

The Healthy Indiana Plan and Health Coverage of Childless Adults Across the States

July 2011

Health Finance Committee

Indiana Legislative Services Agency

Legislative Evaluation and Oversight

The Office of Fiscal and Management Analysis is a division within the Legislative Services Agency that performs fiscal, budgetary, and management analysis. Within this office, teams of program analysts evaluate state agency programs and activities as set forth in IC 2-5-21.

The goal of legislative evaluation and oversight is to improve the legislative decision-making process and, ultimately, state government operations by providing information about the performance of state agencies and programs through evaluation.

The evaluation teams prepare reports for the Legislative Council in accordance with IC 2-5-21. The published reports describe state programs, analyze management problems, evaluate outcomes, and include other items as directed by the Legislative Evaluation and Oversight Policy Subcommittee of the Legislative Council. The report is used by an evaluation committee to determine the need for legislative action.

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Preface

Each year, the Legislative Services Agency prepares reports for the Legislative Council in accordance with IC 2-5-21. As directed by Legislative Council Resolution 08-06, this report concerns the Healthy Indiana Plan (HIP), which is codified in state law as the Indiana Check-Up Plan. The HIP is administered by the Office of the Secretary of Family and Social Services and the Office of Medicaid Policy and Planning. This report has been prepared for use by the Health Finance Committee.

This report contains a nationwide overview and description of 38 programs operated by state governments to address uninsured, low-income, childless adults.

We gratefully acknowledge all those who assisted in preparation of this report. The staff of the Family and Social Services Administration and its contractors were helpful in their responses to our requests for information. We gratefully acknowledge all those who responded to our questions concerning these programs or who assisted in the preparation of this report.

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Issues Concerning the Healthy Indiana Plan

Legislative Council Resolution 08-06 provides that the Legislative Services Agency (LSA) would establish measurements and benchmarks for future evaluation of the Healthy Indiana Plan (HIP). It also directs that LSA, beginning in 2010, undertake an evaluation of the Healthy Indiana Plan using the criteria developed. This report looks at how other states are providing health care or health insurance to one segment of the uninsured population, childless or noncustodial adults, to provide perspective on Indiana's HIP.

What is HIP?

The HIP is a Section 1115 Medicaid demonstration waiver to provide health care coverage through private insurance. The waiver covers a five-year period from January 1, 2008, to December 31, 2012. The HIP waiver covers two groups: children, parents, and pregnant women receiving services under a 1915(b) waiver for capitated managed health care plans (Hoosier Healthwise) who were transferred from the 1915(b) waiver to the 1115 waiver; and the HIP population, uninsured parents with household incomes up to 200% of the federal poverty level (FPL) and childless or noncustodial adults with household incomes up to 200% of the FPL. HIP enrollment of childless or noncustodial adults is limited to 34,000 individuals.

HIP provides healthcare through managed care organizations that contract with the state. Participants make contributions to individual health care accounts (HCA), known as Personal Wellness and Responsibility (POWER) accounts, on a sliding scale to pay for premiums and services. Additionally, participants must complete age-, gender-, and condition-appropriate preventive care testing.

To develop the required benchmarks, LSA reviewed the state law to determine the objectives of the HIP. The following objectives for the HIP were identified through LSA's review and were reported to the Legislative Evaluation and Oversight Policy Subcommittee (LEOPS) of the Legislative Council.¹

Objective One: To extend quality health care coverage for low-income Indiana residents, including extending health care coverage in medically underserved areas and achieving affordable health care costs.

Objective Two: To achieve and maintain wellness by emphasizing preventive care.

Objective Three: To allow for personal empowerment and responsibility for health care.

LSA also identified an important policy question: Is the investment in the HIP the best possible alternative use of the funding to provide health benefits for the uninsured? This is the question that LSA

¹ <http://www.in.gov/legislative/interim/committee/2008/committee/minutes/LEOPB5M.pdf>

sought to discuss through this report. The method by which the evaluation would be conducted, however, has transformed during the period between when the topic was assigned and the development of the report.

Outcome Evaluation

LSA reported to the LEOPS that a health outcome evaluation would be the preferred method to evaluate the program. A health outcome evaluation indicates if a person's health is better after having participated in the program than it was before the program. When this information is compared with health outcomes for a control group, policy questions regarding expenditure of resources can be evaluated. Short of a health outcome evaluation, length of enrollment can be an indicator of improved health. Research has connected continuity of access to care with better health outcome due to better adherence to medical protocols and more consistency of care. Finally, utilization of medical services can provide insight into the health of the population. While prevalence of chronic conditions may not seem like a good indication of health, regular treatment through access to medical services can indicate improved health.

What is an Outcome Evaluation?

This type of evaluation requires a baseline survey of a sample of enrollees at the onset of the program and follows with interviews at one or more intervals using the same measurements of health. Any enrollees who disenroll become part of a comparison group for the enrolled population, if they can be tracked and interviewed at the same time as current enrollees. Another potential comparison group is a general-population group for which health data are already known. Using a general-population group would reduce costs, but increase the possibility of certain errors.

An outcome evaluation is expensive because of the personal interviews required.

Consulting with Family and Social Services Administration (FSSA), LSA learned that one of the health plans serving HIP enrollees would be asking preliminary health status questions upon the enrollee's entry into the program. The questions in this survey were to be used to determine if the enrollee had a high-risk condition that would warrant transfer to Indiana's high-risk pool, the Indiana Comprehensive Health Insurance Association. One of the survey questions concerned overall health information. FSSA discussed with LSA the possibility that other plans participating in HIP might offer similar surveys as part of the quality improvement measures required in the CMS contract. While the survey offered minimal information for an evaluation, it would have provided a baseline at a low cost. If individuals could be tracked through the program and asked this same question at a later point, LSA would have something similar to a health outcome evaluation. FSSA was asked several times to request the data from the plans. When the data were provided by FSSA to LSA, only aggregated responses without individual identification were available and the data were not useful to LSA's evaluation goal.

LSA did not have the data available to complete the type of evaluation it had recommended. However, an FSSA contractor is completing a modified health outcome analysis that appears to fulfill the evaluation requirements. LSA has determined that it would be redundant to develop its own health outcome analysis

based on the contractor’s data or undergo duplicative data collection and analysis efforts for a similar, concurrent evaluation of the HIP program and participants.

FSSA Evaluation and Reporting

Mathematica Policy Research, Inc. (Mathematica) is contracted for evaluation services of the HIP.² The contract calls for the contractor to provide the services relative to an evaluation of the state of Indiana's HIP. Specifically, the contractor would work in collaboration with OMPP to assist in the yearly evaluation plan for HIP; conduct research to complete an annual evaluation; provide CMS with annual and final reports; and produce the OMPP Annual and Final Technical Reports, as well as news releases, dissemination plans, PowerPoint slides, executive summaries or briefing papers, and white papers. The scope-of-work document included in the second amendment to the contract indicated that there are to be a maximum of four white papers per year and that the topics of those papers will be determined after the acceptance of the Annual OMPP Technical Report.

Mathematica has produced a series of annual reports and a paper concerning HIP (Table 1).

