medicaid program provides the infrastructure for both programs and state agencies determine eligibility.

Table 2: State Program Characteristics

State: Program Name (Start Date)	Primary Target Population	Program Enrollment	Program Model	Federal Medicaid Funding	State Matching Funds	State FMAP Amounts (if applicable)	Employer Contribution for Individual Coverage	Employee Contribution for Individual Coverage
Arizona: HCG (1986)	Individuals working for small employers who don't offer insurance and the self employed	24,562 as of December 2006	State-run, but self funding insurance program	No	No		Yes, but no minimum percentage	Yes, but no minimum percentage
Michigan: Muskegon Access Health (1999)	Individuals working for employers who don't offer insurance and whose employees have a low median wage	1,200 as of November 2006	Locally run (county-level) health care program	No, but community share is subsidized by DSH funds	The state provides the matching funds for DSH		Yes, at least 30% of premium	Yes, up to 30% - employer may agree to pay the employee's share
New Mexico: NMSCI (2005)	Low income, uninsured, working adults with family incomes below 200% FPL	4,623 as of December 2006	State-run insurance plan built on Medicaid program	Yes/SCHIP HIFA Waiver	Yes	71.2%	Yes, $75 per month for individual coverage	Yes, sliding fee scale
New York: Healthy NY (2001)	Low wage workers without access to ESI, self-employed, and employees of small businesses where at least 30% of workers earn less that $34,000 annually	130,850 as of December 2006	Employer Sponsored Insurance	No	Yes, funds pay for reinsurance which drives down the cost of the premium		Yes, at least 50% of premium	Yes, up to 50% - employer may agree to pay the employee's share

Table 2 (continued): State Program Characteristics

State: Program Name (Start Date)	Primary Target Population	Program Enrollment	Program Model	Federal Medicaid Funding	State Matching Funds	State FMAP Amounts (if applicable)	Employer Contribution for Individual Coverage	Employee Contribution for Individual Coverage
Oklahoma: O-EPIC Premium Assistance (2005)	Adults with incomes under 185% FPL who work for small employers	1,219 as of October 2006	Employer Sponsored Insurance	Yes/Medicaid HIFA Waiver	Yes, state match is funding with tobacco tax	67.9%	Yes, at least 25% of premium	Yes, no more than 15%
Oklahoma: O-EPIC Individual Plan (to be implemented in 2007)	Adults with incomes under 185% FPL who do not have access to ESI, including self-employed or unemployed individuals seeking work	-	State-run primary care case manage-ment program built on Medicaid program	Yes/Medicaid HIFA Waiver	Yes, state match is funding with tobacco tax	67.9%	No	Yes, sliding fee scale
Utah: PCN (2002)	Adults with incomes under 150% FPL	16,166 as of October 2006	State-run insurance plan built on Medicaid program	Yes/Medicaid HIFA Waiver	Yes	70.8%	No	Yes, annual enrollment charge based sliding fee scale
Utah: UPP (2006)	Adults with income under 150% FPL who have access to ESI	90 as of October 2006 (Assumes transfer from existing program)	Employer Sponsored Insurance	Yes/Medicaid HIFA Waiver	Yes	70.8%	Yes, at least 50%	Yes, whatever remains after employer share & state subsidy

Comparing State Programs

All the programs studied seek to increase access to coverage for low-income uninsured populations. The approaches used to accomplish this goal, however, are extremely varied. The variations highlight the challenges and tradeoffs that policymakers must consider when expanding health care coverage. This portion of the analysis will compare and contrast the different approaches that states take to address this issue in four broad areas.

1. **Program Design**. This section compares state decisions regarding how to target their programs in terms of the size of employers, the income eligibility standards, and the type of delivery system (e.g., managed care) that will be used.
2. **Program Financing**. This section examines the variation in the relative roles of states, employers, and employees in paying for the products. Also discussed are the constraints that Medicaid funding introduces into program operations.
3. **Methods to Keep the Program Affordable**. This section focuses on how programs control the costs by limiting the services. The discussion examines service limits, as well as co-pays and other cost-sharing provisions.
4. **Program Administration**. This section examines the different approaches that states have taken to manage and promote these programs. Specifically, the section will discuss the role that the private market plays, or does not play, in marketing and operating the programs.

1. Program Design

When seeking to expand coverage to uninsured populations, a state must make a series of program design decisions. Two initial decisions, which influence many subsequent choices, are how to target the program and in what manner to provide services. States used SPG dollars to study the uninsured within the state in order to guide these decisions.

Program Targeting – When designing a program to serve low-income uninsured populations, the first decision that states must make is through what avenue they want to reach the population. In the broadest sense, programs may either go through employers or directly target individuals.

Employer Targeting: Since states found that the greatest share of the working uninsured are employed by small businesses, most programs target small employers. Perhaps because the Health Insurance Portability and Accountability Act (HIPAA) of 1996 defined a small employer as one that employs between 2 and 50 people, most states have targeted businesses with fewer than 50 employees, and some states include sole proprietors in their definition. There are, however, exceptions within the states studied.

More than 50 Employees

HCG of Arizona: While the main focus is businesses with fewer than 50 employees, recent legislative changes allow the program to serve employees of political jurisdictions (local government agencies) with more than 50 employees.

UPP: UPP has no limits to the size of the employer that may participate. This program has only just begun and enrollment is, at present, very low.

Access Health: Although originally targeted at businesses with fewer than 20 employees, the limit was lifted when the program failed to meet initial enrollment targets.

Sole Proprietors and Self-Employed

Many uninsured are either self-employed or employed in companies that will not provide health insurance. If a state is interested in serving these individuals, it has several options. For instance, it may allow self-employed and sole proprietors to participate in the program.

Healthy NY: A sole proprietor (or an individual) may participate in Healthy NY as long as his or her income is below 250 percent of the FPL. The individual must pay the full premium that any other employer would pay.

HCG of Arizona: Sole proprietors may participate in the program on the same terms as any other business. The business must have been an "active business" in Arizona for at least 60 days.

Programs for Individuals: Some states have developed programs specifically for individuals without access to ESI.

O-EPIC: In addition to operating the Premium Assistance Program, Oklahoma is in the process of rolling out a program for individual uninsured adults. This program will offer a reduced benefit package. The program will be administered by the existing Medicaid program and will include primary care case management as does the existing Medicaid SoonerCare Program.

PCN: For uninsured individuals who cannot access private insurance, Utah offers a limited primary care benefit, which is targeted at low-income adults.

Table 3 on the following page summarizes employer targeting rules for each state. It includes information on the upper limit on firm size, whether the program allows sole proprietors or the self-employed to enroll and whether employment is a requirement for entry into the program.

Table 3: Employer Targeting Rules

State (Program Name)	Upper Limit on Firm Size	Sole Proprietors and Self-Employed	Is Employment a Requirement?
Employment-Focused Programs			
Arizona (HCG)	50	Yes	No
New York (Health NY)	50	Yes	Yes
New Mexico (NMSCI)	50	No	Yes
Utah (UPP)	None	No	No
Michigan (Access Health)	None	No	No
Oklahoma (O-EPIC Premium Assistance)	50	No	No
Individual Programs			
Oklahoma (O-EPIC Individual Plan)	N/A	Yes	No
Utah (PCN)	N/A	Yes	No

Employee Targeting: Since the programs are intended to promote insurance coverage among low-income individuals, states must wrestle with how to target these individuals. Typically, states try to target the programs at individuals below a certain income threshold, usually about 185 or 200 percent of the FPL. This approach has two problems. First, it requires an administrative step to determine individual eligibility. Second, it can create equity issues for an employer as one individual might qualify for a subsidy and another, making almost the same wage, might not. Both New York and Muskegon County, Michigan, take a slightly different approach. These programs target companies who mostly employ low-income workers as opposed to focusing on the general population of low-income workers. The result is that individual employees do not have to file applications which include means testing for themselves and other family members.

Healthy NY: A company can participate in this program as long as 30 percent of its employees and enrollees earn less than $34,000 annually.

Access Health: A company may participate in this program as long as the company's employees' median income is less than $11.50 per hour.

Delivery Model – When designing these programs, states must also decide how to deliver services. Health care coverage varies from traditional insurance to some form of managed care to models that provide access to health services but are not insurance. Within this range there are further distinctions, as states seek to match the delivery system with the other features of their respective programs.

Insurance Model: In an insurance model, services are provided by qualified entities that operate within state guidelines. The entity provides and assumes financial risk for the benefit

package. Services are often delivered through the networks the entity has in place for other businesses. Participants in these programs have insurance coverage like any other individual, although often with different financing and benefits. A number of variations exist within this type of model.

- Any Qualifying Insurer. Under this approach, the state establishes the features (benefits, co-pays, etc.) that a product must have and then allows insurers to sell that product. Individual states vary this approach slightly.
    - *Healthy NY* requires all HMOs that operate in the state to offer a version of the Healthy NY product, and other insurers may choose to participate.
    - *O-EPIC* Premium Assistance plans must demonstrate that they meet the state minimum benefit and cost-sharing requirements, after which they are available in the market with all other products.
    - With *UPP*, any insurance product that meets or exceeds the state-established minimum benefit and cost-sharing criteria can be offered.
- Selective Contracting. Under this approach, the state establishes a benefit package that it deems appropriate (trading off comprehensiveness against affordability) and then enters into direct negotiations with insurers for that benefit. It is interesting to note that while two of the states examined take this approach, one builds on Medicaid and the other builds off of private insurers.
    - *HCG of Arizona* allows a limited number of insurers to offer its product. It limits the number of participating providers to avoid over-segmenting the available pool.
    - *New Mexico State Coverage Insurance* contracts directly with three MCOs that already participate in the state's SALUD! program. Thus, the program may be thought of as modified Medicaid.

Non-Insurance Model: Most of the state programs discussed follow an insurance model. That is, an organization agrees to provide a fixed set of benefits for a period of time for a set price. This includes bearing the risk if actual service costs exceed the amount paid. Access Health is an interesting exception to that model. Access Health is not an insurance product; it operates as a virtual MCO paying for services out of a fixed budget. It does not, however, bear risk or have to maintain solvency funds like a typical MCO and is specifically exempt from state insurance rules.

2. Program Financing

Underlying all these state coverage initiative programs is the assumption that a root cause of uninsurance is that available insurance products are too expensive. Many states used SPGs to conduct employer/employee surveys or focus groups. A major focus of these efforts was to determine how much small employers and/or their employees say they would be willing to contribute to health insurance premiums. Most programs studied combine some state subsidy with benefit limits (discussed in 3. Program Services) in order to keep the premiums in line with information concerning acceptable levels learned during the survey process. However, state approaches to this topic contain considerable variation.

The following section will include information on where the subsidy is directed, state expectations concerning employer and employee contributions, and the source of subsidy funding.

Where the Subsidy is Directed

For programs that provide them (all but HCG of Arizona), subsidies vary considerably in terms of where they are directed: at the insurance product, at the employer, at the individual, or at the program.

At the Insurance Product. Both New York and New Mexico directly subsidize the insurance product available to participants, although they apply the subsidy differently.

New York provides stop-loss protection for a substantial portion of program costs, thus lowering product prices by reducing the insurer's risk. This reinsurance program results in insurers charging lower premiums for the program because they recognize that they will receive reimbursement from the state for most of the expenses of high-cost enrollees. Instead of directly subsidizing the small business or the low-wage worker, the subsidy pays after the fact for 90 percent of the cost of care for individuals with health care costs between $5,000 and $75,000. Carriers pay all claims below $5,000 and above $75,000.

New Mexico negotiates directly with MCOs to provide a package of services, which are then offered to employers and employees at fixed prices. Employers are charged $75 per month and employees are charged nominal amounts based on their family incomes. For example, employees with family incomes under 100 percent of the FPL pay no premiums, while those between 101 and 150 percent pay a $20 per month premium and those between 151 and 200 percent pay a $35 per month premium. New Mexico pays a monthly capitated payment to the MCO, which equals the difference between the negotiated rate and the amount the employer/employee jointly are required to pay as described above.

At the Employer. Oklahoma pays the employer directly for the difference between the required employer/employee contributions and the cost of the insurance product. The employer is then responsible for collecting the employee share and passing on the blended funding (employer share, employee share, and state subsidy) to the insurer.

At the Individual. UPP provides subsidies directly to individuals to assist them with purchasing insurance from their employer. The state eligibility offices determine the insurance subsidy amount. Under UPP, the employer collects the employee's share of the premium (most commonly through payroll deduction). The state gives money directly to the employee early in the month so he or she can pay for the employee/state share of the premium. The state plans to check every six months with the employer to make sure that the employee continues to purchase the insurance.

At the Program. A number of the programs studied directly enroll beneficiaries and pay

providers for services. These programs keep the subsidy and collect premiums from employers, employees, or individuals in order to pay for the services. Examples of programs that keep the subsidy to pay for services include the Utah PCN, Access Health, and the O-EPIC Individual Plan.

No Subsidy. At present, Arizona provides no subsidies to lower the cost of insurance, although it has provided subsidies in the past.

Expectations of Employer and Employee Contributions

The programs call for employers and employees, sole proprietors, and/or in some cases individuals to participate in funding the cost of care, although what those expectations are and how aggressively they are enforced varies. Methodologies include:

- Fixed Percentages. Some programs specify that employers must contribute set percentages of the cost of the insurance product.
- Fixed Amounts. In this model, employees and employers are expected to contribute a specified amount.
- Employer-Determined Contributions. In some programs, the relative share of employer and employee contributions is set by the employers themselves.
- Non-Employer Programs. Some of the programs provide insurance only to individuals without access to employer-based coverage. In these programs, the individual is responsible for paying the premium, usually with the help of a subsidy.

Table 4 provides information concerning who shares in the cost of the premiums. It also includes information related to the methodologies used by the state to determine each parties share of the premium.

Table 4: Employer/Employee/State Financial Contributions for Individual Adult Coverage

State: Program Name	Minimum Contributions for Employers	Minimum Contributions for Employees	Minimum Contributions for Sole Proprietors	Minimum Contributions for Individual without Access to ESI	State Subsidy
Employer-Determined Contributions					
Arizona: HCG	Employer determines amount	Employee pays balance	100 percent of premium	Not eligible	No subsidy
Fixed Percentages Mandated by Program					
Michigan: Access Health	30 percent	30 percent	Not eligible	Not eligible	40 percent (may include local funds)
New York: Healthy NY	At least 50 percent of already subsidized premium	Up to 50 percent of already subsidized premium	100 percent of already subsidized premium	100 percent of already subsidized premium	State subsidizes reinsurance payments
Oklahoma: O-EPIC Premium Assistance	At least 25 percent	15 percent (up to 3 percent of income)	Not eligible	Not eligible	At least 60 percent
Utah: UPP	At least 50 percent	Whatever remains after employer and state subsidy	Not eligible	Not eligible	State pays up to $150 per month for individuals
Fixed Amounts Mandated by Program					
New Mexico: NMSCI	$75 per month	Based on income	$75 per month plus fee for employee based on income	$75 per month plus fee for employee based on income	State pays remainder
Not an Employer-Based Programs					
Oklahoma: O-EPIC Individual Plan	Not eligible	Not eligible	Sliding fee scale based on family income	Sliding fee scale based on family income	State pays remainder
Utah: PCN	Not eligible	Not eligible	Annual enrollment fee based on family income	Annual enrollment fee based on family income	State pays remainder

Sources of Subsidy Funds

With the exception of Arizona, which lost its public subsidy last year, all the programs examined involve some public subsidy that effectively lowers the cost of insurance to employers and/or employees. Most (but not all) of the programs use Medicaid funds to provide that subsidy, although each type of Medicaid funding leads to specific limitations on the programs. The following section will discuss the different funding sources used and their implications.

State-Only Funding. New York uses purely state funds to cover 90 percent of the cost of care for individuals with health care costs between $5,000 and $75,000, thereby reducing product costs.

Medicaid Funding. Although it is logical for states to look to Medicaid to help fund insurance expansions for low-income populations, stakeholders need to understand the limits and constraints that Medicaid funding rules place on program design and spending. Many states that have expanded coverage through Section 1115 waivers have assured budget neutrality by redirecting federal Disproportionate Share Hospital (DSH) payments toward coverage or by expanding coverage at the same time that they have implemented mandatory managed care (applying the anticipated savings from managed care to the new coverage costs). Other states have used unspent SCHIP allocations. This section will briefly describe these financing mechanisms.