Table 1. Mathematica Policy Research, Inc. Reports about Health Indiana Plan³	
Report Title/Website	Report Date
Healthy Indiana Plan Demonstration, Section 1115 Annual Report, Demonstration Year 1: (1/1/08 – 12/31/08)	September 16, 2009
First Annual Report to the Office of Medicaid Policy and Planning: Evaluation of the Healthy Indiana Plan	December 2009
Healthy Indiana Plan Demonstration, Section 1115 Annual Report, Demonstration Year 2: (1/1/09 – 12/31/09)	October 28, 2009
These reports are available in association with this report on the LSA website www.in.gov/legislative/2398.htm	

Mathematica is in the final stages of producing a modified health outcome analysis as part of the CMS reporting requirements. The survey of HIP participants includes the following topics⁴:

- **Recent history of health insurance coverage**, to distinguish chronically uninsured enrollees from other enrollees (new enrollees only and how long they were uninsured)
- **Health status overall**, including both physical and mental health status, chronic conditions, receipt of disability benefits, and work-related health limitations
- **Access to care** such as having a personal doctor during the previous six months (for new enrollees this question will refer to the six months before enrollment)
- **Utilization of care**, including preventive and specialty care, prescription medications and emergency room visits during the previous 6 or 12 months (for new enrollees, this question will refer to the period before enrollment)
- **Unmet health care needs and barriers to utilization** of health care (for new enrollees, this question will refer to the six months before enrollment)

²The original Mathematica contract amount was \$2.5 million over the four-year period between 2009 and 2012. In the second amendment to the Mathematica contract, the contract value was reduced by \$298,825.88 to \$2.2 million, and the term was extended by two years to 2014.

³ Other reports from Milliman, the Kaiser Commission, and Burns and Associates provide additional information about the HIP and are also available in association with this report through the LSA website at www.in.gov/legislative/2398.htm

⁴ Memorandum from Carol Irvin and Holly Matulewicz to Ginger Brophy, Final Design for the Survey of HIP Participants, August 18, 2010.

- **Satisfaction** with HIP
- **POWER accounts**, including knowledge of how the account works and program incentives
- **Demographic characteristics** such as gender, age, race/ethnicity, education, household size, household income, and employment status

The modified health outcome evaluation separates enrollee respondents into two groups, new members who had been part of HIP for up to five months and established members who had been enrolled five months or more. The respondents of each group were asked an almost identical set of questions to determine their health status and utilization of health services. Rather than tracking individual health outcomes, the analysis looks at the health of the overall group.

The evaluation resulting from Mathematica's work was due to CMS in April 2011. The report is still in draft form and under internal review within FSSA. The Mathematica evaluation is anticipated by FSSA to be in final form in the near future. While LSA has not yet received a copy of the draft report, the FSSA and Mathematica did share the evaluation plan, the survey instrument, and the data that was collected, and these have been reviewed by LSA. On the basis of this review, LSA determined that it would be redundant to develop its own health outcome analysis on the collected data or undergo duplicative data collection and analysis efforts for a similar, concurrent evaluation of the HIP program and participants.

Instead, in conjunction with the administration's program evaluation process and for the purpose of describing Indiana's HIP program within the perspective of other state reform efforts, LSA has undertaken a survey of various states' initiatives that provide health care or health insurance to childless adults. While Indiana's HIP provides services for more than childless adults and the childless adult enrollment is currently closed, coverage of this particular population is receiving attention as states seek to cover uninsured, low-income populations.

Details of the Healthy Indiana Plan

The HIP was established in P.L. 3 of 2008 to provide health care through private health insurance. It is now codified in the state statute at IC 12-15-44.2. The HIP was approved as a Section 1115 Medicaid demonstration waiver project for the five-year period between January 1, 2008, and December 31, 2012. Although included in the waiver, the Hoosier Healthwise population, which was transferred from a separate waiver to the HIP waiver, is considered separate from the HIP population. The HIP population consists of uninsured childless and noncustodial adults and parents to 200% of the FPL. Health care is provided through two managed care plans that contract with the state. The funding for the HIP is provided by an increase in the state tobacco tax as well as funds diverted from the federal disproportionate share hospital (DSH) program.

The following description of the HIP is a summary of the state statute. The differences between the statute and actual practice have been noted.

Office of the Secretary of Family and Social Services

Under IC 12-15-44.2-3, the HIP⁵ is administered by the Office of the Secretary of Family and Social Services (Office). The Office is responsible for the oversight of marketing practices of the HIP and the promotion of the program in medically underserved rural areas. The Office establishes standards for consumer protection, including quality of care standards, a process for grievances and appeals, and reports on provider performance, consumer experience, and cost.

Services and Benefits

The health care services to be offered through HIP by IC 12-15-44.2-4 include the following services: mental health care services; inpatient hospital services; prescription drug coverage; emergency room services; physician office services; diagnostic services; outpatient services, including therapy services; comprehensive disease management; home health services, including case management; urgent care center services; preventive care services; family planning services; hospice services; and substance abuse services.

According to statute, the HIP is to pay 50% of the premium cost for dental and vision services. An individual is to pay a copayment for vision or dental services as determined by the Office. However, dental and vision services are not included in the CMS Approval Plan and are not part of the service provider plan descriptions.

Also, the HIP may not permit treatment limitations or financial requirements on the coverage of mental health care or substance abuse services. An individual may be held responsible for the costs of nonemergency services in an emergency room setting. However, the decision to hold the individual responsible may be challenged, and the statute provides certain nonemergency situations that may allow for use of the emergency room.

⁵ The Healthy Indiana Plan was codified in state law as the Indiana Check-Up Plan. The approval documents from the Centers for Medicare and Medicaid Services refer to the Healthy Indiana Plan.

In IC 12-15-44.2-7, at least 85% of the funds appropriated to the HIP are to be used for health care services payments, and there is a limit on provider administrative costs and profit which may not exceed 15% of the appropriated funds. In the statute, the annual individual maximum coverage limitation is set at \$300,000, and the lifetime individual maximum coverage limitation is \$1.0 million.

Eligibility Requirement

IC 12-15-44.2-9 provides that to be eligible for the HIP, the individual must be at least 18 years of age and less than 65 years of age; be a United States citizen and a resident of Indiana for at least 12 months; have an annual household income of not more than 200% of FPL; not be eligible for health insurance coverage through the individual's employer; not have had health insurance coverage for at least six months; not be eligible for the federal Medicare program or for the Medicaid program as a disabled person; and not be a pregnant woman for purposes of pregnancy-related services.

The CMS did not allow the restriction on Indiana residency, based on case law.

The HIP covers individuals including uninsured custodial parents up to 200% of the FPL. HIP is available for a limited population of 34,000 uninsured, noncustodial parents and childless adults with family incomes up to 200% of FPL. The enrollment of noncustodial parents and childless adults with family incomes up to 200% of FPL is currently suspended beginning in 2010.

A July 2010 review of the HIP population shows that the majority of participants are female, 50 years of age or older, and have income at or below FPL.⁶

HIP Focus – Preventive Care

The HIP has an emphasis on preventive care. IC 12-15-44.2-5 requires the Office to provide a list of health care services that qualify as preventive care services for the age, gender, and preexisting conditions of the individual and that each participant receive not more than \$500 of preventive care services each year. Any preventive care services in excess of \$500 are subject to the deductible and payment requirements of the HIP.