Section 1115 Medicaid demonstration waivers must be "budget neutral," meaning the waiver cannot cost the federal government more than it would have spent without the waiver. When a state applies for a waiver, the Centers for Medicare and Medicaid Services (CMS) and the state estimate federal costs with and without the waiver during the period covered by the proposed waiver. If a state is planning to use a waiver to implement an eligibility expansion—such as covering non-disabled childless adults as is the case with Oklahoma and Utah—it must identify offsetting federal savings. States continue to submit claims for federal matching payments, but the states' federal payments for all waiver-related expenditures cannot exceed the neutrality cap. If actual costs exceed the projections, the state must reduce costs or cover the costs with state general funds. If costs are lower than allowed, the state can develop a budget neutrality cushion, which can then be used for future expansions in populations served under the waiver.

Some states, such as New Mexico, have redirected unspent federal SCHIP funds to pay for new coverage expansions for adults. New Mexico was able to obtain a federal HIFA waiver to cover the expansion population because they had a significant amount of unspent federal SCHIP allotment. This was because New Mexico had expanded coverage to higher-income children prior to the implementation of the federal SCHIP program, so under maintenance of effort rules, the state was unable to draw down SCHIP allotment to serve these higher-income children. New Mexico was able to obtain federal waiver approval to use this money to cover adults through NMSCI. This situation is fairly uncommon, however, and states in this situation have often already used their SCHIP allotment to serve higher income SCHIP children.

Oklahoma and Utah also use Medicaid funds to help finance their programs, although each has a unique agreement with the federal government. Any state applying for a Medicaid waiver to serve expansion populations has an individualized agreement with CMS that includes specific terms and conditions. Therefore, one state's federal arrangement does not necessarily apply to another state's situation. Factors that make states different include whether they have a federal budget neutrality cushion from an earlier 1115 waiver, whether they have unspent SCHIP dollars as was the case with New Mexico, or whether they have excess DSH funding.

The O-EPIC programs are funded through matching federal Medicaid funds, state special funds, and individual and employer contributions. Matching federal Medicaid funds are projected to be $100,000,000 per year. State special funds are generated from a portion of the sales tax on tobacco. The funds from the tobacco tax are non-lapsing and as of October 15, 2006, collections for the program were approximately $58 million. It would be tempting for stakeholders in other states to think that their state could access similar levels of federal funds as long as they were able to come up with the state match. However, this is not necessarily correct. Oklahoma was able to draw down these federal funds for an expansion population because they had a large federal budget neutrality cushion left over from the early years of the SoonerCare 1115 managed care waiver. The federal government, in effect, is allowing the state to spend down the cushion to serve the expansion population. Most states do not have large budget neutrality cushions that can be used in such an effort.

Unlike Oklahoma or New Mexico, Utah did not have a large cushion under its budget neutrality agreement or a large unspent SCHIP allotment. Thus Utah had to be very cautious in terms of the size of the benefit package and the populations served under the waiver. It also had to agree to some reductions in the Medicaid benefit package for current eligibles and increases in co-payments for certain eligibles in order to provide primary care services for the expansion population. Therefore, PCN was developed with a very limited benefit package. In addition, the state has to limit the number of childless adults entering the program in order to meet budget neutrality calculations. Because of the tight budget neutrality situation, the state will have to closely monitor enrollment under the new program, UPP.

One final Medicaid funding source for helping to cover the uninsured is the Medicaid Disproportionate Share Hospital (DSH) Payments Program. Forty percent of the cost of Access Health is funded with part of Michigan's DSH allowance. The Medicaid DSH Payments Program was established by Congress in the Omnibus Budget Reconciliation Act of 1981 to support hospitals that serve large numbers of Medicaid and low-income patients. The rationale for developing the program was that hospitals with a high proportion of Medicaid patients often also have many uninsured patients and few privately insured individuals. Therefore, these hospitals may be limited in their ability to shift the costs of uncompensated care to the privately insured. Under the DSH program, a state makes a separate payment to a hospital in addition to its standard Medicaid reimbursement. After the state makes the DSH payment, the federal government reimburses the state for part of the cost of the payment, based on the state's Medicaid matching rate. States and local hospitals practice a great deal of discretion in the use of these funds.

If DSH rules were to change, or state priorities for use of DSH funds were to shift, the program would be forced to seek alternative funding. Although this funding source has been critical to the success of Access Health, it would be difficult to replicate in other states—especially since CMS has increased federal scrutiny over the allocation of DSH funds within states. Access Health is the only program in this study that uses part of the state's DSH allowance as a funding source.

3. Methods to Keep the Program Affordable

In an effort to keep programs affordable, most states combine a subsidy with limitations on benefits. The extent of benefit limitations varies from program to program, and even within programs. In half of the states examined (New York, New Mexico, and Michigan) a single benefit package is defined. In the other three states, the packages have more variety. Oklahoma and Utah established a qualifying benefit package and any product that meets or exceeds that level is acceptable. Arizona takes a unique approach by defining a variety of packages that meet different needs and price points and allowing them to be sold by a limited number of insurers.

Within these variations, however, there are some common approaches to limiting the cost of the packages.

Limits to Benefits

Primary Care Only. The Utah PCN limits benefits to primary care services. Hospitals in Utah committed to "donating" $10 million in care to PCN enrolled individuals who are referred to them for services. Given limited funds, the state decided to offer primary care services to more individuals rather than comprehensive services to a few individuals. The downside to this approach is that individuals have limited access to specialty care. Another state studied, Arizona, is preparing to make available a primary care product (Access Copper) on a limited basis in 2007.

Varied Packages. Arizona takes a unique approach in that it offers a variety of packages with different benefit mixes intended to meet the needs of different populations at different price points. One downside of this approach is that an individual may buy a limited and therefore less costly benefit package and end up needing more comprehensive services.

Broad Benefit Package. Healthy NY offers a broad benefit package, but specifically excludes several services that typically add significantly to the cost of insurance (i.e., mental health services, substance abuse treatment, and home health care). Similarly, New Mexico offers a fairly comprehensive package but has an annual cost limitation of $100,000. Oklahoma's Premium Assistance Program builds on the private sector benefit packages.

De Facto Restrictions. The Michigan program is unique in that as a county-specific, non-insurance product, it only pays for services delivered by providers in the county. This effectively eliminates many tertiary services from the benefit package (e.g., burn care, neonatal intensive care, and transplants).

Limited Provider Networks

Most of the programs examined follow an insurance model for delivering care. The insurer, in most cases an MCO, agrees to provide a package of services for an agreed price and is responsible for providing access to those services. Programs that rely on managed care may restrict client's choice to providers within a network. Again, Access Health is an exception. The program's central feature is that all services under the program (physician, hospital, etc.) are delivered only by providers in the county. This program model reduces cost since there are no tertiary care providers within the county, but it would not work in a program which with a larger geographic area that includes tertiary care providers.

No ESI programs studied take special accounts of federally qualified health centers (FQHCs). If the program is a Medicaid expansion, FQHCs participate in the same way that they do in the general Medicaid program. If the program is not a Medicaid expansion and uses an insurance model, FQHCs participate in the same way that they participate in the private insurance market. Therefore, they are more involved in care delivered through Medicaid expansion programs.

Co-Pays and Deductibles

In addition to employee premiums, most programs feature a variety of copays to discourage inappropriate use and to further hold down program costs. The co-pay amounts and provisions are, like any health coverage product, highly variable. The most interesting commonality is among those programs that are Medicaid expansions or that use Medicaid matching funds to provide a subsidy (such as the O-EPIC Premium Assistance Program). In these programs, there are caps on member out of pocket expenses. Typically, these programs limit out-of-pocket expenses to no more than 5 percent of family income. Utah's UPP is the exception. Perhaps because the Utah waiver program already included a limited benefit package, CMS did not require Utah to cap member out-of-pocket expenses.

These limitations are intended to assure that low-income individuals with limited resources are not overly burdened by cost-sharing. The problem is that such restrictions can add significant additional cost to the administration of the program (e.g., collecting health care expenditure receipts from individual, validating expenses, reimbursing individuals for costs above the program limit on out-of-pocket expenses) that might be otherwise spent expanding coverage. Table 5 describes cost-sharing rules for each program.

Table 5: Cost-Sharing Rules

State: Program Name	Summary of Co-Pay Rules	Summary of Cost-Sharing Limits
Private Employer-Sponsored Insurance Coverage		
Oklahoma: O-EPIC Premium Assistance	Since the plan is helping subsidize ESI coverage, co-payments vary according to enrollee's health plan.	Plans must have: • $3,000 maximum out of pocket payments • $50 office visit co-pay maximum • $500 maximum annual pharmacy deductible • 5 percent family income limit on health care expenditures
Utah: UPP	Since the plan is helping subsidize ESI coverage, co-payments vary according to enrollee's health plan.	Although Utah does not pay any portion of an enrollee's cost sharing, it does require plans to have a maximum deductible of $1,000 per person per year and to pay 70% of inpatient costs after the deductible
Program-Defined Benefit Packages/Medicaid Expansions		
New Mexico: NMSCI	Nominal co-payments which correspond to income grouping: • 1-100 percent FPL • 101-150 percent FPL • 151-200 percent FPL	Pharmacy out-of-pocket charges limited to four (4) prescriptions per month (i.e. no copayments on additional prescriptions) 5 percent family income limit on health care expenditures.
Oklahoma: O-EPIC Individual Plan	Examples of co-payments include: • Physician office visit – $10 • Emergency services – $30 per visit • Inpatient hospital – $50 per admission • Generic drugs – $5/Single source brand – $10	No annual limits on out-of-pocket costs. Co-payment for emergency services is waived if admitted to hospital.
Utah: PCN	Examples of copayments include: • Physician visits – $5 co-pay per visit • Emergency services – $30 co-pay per visit for emergencies • Pharmacy $5 co-pay for prescriptions on the preferred list; 25% of the allowed amount for drugs not on preferred list	Maximum co-payment – $1,000.00 per person/per calendar year
Program-Defined Benefit Packages/Not Medicaid Expansions		
Arizona: HCG	The HealthCare Group offers a wide variety of plans and each plan has different cost-sharing requirements. Plans with higher cost sharing have lower premiums.	No overall limits on cost sharing

State: Program Name	Summary of Co-Pay Rules	Summary of Cost-Sharing Limits
Michigan: Access Health	Extensive list of co-payments related to covered services. Examples: • Primary care visits – $10/Specialty care visits – $25 • Inpatient Hospital – 25% w/limit • Emergency services – $75 • Generic drugs – $7//Brand drugs – 50% • Chemotherapy – $20 per visit	No overall limits on cost-sharing Certain services have limits on co-payments. Examples include: Inpatient hospital – $300 per stay Emergency services – Co-pay waived if admitted to hospital Chemotherapy – $200 maximum out-of-pocket
New York: Healthy NY	Extensive list of co-payments related to covered services. Examples: • Prenatal visits – $10/Well-child visits – $0 • Other physician visits – $20 • Inpatient Hospital – $500 • Emergency Service – $50 • If drugs included in plan, $100 deductible and $10 co-pay for generics/$20 co-pay for brand (plus differential in cost between brand and generic equivalent)	No overall limits on cost sharing. Co-payment for emergency services is waived if admitted to hospital.

4. Program Administration

Oversight Responsibility

Medicaid Agency. Four of the six programs included in the study fall under the oversight of the state Medicaid agency: Arizona, New Mexico, Oklahoma, and Utah. Although all of these states have dedicated units and administrators for the coverage expansion programs, many of them also depend on staff and resources within the Medicaid agency (see Table 6 for details).

Table 6: Medicaid Infrastructure

State: Program Name	Use of Medicaid Computer System	Use of Local/State Medicaid Eligibility Workers	Build on Medicaid Provider Base	Build on Medicaid Quality Assurance Program
Arizona: HCG	Yes, but program reimburses state for all costs	No	Partly. Initially MCOs were limited to a subset of Medicaid MCOs	No
New Mexico: NMSCI	Yes	Established a new central eligibility unit using state employees	Yes, uses the same MCOs as the Medicaid SALUD! Program	Yes
Oklahoma: O-EPIC Premium Assistance	No	No, Medicaid TPA is responsible	No	No
Oklahoma: O-EPIC Individual Plan	Yes	No, Medicaid TPA is responsible	Yes	Yes
Utah: PCN	Yes	Yes	Yes	Yes
Utah: UPP	No	Yes	No	No

State Insurance Agency. Healthy NY is administered by the Insurance Department of New York which drafted the regulations, developed the administrative procedures, obtained the cooperation of HMOs, and implemented the program within an aggressive one-year timeframe.

Local Entity. Access Health, Inc., which was established in September of 1999 as an independent 501(c)(3) corporation, manages the Access Health program. To identify and enroll businesses and members, Access Health, Inc. contracts directly with providers; maintains its own sales staff; and also works through local insurance agents who donate their time. Claims and payments are managed through two third-party administrators.

Enrollment and Processing Premium Subsidies

All six states attempted to streamline eligibility determinations in order to encourage the use of employer-based insurance. However, this process is inherently more complex for agencies that use federal Medicaid funds because it involves individual eligibility processing, including means testing. Table 7 describes eligibility processes for insurers, employers, and employees. It also compares ways in which the subsidy is processed. PCN and the O-EPIC Individual Plan are not included in the table because they do not follow the employer-based insurance model.

Table 7: Enrollment of Businesses and Employees

State: Program Name	Process for Enrolling Businesses	Does Program Means Test Employees/Dependents?	How is Subsidy Processed?
Arizona: HCG	Program enrolls businesses	No	No subsidy
Michigan: Access Health	Program enrolls businesses – median wage of workers cannot exceed $11.50/hour	No	Subsidy (combined with employer and employee premiums) is used to pay provider claims
New Mexico: NMSCI	Program delegates business enrollment responsibility to MCOs	Yes, family income under 200% FPL	Program sends subsidy (combined with employer and employee premiums) directly to MCO providers
New York: Healthy NY	Program delegates business enrollment responsibility to HMOs – at least 30% of employees must earn less than $34,000 annually	No	Subsidy is used to pay 90% of the cost of care for individuals with health care costs between $5,000 and $75,000
Oklahoma: O-EPIC Premium Assistance	Program enrolls and signs contracts with qualified businesses	Yes, family income under 185% FPL	Program pays subsidy directly to employer to use in purchasing health insurance
Utah: UPP	Program enrolls business	Yes, family income under 150% FPL for adults and 200% FPL for children	Program pays subsidy directly to employee to reimburse for cost of health insurance

Product Marketing

Each of the states has developed its own marketing strategy for its insurance programs. Many of the differences relate to the populations being targeted for enrollment. For example, if a program is only enrolling employees of small businesses (Access Health and Premium Assistance), then it can direct its marketing efforts at the small businesses first and their employees second. If, on the other hand, the state is targeting uninsured low-income working populations, regardless of whether they have access to ESI coverage (Healthy NY, NMSCI, O-EPIC Individual Plan, UPP, and PCN), then the state has to develop a much broader marketing plan. HCG of Arizona is in the middle of the spectrum, marketing to employees of small businesses plus sole proprietors only.

Use of Insurance Brokers/Agents. Many states have found that it is critical to work with insurance brokers or agents when trying to engage the small business community. This is

because small businesses often do not have human resource staff and therefore frequently choose health insurance through an insurance broker. Brokers often represent a number of companies and when this is the case, they are authorized by the insurance company to act on their behalf in marketing the insurance product. In exchange, the insurance company pays them a commission to sell the product. The cost of this commission is built into the rates that the company pays for the health insurance product. Even if a small business bypasses the brokers, they still end up paying the same for the product, so there is no financial advantage for small businesses not to use the brokers.

Brokers help the small business choose an insurance product and complete the application paperwork for the business and the individual employee, as well as help settle insurance claims. Two key issues that need to be considered by states that want to use insurance agents/brokers to sell their products are 1) whether there is value-added by using brokers who can effectively market the plan and 2) how to pay insurance agents/brokers.

The state that had the most extensive online information for brokers was Oklahoma. The O-EPIC Premium Assistance site includes training materials for brokers and online application processes for them to use to enroll businesses and employees. Since this program is building on the ESI market in Oklahoma, payment for brokers is directly handled by the insurance companies. Although UPP is just being implemented, it plans to build on this type of approach as well. Healthy NY leaves the use of brokers up to the health plans. However, if the health plan provides commissions on regular small group contracts, then the State Insurance Commission requires it to provide commissions with the Healthy NY small group contracts.