Currently, service providers have chosen not to have an upper limit for preventive services, which is allowed under the state rules.

HIP Focus – Personal Responsibility

The HIP also emphasizes personal responsibility by requiring each participant to have a health care account (HCA), or POWER account. The HCA is used to pay the individual's deductible for health care services. IC 12-15-44.2-10 states that for the individual's payment into the HCA, an employer may withhold payments from an employee's wages, the individual may make a payment to the Office for deposit in the account, or the Office may determine another method of payment. Employers may pay an employee's share, but not more than 50% of the required payment may be made by the employer.

⁶ "Healthy Indiana Plan: The First Two Years." Presentation in Indianapolis, IN, to the Health Finance Commission, July 2010, Carol Irvin. Document No. PP10-73.

The maximum contribution to an HCA in statute is \$1,100 per year, and the state contributes the difference between what the individual is required to pay and the maximum contribution. The maximum contribution may be reduced due to other payments the participant makes under the Medicaid or Medicare program or the Children's Health Insurance Program. Also, there is a limit to individual contributions based on the household income percentage of FPL, as follows.

Household Income % of FPL	Maximum Contribution % of Income
Less than 100%	2%
100% but less than 125%	3%
125% but less than 150%	4%
150% but less than 200%	5%

Upon reenrollment in the HIP, any funds that remain in the HCA are applied to the next year's payments. However, if the individual did not receive all recommended preventive services, any state contribution to the HCA may not be rolled over to the individual's account for the following year. If an individual no longer participates in the HIP, an amount from the balance of the HCA may be returned to the individual based on whether the individual voluntarily withdrew from the program or was terminated. The formula to determine the remainder of the HCA to be returned is specified in statute.

An individual may be terminated from the HIP if the required payment is not made within 60 days of the required payment date and once terminated may not reapply to the HIP for 12 months. However, the individual must receive written notice before being terminated. Also, an individual may be prohibited from using the HCA to pay for nonemergency services received in an emergency setting.

Renewal

To participate in the HIP, according to statute, an individual must apply to the HIP and make an initial payment. A person is approved to participate in the HIP for a 12-month period and may be refused renewal if the HIP has reached maximum enrollment. To renew participation, the individual is to complete a renewal application, obtain any necessary documentation, and submit the information to the Office.

About HIP Providers

According to IC 12-15-44.2-14, providers are to receive enhanced reimbursement from the managed care plans contracted with the Office. The reimbursement rate may not be less than the federal Medicare rate for the service provided or 130% of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate. IC 12-15-44.2-15 states that if the HIP reaches its maximum enrollment, an insurer or HMO is required to offer the HIP coverage to individuals who would otherwise qualify for the program but who cannot enroll because the maximum enrollment has been reached. The state does not provide funding for this coverage.

Indiana Check-Up Plan Trust Fund

According to IC 12-15-44.2-17, the Indiana Check-Up Plan Trust Fund is to be used to administer the HIP; provide copayments, preventive care services, and premiums for individuals enrolled in the HIP; and to fund tobacco use prevention and cessation programs, childhood immunization programs, and other health care initiatives designed to promote the general health and well being of Indiana residents. It consists of cigarette tax revenues and other funds designated by the General Assembly to be part of the Fund, federal funds available for the purposes of the Fund, and gifts or donations. Money must be appropriated before it can be used.

Financial Obligation

The statute provides that the HIP may not obligate the state to financial participation beyond the level of state appropriations for the HIP. Before the HIP could begin operations, there was a requirement that there be sufficient funding for five years of operation based on an actuarial analysis. The Office is prohibited from implementing the HIP if there was a denial of federal approval and federal financial participation.

State funding for the HIP is provided by a portion of a \$0.40 increase in the state cigarette tax enacted in 2008. As a Medicaid waiver, the program is eligible for matching federal funds, including enhanced funding due to the American Recovery and Reinvestment Act.

In order to provide federally required cost neutrality for the coverage of childless adults, a group not normally covered by Medicaid, and to receive federal Medicaid reimbursement in the HIP program, the state agreed to waive annual federal Disproportionate Share Hospital (DSH) distributions above a negotiated base level of about \$151 million. The state must also demonstrate additional savings of \$15 million after five years in other areas of the program as identified in the Special Terms and Conditions that govern the waiver.

Health Insurance Premium Assistance Program

The statute also authorizes the Office to establish a Health Insurance Premium Assistance Program, a strategy used by several other states surveyed by LSA. Statute provides that this type of program can be for individuals with an annual household income of not more than 200% of the FPL, eligibility for health insurance coverage through an employer, and an inability to afford the health insurance coverage premiums. The program must have eligibility requirements that are similar to the eligibility requirements of the HIP, include an HCA, and provide that an HCA or health insurance coverage premium payment may not exceed 5% of the individual's annual income.

Survey of the States

LSA initially sought to answer the policy question of whether the investment in the HIP is the best possible alternative to provide health benefits for the uninsured within the funding sources. Since the data were not available to evaluate this question, LSA refocused its efforts to look at alternatives undertaken by other states.

A Kaiser Commission report on the HIP indicates the program is of interest because it is the first with a high-deductible plan and health savings account aimed at a low-income population.⁷ This led LSA to investigate how other states are providing coverage to uninsured, low-income adults. Using a report produced by the National Academy for State Health Policy⁸ (NASHP) and additional research, LSA identified 38 programs that provide benefits or services to childless or noncustodial adults in 24 different states and the District of Columbia.

In this look across the states, LSA found great variety in the programs, which was not surprising since most programs are demonstrations or must work within limited budgets. For programs for which data were available on the childless adult population, the enrollment ranged from 108 to 225,000, with the average number of enrollees being 39,143.

The programs used many different mechanisms to deliver health care or health care insurance. Some states contain costs with packages with limited benefits or services or through managed care contractors or by adding the participants onto the state's Medicaid program. In some cases, insurance-buying pools or state-run plans are provided, or an individual receives reduced-cost services or sliding-scale reductions in service costs. A few programs rely on private entities to provide services in exchange for tax benefits or other incentives.

The structure of the delivery mechanism seems to be unrelated to the funding source of the program. The majority of the programs (24, including Indiana) are 1115 Medicaid waiver programs⁹. A few of these had begun as state-funded programs, but as budgets have tightened, they have moved to waiver programs. As a result of the move, the income requirements have tightened. Of these waiver programs, 9 involve employer-sponsored insurance, resulting in a private funding source within the waiver program. Of the 14 state-funded programs, 5 include a private funding source by pairing with employer-sponsored insurance.

The following describes the delivery mechanisms and other program statistics in relation to the funding source of the program. The programs that have private funding within another source of funds have been identified in separate groups.

1115 Medicaid Demonstration Waivers. In order to have a program approved by CMS to provide services to a nontraditional Medicaid population, the federal government requires budget neutrality (i.e., the amount of federal funding may not increase beyond the state's existing federal expenditures). In this review, some of the programs provide Medicaid packages or full services to childless adults. Most of

⁷ Kaiser Commission, *Summary of Healthy Indiana Plan: Key Facts and Issues*, June 2008.

⁸ Klein, Keavney and Schwartz, Sonya, *State Efforts to Cover Low-Income Adults Without Children*, State Health Policy Monitor, September 2008.

⁹ MinnesotaCare receives federal funds under a Medicaid waiver. However, documentation indicated that childless adults were not funded with these federal sources, and the program is listed as a state-funded program.

these programs use existing federal resources by foregoing increases or capping the amount received for the Medicaid disproportionate share hospital program. Other states increase the program funding with state tobacco funds or increases in tobacco taxes or health provider taxes. Mandatory managed care savings are expected to reduce overall costs and maintain budget neutrality for several programs. Several programs offer services or benefits that are reduced from their Medicaid package as a way to reduce expansion costs. Limiting the number of providers or using community health systems are other ways states seek to reduce costs. In addition to providing a benefits package for childless adults, two programs offer premium assistance to qualified employees who cannot afford premiums for employer-sponsored health care insurance.

State-Funded Programs. Four of the state-funded programs provide health services to enrollees. In general these programs are not insurance packages, but rather the services are provided by managed care providers or a panel of providers who have agreed to accept a reduced fee. The remaining programs provide access to health insurance or a buy-in opportunity for a state insurance plan. Funding sources for the state-funded programs come from tobacco settlement funds or increased taxes on tobacco products, alcohol, or health care providers. Only one state uses state general fund dollars currently, although some others began programs with this funding source. A Washington State program does not contribute any funds, but rather sponsors a benefits package for which the individuals pay the full premium and program costs. All of the programs have some cost sharing, and almost all have a premium or deductible.

Medicaid Waiver-Employer Participation. Only one of these programs provides health insurance for individuals whose employer does not offer insurance. Five of the programs provide assistance directly to the individual, and two of the programs provide subsidies to the employer. Six of the programs offer assistance specifically to small-business employees or employers. Often these programs require that employers pay at least 50% of the monthly premium. One program requires a certain percentage of the employees participate in health insurance for everyone to receive the assistance. All of the programs require an individual premium, and most premiums are based on the employee's or individual's income. In addition, a few of the programs have deductibles and copays.

State Program-Employer Participation. Two programs offer state-sponsored health insurance, two offer subsidies to small-business employers, and one offers premium assistance to small-business employees. Most of these programs have reached capacity or have their enrollment closed or have been discontinued.

For a variety of reasons, when LSA looked for evidence of success, the number of evaluations that provided health outcome or length of enrollment data was minimal. Often, the information available about a program has a specific use. Demographics or utilization of services data are useful to estimate future service use and cost. Available audits look at operational management of the program, and marketing surveys look at satisfaction and quality of care. A number of the childless adults programs are nested within larger populations so that the data addresses the general or blended populations. Policy information about these programs seems to take second place to these other uses.

LSA was not able to find any reports about 13 of the programs. Of the reports identified, only 3 had health outcome information, but 10 had length-of-enrollment data. Based on the data found, length of enrollment was about 7 or 8 months on the low end and 2 to 3 years on the high end. Most of the short-

term enrollment was for premium assistance programs while the longer-term enrollment was in state-sponsored plans.

The following pages provide program detail for each of the 38 programs serving childless adults. On the left-hand side of the page is an overview of the state populations and program statistics. The program description includes information on the history of the program. Also provided are details on eligibility, benefits, and services offered, the current status of the program, and any evidence of success that could be uncovered. The sources and additional information section provides the sources of LSA's reviews and links to references for further investigation by the reader. The programs are alphabetized by state and sorted by funding source.

State	Program Name	Enrollment CA=Childless Adults TE= Total Enrollment		Current Status	Page Number
Medicaid Waiver Programs					
Arizona	AHCCCS	225,000	CA	Discontinued	15
Delaware	Diamond State Health Plan	27,000	CA	Ongoing	17
District of Columbia	Healthcare Alliance Program	1,309	TE	Converted to cover population expansion under ACA	19
Hawaii	QUEST Adult Coverage Expansion	77,405	TE	Waiver expires June 30, 2013	21
Indiana	Healthy Indiana Plan	14,841	CA	Waiver expires December 31, 2012	23
Iowa	IowaCare	50,407	CA	Ongoing	25
Maine	MaineCare for Childless Adults	20,000	CA	Ongoing	27
Maryland	Primary Adult Care Program	40,397	CA	Ongoing	29
Massachusetts	Commonwealth Care	160,318	TE	Renewal under review by CMS	31
Michigan	Adult Benefits Waiver	61,000	CA	Ongoing with changes in covered	33
New York	Family Health Plus	378,034	TE	Ongoing	35
Oregon	Health Plan	26,857	Avg mo.	Ongoing	37
Utah	Primary Care Network	18,248	TE	Enrollment closed	39
Vermont	Health Access Plan	37,383	CA	Ongoing	41
Wisconsin	BadgerCare Plus Core Plan	35,961	TE	Ongoing	43
State-Funded Programs					
Arizona	Primary Care Program	78,000	TE	Ongoing	45
Delaware	Community Healthcare Access Program	22,241	TE	Ongoing	47
Minnesota	General Assistance Medical Care	35,194	TE	Discontinued	49
Minnesota	MinnesotaCare	72,230	CA	Discontinued	51
Pennsylvania	adultBasic	42,783	TE	Transitioning to 1115 Waiver	53
Washington	Basic Health	56,394	TE	Ongoing	55
Washington	Health Program	1,200	TE	Ongoing; over subscribed	57
Wisconsin	BadgerCare Plus Basic Plan	5,714	CA	Ongoing	59
Medicaid Waiver-Employer Participation					
Arkansas	ARHealthNet	7,372	CA	Waiver ends September 2011	61
Idaho	Access to Health Insurance	108	CA	Ongoing	63
Massachusetts	Insurance Partnership	13,369	Individuals	Ongoing	65
New Mexico	State Coverage Insurance	27,961	CA	Currently on waiting list	67
Oklahoma	Insure Oklahoma	18,830 13,413	ESI Adults IP Adults	Ongoing	69
Oregon	Family Health Insurance Assistance Program	5,677	Adults	Ongoing	71
Utah	Premium Partnership	29	CA	Possible expansion	73
Vermont	Catamount Health	12,997	TE	Ongoing	75
Vermont	VHAP ESI	890	CA	Ongoing	77

State	Program Name	Enrollment		Current Status	Page Number
		CA=Childless Adults	TE= Total Enrollment		
State-Employer Participation					
Kentucky	Insurance Coverage Affordability and Relief to Small Employers	1,000	Lives	Discontinued	79
Maine	Dirigo Choice	7,474	TE	Discontinued	81
Montana	Insure Montana	1,372	Businesses Covered	Ongoing with funding decrease	83
New York	Healthy New York	165,891	TE	All available slots are filled	85
Tennessee	CoverTN	19,118	TE	Ongoing	87
Washington	Health Insurance Partnership	67	Individuals	New enrollment suspended	89

AHCCCS Care

Overview

State Populations -

General	6,511,200	100%
Uninsured	1,273,300	20%
Medicaid	1,237,100	19%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Voter approved extension of Medicaid benefits to childless adults.