New Mexico and Arizona contract directly with health plans and then have employers enroll through the health plan. These states have different mechanisms for reimbursing brokers. New Mexico's federal 1115 waiver does not allow any federal funds to be used for payments to brokers. This means that employer premiums that are not matched with federal dollars are used to pay for broker commissions. Arizona law has restricted payments for brokers to a one-time payment when the broker helps with enrolling the business/employees.

Access Health does not pay brokers for assisting with the application process, but it has employed sales staff to assist with this process.

The bottom line is that states need to develop mechanisms for marketing and enrolling small employers. This process is time consuming in the small employer market. If the process involves private insurance brokers or agents, the state must consider how to pay these entities. If the program decides to employ staff to take on this role, they need to understand that the staff will have to directly outreach and complete applications and other paperwork for small employers and their employees. New programs need to budget for this significant administrative burden.

Lessons Learned

As the number of uninsured continues to grow and ESI rates decline, individual states have stepped in to help improve access to insurance. With the help of HRSA state planning grants, several states decided to build on employment-based coverage, generally through publicly funded premium subsidies.

The purpose of this report was to closely examine six state coverage initiatives to identify key design issues confronted by the architects of these programs. By following the initiatives through the implementation phase, we have been able to glean insights into the range of choices and the implications of pursuing different paths.

States embarking on insurance expansion will benefit from the detailed descriptions of the six state programs included in the Case Studies section that follows. Taken as a whole, the cross-state analysis reveals some overall lessons which clarify the trade-offs all states face when they come to grips with the realities of constructing and managing insurance programs targeted at low-income workers. A particular conundrum is finding the right balance between affordable premiums and attractive benefit packages. The size of the public subsidy affects the level of difficulty in striking the right balance. Finally, controlling administrative complexity and resultant costs is a major challenge.

1. **Make realistic enrollment goals –** Programs targeted at small businesses have a long take-up process in part because states not only have to implement these complex programs, but they and their partners also have to sell them to a skeptical audience. This is both positive and negative. On the positive side, low enrollment means that states do not need as much money to pay subsidies in the early stages of the program. On the negative side, stakeholders and even states often expect the program to grow more quickly and when it does not, political pressure is exerted to make changes to jumpstart enrollment.

2. **Pay attention to the whole package –** Premiums have to be affordable and benefit packages have to be meaningful for small employers to participate in the programs. States need to listen to their small employer community before designing the benefit package and the cost-sharing strategies.

3. **Carefully consider the employee cost-sharing requirements** – Affordability is key as most of the programs studied targeted low-wage workers. Although health insurance is important to this population, this need has to be balanced against such daily needs as housing, food, and transportation. The employer share of the premium and available public subsidies will often make the difference in this population's ability to participate in the program.

4. **Making it easy for the employer/employee does not translate into making it easy for the state** – A lot of work has to go on behind the scenes for the state-sponsored program to appear like a regular employer-sponsored insurance program. There is

recognition that employers and employees are not likely to participate unless the administrative processes are sufficiently simple and clear. States need to carefully plan for expansions and build an infrastructure that allows for a smooth implementation.

5. **Marketing is critical** – States must develop strategic plans and have adequate funding for marketing to employers, employees/ individuals and to health plans/ insurers. Most small employers do not have dedicated human resources staff. Therefore, successful programs need to engage small employers through insurance brokers or agents or by hiring individuals dedicated to this function. States have to carefully consider how they are going to pay insurance agents or brokers if they are going to rely on them for marketing. For programs that depend on attracting and sustaining employee or individual consumer interest, adequate marketing to consumers needs to be in place. For example, having an online application process can help make the paperwork manageable. Finally, most states studied provided services through health plans. In order to attract sufficient health plans, some states developed stop loss reinsurance programs so that health plans would be protected from adverse selection.

6. **Individual means testing is a significant administration burden and barrier to enrolling members quickly in the program** – State programs that do not require individual means testing are easier to administer. Three of the six states studied required individual means testing. This requires the application process to involve a review of family income. States try to streamline this process by having mail-in or online applications. In addition, some states do not require verification of income (pay stubs) by the applicant, but instead use other internal methods to verify income such as state workforce agency data or data from other means tested programs, like food stamps. Alternatively, some states do post eligibility audits to verify that submitted information is valid.

7. **Plan on the program costing more than expected per member due to pent up demand for services** – States have estimated the per-person cost of services based on past experience and then found that the per-person costs have out-stripped these estimates. Two factors undoubtedly contribute to problem. First, some people have put off obtaining health services because they did not want to pay out-of-pocket for care when they were uninsured. Second, the initial population applying for services may be sicker than expected because healthier individuals may not want to pay even nominal premiums for health insurance.

8. **Appreciate the tension between adding benefits and keeping program costs low –** Employers, employees, and the general public are often not aware of the true cost of health care services. Therefore, they have unrealistic expectations of what they should be paying for health insurance. They also have strong expectations regarding services that should be included in the benefit package. States have found that they need to be cautious in making changes to benefit packages that result in large increases in

premium costs. At the same time, benefits need to be at an acceptable level to attract buyers.

9. **States without premium subsidies or with small subsidies must be extremely creative in developing affordable benefit packages –** HCG is the perfect example of this situation. Arizona began the program with a state subsidy. When Arizona lost the subsidy, it did not abandon the program, but instead developed multiple benefit packages. These packages meet the needs of certain employers and employees and HCG has been able to maintain enrollment levels and even expand coverage to additional employers through this strategy.

10. **Know your target population –** Each of the lessons learned illustrates the importance of knowing the target populations of the state initiatives. Understanding the behavior of small employers can help states set realistic enrollment goals through an understanding of employer take-up behavior. Knowledge of consumer's insurance needs and their ability to share costs aids in the design of attractive benefit packages, affordable premiums, and meaningful subsidies.

Case Studies

Arizona (The Healthcare Group of Arizona)

Background – The Healthcare Group of Arizona (HCG) was created in 1985 to provide affordable and accessible health care coverage to sole proprietors, small businesses with 50 or fewer employees, and political subdivisions (e.g., a city, town, or county) of any size – making the program available to public school teachers, firefighters, and so on. The program was initially funded by a grant from the Robert Wood Johnson Foundation. In 1988, small employers in four counties were allowed to participate and the program was launched statewide in 1993.

Full-time employees and dependents at qualifying firms are eligible to participate in the program. Employers with fewer than six employees must have 100 percent participation; otherwise, 80 percent of employees must enroll in a HCG plan. As of December 2006, there were 24,562 lives covered by HCG. Although few states or programs publish enrollment targets, HCG enrollment in December 2006 was below the July 2006 target of 27,698 and short of the January 2007 target of 43,381. HCG estimates that once enrollment reaches 100,000 the program could afford to provide individual coverage. HCG is a state-sponsored public-private partnership that is operated under the Arizona Health Care Cost Containment System (AHCCCS) but HCG is entirely separate from the state's Medicaid and SCHIP (State Children's Health Insurance Program). The state contracts with managed care organizations (MCOs) and a statewide preferred provider organization (PPO) for insurance plans. As of the 2005/2006 state budget, HCG is completely self-funded via premiums.

Program History – HCG was created by the Arizona state legislature in 1985 to provide affordable and accessible health care coverage to sole proprietors, small businesses with 50 or fewer employees, and political subdivisions. The state estimates that 96 percent of employers in the state are small businesses and that fewer than 30 percent offer health insurance to employees. HCG was initially operated under AHCCCS and began in November of 1986 with a $400,000 grant from the Robert Wood Johnson Foundation. In 1988, small employers in four counties were allowed to purchase health coverage for their employees from AHCCCS health plans through the HCG. In 1993, HCG availability to small businesses was expanded statewide. In the late nineties, three of the five managed care health plans participating in HCG withdrew from the program due to concerns over slow growth in program participation and the potential for significant financial losses from adverse selection. Since its inception, HCG had experienced difficulty growing enrollment beyond 20,000. Difficulties stemmed from a reluctance on the part of health plans to invest in marketing a product that competed with their Medicaid plans as well as fears on the part of plans that brokers were only enrolling high risk uninsurable individuals in HCG. The issue of enrolling high risk individuals led state lawmakers to pass a requirement that employers with more than 5 employees, wishing to participate in HCG, enroll at least 80 percent of their employees. The legislature also agreed to appropriate $8 million to protect the remaining health plans from substantial financial losses. In 2000, the legislature transferred administrative functions, including marketing/sales, rate setting, and enrollment and eligibility, to HCG administration.

HCG originally offered a single managed care benefit package, but the premium rate for the plan did not compare favorably with commercial premium rates in the small group market. HCG determined that the single plan design was not adequate to meet the unique demands of the small group market. To address this problem, HCG developed a new benefit design strategy in 2003 with multiple product offerings. There are currently three managed care benefit packages and four PPO packages; a fifth PPO package is being considered. HCG was implemented during a time of other health care reform in Arizona. In 1990, the state phased in behavioral health services for Medicaid recipients and in 1997 AHCCCS submitted a federal amendment to cover adults and children up to 100 percent of the federal poverty level (FPL). Arizona's SCHIP, KidCare, was implemented in 1998. During the 2006/2007 legislative session, several measures were introduced to ease health insurance benefit requirements on small businesses and a tax credit was created for small businesses and employees.

Eligibility Requirements – Participation in HCG is limited to full-time (20+ hours per week) employees (and their families) of small businesses and sole proprietorships that have not offered insurance for at least six months. Participation is also open to political subdivisions (e.g., a city, town, or county) of any size. To participate, a small business must have 50 or fewer employees and the business cannot have had group health insurance for the past 180 days, or six months (excluding individual coverage). Additionally, the business must be an active business in Arizona for at least 60 days. Employers with one to five eligible employees are required to enroll 100 percent of their employees in HCG or provide a valid waiver from individuals who have other health care coverage. Employers with 6-50 eligible employees are required to enroll 80 percent of these employees or provide valid waivers indicating that the employees have insurance through other means. For political subdivisions, there are no employee limits or eligibility requirements. More than 90 percent of HCG's covered lives work for businesses with three or fewer employees.

Program Funding – As of the 2005/2006 budget, the HCG is totally self-funded from premiums. For fiscal year 2005, 6 percent of all premium revenues were allocated to fund HCG's administrative operations. The percent of the premiums required to fund HCG operations is determined by expected membership growth and the mix of health benefits members are expected to choose. The premiums are actuarially set and MCOs are paid monthly capitation. Premiums vary depending on the HCG benefit package purchased and the plan selected. Contracted MCOs are at risk for the medical losses from their enrolled members and they must maintain adequate financial equity to cover short term losses and the state has risk only for the PPO product which is managed by HCG directly. HCG retains 5 percent of all premiums (PPO and MCO) to fund a financial stability reserve, which is used to protect plans from substantial loss. Premiums paid for all plans are used to fund the reserve, so premiums paid into one plan may be used to subsidize another plan. The financial stability reserve is used to reconcile the health plans for medical losses above an aggregate medical loss ratio of 86 percent annually. HCG also uses a small portion of each premium paid to purchase a commercial reinsurance product to protect plans from patients whose claims exceed $125,000 per occurrence. Reinsurance PMPM is allocated from each premium to pay the commercial reinsurance carrier.

Prior to the 2005/2006 budget year, the state subsidized the program with approximately $8 million per year in state funds (beginning in 1999). The subsidy has since been discontinued and the program is now self-funded from premiums. Simultaneous to the elimination of the subsidy, the state also permitted HCG additional flexibility with regard to benefit design and permitted the creation of PPO packages. The HCG estimates that plan premiums increased 15 to 30 percent (depending on the plan) during the 18 months following the elimination of the subsidy. Although enrollment did not decline, there was some shifting to lower cost HCG products. There are no guidelines for employer/employee premium responsibility. Employers or Employees may pay anywhere from 0 to 100 percent of the premium.

Program Design – HCG is a state-sponsored (but self-funded) public-private partnership. The HCG is operated under the Arizona Health Care Cost Containment System (AHCCCS) and is administered as totally separate from Arizona's Title XIX and XXI programs. HCG contracts with private MCOs and a statewide PPO network for insurance plans marketed to small employers. Prior to 2004, only health plans contracted with AHCCCS to serve the Medicaid market were allowed to provide coverage through HCG. Although HCG continues to give preference to Medicaid-participating plans, any commercial plan may apply for participation. Currently, only Medicaid-participating MCOs provide the managed care coverage under HCG and the PPO is the same plan that is available to state employees. Dental and vision coverage are provided by private firms as will be behavioral health services. Although HCG imposes no limit on the number of participating plans, participation is naturally limited by the need to ensure sufficient membership in each plan. HCG handles the marketing of the plans. Until 2004, only health plans that contracted with AHCCCS to serve the Medicaid market were allowed to provide coverage to small businesses through HCG. Legislative changes implemented in 2004 opened the program to commercial insurers.

Delivery of Services – HCG contracts with three managed care network contractors and a third party administrator contracted with the Arizona Medical Care Foundation for the PPO network. The managed care plans are offered by Care1st Health Plan, University Physicians Health Plan, and Mercy Healthcare Group. Avidity HCS is the third party administrator that contracts with the Arizona Medical Care Foundation for the HCG PPO plan. The MCOs are Medicaid-participating plans and have extensive provider networks. A PPO is also available and HCG makes use of preferred provided networks. Provider networks include hospitals, primary care providers, specialists, and ancillary providers. Participating plans typically bring their existing network of contracted providers and then add providers as needed to support their HCG product. Safety net providers, such as community health centers and federally qualified health centers (FQHCs), are included in the HCG provider networks. A dental HMO (health maintenance organization) benefit is offered through Employer Dental Services and a vision plan is offered through Avesis Vision. Employers select which plans to offer their employees and services are provided via an employee-selected plan.

Payment and Reimbursement – HCG has two senior actuarial staff that provide analysis and recommendations on capitation to be paid to MCO contractors. They also analyze and make recommendations on healthcare benefit plan premiums. These staff members are responsible for analyzing medical cost encounter data and projecting trends in utilization and cost. The plan rate

is community-rated (premiums are based on age, gender, and county). The HCG actuaries use both medical loss trend factors and size of the group to determine premiums. As such, a group with only one subscriber would have one set of community premiums and groups of two or more subscribers would have another set of premiums. HCG has established specific geographic regions of the state to base its community rated premiums and premiums are analyzed based on medical loss experience within a given geographic area.

In both the managed care and PPO options, members are responsible for co-pays and co-insurance; the amounts vary by product and benefit plan. Managed care providers are typically paid Medicaid rates (which range from 95 to 105 percent of Medicare). The PPO providers are reimbursed according to a negotiated fee schedule. The MCOs and PPO directly negotiate payment rates for FQHCs and the program does not require MCOs or the PPO to pay cost-based rates.

Plan Benefits – HCG provides a cafeteria plan of benefit choices and options to the small business employer. An employer and employee can choose from a comprehensive, medium, or basic benefit plan. There are several deductible options that employees may choose based on price, deductible, and benefit coverage. To make premiums affordable to employers and employees, HCG has tried to develop a premium package for every employee income level and employer health care budget. There are three benefit plans offered under the managed care option and four benefit plans offered under the PPO option. A fifth PPO option, Medallion Copper, is currently being considered. Medallion copper would be offered as a very basic and limited insurance product and would not be available to all purchasers, owing to concern that it may crowd out more appropriate and comprehensive insurance products. HCG has the authority to determine which packages will be offered to potential program participants. If, for example, Healthstyles Active is determined to be an inappropriate fit for a given employer, then HGCA will not make that package available to the employer. Approximately 90 percent of HGCA's covered lives are enrolled in one of the managed care packages.

Managed Care Options:

Healthstyles Classic is the richest managed care benefit package, intended for employees with existing diseases or chronic conditions and employees wanting the added security of a wide range of benefits. Individual deductible options are available at the $500, $1,000, and $2,000 level and family deductibles are equal to twice the individual level.

Healthstyles Secure is intended for healthier employees with fewer health care needs beyond routine and preventive care. There are little or no co-pays for most physician office visits, diagnostic services, and prescriptions. Maternity services are excluded from the plan. Individual deductible options are available at the $500 and $1,000 level and family deductibles are equal to twice the individual level.

Healthstyles Active is a variation of the Healthstyles Secure plan, but with a lower premium and higher co-pays and co-insurance. Maternity services are excluded from the plan. Healthstyles Active is HCG's low-cost managed care plan. Co-payments and co-insurance

are higher. The plan is designed to offer physician office visits, a drug benefit, and emergency medical coverage. Ancillary services have higher co-pays. Individual deductible options are available at the $500 level and family deductibles are equal to twice the individual level.

Table 1: HCG Covered Services under Healthstyles HMO Plans

Covered Services (partial list)	**Healthstyles HMO**		
	Classic	**Secure**	**Active**
Physician Services (PCP/Spec)	Yes	Yes	Yes
Inpatient - Medical	Yes	Yes	Yes
Outpatient - Medical	Yes	Yes	Yes
Maternity	Yes		
Acute Ancillary (SNF, HH, Dialysis)	Yes	Yes	Yes

Table 2: HCG Healthstyles HMO Deductible (Exclusions) and Benefit Limits

Benefit Plan Features (Deductible)	**Healthstyles HMO**		
	Classic	**Secure**	**Active**
Formulary Tiers	3	3	3
Rx Benefit Limit	None	None	None
Number of Deductible Options	3	2	1
Zero Deductible Option	Yes	Yes	Yes
MD Office Visit (E&M) excluded	No	No	No
Preventive Care excluded	Yes	Yes	Yes
Mammography excluded	Yes	Yes	Yes
Prescription Drugs excluded	Yes	Yes	Yes
Emergency/Urgent Care excluded	Yes	Yes	Yes
Prescription Drugs excluded	Yes	Yes	Yes
Out-of-Pocket Maximum	No	No	No
Out-of-Network Benefit (NPPN)	Emergency Care only		

Table 3: HCG Healthstyles Co-Payments and Co-Insurance

Benefit Type (partial list)	Classic	Secure	Active
Physician Services (PCP)	$20	$15	$10
Specialist Services	$20	$25	$30
Preventive Care	$20	$10	$10
Maternity Services	$20 first prenatal $100 delivery admission	None/Rider	None/Rider
Urgent Care	$40	$20	$20
Emergency Care	$100 In network $150 Out of network	$50	20% co-insurance
Inpatient Hospitalization	$100 admission	$50 50% co-insurance[2]	20% co-insurance
Diagnostic Services	$0	$0	20% co-insurance
Rehabilitation Services	$15	20% co-insurance	20% co-insurance
Prescription Medicine	$10 Generic $30 Preferred $50 Non-preferred	$10 Generic $30 Preferred $50 Non-preferred	$10 Generic $30 Preferred $50 Non-preferred

Medallion Platinum is similar to the Healthstyles Classic and is the richest, most comprehensive of the PPO plans intended for individuals with existing health conditions or diseases requiring on-going medical care, and those individuals wanting the added security of a wide range of benefits. Medallion Platinum also includes inpatient and outpatient behavioral health services, more generous benefit limits on outpatient and acute ancillary services, and a four-tier formulary that includes generic, preferred, non-preferred, and high-cost injectible drugs with varying co-payments and co-insurance. Deductible options are available at the $500, $1,000, and $2,000 level, but unlike Healthstyles, there is no $0 option. Family deductibles are equal to twice the individual level.

Medallion Platinum Plus is a high-deductible, consumer-driven benefit plan that meets federal requirements for pairing with an optional Health Savings Account (HSA). HCG does not offer the HSA itself, but will make a referral available with the nation's largest HSA provider, HSA Bank. Platinum Plus also includes inpatient and outpatient behavioral health services, more generous benefit limits on outpatient and acute ancillary services, and a four-tier formulary that includes generic, preferred, non-preferred, and high-cost injectible drugs with varying co-payments and co-insurance. Deductible options are available at $1,250 and $2,250 levels and family deductibles are equal to twice the individual level.

Medallion Gold is similar to Healthstyles Secure and is a medium range benefit intended primarily for individuals with limited health needs and manageable conditions. Medallion Gold also includes outpatient mental health services, and deductible options are available at the $500, $1,000 and $2,000 level. Family deductibles are equal to twice the individual level.

[2] $50 co-pay per day for maximum of 10 days each year, thereafter 50% co-insurance.

Medallion Silver is similar to Healthstyles Active and is intended for individuals who are generally healthy but want low co-pay access for physician office visits, a good drug benefit, emergency medical coverage, and are willing to pay high co-insurance for ancillary services. Deductible options are available at the $500, $1,000, and $2,000 level and family deductibles are equal to twice the individual level.

Medallion Copper is a basic plan intended for calendar year 2007 that will offer limited benefits for a modest monthly premium. Medallion Copper is intended for younger, healthy individuals requiring mostly routine primary care services and basic protection for emergencies. Benefits will include emergency and urgent care subject to co-insurance and annual expenditure caps, and limited access to physician office visits, inpatient hospitalization, outpatient diagnostics, and ambulatory surgery. Deducible options will be limited, and co-payments and co-insurance will be higher than other Medallion plans.

Table 4: HCG Covered Services under Medallion PPO Plans

Covered Services (partial list)	**Medallion PPO**			
	Platinum	**Platinum Plus**	**Gold**	**Silver**
Physician Services (PCP/Spec)	Yes	Yes	Yes	Yes
Inpatient - Medical	Yes	Yes	Yes	Yes
Outpatient - Medical	Yes	Yes	Yes	Yes
Maternity	Yes	Yes		
Acute Ancillary (SNF, HH, Dialysis)	Yes	Yes		
$0 Preventive Care	Yes	Yes	Yes	Yes
Inpatient - MH/SA	Yes	Yes		
Outpatient - MH/SA	Yes	Yes	Yes	

Table 5: HCG Medallion PPO Deductible (Exclusions) and Benefit Limits

Benefit Plan Features (Deductible)	**Medallion PPO**			
	Platinum	**Platinum Plus**	**Gold**	**Silver**
Formulary Tiers	4	4	3	3
Rx Benefit Limit	None	None	$12,500	$7,500
Number of Deductible Options	3/2	3/2	3	3
Zero Deductible Option	No/No	No/No	No	No
MD Office Visit (E&M) excluded*	Yes	No	Yes	Yes
Preventive Care excluded	Yes	Yes	Yes	Yes
Mammography excluded	Yes	Yes	Yes	Yes
Prescription Drugs excluded	Yes	No	Yes	Yes
Emergency/Urgent Care excluded	No	No	No	No
Prescription Drugs excluded	No	Yes	Yes	Yes
Out-of-Pocket Maximum	Yes	Yes	Yes	Yes
Out-of-Network Benefit (NPPN)	Emergency Care covered and 50% for out of state, but in Network providers			

Table 6: HCG Medallion PPO Co-Payments and Co-Insurance

Benefit Type (partial list)	Platinum	Platinum Plus	Gold	Silver
Physician Services (PCP)	$25	$25	$25	$25
Specialist Services	$25	$25	$25	$25
Preventive Care	$0	$0	$0	$0
Maternity Services	$30 first prenatal 10% delivery admission	$30 first prenatal 10% delivery admission	Not covered	Not covered
Urgent Care	$50	20% co-insurance	$50	20% co-insurance
Emergency Care	$150	20% co-insurance	$150	20% co-insurance
Inpatient Hospitalization	10% co-insurance	20% co-insurance	10% co-insurance/ 50% co-insurance[3]	20% co-insurance
Diagnostic Services	10% co-insurance	20% co-insurance	10% co-insurance	20% co-insurance
Rehabilitation Services	10% co-insurance	20% co-insurance	10% co-insurance	20% co-insurance
Prescription Medicine	$10 Generic $30 Preferred $45 Non-preferred 50% Specialty	$10 Generic $30 Preferred $45 Non-preferred 50% Specialty	$10 Generic $30 Preferred $45 Non-preferred	$10 Generic $30 Preferred $45 Non-preferred

Impact of SPG Program – Money from the state planning grant (SPG) funded two studies to help with HCG product design. First, staff conducted a literature review on the topic of pent-up demand to help HCG identify the utilization characteristics of a newly insured population, and thereby modify their actuarial assumptions and pricing models. Second, HCG conducted focus groups with a representative sample of participating employer groups to determine 1) if HCG products and benefits were meeting their needs, 2) if HCG products and benefits were priced appropriately (i.e., affordably), and 3) what features and services keep them with HCG (and consequently, what would cause them to leave HCG). Findings from the focus groups resulted in changes in the HCG pharmacy benefit, as well as the addition of vision and dental coverage.

Lessons from Administering the Program – According to HCG administrators, in order to compete in the small group market a state must offer attractive benefit options, have adequate funding for marketing and member education, and have the ability to manage care. Strong actuarial and management decision support, reporting, databases, and analytical tools are seen as being critical to pricing and benefit management strategies. A state must decide which business model (e.g. Managed Care HMO, PPO, limited provider network) would work best and a decision must be made as to whether the program will be market driven and compete with the private sector or a subsidized program. Establishing a reinsurance stop-loss level that protects health plans against adverse selection and treating participating health plans as valued partners were also considered to be important lessons.

HCG is self-administered and uses a combination of HCG sales staff, sales staff hired through UPH (a participating MCO), and licensed producers (brokers) to meet enrollment targets. Legislation enacted in 2004 prohibits HCG from paying brokers a commission – as they are by

[3] $50 co-pay per day for maximum of 10 days each year, thereafter 50% co-insurance.

commercial health plans. HCG pays brokers a one-time enrollment fee that ranges from $90 to $140 per subscriber enrolled. Because it is a one-time fee rather than a commission (commissions are usually 4 percent to 6 percent of premium in the small business market), many brokers are hesitant to enroll larger groups with HCG. Brokers have questioned why they do not receive a re-enrollment fee as with the commercial market, but this is legislatively prohibited. The broker enrollment fee is commensurate with local commercial plans and HCG believes that the addition of the fee and a strategy of broker education and contract execution have yielded positive results.

Although separate from Arizona's Medicaid program, HCG does make use of the state's Medicaid Management Information System (MMIS) for financials, membership tracking and eligibility determination, and premium collection. HCG has leveraged AHCCCS management expertise in managed care to create the health benefits packages and to manage the financial and medical risk associated with the providing health care coverage to the small business market. In the future, if HCG expands beyond the small group market, they recognize that pricing competitiveness and benefit compatibility with the private small group market does not necessarily translate into competitiveness and compatibility with regard to larger groups. State law requires that HCG reimburse Medicaid for all expenses related to HCG administration. Although IT services are shared, no state or Medicaid funds are used to cover HCG program costs.

Finally, program administrators wish that there was a source for a better profile of the working uninsured, on a county-by-county basis. Overall, state-level statistics are very reliable and come from respected sources (such as the U.S. Census Bureau and The Kaiser Foundation). County-level data are less reliable. HCG's recent statewide assessment of the working uninsured was an effort to collect more reliable county-specific data.

Evaluation – A comprehensive evaluation of the program was conducted in 2002 and the Arizona legislature mandates a biannual report. HCG also undertakes consumer satisfaction surveys to determine areas for improvement or benefit redesign. The PPO option was designed following discussions with employers and employees in an effort to create a more marketable product. Market research conducted by HCG found that benefit packages and premiums offered through the program are comparable and competitive for very small employers. With regard to larger groups, especially those with younger low income employees, HCG has determined that there is a need to revise its premium schedule to be more competitive with the commercial market

To date, HCG remains solvent as a self-funded program. Owing to rising medical costs, however, HCG administrators estimate that it may not be possible to operate without a subsidy unless membership reaches 50,000 members by July 2008. If HCG cannot attract enough small businesses to grow membership, or to keep premiums affordable, and manage medical costs it may be necessary for the state to subsidize the HCG premiums in the future.

Michigan (Access Health)

Background – Access Health, which began operations in 1999, provides access to a comprehensive array of health care services for uninsured workers of businesses who did not previously provide health insurance coverage. It is a national model for the local approach to health care reform. Health care services are provided by local county-based providers and the care is paid for on a fee-for-service (FFS) basis. Certain services, such as routine dental care, vision and hearing exams, neonatal intensive care outside the county, injuries resulting from automobile accidents, workplace injuries, organ transplants, and treatment for serious burns are not covered by the program.

Access Health currently serves approximately 1,200 employees and dependents. It is known as a "three-share plan" whereby employers and employees each pay approximately 30 percent of the cost of the program and the community pays the remainder. The community share for Access Health is largely composed of Michigan's Medicaid disproportionate share hospital (DSH) funds. The state has allowed the program to use local match for DSH as opposed to using state general funds.

Michigan law allows Access Health to be overseen by the state treasurer rather than the insurance commission, thereby allowing the program to be exempt from health insurance rules such as state benefit mandates and solvency requirement. Access Health, Inc. administers the program and provides a comprehensive set of services through a local network of physicians, hospitals, and other providers. Although they pay for services on an FFS basis, Access Health managers do not see themselves as a traditional health insurance agency. Instead, they see themselves as hands-on care managers who help individuals get preventive health care and who provide disease management to members with chronic health care conditions.

Program History – The program history of Access Health is well documented in an Issue Brief called "The Muskegon Access Health Three-Share Plan: A Case History," published in June 2005 by the Employee Benefit Research Institute (EBRI).

In summary, the W. K. Kellogg Foundation developed a Comprehensive Community Health Models (CCHMs) Initiative to increase access to health care through an inclusive community-based decision-making process. Through this initiative, three counties received funding to develop "alternative, comprehensive, high-quality, and affordable health services models." The CCHMs Initiative awarded a planning grant to the Community Foundation of Muskegon County for the 1994-1996 period. The Community Foundation received the Kellogg grant at least in part because of its long history of investing in community-based health and human services.

The Community Foundation used this planning grant to establish the Muskegon Community Health Project (MCHP), which was responsible for facilitating the community-based decision-making process. Through this process, community stakeholders, including community residents and organizations, worked together to redirect the flow of resources in order to create a more efficient and effective health care system. Access Health was the product of one of many MCHP

health initiatives.

Between the end of the planning grant and the beginning of the program, MCHP developed a program model and reached consensus on that model among the many stakeholders. They also negotiated with the state a community subsidy for the program. After receiving significant input from the provider community, stakeholders decided to implement a FFS model. Stakeholders developed the benefit package and the cost-sharing rules within the context of trying to keep the premium at a level that would be affordable for small businesses and low-wage workers.

MCHP also received funding from HRSA in 2002 and 2003 which was used to develop a sustainable risk pool for their program and to enhance ongoing marketing and education efforts.

Eligibility Requirements for Employers – Access Health enrolled its first provider in late 1999. Although the program is intended for and typically serves small and medium-size employers, there is no upper limit on the size of eligible firms. Initially, employers with more than 20 employees were not eligible for the program, but the ceiling was lifted in order to meet initial enrollment targets. Program staff believe this decision was wise and that it is better to target businesses of all sizes that employ low-wage workers. In order for employers to offer Access Health, a number of criteria must be met. The employer:

- Must be headquartered in Muskegon County.
- Must not have offered health insurance for their defined employee group for at least 12 months. New employers that have never offered health benefits can start offering Access Health after being in operation for 13 weeks, as long as they have never before provided health benefits to employees.
- Must not be self-employed without any employees. These employers are not eligible for Access Health.
- Is eligible to offer Access Health only if the median wage of workers in the business does not exceed $11.50 per hour.
- Must agree to its share of the premium, currently set at about 30 percent. Some employers could choose to pay the employee's share as well, but they are not required to.
- Must offer Access Health to all uninsured workers employed at least 15.5 hours per week.
- Must offer dependent coverage equally. That is, if the employer offers dependent coverage to one eligible employee, all workers eligible for Access Health must also be eligible for dependent coverage.
- Cannot offer Access Health to retirees, seasonal or temporary employers, or temporarily laid-off employees.

Eligibility Requirements for Employees – Employees and dependents must meet a number of criteria to be eligible for Access Health. They must work for an employer who agrees to offer the program and they must work at least 15.5 hours per week over a 13-week period. Employees and dependents must be uninsured and not eligible for public programs such as Medicaid, SCHIP (State Children's Health Insurance Program), or Medicare. The staff at Access Health help employees and dependents enroll in public programs when it is determined that they are eligible

for such a program. The higher income standards for children in Medicaid and SCHIP explain why children account for only 10 percent of the Access Health population. If the employer qualifies to offer Access Health, individual employee income is not used to determine employee eligibility.

Employees and dependents are able to remain members of Access Health if they experience a COBRA-qualifying event. Only employers with 20 or more employees are required to provide COBRA coverage. A worker and his or her dependents can maintain COBRA coverage for 18 months if the worker was terminated (other than for gross misconduct) or if the worker experienced a reduction in hours of work, resulting in a change in eligibility for health benefits. Dependents of active workers are able to continue coverage under COBRA for 36 months in the case of the employee's death, divorce, or legal separation; the employee's entitlement to Medicare benefits; or if a dependent child ceased to be a dependent under applicable plan provisions. Employees and their dependents are required to pay the full premium, which includes the employee share, the employer share, and the community subsidy.