Program Enrollment* -

Childless Adults 225,000

*June 1, 2011

Start Date: 2001

Annual Costs: Expenditure for AHCCCS Care was \$1.4 billion in CY 2009.

Funding Sources: Generally, Medicaid matching funds are appropriated by the legislature or through initiatives enacted by Arizona voters. Sources include the General Fund, the Tobacco Settlement Fund, Tobacco Tax funds, and county funds.

Cost Sharing, Premiums, and Deductibles: After an injunction had been ordered, a federal appeals court ruled that AHCCCS may charge copayments for the AHCCCS expansion population, which includes childless adults.

People on AHCCCS Care have to pay higher copays for some medical services than other plans. Pharmacists and medical providers can refuse services if the copayments are not made.

Copayments for AHCCCS Care:

- \$4 for generic prescriptions (or brand name prescriptions when there is no generic)
- \$5 for doctor office visits
- \$10 for brand name prescriptions when there is a generic
- \$30 for nonemergency use of an emergency room

Program Description

General and History: Arizona did not have a Medicaid program under Title XIX until 1982 when AHCCCS was established as an 1115 waiver demonstration project.

Arizona voters approved expanding the income limits for full acute care Medicaid, and this group is known as the Proposition 204 expansion. CMS approved the Medicaid expansion to include coverage up to 100% of FPL for adults without dependent children, among other groups.

In 2001, the AHCCCS program submitted a HIFA amendment, and the state received permission from CMS to use Title XXI funds to expand coverage to two populations, one of which was adults over age 18 without dependent children.

The AHCCCS program that serves childless adults is known as AHCCCS Care. Acute care services are provided by ten private or county-owned health plans.

Eligibility: Childless adults who are not eligible under one of the regular Medicaid categories. An asset test is not required, but income must be under 100% of the FPL. Eligibility is renewed every 12 months.

AHCCCS Care qualifications include:

- No eligible deprived child living with the adult
- Not pregnant
- Not aged 65 or over
- Not disabled

Benefits and Services: Services for adults include behavioral health; dialysis; emergency care; family planning; hospital services; immunizations; lab and x-ray; doctor visits; podiatry services; physical exams; prescriptions; specialist care; surgery services; medical transportation; and annual well-women exams.

Current Status: On March 13, 2006, the state of Arizona submitted a "Waiver Renewal Proposal" for its entire 1115 demonstration. The extension was granted for five years by CMS, with operating dates between October 27, 2006, and September 30, 2011.

However, on July 1, 2011, AHCCCS Care will disenroll 250,000 childless adults in order to balance the state budget. A revised waiver request to CMS would allow Arizona to create a new childless adult program that limits enrollment to individuals who are enrolled on July 1, 2011, and who

continue to meet enrollment requirements in subsequent months thereafter.

Evidence of Success: A snapshot of the population on January 1, 2010, shows the majority of the population is over 21 years of age (87.6%) and male (55.6%). In CY 2009, of the identified diseases, expenditures for injury including trauma, heart and circulation, and musculoskeletal systems were the highest.

Sources and Additional Information:

Copayment information: <http://www.azahcccs.gov/members/copayments.aspx#AHCCCScare>

Covered Services Information: <http://www.azahcccs.gov/applicants/medicalservices.aspx?ID=acute>

AHCCCS Care Transition Plan:

http://www.azahcccs.gov/publicnotices/Downloads/ChildlessAdultTransitionPlan_Handout.pdf

CMS Website:

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=Arizona&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS028619&intNumPerPage=10>

Quarterly Progress Report, January-March, 2011:

http://www.azahcccs.gov/reporting/Downloads/QuarterlyProgressReports/2011/CMS_QuarterlyReport_January_March_2011.pdf

Newspaper article concerning approval for disenrollment:

<http://www.azcentral.com/arizonarepublic/news/articles/2011/02/16/20110216arizona-health-care-cuts.html>

Arizona's request to disenroll childless adults:

<http://www.azahcccs.gov/reporting/Downloads/BudgetProposals/FY2012/AZMOEWaiverAttachment.pdf>

Joint Legislative Budget Committee, *AHCCCS Historical Spending FY 2004-FY 2011*:

<http://www.azleg.gov/jlbc/AHCCCSHistoricalSpending.pdf>

1115 Waiver Population Data:

<http://www.azahcccs.gov/reporting/Downloads/1115waiver/DataNarrativeandDetail.pdf>

*Diamond State Health Plan***Overview****State Populations -**

General	868,600	100%
Uninsured	105,900	12%
Medicaid	121,100	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Same managed care benefits as for the Medicaid population.

Program Enrollment* -

Childless Adults	27,000*
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*approximate enrollment September 2010.

Start Date: April 1, 1996.

Annual Costs: The SFY 2012 Governor-recommended appropriation for all Medicaid services is \$644 million.

Funding Source: Savings achieved by mandatory managed care.

Cost Sharing, Premiums, and Deductibles:

Demonstration participants are charged nominal copayments as defined by the Delaware Medicaid State Plan.

Program Description

General and History: Delaware implemented a mandatory Medicaid managed care program on January 1, 1996. The managed care waiver included the majority of the state's Medicaid population (80%), uninsured adults, and the family planning expansion population. Using savings to be achieved under managed care, Delaware expanded coverage on April 1, 1996, to additional low-income adults, as well as a family planning expansion.

Eligibility: Uninsured Delawareans with incomes up to 100% FPL.

Excluded are individuals:

- Who receive long-term care services (nursing facility, acute care, and home and community-based waivers).
- Who have comprehensive health insurance.
- Who are entitled to or eligible to enroll in Medicare.
- Who have coverage through military health insurance for active duty, retired military, and their dependents.

Adults are not eligible for Medicaid benefits until they are enrolled in a managed care organization.

Benefits and Services: Services for adults include the basic benefit package, including medical and mental health services, as available to the Medicaid population. Certain optional Medicaid services are not available to the adult expanded group through the managed care plans. Mental health services exceeding those provided in the basic benefit package are being provided through the relevant state agencies and are reimbursed on a fee-for-service basis.

Current Status: Ongoing.

Evidence of Success: Goals of the state program are to improve and expand access to health care to an additional 10,000 to 12,000 adults and children throughout the state, create and maintain a managed care delivery system emphasizing primary care, and to strive to control the growth of health care expenditures for the Medicaid population.

Sources and Additional Information:

CMS 1115 Waiver webpage:

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=Delaware&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS035515&intNumPerPage=10>

Delaware Health Care Commission Minutes: http://dhss.delaware.gov/dhss/dhcc/files/min_dhcc_sep10final.pdf

State Health Plan Information:

http://www.workworld.org/wwwwebhelp/de_medicaid_diamond_state_health_plan.htm

Governor's Recommended Budget Detail SFY 2012:

<http://budget.delaware.gov/fy2012/operating/vol1/12-vol1-dept35.pdf>

Healthcare Alliance Program

Overview

Local Populations -

General	593,000	100%
Uninsured	66,500	11%
Medicaid	127,000	21%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: DSH diversion to provide Medicaid managed care to childless adults.

Program Population

Total 1,309 *

*Enrollment as of March 2009

Start Date: Original waiver implemented February 2003. Extension - October 1, 2008, through September 30, 2011.

Annual Costs: Capped at \$12,857,142.

Funding Sources: Diversion of no more than \$12,857,142 in annual DSH payments. This is the federal funding limit.

Cost Sharing, Premiums, & Deductibles:

No premium contribution and no copayments are required.

Program Description

General and History: In October 1998, the District of Columbia submitted a waiver application to provide Medicaid coverage to all childless adults between the ages of 19 and 64 with incomes below 50% of FPL. The DSH diversion dollars were initially limited to \$6 million, so the expansion was subsequently limited to persons ages 50 to 64 and below 50% FPL. While expansions to younger age groups were initially planned, no subsequent eligibility expansions have been requested. The waiver was implemented February 1, 2003, and in 2004 the amount of DSH diversion was increased to \$12.9 million, annually.

The waiver extension was granted, and the waiver was extended to September 30, 2011.

Eligibility: U.S. citizens who are childless adults aged 50 through 64 with incomes at or below the medically needy limit or 50% of the FPL, whichever is higher, and not otherwise eligible for the Medicaid program are eligible. Applicants must have resources of less than \$2,600 and may not reside in long-term care, mental health, or penal institutions. Enrollment is limited each month to the number of individuals that can be supported by the available DSH diversion dollars. Enrollment and expenditures are monitored monthly, and the District may close enrollment if projections indicate the expenditure cap will be exceeded.

Benefits and Services: Childless adult enrollees receive full Medicaid benefits as delivered by managed care contractors.

Current Status: The District implemented the ACA option to expand Medicaid eligibility to nondisabled childless adults below 133% of FPL on July 1, 2010. The waiver population appears to have been changed to cover individuals between 133% and 200% of FPL.

Evidence of Success: The goals of the demonstration are to improve the health status of very low-income adult residents of the District by improving access to health care, improving the quality of health services delivered, reducing uncompensated care, and providing continuity of insurance status as older adults become eligible for Medicare.

Sources and Additional Information:

CMS website for state 1115 waivers:

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=District%20of%20Columbia&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS028930&intNumPerPage=10>

DC Department of Health Care Finance Proposed 2012 Budget:

http://cfo.dc.gov/cfo/lib/cfo/budget/fy2012/chapter/human_support_services/ht_dhcf_chapter.pdf

DC Health Reform Implementation Committee Charges (See Medicaid Expansions Sub-Committee):

http://hc.rrc.dc.gov/hc/lib/hc/mtg/HRIC_Sub-Committee_2010-2011_Charges_Final.pdf

Hawaii QUEST Expanded

Overview

State Populations -

General	1,225,900	100 %
Uninsured	100,300	8 %
Medicaid	176,000	14 %

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Three programs that provide care either with managed care or limited benefits packages.

Program Enrollment* -

QUEST	65,855
QUEST-ACE	11,550

* Avg. monthly enrollment 4/2010 to 3/2011

QUEST Start Date: August 1994
QUEST-ACE Start Date: February 2008

Annual Costs:** \$12.6 million

** The annual cost reflects the appropriation for SFY 2012 of \$5.7 million plus \$6.9 million in supplemental payments being provided by the QUEST Expanded health plans. It does not include the amount of federal matching funds.

Funding Sources: State general fund and federal Medicaid funds.

Cost Sharing, Premiums, and Deductibles:

Generally, QUEST-ACE enrollees are not responsible for deductibles or copayments. Pregnant women whose incomes exceed 185% of the FPL can enroll in Quest-ACE by paying premiums.

Program Description

General and History: Hawaii's QUEST Expanded section 1115 demonstration provides comprehensive Medicaid managed care coverage to children and adults. The demonstration builds upon the Hawaii Prepaid Health Care Act (HPHCA), which requires all employers to provide insurance coverage to any employee working more than 20 hours per week.

Under the QUEST Expanded demonstration, Hawaii has implemented three programs: QUEST, QUEST-Net and QUEST Adult Coverage Expansion (QUEST-ACE).

QUEST is primarily managed care for pregnant women and children with family incomes under 200% FPL. QUEST also includes coverage of childless and caretaker adults up to 100% of FPL. The Quest program has an enrollment cap of 125,000.

QUEST-Net covers children and qualified adults up to 300 % FPL.

QUEST-ACE provides limited benefits for childless adults with income of between 100% FPL and 200% FPL who are not eligible for QUEST coverage, as well as for childless adults who are eligible for QUEST but cannot enroll due to the QUEST enrollment caps. QUEST-ACE is also subject to an enrollment cap. Pregnant women whose income exceeds 185% of the FPL can enroll in Quest-ACE by paying premiums.

The QUEST-ACE program was required to meet an enrollment benchmark of 3,500 enrollees by June 30, 2010, which was achieved in SFY 2009. QUEST-ACE enrollment was 8,089 in SFY 2009 and 11,550 in SFY 2010.

Eligibility: In order to be eligible for QUEST-ACE benefits, an individual must be 19 years or older, be a resident of Hawaii and a U.S. citizen, reside in a household with income up to 200% FPL, and not have other insurance coverage. Enrollees may have assets in excess of the Medicaid State Plan limits - \$2,000 for a household of one and \$3,000 for a household of two. Individuals unable to enroll in the QUEST full Medicaid program due to the enrollment caps may enroll in the QUEST-ACE program. Additionally, medically needy individuals whose income exceeds the State Plan limits may elect QUEST-ACE limited coverage in lieu of spending down to the medically needy income level.

Benefits and Services: Services include 12 outpatient physician visits per year; 10 inpatient hospital days per year and inpatient physician visits for medically necessary medical care, surgery, psychiatric care, and substance abuse treatment; six mental health visits per year; prescription drugs (includes certain antibiotic and specific contraceptives only); emergency room services; and limited preventive and restorative dental benefits.

Current Status: The current 1115 demonstration of Hawaii QUEST Expanded was extended on February 1, 2008, and is scheduled to expire June 30, 2013.

Evidence of Success: The Consumer Assessment of Healthcare Providers and Systems (CAHPS) health plan surveys are standardized survey instruments that measure members' satisfaction levels with their health care. The 2010 Hawaii External Quality Review Report provides the results of the administration of the CAHPS Adult Medicaid Health Plan Survey to members 18 years of age and older. The survey was administered by the Health Services Advisory Group, the external quality review organization contracted by Med-QUEST. The category of "getting needed care" was rated at 48.5%, while "getting care quickly" was rated at 53.4%. Overall, QUEST received a favorable 60.4% rating for approval of the health plan.

Sources and Additional Information:

State of Hawaii Department of Human Services, Med-QUEST Division: <http://www.med-quest.us/>.

Centers for Medicaid and Medicare Services, Medicaid Waivers and Demonstration List, Details for Hawaii Quest Expanded: <http://www.cms.gov/medicaidstwaivprogdemopgi/mwdl/itemdetail.asp?itemid=CMS028411>.

National Conference of State Legislatures, *Using Medicaid Dollars to Cover the Uninsured*, Updated August, 2009: <http://www.ncsl.org/default.aspx?tabid=14486>.