Program Funding – Funding for Access Health is based on the "three-share" model: the employer share (30 percent), the employee share (30 percent), and the community share (40 percent). The community share is funded mostly using Medicaid DSH funding, although sometimes it includes funding like United Way and foundation grants for special projects, such as marketing and outreach for the SCHIP program. The federal DSH dollars are matched by the employer premium.

The main threat to sustainability of the program would be loss of DSH funding. CMS is critically examining DSH payments across the country. If this funding were reduced or redirected, it would affect the sustainability of Access Health. In addition, federal scrutiny of DSH funding is making it less and less likely that other states could take advantage of DSH funding to establish similar programs. On the other hand, national legislation (Communities Building Access Act) could support and expand community-based programs that have successfully provided health care coverage to uninsured individuals. This legislation was inspired by Access Health of Muskegon and CareNet of Toledo/Lucas County, Ohio.

Prior to implementing the program, MCHP interviewed uninsured businesses in Muskegon County to determine what level of premium would be acceptable. The vast majority of the businesses reported that they could afford between $35 to $50 per person per month. With this information in hand, the program developed a benefit package that would fit into this price range. In 1999, the program began by charging the employer and the employee $38 per person per month. The current premiums are $46 per person per month for both the employer and employee. The community share is $62 per person per month.

Program Design – Access Health is a stand-alone program that is not an insurance product and thus is not subject to state benefit mandates or solvency requirements. Members are required to select a primary care physician (PCP). It is the responsibility of the PCP to refer patients for specialty care, diagnostic tests, and other necessary services. Care is only covered within Muskegon County. Services received outside the county, including emergency services and

specialty services not available within the county, are not covered. There are full-time employees providing case and disease management services.

Providers are paid fee-for-service minus applicable co-payments. In the case of physicians a 10 percent deduction is subtracted from the physician fee-for-service payment as a provider donation toward the member's total cost of coverage. Access Health contracts with a Pharmacy Benefits Manager for processing pharmaceutical claims. Access Health processes and reviews medical claims internally and provides utilization review, case management, and disease management for enrollees.

Access Health maintains its own sales staff and also works with local insurance agents/brokers, who donate their time, to identify and enroll eligible businesses and members. Although the program is not a Medicaid or SCHIP expansion, MCHP staff for the program link low-income people and dependents to the Medicaid and SCHIP program whenever possible. This is especially common for child dependents and pregnant women.

Delivery of Services – Access Health, Inc. is an independent 501(c)(3) corporation that contracts directly with providers. The program is not a managed care organization (MCO) or a health maintenance organization (HMO). One study of the program indicated that local physicians supported the program because it only covers services provided inside the county and because, after years of unsatisfactory experiences with MCOs, the MHCP Board negotiated to pay for services on an FFS basis. This decision was later endorsed by the Access Health Board once the board was convened. However, Access Health is quick to point out that they do provide strong case management and they believe this has been a key element in keeping premiums under control.

Over 97 percent of the physicians in the county participate. In addition, the two hospitals participate in the program. Because the program is community-sponsored and perhaps because payment rates are generous, Access Health has no problems with access to care for their enrollees. The program works closely with safety net providers, but not necessarily as enrolled providers. Instead, safety net providers such as local health departments provide supportive services to patients in this program. These services are also available to the general public; however, the program uses its case managers to link individuals with the programs. In addition, although federally qualified health centers (FQHCs) are allowed to participate in the program, most enrollees choose private practicing physicians as their primary care providers. Program staff believe this allows FQHCs to concentrate their efforts on Medicaid and uninsured populations within the county.

Payment and Reimbursement – Access Health pays physicians 120 percent of Medicare. In turn, physicians provide a 10 percent donation to Access Health to subsidize the cost of program administration. This generous payment rate, along with a decision not to implement an MCO or an HMO, allowed the program to attract 97 percent of the providers in the community. Hospitals are paid 101 percent of diagnosis related groups (DRGs) and both hospitals in the county participate in the program.

Plan Benefits – Access Health covers a comprehensive array of services, but there are also unique benefit exclusions. For example, the benefit package only includes services delivered in the county. This does not create access problems with most services.

Stakeholders working with MCHP staff developed the benefit package. MCHP staff determined, in advance of the stakeholder process, the level of premium that target employers were willing to pay. This pre-determined premium allowed the stakeholders to carefully consider which benefits and cost sharing would be necessary to meet the cost goal. With planning, they were able to cover the following in-county services:

- Physician primary and specialty care
- Radiology and labs
- Emergency visits
- Ambulance
- Durable medical equipment and supplies
- Pharmacy
- Hospital care
- Therapies with limitations
- Home case
- Outpatient behavioral health with limitations

Access Health does not provide an insurance product and therefore does not have to meet state benefit mandates or solvency requirements. By only paying for care delivered in the county, Access Health does not have to pay for some of the tertiary care paid for by private insurers, such as neonatal intensive care, organ transplants, or serious burn care. Even though the services are not paid for by the program, enrolled providers are responsible for referring individuals out-of-county for services. In addition, many Access Health enrollees become eligible for Medicaid when they are pregnant; Access Health and MCHP staff assist with the Medicaid application process so that these services do not need to be covered at the same level as in a private insurance company. All of these factors allow Access Health to offer a lower cost product with an attractive benefit package.

In order to keep the premiums low, the program also implemented the following cost-sharing/prior authorization rules:

- Primary care office visit - $10 co-payment
- Home care services - $10 co-payment, needs prior authorization
- Pre- and post-natal care - $110 maximum co-payment
- Surgical services (office visit) - $25 co-payment
- Specialist provider service (office visit) - $25 co-payment
- Blood component (hospital outpatient) - $20 per unit
- Physical, occupational, or speech therapy - $25 co-payment, 20 visit maximum per year
- DME, prescribed prostheses, or orthotics - 20% co-insurance, needs prior authorization
- Radiation therapy in hospital OPD - $50 co-payment, no co-payment in physician office

- Chemotherapy - $20 co-payment per visit, $200 maximum out-of-pocket
- Vision and hearing exams - Primary care office visit - $10 co-payment
- Vision and hearing exams - Specialist provider service (office visit) - $25 co-payment
- Inpatient Hospital Services - 25% co-insurance, $300 maximum out-of-pocket per stay
- Outpatient Hospital Services - 25% co-insurance, $300 maximum out-of-pocket per service
- Emergency room services - $75 co-payment per visit, co-payment is waived if admitted as inpatient
- Urgent care centers $30 co-payment per visit - subject to retrospective review
- Ground ambulance services - 25% co-insurance
- Prescription Drugs and Supplies - up to $6,000 maximum calendar year benefit
- Generic drugs $7 co-payment - up to a 30-day supply
- Brand name drugs 50% co-insurance - up to a 30-day supply
- Supplies needed to administer medication - 20% co-insurance

The program has also controlled premiums by the use of care management, disease management, and outside available community resources (such as tobacco cessation classes at local health department). By aggressively pursuing these strategies, they have not seen large increases in premiums.

Impact of SPG Program –The W. K. Kellogg Foundation provided funding to allow the MCHP to conduct the types of surveys and data studies that have been the hallmark of SPGs. Community leaders in Muskegon County widely acknowledge that Access Health would not have evolved without the funding and support of the W. K. Kellogg Foundation. Kellogg provided funding for the employer surveys that were critical in determining target populations, employers, and premium levels. MCHP also received funding from HRSA in 2002 and 2003 to develop a sustainable risk pool for their program and to enhance ongoing marketing and education efforts and assist with evaluation efforts.

Lessons from Administering the Program – Program administrators offered the following advice for local communities considered a “three-share” program.

It takes time, energy, and information to bring all the stakeholders together and to develop a common mission and goal. Even with a common goal, there needs to be a strong leader to keep the project and the stakeholders on track toward implementation.

Programs that include encouraging small businesses to offer health insurance have a long take-up process. Therefore, initial public funding does not need to be as large. Be flexible about changing target population if necessary to meet enrollment and funding targets. The Access Health decision to include larger providers is an example of such flexibility.

Programs that require means testing of individuals are inherently complicated; programs need to understand that low-wage workers are hesitant to provide this kind of information to the state.

In order to attract small businesses and low-wage workers, there needs to be a significant community subsidy.

Conduct careful surveys of small businesses and employee market prior to developing the benefit package. Find out how much these parties are willing to pay for insurance and then use this information to build the benefit package.

Evaluation – Access Health has been studied by the Employee Benefit and Research Institute (EBRI). The study can be found at www.ebri.org and it is EBRI Issue Brief No. 282, June 2005.

The study was descriptive in nature and concentrated on lessons learned rather than on recommendations. The authors maintain that the program was a success because it overcame barrier to providing coverage for uninsured working members of the county and it attracted the interest of federal policymakers as well as community organizers and politicians in other states. The one area in which concern was expressed is financial sustainability (given the uncertain future of DSH money it uses to fund its community share).

New Mexico (The New Mexico State Coverage Insurance)

Background – The New Mexico State Coverage Insurance (NMSCI) began enrolling small employers (less than 50 employees) and individuals on July 1, 2005. The program provides access to a statewide managed care system primarily targeted to employers and low-wage employees, although low-income uninsured individuals are also allowed to participate in the program. Individuals must have family incomes below 200 percent of the federal poverty level (FPL) to participate in the program. As of December 2006, there were 4,623 individuals enrolled in the program.

NMSCI is a Medicaid and SCHIP (State Children's Health Insurance Program) expansion program. The federal funds are composed of New Mexico's unspent SCHIP funds. In addition to the federal SCHIP funding and the required state match, it is also financed with employer and employee contributions. This blended funding is used to offer managed care coverage provided by private plans selected through a competitive bidding process. New Mexico decided not to use an Employer Sponsored Insurance (ESI) model because the state has a low rate of ESI coverage among small businesses. Benefits are similar to a comprehensive commercial plan, but with a $100,000 annual benefit limit.

Program History – In 2001, the New Mexico Human Services Department (HSD) applied for planning and implementation funding through the Robert Wood Johnson State Coverage Initiatives program. The funding was received in April (for planning) and October (for implementation) of 2001. This funding allowed New Mexico to develop options for targeting the uninsured.

In August 2002, New Mexico received federal approval under a Health Insurance Flexibility and Accountability (HIFA) waiver to implement a Medicaid expansion—NMSCI—to provide managed care coverage for uninsured adults with incomes up to 200 percent of the FPL. The adults are divided into two groups: 1) parents of children with SCHIP or Medicaid coverage and 2) childless adults.

In September 2003, New Mexico received a state planning grant (SPG) from the Health Resources and Services Administration (HRSA). This grant allowed the state to conduct surveys of households, employers, non-profit agencies, and state employees. These surveys provided critical data to the *Insure New Mexico!* Council, which was created by Governor Bill Richardson in October of 2004. The Council utilized data provided through the SPG to develop a number of initiatives aimed at reducing the number of uninsured people in New Mexico. One of the recommendations of the Council was for the state to fund the NMSCI program.

NMSCI received funding from the legislature during the 2005 legislative session and was implemented July 1, 2005. NMSCI combines unspent federal SCHIP funding, state matching funds, and employee and employer contributions, to offer managed care coverage for low-income uninsured state residents. Care is provided by three managed care organizations (MCOs) selected through a competitive bidding process and by the University of New Mexico Health

Sciences Center (UNM). The first phase of the demonstration will last until July 1, 2010.

Eligibility Requirements for Employers – In order to participate in NMSCI, employers must have fewer that 50 employees. In addition, they must not have voluntarily dropped commercial health insurance in the past twelve months. The MCOs that contract with HSD to provide health care services under NMSCI directly market and enroll small employers in the program. Employers may initiate the process via a website.

MCOs are allowed to use enrollment brokers to market and help enroll businesses, but MCOs are not allowed to pay the brokers with state or federal funding. This funding restriction has a negative effect on the marketing of the program. HSD also provides outreach and marketing to small employers, as well as to individuals not attached to employers.

Eligibility Requirements for Employees – Although NMSCI targets uninsured working adults between the ages of 19 and 65 with family incomes below 200 percent of the FPL, there is no program requirement for individuals to be employed. In addition, individuals below 200 percent of the FPL can enroll in the program even if their employer is unwilling to participate. In this scenario, the individual would pay the employer portion of the premium as well as the employee portion. In addition, employees who have been unable to take up their employer-sponsored health plan because of cost can be covered by the employer through NMSCI if they meet eligibility and crowd-out requirements.

The program prohibits eligibility if an individual has voluntarily dropped insurance coverage within the last six months. In addition, NMSCI is not available to individuals with other insurance coverage, including Medicaid, Medicare, private health insurance, and other public or private insurance programs. All NMSCI applicants are screened for Medicaid coverage before being allowed in the program.

State staff determine eligibility for all programs administered by HSD, including NMSCI and Medicaid. New Mexico has developed a single NMSCI eligibility office with staff dedicated to processing NMSCI applications. The smaller size staff allows for more rapid communication concerning changes in policies and procedures between program administrators, front-line eligibility staff, and contracted MCOs. The application process is streamlined to accommodate working populations. For example, eligibility requirements do not include a resource test. Also, NMSCI income definitions and disregards are based on the state's Section 1931 Medicaid income definitions and disregards so that there is continuity between the programs.

Individuals found eligible for NMSCI are assigned to an NMSCI eligibility category based on income grouping/tiers as determined at the time of application. Premium and co-payment amounts vary based on the individual's income tier. Benefits begin only after eligibility has been established, the individual has enrolled in a health plan, and the individual has paid his or her premium to the selected health plan.

As of December 1, 2006:

- 4,263 people were enrolled in NMSCI
- 3,297 people (77 percent) were below 100 percent of the FPL, 675 (16 percent) were between 100 and 150 percent, and 291 (7 percent) were between 150 and 200 percent
- 2,434 people (57 percent) were not parents and 1,829 (43 percent) were parents
- 292 people (7 percent) had employers that paid a premium
- 3,961 (93 percent) were individually enrolled

Program Funding – The program is funded with unspent federal SCHIP funding and state matching funds. In addition, employers pay $75 per employee per month (this is not used as the SCHIP state match). Cost sharing for individuals is on a sliding fee scale, with the premium and co-payment amounts corresponding to three income groups. Individuals with incomes under 100 percent of the FPL pay no monthly premiums; individuals between 101 and 150 percent of the FPL pay a $20 monthly premium; and individuals between 151 and 200 percent of the FPL pay a $35 premium. Self-employed individuals or those without employer participation pay the $75 employer premium in addition to the employee premium. Also, the state has allowed University of New Mexico Health Sciences Center (UNM) to pay the employer contribution for individuals enrolled by UNM in NMSCI .

The financing model for NMSCI is different from the ESI model used by most of the other states in this study because New Mexico has a disproportionately large number of small employers and a low rate of employer-sponsored insurance coverage.

In addition to premiums, the program has sliding scale co-payments and a $12 per month limit on prescription co-payments. Beneficiaries are responsible for keeping track of their co-payment expenditures and notifying the MCO if cost sharing exceeds the out-of-pocket maximum of 5 percent of the program participant's annual income.

Program Design – Program coverage is provided by three private MCOs selected through a competitive bidding process. Two of these plans also provide coverage in the commercial market. One MCO has an arrangement with UNM, the state teaching hospital, to administer care through its health care delivery system. UNM pays the cost of premiums for those members. Employers have a choice in selection between the plans if they are not already participating in one of the commercial plans, as do individuals who are not affiliated with an employer group.

There are no differences in the premium amounts or benefits between the three plans, although MCOs are allowed to provide enhanced benefits. In order for an MCO to participate in NMSCI, it must submit a proposal to participate in the Medicaid managed care program, SALUD! Both programs are overseen by HSD and staff enter eligibility information for both programs into the same information technology system.

Delivery of Services – Services are delivered by providers that contract with the three MCOs and by providers within the UNM system. Because they participate in the Medicaid managed care program, the MCOs were already familiar with its administrative requirements, which are

similar to NMSCI's. Because HSD oversees both the Medicaid and SCI programs, program administrators were already familiar with the MCO operations and already had procedures in place for monitoring the adequacy of provider networks.

The program allows MCOs to have contracts with Indian Health Service (IHS) facilities and Native Americans enrolled in SCI may access services at IHS facilities as well as other MCO service providers. Services provided at IHS facilities, by urban Indian providers and by tribal organizations that own or operate health care facilities, are also exempt from co-payment requirements. MCOs are also allowed to determine whether or not to have contracts with FQHCs.

Payment and Reimbursement – Capitation payment rates are negotiated with each individual MCO during the competitive bidding process, as is the case with the Medicaid managed care program. HSD pays the MCOs a "net capitation" amount, which is the total capitation for the rate cell less the employer and the employee premiums collected by the MCO. Please note that under federal Medicaid rules, these negotiated rates must be actuarially sound and approved as such by an actuary meeting the qualification standards of the American Academy of Actuaries.

The MCOs pay providers directly for services delivered under the program. The providers negotiate payment rates with MCOs before signing contracts to deliver services. MCOs use the same payment schedule for both Medicaid and SCI. The state requires MCOs to pay IHS facilities at the rate established by the federal Office of Management and Budget. In addition, MCOs can negotiate payment rates with FQHCs or opt not to contract with them.

Plan Benefits – Benefits under NMSCI are fairly comprehensive (although not as comprehensive as the full New Mexico Medicaid benefit package) and include a $100,000 annual benefit limit. The benefit package includes, but is not limited to:

- Physician office visits
- Preventive services
- Inpatient hospital and home health services (25-day combined limit)
- Outpatient services
- Pharmacy services
- Emergency and urgent services
- Women's health services
- Behavioral health services

Benefits not included are non-emergency transportation, vision, chiropractic, routine dental, hearing aids, skilled nursing services, pulmonary rehabilitation, and hospice. With the exception of the $100,000 limit, the package is similar to commercial packages, only less expensive because the program provides a significant federal/state subsidy. The program estimates that the federal/state subsidy is approximately 80 percent of the premium.

The benefit package was designed via extensive interactions with a design workgroup as well as input from focus groups and experience garnered from a managed care indigent program at the

University of New Mexico Health Sciences Center.

NMSCI co-payments are smaller than in commercial plans and are different depending on family income. The program has provisions to step in and cover the costs when out-of-pocket cost sharing exceeds 5 percent of a program participant's annual income. Under the program, participants keep track of their out-of-pocket costs and then bring the evidence to the state for reimbursement. States with such provisions need to build in costs for staff to review and handle such requests. Co-payment details can be found in the following table.

Current SCI Co-Payments

Service	Co-Pay at 0 to 100% FPL	Co-Pay at 101 to 150% FPL	Co-Pay at 151 to 200% FPL
Physician/provider visits (no co-pay for preventive services)	$0	$5	$7
Pre/Postnatal care	$0	$0	$0
Preventive services	$0	$0	$0
Hospital Inpatient Medical/Surgical	$0/day	$25/day	$30/day
Hospital Inpatient Maternity	$0/day	$25/day	$30/day
Hospital Outpatient Surgery/Procedures	$0	$5	$7
Home Health	$0	$5	$7
PT, OT, SLP	$0	$5	$7
Diagnostics (excluding routine lab and X-ray)	$0 (included in office visit)	$0 (included in office visit)	$0 (included in office visit)
DME/Supplies	$0	$5	$7
Mental Health/Substance Abuse Outpatient	$0	$5	$7
Mental Health/Substance Abuse Inpatient	$0/day	$25/day	$30/day
Emergency services	$0	$15 per visit, waived if admitted to hospital within 24 hours	$20 per visit, waived if admitted to hospital within 24 hours
Urgent care	$0	$5	$7
Prescription Drugs	$3 per prescription	$3 per prescription	$3 per prescription
Inpatient behavioral health and detoxification	$0/day	$25/day	$30/day

Impact of SPG Program – New Mexico received funding through a Health Resources and Services Administration (HRSA) state planning grant (SPG) in September of 2003. The grant helped the state gain significant new data on its uninsured populations. Funding was used to

conduct an extensive household survey, which included information on barriers to health care coverage and the types of coverage needed by the uninsured. It also included a survey of New Mexican employers to determine what percentage did not provide coverage, why coverage was not provided, and what factors might encourage employers to provide health insurance for their employees. There was also a small survey that focused on specific issues relating to non-profit agencies and a survey to determine why some state employees chose not to take up employer sponsored insurance.

The data were used to provide technical assistance to the *Insure New Mexico!* Council, which was created by Governor Bill Richardson in October 2004. The Council was charged by the Governor to identify initiatives to reduce the number of uninsured New Mexicans. It also aims to increase the number of small employers, including non-profits, offering health insurance to their employees. The HRSA SPG project supplied information that allowed the Council to focus on specific initiatives. As surveys were completed and analyzed, information was presented to the Council, which then recommended initiatives to the Governor. The SPG was a primary factor in aiding reform efforts, which culminated in March 2005 when the Governor signed six *Insure New Mexico!* initiatives into law, including NMSCI.

Lessons from Administering the Program - The state found it difficult to gain acceptance of an ESI product for workers with family incomes below 100 percent of the FPL. Employers hiring this very low wage population have been hesitant to take on the added financial burden of paying monthly premiums. The program is designed so that if the employer does not agree to pay the premium, then the program participant may choose to pay the employer portion of the premium. Often individuals with family incomes below 100 percent of FPL are unable to pay the employer share. This has made it difficult for program has to meet enrollment projections.

When applying for federal Medicaid funds, the state had to agree not to allow insurance brokers or agents to receive any federal or state funds to help with enrolling businesses and low wage workers into the program. This requirement has made it difficult for the state to elicit the support of these critical marketing partners. The federal government may need to reconsider issues that make it more difficult for states to expand coverage through ESI programs.

Initially, the state attempted to use local eligibility workers to process applications. However, communications with local staff can be slow because of the large number of staff involved and high staff turnover rates in some parts of the state. The program is also very different from the standard Medicaid program; therefore, it became more efficient for the state to set up a central office for processing eligibility applications.

Cost per member under the program was more expensive than expected because of pent-up demand for services. This may in part relate to the fact that the New Mexico Medicaid program does not include a Medically Needy program.

The program includes a $100,000 annual benefit cap. Other states implementing such a feature as part of a Medicaid waiver may want to consider building an inflation index on to such a cap so that they do not make on-going waiver amendments.

The recent Deficit Reduction Act of 2005 has added further complications to the program because now states with federal Medicaid waivers will have to verify citizenship for ESI programs. By adding administrative burdens, the federal government is discouraging the successful implementation of ESI programs.

Evaluation – The program was implemented in July 2005 and therefore has not yet been through a formal evaluation. The two main topics that will be studied in the future include whether:

- Employers/employees will sign up for a state-determined, standardized benefit package
- An affordable, basic benefit package that costs less than the typical commercial product will result in crowd-out of the private insurance market

New York (Healthy NY)

Background – Healthy NY, which began enrolling individuals in January 2001, has three target populations: small business employers and their employees, sole proprietors, and working individuals who cannot obtain insurance through their employers. All health maintenance organizations (HMOs) in the state of New York must participate in the program. Other carriers may also participate. The program includes a fairly comprehensive benefit package (it does not include mental health or substance abuse) and a stop-loss fund to reimburse health plans for 90 percent of claims paid between $5,000 and $75,000. The plans are fully at risk for claims under $5,000 and over $75,000. This reinsurance program allows premiums to be kept below market rates.

Healthy NY was designed for workers who are ineligible for other state insurance programs. As of November 1, 2006 Healthy NY currently serves approximately 130,850, comprised of 90,859 subscribers and 39,991 dependents. The enrollment is disproportionately higher in upstate New York, although this is gradually changing. Healthy NY does not have an official position on the number of people who could be served by the program.

The Insurance Department of New York drafted the regulations, developed the administrative procedures, obtained the cooperation of HMOs, and implemented the program within an aggressive one year timeframe. Unlike previous programs in New York and unlike many of the other programs in this study, Healthy NY does not directly provide subsidies to small businesses or to low-wage workers. Instead, the subsidy is directed at the insurance product through a reinsurance program that pays most of the expenses of the high-cost people who join the program. This results in lower premiums for employers and employees. The state budget contains the funds for the reinsurance subsidies.

The program builds upon the private insurance market. In addition to all the HMOs in the state offering a product under the program, there are a few plans that offer a Preferred Provider Option (PPO).

Program History – Healthy NY was initiated after the passage of New York's Health Care Reform Act (HCRA) of 2000. Before Healthy NY was implemented, New York had implemented two small programs that provided subsidies to help low-income individuals or small employers purchase private health insurance. These programs have since ended, but their enrollees have been allowed to enroll in Healthy NY.

When creating the program, the legislature recognized that many carriers in the individual market were incurring losses. Without the stop-loss relief, it would have been difficult to pass legislation that would have required all the HMOs in the state to offer policies under Healthy NY. In addition, without the stop-loss relief, it is unlikely that the employers and individuals could have paid the premiums necessary to provide even the current benefit package.

Eligibility Requirements for Employers and Employees – Healthy NY targets three populations: small business employers and their employees, sole proprietors, and working individuals who cannot obtain insurance through their employers. Generally speaking, none of the populations can be eligible if they have been insured in the past 12 months.

Healthy NY allows small employers with 50 or fewer employees to buy into the program if at least 30 percent of their employees earn less than $35,000 annually (adjusted annually for inflation). Employers must contribute at least half of the premium for full-time employees. Further, at least 50 percent of employees within each business must participate in the program or have coverage through other means. At least one of the employees who participates in Healthy New York must earn less than $35,500 per year.

For sole proprietors (independent contractors and self-employed individuals) and working individuals who cannot obtain insurance through their employer, gross family income must not exceed 250 percent of the federal poverty level (FPL). The sole proprietors and the individuals pay the entire premium and there is no sliding fee discount based on family income. At least one member of the family has to be employed, or if not currently employed, must have been employed at some time during the preceding 52 weeks. The applicant must have been uninsured for the past 12 months or lost their coverage under certain allowed conditions. Applicants with COBRA or public coverage may enroll directly in Healthy NY.

The proportion of individuals in each of the target groups has remained fairly consistent over time. Approximately 56 percent of enrollees are working individuals, 17 percent are sole proprietors, and 27 percent are with small businesses. Since its beginning in 2001, Healthy NY has enrolled more than 296,250 people. Enrollment for November 2006 is shown below.

Subscribers:	90,859
Dependents:	39,991
Total Enrollment:	130,850

Evaluations have shown that the working individual population and the sole proprietor population are higher-cost groups than the small business population. Therefore, the single set of premiums creates a more favorable cost/benefit ratio for the individual than for the small group participants' market.

Because the program income guidelines are similar, Healthy NY encourages parents to enroll their children in the state's Child Health Plus program because is provides a richer benefit package for children. This helps explain why there are few children enrolled in Healthy NY.

Program Funding – The program is funded through a reinsurance subsidy from the State of New York and employers and employees pay premiums to participating plans. In December 2005, EP&P Consulting, Inc. released a report on Healthy NY, which found that the subsidy funding was more than sufficient to support program growth through 2007 but would not sustain additional enrollment. Stop-loss spending for the program totaled $61.7 million in 2005 and EP&P estimated that it would approach $71 million by 2006. As of the date of the report, EP&P

reported a $69.2 million allocation for 2005 spending, and a $109.6 million allocation for spending in 2006.

Premiums for the program are community-rated (no under-writing), do not vary by eligibility category (i.e., small employer, sole proprietor, and individual), and are divided into four tiers (one-adult, two-adult, one parent with child(ren), and family). Rates may vary by county, and since they are set by the carrier, from plan to plan. Each carrier sets its own premium for each of the four contract tiers.

The state subsidy is a reinsurance program that results in insurers charging lower premiums for the program because they must take into account the stop-loss reimbursement from the state for most of the expenses of high-cost enrollees when determining premiums. Instead of directly subsidizing the small businesses or the low-wage workers, the subsidy pays (after the fact) 90 percent of the cost of care for individuals with annual health care costs between $5,000 and $75,000. Carriers pay all claims below $5,000 and above $75,000.

Initially, the reinsurance program paid up to 90 percent of claims between $30,000 and $100,000 per year for each enrollee. However, this changed in 2003 because of lower-than-expected claims activity. This change in reinsurance resulted in significant premium reductions for Healthy NY: with most plans reducing their premiums by approximately 17 percent. In addition, Healthy NY developed an option that allows enrollees to further reduce their cost by approximately 12 percent by selecting a benefit package without prescription drug coverage.

Program Design – Healthy NY is not a Medicaid expansion and does not receive federal Medicaid funding. Instead, it builds on the private insurance market and encourages efficient use of health care resources by requiring all HMOs in the state to participate in the program. State reinsurance dollars are used to bring down the cost of the premium so that it will be affordable to low-wage employees. The program also eliminated some mandated benefits from covered services, in order to further reduce the cost. While studies have shown that it works and Healthy NY premiums are approximately 20-30 percent lower than small group market HMO premiums and 50 percent lower than the individual market, comparisons are difficult to make due to the lack of standardization of coverage in the small group market.

The HMOs that participate in the program are responsible for:

- Processing member applications
- Collecting member premiums
- Conducting annual recertifications for member renewal
- Providing services according to the benefit package requirements
- Processing claims
- Submitting certain required data to the New York State Insurance Department, including monthly enrollment totals, quarterly expenditures incurred by members, and annual reconciliation reports in order to obtain stop-loss reimbursement

Providers are paid by the HMOs according to the specifications of their provider contracts.

Delivery of Services – Services are delivered by HMOs throughout the state. Healthy NY is administered by the New York State Insurance Department. Specific duties of the Department include:

- Tracking enrollment data
- Reviewing initial premiums and contracts proposed by health plans
- Maintaining the Healthy NY website and toll-free telephone lines
- Overseeing state-sponsored media advertising and other sources of promotion, such as health fairs, small business development centers, and presentations to chambers of commerce
- Providing technical assistance to health plans concerning programmatic matters such as eligibility and benefits
- Administering the stop-loss/reinsurance program
- Handling consumer questions, complaints, and appeals of eligibility denials

The state does not dictate which providers have to be part of the HMO panels. Each HMO has its own preferred provider panel. When members were surveyed in 2004 and 2005 concerning their satisfaction level with the program, the areas with the highest ratings were provider network and education materials. The areas with the greatest dissatisfaction were cost and benefits. Not surprisingly, members want more benefits for less cost.

Payment and Reimbursement – HMOs participating in Healthy NY pay claims for services. Payment rates are not available. However, one study of the program indicated that HMOs had negotiated payment rates for providers below market reimbursement rates by requiring enrollees to obtain services in-network. It is unclear whether safety net providers [e.g., federally qualified health centers (FQHCs)] participate in the program.

Plan Benefits – In order to further reduce costs, the Healthy NY benefit package does not include the full range of benefits mandated for typical policies sold in the state's small group and individual markets. For example, inpatient and outpatient mental health, chiropractic services, and outpatient treatment for alcohol and substance abuse are not covered under the program. In addition, the program offers two benefit packages, one with and one without prescription benefits. Covered services include:

- Inpatient and outpatient hospital services and emergency services
- Physician services
- Outpatient surgical facility charges related to a covered surgical procedure
- Pre-admission and diagnostic testing
- Laboratory and x-ray
- Adult preventive services, including maternity care, immunizations, mammographies, PAP smears, and periodic physical exams once every three years
- Preventive and primary health care services for dependent children, including routine well-child visits and necessary immunizations

- Equipment, supplies, and self-management education for diabetics
- Therapeutic services consisting of radiology, chemotherapy, and hemodialysis
- Blood and blood products furnished with surgery or inpatient hospital services

In order to keep the premiums at an affordable level, the benefits package requires cost sharing. Regular small group policies in New York typically have much larger co-payments. The co-payment listed in the table below is an amount that an individual must pay at the time he or she receives services. Additionally, if an individual chooses the benefit package that includes prescription drug coverage, there is an annual deductible for prescription drugs. The amounts of the co-payments and deductibles are the same for each health plan. The applicable co-payments are as shown in the following table.

Services	Co-Payments
Inpatient hospital services	$500 co-pay
Surgical services	20% or $200 co-pay, whichever is less
Outpatient surgical facility	$75 co-pay
Emergency services (waived if admitted to the hospital)	$50 co-pay
Prenatal services	$10 co-pay
Well-child visits/Immunizations	$0
All other services	$20 co-pay
Optional prescription drug benefit	Maximum benefit of $3,000 per individual per year; $100 deductible per calendar year; generic drugs have a $10 co-pay; brand name drugs have a $20 co-pay plus the difference in cost between the brand name drug and generic equivalent

The program has also controlled premiums by using HMOs that only pay for services obtained from providers within their networks.