State of Hawaii Department of Human Services, Med-QUEST Division, *External Quality Review Report of Results for the QUEST and QUEST Expanded Access Health Plans*, November 2010: <http://www.med-quest.us/PDFs/Consumer%20Guides/2010%20External%20Quality%20Review%20Report%20of%20Results%20for%20the%20QUEST%20and%20QUEST%20Expanded%20Access%20Health%20Plans.pdf>.

State of Hawaii Department of Human Services, Med-QUEST Division, Community Discussion on Decreasing Med-QUEST Expenditures: <http://hawaii.gov/dhs/quicklinks/MQDPresentation/Presentation%20on%20Decreasing%20Medicaid%20Expenditures.pdf>.

Session 2011 Bills, HB 200: http://www.capitol.hawaii.gov/session2011/bills/HB200_CD1_.pdf.

Proposed changes to Med-QUEST May 2011: <http://hawaii.gov/dhs/quicklinks/Proposed-Medicaid-Eligibility-and-Benefits-Changes/MQD%20Budget%20Presentation%205-10-2011.pdf>

RFP detailing QUEST amendments and provisions: <http://www.med-quest.us/PDFs/Quest/RFI-MQD-2011-002.pdf>.

Healthy Indiana Plan (HIP)

Overview

State Populations -

General	6,321,100	100%
Uninsured	837,200	13%
Medicaid	945,200	15%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Health coverage through private health insurance and that emphasizes personal responsibility and "ownership" of health care.

Program Enrollment* -

HIP Total	41,946
Childless Adults	14,841
Caretaker Adults	27,105

*Enrolled February 2011 enrollment for childless adults was suspended March 2009 when caps were reached.

Start Date: January 1, 2008.

Annual Costs: \$233.4 million estimated for FY 2011 (state and federal dollars). The per member, per month cost in the first three months of 2011 (demonstration year 4) is \$482.92.

Funding Sources: Portion of cigarette tax is used for the state share. Federal cost neutrality is to be met through the diversion of DSH, and from savings from managed care and expanded third-party cost recoveries, estate recoveries, and fraud and abuse recoveries.

Cost Sharing, Premiums, and Deductibles:

Enrollees are required to make specified monthly contributions to their POWER accounts. The deductible is \$1,100, which is intended to be paid from the POWER account. Copayments are required for prescriptions and emergency department use.

Program Description

General and History: The Healthy Indiana Plan (HIP) waiver was approved in December 2007. The Hoosier Healthwise program that provided managed care coverage for pregnant women, certain parents, and children under Medicaid before the approval of the HIP waiver was transferred to the 1115 HIP demonstration waiver. However, that population continues to receive benefits under the Hoosier Healthwise program.

The HIP program covers two additional populations. HIP provides coverage modeled after a high-deductible plan for uninsured, low-income adults who were not previously eligible for Medicaid – custodial parents and childless or noncustodial adults.

Within a managed care environment, HIP provides age- and gender- appropriate preventive care, an account similar to a health savings account (i.e., a Personal Wellness and Responsibility or POWER account), and a high-deductible health insurance plan.

A \$0.40 increase in the cigarette tax provides the funding for the state share of the HIP program. Federal cost neutrality is to be met through (a) the diversion of DSH allotments in excess of \$151.2 million (or more than \$50 million annually), (b) savings to be achieved within the HoosierHealthwise managed care environment, and (c) an additional \$15 million in savings over the 5-year period of the waiver that is anticipated to be achieved through expanded third-party cost recoveries, estate recoveries, and fraud and abuse recoveries.

Eligibility: Generally, uninsured low-income custodial parents and childless or noncustodial adults with incomes below 200% FPL and who are not otherwise eligible for Medicaid are eligible for the HIP program. Adults need to have been uninsured for at least 6 months and Medicare, Medicaid, or employer-provided insurance may not be available to them. The enrollment for childless and noncustodial adults is capped at 34,000 under the terms of the waiver. Pregnant women are eligible for Medicaid up to 200% FPL and are not eligible for HIP enrollment.

Benefits and Services: Within the managed care environment, HIP enrollees are eligible for all age- and gender-appropriate preventive care services. The state requires the managed care plans to provide up to \$500 in preventive care per year that is not subject to the deductible

of \$1,100 and does not draw from the enrolled's POWER account. (Currently, participating plans have chosen not to cap their coverage for preventive care.) Preventive care services must be kept up-to-date or the enrollee may have penalties associated with the POWER account.

Unlike regular Medicaid, the coverage is subject to a \$1,100 deductible and benefits are capped at \$300,000 annually with a \$1 million lifetime benefit cap. The POWER account is HIP's version of a health savings account and is used to cover the \$1,100 deductible. The account is funded through enrollee contributions (determined using a sliding scale based on income and which may not exceed 5% of annual family income) plus subsidies from the state and federal governments. Employers and not-for-profit corporations may make specified levels of contributions on behalf of an enrolled. The POWER accounts are managed by the managed care plans and may only be used to pay for authorized services provided by the plan's network of providers. Once the deductible is met, the enrollee is covered up to the annual and lifetime caps.

Failure to make required POWER account contributions will result in disenrollment. Individuals who are discontinued from HIP may not reenroll for 12 months.

HIP does not cover dental services, vision services, chiropractic services, podiatry services (excepting diabetics), hearing aids (excepting 19 and 20 year olds), maternity services, and various other services.

Enrollees who have an identified high-risk condition (such as cancer, organ transplant recipients, or HIV/AIDS patients) are to receive benefits through the Enhanced Services Plan (ESP), which is a fee-for-service inpatient health plan that also manages the state's high-risk pool.

Current Status: Ongoing. The waiver expires December 31, 2012.

Evidence of Success: The second-year evaluation of the HIP indicates that 71% of enrollees are at or below FPL. It is estimated that the HIP population represents 25% of those who were uninsured in the baseline period before HIP.

Of the noncaretaker population, the majority is female (58%), 50 years of age or older (45%), white (79%), and are the only member of their family (68%).

For HIP enrollees who entered between January 2008 and June 2008, 36% had money left in their POWER account. Of those, 71% were eligible for a full rollover of funds. This is an indication that appropriate preventive testing has been completed.

In 2008 and 2009, there were 1,835 HIP members (3%) who were disenrolled for failure to pay monthly contributions. In total, about 11% of enrollees have disenrolled from HIP. Two members met the annual or lifetime benefit limit in this period.

The 138 HIP enrollees who have disenrolled and then reentered the program tend to be female (83%) and between 30 and 39 years of age (47%). The data reflect the policy to transfer pregnant women to another program and then return them to HIP at the end of the pregnancy.

Sources and Additional Information:

HIP Waiver Request Documents:

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual.%20data&filterValue=Indiana&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS1201233&intNumPerPage=10>

Mathematica Policy Research, Inc., Healthy Indiana Plan Demonstration, Section 1115 Annual Report, Demonstration Year 2: (1/1/09 – 12/31/09), October 28, 2010.

*IowaCare***Overview****State Populations -**

General	2,990,300	100%
Uninsured	312,600	10%
Medicaid	386,100	13%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Program Type: Managed care; limited services

Program Enrollment* -

Total	68,532
Est. noncustodial adults**	50,407

*Enrolled SFY 2010

**CMS Renewal Application indicates that 88% of enrollees are noncustodial adults.

Start Date: 2005

Annual Costs: SFY 2010 appropriations of \$122.8 M.