Impact of SPG Program – Healthy NY did not apply for a state planning grant.

Lessons from Administering the Program – In order to attract small businesses and low-wage workers, there needed to be a significant community subsidy. Program design must be evaluated for effectiveness and adjusted if necessary. The stop-loss corridors in Health NY had to be adjusted downward because of low claims activity (from $30,000 - $100,000 to $5,000 - $75,000). This resulted in lower premiums for the program. Administrators need to appreciate the tension between adding benefits and keeping program costs low.

Evaluation – The Health Care Reform Act of 2000 required an annual evaluation of the program

by an independent entity and an annual report to be submitted to the Legislature and the Governor by January 1st of each year. The report must address:

- Employer participation
- An income profile of enrollees
- An analysis of claims experience
- The impact of the program on decreasing the number of uninsured

The Lewin Group, in partnership with Empire Health Advisors, conducted the report in 2003. EP&P Consulting, Inc. conducted the independent evaluation in 2004 and 2005.

The evaluators have made a number of recommendations in their most recent report. These include recommendations related to increasing enrollment, such as:

- Eliminating the crowd-out provision for small business owners
- Reducing the waiting period for sole proprietors and working individuals from 12 to 6 months
- Allowing enrollees in the State's Direct Pay insurance product to move to Healthy NY without requiring the gap in insurance coverage
- Eliminating the "working" requirement for certain populations to enable them to participate in Healthy NY
- Considering allowing individuals at higher FPLs to enroll in Healthy NY at graduated-scale premiums

All of these recommendations require legislative change.

The evaluators have also encouraged the Department of Insurance to move forward with a number of other program changes. These include:

- Exploring the opportunity to obtain federal financing for Healthy NY
- Providing more intensive broker education
- Developing an eligibility screen tool on the Healthy NY website
- Developing a Healthy NY report card on the Healthy NY website

More information concerning the evaluations can be found on the Healthy NY website at www.healthyny.com.

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Oklahoma (O-EPIC)

Background – The Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program is a financial subsidy initiative that assists qualified Oklahoma small businesses and employees in paying for health insurance premiums. The target population includes low-income individuals and small employers. Two programs were created for the target population: the Premium Assistance Partnership Program (referred to as just Premium Assistance Program) and the Premium Assistance Public Program (referred to as Individual Plan). The Premium Assistance Program began enrolling beneficiaries in November 2005 and the Individual Plan will be implemented in January 2007.

O-EPIC is covered under a HIFA waiver and is funded through federal Medicaid funds, state matching funds generated from a tobacco sales tax, and individual and employer premiums. The Premium Assistance Program utilizes the private employer-sponsored insurance (ESI) market and provides subsidies to employers to pay for employee health insurance premiums for the Premium Assistance Program. The state's goal is to allow market forces to determine the benefit package and integrate low-wage workers into the private insurance marketplace. Regulation of private plans is not carried out by O-EPIC. Rather, the State Insurance Commission provides general oversight and approval of the private plans.

The Individual Plan is a primary care case management program that will be administered by the state Medicaid agency providing limited benefits and a one million dollar maximum lifetime benefit. Primary Care Providers provide primary care services and refer enrollees for specialist services as medically necessary. The state Medicaid infrastructure provides administrative support and utilizes Medicaid providers to deliver care. Providers are paid Medicaid premiums and may charge additional co-pays.

The Health Resources and Services Administration (HRSA) state planning grant (SPG) program provided information that was useful for problem identification, demonstrating to stakeholders the nature of the problem and influencing legislation that created funding for the program. The state leveraged existing Medicaid infrastructure to support O-EPIC. The state Medicaid agency will provide administrative support for the Individual Plan and provides program oversight for the Premium Assistance Program. Web-based applications are utilized for enrollment and marketing activities for both programs.

Program History – O-EPIC was the culmination of work by Governor Brad Henry, the Oklahoma State Legislature, the Oklahoma Health Care Authority, and other stakeholders to assist Oklahoma residents in purchasing health care insurance. State Senate Bill 1546, which passed in April 2004, charged the Oklahoma Health Care Authority (OHCA), which also administers the State Medicaid agency, with the task of designing a health insurance initiative that would target uninsured working adults. The OHCA was commissioned to create a program for adults with incomes below 185 percent of the federal poverty level (FPL). This program was to either provide subsidies to pay for a portion of health insurance premiums or allow individuals to purchase a state-sponsored health plan operated by the state Medicaid program. The OHCA

utilized a HRSA SPG to study the problem and design an approach to provide insurance coverage. No other state health insurance initiatives exist for this population.

The program design includes two initiatives: the Premium Assistance Program and the Individual Plan. The Premium Assistance Program pays subsidies to small employers to help them pay for employee and family insurance. The Individual Plan will provide a state-run reduced benefit plan to the self-employed, some unemployed individuals, and workers with no access to small group health insurance. Funding for the programs comes from an increase in tobacco sales taxes, which was passed by Oklahoma voters in November of 2004 under the Oklahoma Health Care Initiative.

The Premium Assistance Program began enrolling beneficiaries in November of 2005. As of October 26, 2006, 645 businesses and 1,219 employees and spouses were enrolled. Roughly 430 of the participating businesses have enrolled individuals, while 200 employers have no enrollees. The Individual Plan will be implemented in January of 2007.

O-EPIC is designed to serve 50,000 to 70,000 individuals. The target is based on the total amount of money that the state has to serve the population, divided by the average projected cost to serve each person. Currently, there is a cap of 25,000 enrollees on the Premium Assistance Program and 25,000 on the Individual Plan. The programs have not been in operation long enough to determine if the target number will need to be revised, but they could change as the program evolves.

Eligibility Requirements for the Premium Assistance Program – Employed adults aged 19 to 64 who earn less than 185 percent of the FPL are eligible for the program. In addition, employees must meet the following criteria:

- Be an Oklahoma resident and a U.S. citizen or legal alien
- Be ineligible for Medicare or Medicaid
- Contribute up to 15 percent of health insurance premium costs
- Be enrolled in an O-EPIC qualified Premium Assistance Program (sole proprietors are not covered by the program)

Coverage in the Premium Assistance Program is limited to low-income adults with ESI coverage. The state assumes that children whose family income levels meet the requirements will be eligible for the SoonerCare program, which provides primary care case management services. The state has applied to raise the income level cap to 200 percent of the FPL in an 1115 Medicaid waiver renewal application. However, this is subject to approval by the state legislature.

There are no employer or employee crowd-out restrictions for the Premium Assistance Program. Employers are now eligible for participation in the program if the size of their firm is less than 50 employees.[4]

[4] In October 2006, State House Bill 2872 increased firm size restrictions from 25 employees to 50.

Eligibility Requirements for the Individual Plan – The Individual Plan was designed as a "fall-back" program that offers primary care case management to qualified individuals who are ineligible to participate in the Premium Assistance Program. Individuals who may be eligible include:

- Adults aged 19-64 who earn less than 185 percent of the FPL
- Oklahoma residents who are U.S. citizens or legal aliens
- Individuals who are ineligible for Medicare or Medicaid
- Individuals not eligible for small group health coverage (this includes sole proprietors)
- 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
- Unemployed individuals who are currently seeking work
- Working individuals with a disability who meet the Ticket-to-Work program requirements and have incomes above the Medicaid level, but below 200 percent of the FPL

If an individual drops his or her own private coverage, he or she can join the Individual Plan without a waiting period as long as the person's employer does not enroll in the Premium Assistance Program. However, for employees of employers who drop ESI coverage, there is a waiting period of six months from the time that their employer dropped previous insurance to when they can enroll in the Individual Plan. Employers must also certify that they do not offer health insurance to employees in order for the employee to receive coverage under the Individual Plan.

Program Funding – O-EPIC is funded through federal Medicaid funds, matching state special funds, and individual and employer contributions. Matching federal Medicaid funds can be as high as $100,000,000 per year. State special funds are generated from a portion of the sales tax on tobacco; these funds are non-lapsing. As of October 15, 2006, collections for the program were approximately $58 million.

Individuals in the Premium Assistance Program pay up to 15 percent of monthly premium costs. Total employee contributions cannot exceed 3 percent of the gross household income. The state pays 60 percent of an individual's premium and 85 percent of a spouse's premium. However, if an individual and spouse are spending more than 3 percent of family income on the premium itself, the state may provide additional contributions. Employers in the Premium Assistance Program are responsible for contributing at least 25 percent of eligible employee premiums. For the Individual Plan, enrollees pay on a sliding fee scale, with fees ranging from $8 to $64 per month. The state then pays the remaining amount.

Program Design – O-EPIC is covered under a Medicaid HIFA waiver. The state will administer the Individual Plan. The benefit package will be a more limited product than the SoonerCare plan, which provides primary care and case management services. Enrollees will choose a primary care case manager, who will be responsible for linking them with necessary covered services. The state will enroll and pay providers directly.

The Premium Assistance Program builds upon the private Oklahoma insurance market. At present, there are 11 private insurance companies participating (additional companies may join in the future). Some insurers in the market have not yet applied to have their products approved. Any health plan producer licensed by the Oklahoma Insurance Department may choose to use O-EPIC as a selling tool. The carrier sends a list of product lines that they think meet program guidelines to the OHCA. The OHCA then reviews the products and forwards them to the Oklahoma Insurance Department to confirm that they are licensed in the state. Employers who use or want to use any of these product lines can then apply to be in the program. Once the employer has been approved, the employees can apply for the program. All employer, employee, and insurance plan applications are completed online.

One of the advantages of the Premium Assistance Program is that it utilizes existing insurance plans. Therefore, employers can use the same private plans that they had previously been offering. The state does not limit the number of private plans that participate and would like to include as many plans as possible. With the exception of the original enrollment procedures, the process and administration of the Premium Assistance Program are invisible to private insurance companies. The state contracts with the employer for all of its eligible employees and the employer works with the program to receive premium subsidies for his or her employees. The state directly pays employers for the state subsidy for each of their employees.

Delivery of Services in the Premium Assistance Program – The Premium Assistance Program relies on existing insurance carriers to provide health coverage. As such, the program incorporates service delivery models that are available in the health insurance market, including managed care providers and preferred provider organization (PPO) plans. The state believes that safety net providers are enrolled in PPO plans or the commercial networks to the extent they that participate in the private insurance sector. Currently, six of the eleven private carriers offer PPO plans and other alternatives. Since the Premium Assistance Program uses commercial products, the OHCA is not involved in the regulation of the products, nor is it involved in the business practices, reimbursement, billing, standards of care, encounter data reporting, or access issues of the carriers.

Delivery of Services in the Individual Plan – The Individual Plan uses the Oklahoma Medicaid infrastructure to deliver services, including the staff, Medicaid fee-for-service (FFS) networks, and the Medicaid Management Information System. SoonerCare primary care providers have agreed to accept enrollees from the program. The Individual Plan also incorporates safety net providers, such as federally qualified health centers (FQHCs), to deliver care.

Payment and Reimbursement – The state is not involved with negotiating payments and reimbursements in the Premium Assistance Program because the program relies on private insurance carriers to perform these activities.

The Individual Plan will pay providers 100 percent of Medicaid's payment rates. Additionally, providers will be allowed to charge a co-pay on top of the Medicaid fee. The impact of the program on safety net provider revenues will not be seen until after the program is initiated in

2007.

Plan Benefits for the Premium Assistance Program – The Premium Assistance Program requires that private insurance carriers include:

- Hospital services
- Physician services
- Laboratory services
- X-ray services
- A pharmacy benefit
- Office visits
- $3,000 maximum out-of-pocket payments
- $50 office visit co-pay maximum
- $500 maximum annual pharmacy deductible

When determining the benefit package, the state set a minimum threshold that was very flexible. The goal was to allow market forces to determine the benefit package and integrate Premium Assistance Program enrollees into the private insurance marketplace. Cost control is also the responsibility of private carriers. In short, the state is taking a hands-off approach to the market and leaving it to employers to obtain the best value in the health insurance marketplace.

There is a 5 percent family income limit on health care expenditure. Families have to keep records of their expenditures and apply to the state when the expenditures exceed the 5 percent level. The state will reimburse enrollees up to $900.

Plan Benefits for the Individual Plan – The Individual Plan offers a limited package of benefits with a lifetime maximum benefit of one million dollars. Enrollees select a primary care physician as part of the application process and PCP referral is required for most services and those outside of the following list. Benefits are limited to a maximum number in a specified time period, including pharmaceuticals. The Individual Plan benefits include:

- Office visits for evaluation and medical management – one wellness exam per year and 4 visits per month
- Women's routine and preventive health care services –one mammogram per year
- Services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics
- Inpatient, emergency, and outpatient hospital services – 24 inpatient days per year
- Behavioral health services, including inpatient, outpatient, and outpatient substance abuse – subject to maximum numbers of days per year
- Maternity/Obstetric care
- Diagnostic imaging, lab services, oxygen, blood and blood products
- Pharmacy – 6 prescriptions per month total with a 3 brand name per month maximum
- Dialysis services
- Diabetic supplies

- Family planning methods
- Adult Immunizations
- Smoking cessation – one 90 day therapy per year

The Individual Plan will utilize co-pay and benefit maximums in order to control costs. Examples of co-pays include:

- Physician office visits: $25 co-pay per visit
- Pharmacy: $5 per generic and $10 per brand name
- Hospital emergency room: $30 co-pay per occurrence, waived if admitted to hospital
- Inpatient hospital admission: $50 co-pay per admission
- Specialized imaging scan: $25 co-pay per scan
- Hospital outpatient services: $25 co-pay per visit; $10 per visit for cancer treatment
- Durable medical equipment/supplies: $15,000 lifetime maximum

When determining the benefits for the Individual Plan, the state tried to balance monetary constraints with the desire to provide comprehensive primary care services. There was average monthly allocation of about $200 for enrollees with which to guide the benefit determination. The benefit packages of several health plans, including the Medicaid benefit plan, the state employee plan, and other commercial plans, were examined. In order to reach the monetary target, the state reduced some of the proposed benefits in the Individual Plan, making it more limited than commercial plans. Actual monthly expenditures for the Premium Assistance Program are running a bit higher than allocated: around $240 per member per month (PMPM).

Impact of SPG Program – The state planning grant (SPG) program was useful in providing data that assisted in problem identification and helped stakeholders understand the scope of the problem. The data also helped influence the legislature to pass the tobacco tax, which funds the program. CPS and telephone surveys were the most important sources of information in the SPG program. The state expressed the desire for more information on carriers and the benefits that were being offered in the commercial market, as this type of information was not readily available.

The OHCA utilized SPG funds to develop the Oklahoma state planning grant (OSPG) program. The OSPG program conducted research projects for the purpose of studying the uninsured in the state and for collecting and analyzing data on this population. The research projects included a household survey, focus groups, and a small business survey. The results from these projects provided data and information on the characteristics of the uninsured and the extent of the uninsured problem in the state; beneficiary attitudes; appropriate rate structures for a subsidy program; key determinants to provider participation in the Oklahoma Medicaid program; and the receptivity of small businesses to a state-run ESI subsidy program.

Lessons from Administering the Program – O-EPIC found that it was important to utilize existing health care market structures for the administration and operation of the program. State agencies, insurance plans, brokers and agents, third-party administrators (TPA), and the internet

are incorporated into the program. This allowed the program to be implemented with few additional staff positions.

Having a strong Medicaid program, SoonerCare, made it easier to implement the O-EPIC Individual Plan because there is sufficient primary care case management capacity in the SoonerCare program to serve the new population. The OHCA will also utilize the existing SoonerCare quality assurance unit for the Individual Plan.

The O-EPIC Premium Assistance Program is an ESI program. Therefore, the Oklahoma State Insurance Commission determines whether insurance products meet the Premium Assistance Program minimum requirements.

Insurance brokers/agents are heavily involved with the Premium Assistance Program. Brokers and agents have been trained by the state and help employers enroll in the program. In addition, they may have encouraged insurance carriers to enroll products in the program. Brokers are not paid commission by the state, but by insurance carriers, as is the case with the commercial market. O-EPIC uses the Internet to disseminate program information, market the program, provide training resources, and enroll individuals and employers. There is a web-based application process for determining employer and employee eligibility.

Evaluation – A survey of small businesses was carried out for the Premium Assistance Program and a final report has been developed. The report describes the experiences that employers have had with the Premium Assistance Program. It also includes information on employee uptake of the program, benefits of participating in the plan, effectiveness of information sources, and the impact of insurance agents/brokers on successful program implementation. Findings from the evaluation showed that insurance agents were utilized and heavily depended upon in the application and implementation phases of employer participation. Information provided by insurance agents as well as newspapers made income eligibility requirements more comprehensible than information from other sources. Employers reported that the most important benefit of participation in O-EPIC was the ability to offer ESI coverage, which they perceived would improve existing employee morale and productivity. Furthermore, offering health benefits could assist them in attracting new employees. The evaluation also indicated that O-EPIC could potentially increase ESI coverage of previously uninsured workers by 46 percent. However, employers commented that the income eligibility ceiling unfortunately still excluded some lower-wage workers in need of ESI coverage.

Utah (Utah Primary Care Network and Utah's Premium Partnership for Health Insurance)

Background – The Utah Primary Care Network (PCN) provides primary care coverage to previously uninsured individuals under an 1115 Medicaid waiver. PCN enrolls approximately 18,000 individuals and provides a limited benefit package of primary care services. PCN is a fee-for-service (FFS) state-run Medicaid expansion program. Primary care providers and federally qualified health centers (FQHCs) that participate in PCN are paid at the Medicaid physician payment rates. The program does not cover specialty physician services. In addition, although there is no coverage for inpatient hospital care under PCN, Utah hospitals agreed to donate $10 million of inpatient care annually to PCN enrollees.

In November of 2006, Utah began another program called Utah's Premium Partnership for Health Insurance (UPP). UPP provides subsidies to uninsured employed individuals to help them pay for employer-sponsored health insurance (ESI) plans. The program targets low-wage workers regardless of health status and assists them in gaining entry into the ESI market.

Uninsured individuals and families with incomes below 150 percent of the federal poverty level (FPL) may be eligible for PCN and UPP, and children with families below 200 percent of the FPL may be eligible for UPP. Employers do not participate in PCN, but in UPP they must cover 50 percent of ESI premiums and offer plans that meet the program's minimum standards. UPP utilizes existing employer-sponsored insurance (ESI) plans in the Utah market.

Both programs are financed through federal and state general funds. UPP also receives a limited allocation of tobacco tax revenue for SCHIP (State Children's Health Insurance Program) allotments. The state Medicaid program provides the infrastructure for both programs and state agencies determine eligibility and enrollee participants.

Program History – PCN began providing primary care coverage to previously uninsured adults under an 1115 Medicaid waiver in July of 2002. The primary care benefits provided to uninsured adults were funded in part through cost-sharing measures and through slight reductions in the benefits for adults who were previously eligible for Medicaid but not pregnant, aged, blind, or disabled. PCN also replaced the Utah Medical Assistance Program (UMAP). UMAP was a fully-funded state program that provided care for acute and life-threatening conditions of the very poor and Medicaid ineligible residents.

PCN provides primary care services but does not include hospitalization or specialty services. As a result of public concern about the limited benefits, the state entered into an agreement with hospitals to provide up to $10 million of donated care. The state also seeks to arrange donated or reduced cost specialty care.

As of August 2006, 16,166 individuals were enrolled in PCN. This number changes constantly as the state holds selected open enrollment periods in order to stay within available state funding. PCN has an overall enrollment cap in the waiver of 25,000.

Utah began taking applications in November of 2006 for its new program, UPP. UPP provides subsidies to working individuals and families to pay for employer-sponsored health insurance premiums. The program replaced the small Covered at Work (CAW) program and differs from PCN in that it helps pay for existing ESI plans. UPP subsidizes enrollment in employer health plans to provide services beyond primary care, such as hospital and specialty services. The ESI plans must meet basic program requirements and employees must meet eligibility guidelines for income and coverage. UPP targets uninsured, low-wage workers regardless of health status and tries to help them gain entry into the ESI market.

Enrollees participating in CAW who meet UPP requirements will be transferred to UPP. Enrollment in CAW was capped at 6,000, but the program has only enrolled 90 individuals. The state believes that the low enrollment rates for CAW are related to the fact that subsidy payments were too low. While UPP does not have an enrollment cap per se, budgetary limits restrict the number of enrollees. Utah projects the ability to serve 1,000 adults and 250 children in the first year of UPP operations.

In addition to PCN and UPP, resources for the uninsured and poor include traditional Medicaid, a pool of state funds for high-risk uninsurable individuals, and community health clinics.

Eligibility Requirements for the PCN Program – Eligibility is limited to adults aged 19 to 64 who are below 150 percent of the FPL. Individuals are eligible for PCN only if they:

- Are not eligible for Medicaid
- Are U.S. citizens or legal residents
- Are not full-time students
- Do not have health insurance or access to Medicare or Veterans Benefits
- Do not have access to ESI, or the cost of their ESI is more than 15 percent of their income
- Have voluntarily terminated their health insurance in the six months prior to PCN enrollment

Budget considerations require PCN to enroll more parents than childless individuals. This is mostly driven by federal budget neutrality calculations because childless adult member months do not count in the denominator in the 1115 budget neutrality formula even though their health care costs are in the numerator. In addition, childless adults are significantly more expensive than parents (approximately $130 per member per month (PMPM) versus $60 PMPM for parents). Therefore, PCN has procedures to enroll more parents than childless adults and often only opens enrollment to parents.[5]

Eligibility Requirements for the UPP Program – The state will cover eligible employees aged 19 to 64 with incomes up to 150 percent of the FPL. In addition, employees must:

[5] Currently, 62 percent of enrollees are parents and only 38 percent are childless individuals.

- Not be eligible for Medicaid
- Be U.S. citizens or legal residents
- Be uninsured at the time of application
- Have access to their employer's health plan or their spouse's employer-sponsored health plan
- Have access to plans where the most inexpensive option is at least 5 percent of total household income before taxes

Employees who voluntarily terminate their health insurance are not eligible for UPP for 90 days. Spouses of employed individuals may be eligible for UPP if they meet the same requirements and can be enrolled in their spouse's employer-sponsored health insurance. Children aged 0 to 18 with family incomes up to 200 percent of the FPL may also be eligible for UPP. Children are subject to the same UPP requirements as adults, with the exception of the employment and FPL requirements.

Subsidies for health insurance premiums will be up to a maximum of $150 for the employee, $150 for the spouse, and $100 for each dependent child. The employer is required to pay 50 percent of the employee insurance premiums; UPP will cover the remaining premium up to the maximum allowable amount. In addition, children with family incomes up to 200 percent of the FPL are eligible for UPP.

The employers' main role is to complete a bi-annual form certifying that they offer a qualifying insurance plan and that they are paying at least 50 percent of the premium for their employees. Qualifying insurance plans cover physician visits, hospital inpatient, pharmacy, well-child visits, and immunizations. Employers are not required to pay for the employee's share of spousal or dependent coverage.

Program Funding – The PCN and UPP are funded through federal funds, state general funds, and individual/employer contributions. State general funds provide the match for federal funds for PCN and the adult/family part of UPP. In addition, UPP funds children with the federal SCHIP allotment and state tobacco tax funds.

PCN is funded through federal and state funds and individual premiums. Premiums are means-tested: $15 per year for individuals receiving General Assistance (financial assistance to a person not otherwise eligible for some other types of cash assistance); $25 per year for individuals with incomes below 50 percent of the FPL; and $50 per year for all other individuals.

UPP subsidies are funded through federal and state funds. Employers are required to contribute 50 percent of employee premiums (which is the average for small businesses around the state). Individuals are responsible for any remaining premiums after applying the state-provided subsidy.

Program Design – PCN and UPP were approved under a Medicaid 1115 waiver. PCN is an FFS state Medicaid expansion program that provides a limited benefit package of primary care

services. UPP relies on existing ESI plans that meet the minimum benefit standards of the program.

The goal of UPP is to encourage employer-sponsored insurance for low-income workers. The state believes this can be accomplished by utilizing the existing insurance market structure and agreeing to subsidize all plans that provide employer-sponsored coverage for low income workers. There is relatively little administrative burden for private insurance carriers and these carriers can use existing insurance agents or brokers to enroll businesses in their qualifying health plans.

Delivery of Services – PCN is an FFS program that uses existing Medicaid providers to deliver a limited set of primary care services. Managed care is not a component of PCN for a number of reasons. The state chose not to build on the Medicaid managed care organization (MCO) market because 1) PCN offered only a limited benefit package, 2) MCOs were not available statewide, and 3) it was easier to build the changes into the MMIS FFS payment structure than to build a new partial capitation subsystem. PCN does not have preferred provider networks, but PCN enrollees use safety net providers, such as FQHCs. As a Medicaid expansion program, PCN employs the existing Medicaid infrastructure for program operations, includes an overall quality assurance program, and operates its own MMIS.

Services delivered in UPP are based on ESI plans. As a result, they may include managed care, preferred providers, and other commercially available methods of delivery.

Payment and Reimbursement – PCN pays primary care providers using Medicaid payment rates, which are about 50 percent of the Medicare rate for physicians. FQHCs are paid using this same methodology and therefore do not receive cost-based reimbursement rates. FQHCs have continued to participate despite the lower reimbursement.

The state is not involved in determining reimbursement rates in UPP because the program is based on existing private insurance plans.

Plan Benefits for PCN – PCN covers only a limited set of primary care benefits and does not include hospitalization or specialty services. PCN covers:

- Primary care visits
- Some emergency room visits
- Emergency medical transportation
- Lab services
- X-rays
- Up to 4 prescriptions per month
- Dental exams, dental x-rays, cleanings, fillings
- One eye exam per year; no glasses
- Family planning methods

PCN attempts to control costs with member co-payments. Co-payments include:

- Maximum co-payment: $1,000.00 per person/per calendar year
- Physician visits (pregnancy-related services are not covered): $5 co-pay per visit
- Hospital emergency room: $30 co-pay per visit for emergencies (subject to ER visit limitations)
- Medical equipment and supplies: 10 percent co-pay for covered services
- Pharmacy (four prescriptions per month): $5 co-pay for prescriptions on the preferred list; 25 percent of the allowed amount for drugs not on preferred list
- Laboratory: 5 percent co-pay of the allowed amount if over $50
- X-rays: 5 percent co-pay of the allowed amount if over $100
- Dental primary care services: 10 percent co-pay of allowed amount
- Vision screening: $5 co-pay; benefit limited to one eye exam per year

Plan Benefits for UPP – The simplicity of UPP makes it unnecessary for the state to determine benefit designs of ESI plans. Existing health plans decide on the benefit packages to be offered in the Utah insurance market and employees select from plans offered by their employers. The state then provides a subsidy to the employee to pay for the ESI plan. It is up to the private insurance carriers to determine the most effective cost containment mechanisms and benefit packages. UPP does, however, require employers and ESI plans to provide, at a minimum:

- Physicians visits, well-child exams, hospital inpatient services, child immunizations, and pharmacy
- Payment of at least 50 percent of the employee's ESI premium
- Deductible of $1,000 per person or less
- Lifetime maximum benefits of $1,000,000 or more
- Payment of 70 percent of inpatient costs after the deductible

Children who receive dental coverage through their parent's employer will receive an additional $20 per month subsidy. If children do not have dental coverage through an employer's plan or choose not to enroll in the employer's plan, then they will receive the traditional CHIP dental coverage provided through the state-contracted managed care plan.

Determination of Benefit Package for PCN – Budgetary limits determine the range of services that is offered by PCN. The state was faced with the task of deciding which services were essential, given the limited funds for the program. The challenge in balancing budgetary restrictions with the need to cover critical services resulted in a benefit package that included primary care services but excluded specialty physician care and inpatient hospital care. The state has an on-going stakeholder process for the program. When stakeholders want to add services to the benefit package, the state holds discussions concerning the impact the additional services would have on the program, including what current services would need to be cut to pay for new services.

While inpatient hospital and specialty care is not provided as a benefit, hospitals have agreed to

donate up to $10 million annually in inpatient financial charges to pre-authorized PCN patients. Before the state implemented PCN, hospital rates were increased to make up for lost revenue from moving formerly funded patients into the donated arrangement. UMAP had previously provided medical payments for 3,000 to 4,000 chronically and terminally ill recipients.

The PCN benefit package is limited compared to commercial products. Commercial plans have richer benefit packages that include such services as hospital inpatient care and therapies. When developing PCN, the state of Utah designed a benefit package that would originally cost approximately $50 PMPM for 25,000 enrollees. Even with the limited package, the program currently costs approximately $60 PMPM for parents and $130 PMPM for childless adults.

Determination of Benefit Package for UPP – Because Utah decided to build on its private insurance market, a policy decision was made to make benefit requirements very general. UPP requires the most critical services to be part of the minimum benefit package– physician, pharmacy, and hospital inpatient care. The state did not try to intervene in cost sharing under the program, but left it to the market to determine the most efficient means of accomplishing this. In addition, Utah does not have cost-sharing limits.

Impact of SPG Program – The Health Resources and Services Administration state planning grant (SPG) program helped generate data for reports that guided the implementation of PCN and UPP and selection of the target population. The SPG program also helped raise awareness of the problem with uninsurance in Utah and fostered a favorable political climate for offering PCN. Additionally, internal claims experience was utilized to develop the benefit package. For example, emergency room utilization was gathered from claims data and was used to evaluate the tradeoff between offering emergency room benefits or specialist care. Due to budget limitations, only one of the two benefits could be offered and it was decided that emergency treatment was a necessity.

Lessons from Administering the Program – The state Medicaid agency infrastructure supports the administration of both PCN and UPP through a variety of activities. PCN and UPP are administered within the state Medicaid agency. Eligibility for PCN and UPP is determined by the same staff that determine Medicaid eligibility. This arrangement allows staff to easily consider other program options when a client loses eligibility. In addition, PCN utilizes Medicaid providers, payment systems, and so on so that a separate payment or service delivery structure did not need to be developed.

Utah has found that the PCN benefits should be expanded to pay for urgent care services. Currently, clients do not have an after hours option for non-life threatening situations. By adding urgent care services, PCN would reduce the burden on hospitals for uncompensated emergency room visits.

Utah also would like to offer alternative primary care benefit packages and open up PCN to a private carrier plan. The private plan would be allowed to offer a different limited benefit package and individuals could choose between the state-run PCN and private carrier coverage.

Utah has found that the premium subsidy for low-wage workers has to be substantial and meaningful. With this in mind, the state is implementing UPP with a significantly increased subsidy level above what was allowed under CAW. In addition, the state reduced PCN's annual enrollment fee for individuals with incomes below 50 percent of the FPL.

Evaluation – The Utah Department of Health has completed a number of evaluations of the PCN program, including health outcomes, utilization reviews, and disenrollment and re-enrollment surveys. Health outcomes evaluations based on pre- and post- self-health assessments were completed in 2002 and 2003. Hospital and pharmacy utilization reviews were performed for individuals enrolled between July of 2002 and February of 2004. A disenrollment survey of PCN members was completed between November and December of 2003, and a re-enrollment survey report was completed in 2005. Utah is completing a more comprehensive final review as part of its current waiver reauthorization process.

The 2002 self-assessment health outcomes survey revealed that PCN enrollees were more likely than the general population of Utah to have arthritis, diabetes, or heart disease. Minimal change in health status was reported in the 2003 follow-up health outcomes survey. In 2003, participants were more likely to have received needed care after enrollment, while inpatient utilization decreased. However, enrollees were also more likely to have been diagnosed with a chronic condition after enrollment, to have reported difficulty accessing specialty care, and were less satisfied with the PCN program than traditional Medicaid enrollees' assessment of Utah Medicaid.

Evaluation of hospital and pharmacy utilization showed that a greater proportion of PCN clients utilized hospital services prior to, or in place of, primary care services, resulting in slightly higher inpatient costs. High intensity users of pharmacy services accounted for a high percentage of the program's costs. These enrollees were also using drugs that had the potential for abuse and misuse, with some of the costliest drugs having lower-cost alternatives. The 2003 disenrollment survey indicated that over 27 percent of enrollees left the program. Nearly one-third of those who left had health insurance from other sources and half were still eligible for PCN. As the reason for not re-enrolling, nearly half of the respondents indicated positive health status; 29 percent reported finances, with a majority citing premium cost; 26 percent reported that PCN did not meet their health care needs; and about one-third cited the inability to receive needed medical care or prescriptions. In the 2005 re-enrollment survey, 63 percent of the enrollees expressed need for expanded service coverage by the PCN program and 21 percent were complimentary toward the program.