Funding Sources: For SFY 2010, the funding sources include local governments and federal support. IowaCare demonstrated budget neutrality by shifting federal funding from intergovernmental transfers to the program. Program costs were capped over the life of the project with the base year (FFY 2006) set at \$102.2 million, and each other year of the project, the cap increased by 7%.

Cost Sharing, Premiums, and Deductibles:

Monthly premiums are for members who are above 100% of the FPL. Members below the FPL are not required to pay a premium.

After paying a premium for at least 4 months, a member may request a hardship waiver of the premium payment.

Data year-to-date in SFY 2011 shows that 93% do not pay any premium, 3% have a hardship waiver, 3% pay premiums, and 1% has not responded to requests for payment.

Copays apply to take home medicines resulting from an inpatient stay. The facility issuing the medication decides the amount of the copay.

Program Description

General and History: In 2005, Iowa lost \$65 million in federal intergovernmental grants from a prior program called "State Papers". Iowa looked to the state and counties for indigent care at a university hospital and other clinics to provide the match to federal funding, thus creating savings for the state general fund.

Eligibility: The IowaCare program covers adults, age 19 to 64, with incomes below 200% of the FPL. The program also covers a small number of pregnant women whose income is between 200% and 300% of FPL but below 200% FPL after spending for medical expenses are considered.

Certification for IowaCare lasts 12 months, and renewal upon application is available.

Benefits and Services: The services covered include limited inpatient and outpatient hospital services, physician services, and some dental services. Prescription drugs for smoking cessation and prescribed for take home after a hospital stay are covered. However, the University of Iowa Hospitals and Clinics (UIHC) and Broadlawns Hospital provide limited drugs and durable medical equipment through their own funds.

The IowaCare provider network is limited to the University UIHC in Iowa City and Broadlawns Hospital in Des Moines. Services provided by any other provider are not covered, except for an annual preventive physical exam, associated laboratory tests, and pregnancy-related and newborn services, which can be provided by any Medicaid provider who is authorized to provide physician services.

Current Status: The IowaCare original waiver expired in June 2010, and a renewal was approved by CMS on September 1, 2010.

Evidence of Success: IowaCare maintains a data warehouse. Using the reports from this warehouse, it appears that throughout the life of the project, 70% of disenrolled members disenrolled after one year in the program and that another 19% disenrolled between 13 months and 2 years in the program.

According to the waiver renewal application in 2009, 88% of IowaCare members were childless adults and 83% had incomes below 100% of the FPL. The average monthly income for an IowaCare member was \$850 according to the

report. Two-thirds of enrollees have had no health insurance for more than two years prior to enrollment, and enrollees have a much higher incidence level of chronic disease and self-reported poorer health status than the general Medicaid population. The application indicates that the most frequent chronic conditions for which IowaCare members are seen, based on primary diagnosis codes, include hypertension, chronic pain, diabetes, acute upper respiratory infections or bronchitis not specified as acute or chronic, and dental carriers.

Sources and Additional Information:

IowaCare Website: <http://www.ime.state.ia.us/IowaCare/index.html>

IowaCare Fund FY 2012 Annual Budget:

<http://www.legis.state.ia.us/lsadocs/FiscalDocs/FY2012/dept460/SCH6.PDF#41300000500>

1115 Demonstration Waiver Renewal Application:

<http://www.ime.state.ia.us/docs/IowaCareRenewalFinal100809.pdf>

Damiano, Peter C., Momany, Elizabeth T., and Carter, Knute Derek, *Outcomes of the IowaCare Program, SFY 2008*, July 2009: <http://www.ime.state.ia.us/docs/DraftSecondEvaluationIowaCareoutcomes.pdf>

PowerPoint presentation: www.ime.state.ia.us/docs/IowaCareWorkgroup111708.ppt

PowerPoint presentation:

<http://www.ime.state.ia.us/docs/BroadlawnsMedicalCenterHealthHumanServicesAppropriations.pdf>

MaineCare for Childless Adults

Overview

State Populations -

General	1,305,300	100%
Uninsured	134,700	10%
Medicaid	280,800	22%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: DSH diversion to provide Medicaid managed care to childless adults.

Program Enrollment -*

Total capped at	20,000
Waiting list (June 2010)	13,382

*Average monthly enrollment

Start Date: January 2002.

Annual Costs: Capped at maximum federal DSH diversion of \$90 million.

Funding Source: DSH diversion of \$90 million. These dollars are reported to have been unused when the waiver was implemented.

Cost Sharing, Premiums, and Deductibles: Copayments are the same as are allowed for Medicaid; \$1 to \$3 for defined services, \$2 for generic drugs, and \$3 for brand-name drugs. No premiums or deductibles are assessed.

Program Description

General and History: Maine discontinued the Maine Health Program, a state-funded program for the uninsured in 1995 due to a lack of funding. The 1115 waiver application to cover childless adults was submitted to CMS in February 2002.

Eligibility: Childless adults with incomes at or below 100% FPL are eligible for the program. Assets may not exceed \$2,000 for individuals or \$3,000 for couples; savings may not exceed \$8,000 for individuals or \$12,000 for couples. Cars, homes, and college savings are not counted against eligibility. The waiver is capped at \$20,000 per individual. The waiver was authorized to expand to 125% of FPL, but this was never implemented due to budget constraints.

Services and Benefits: Most enrollees participate in a primary care case management (PCCM) system although waivers are given to participants for fee-for-service due to health status or geographic location.

Covered services for adults include the following: Outpatient mental health (Up to 16 visits per year with licensed practitioners, limit does not apply to emergency and crisis services); alcohol/drug treatment; chiropractic; limited dental; emergency room; vision services (glasses excluded); family planning; hospital; ambulatory clinic services and ambulatory surgical center services; physicians and clinics; advanced practice RN services; pharmacy; and transportation.

Current Status: Ongoing as of June 15, 2011.

Evidence of Success: Goals were to lower safety net expenses by providing Medicaid coverage to low-income childless adults.

The rise in enrollment at the beginning of the program was accompanied by a decrease in the number of uninsured individuals. However, a cap on enrollment led to a rise in the proportion of uninsured adults in a 2006-2007 survey.

Sources and Additional Information:

Discussions of benefit cuts for noncategoricals:
http://www.mejp.org/mainecare_cuts.htm
http://www.mejp.org/Update/9-2/mainecare_cuts.htm

Progress of current budget proposals to eliminate adult coverage:

<http://www.newmainetimes.org/articles/2011/05/18/lepage-plan-drops-28000-mainecare-health-coverage/>

<http://www.pressherald.com/news/maine-State-House-panel-moves-forward-on-key-issues.html>

Childless Adult Coverage in Maine, 2004 Kaiser Foundation Report:

<http://www.kff.org/medicaid/upload/Medicaid-and-Other-Public-Programs-for-Low-Income-Childless-Adults-Maine.pdf>

Anderson , Nathaniel and McGuire , Cathy, *MaineCare Non-Categorical Waiver, Year 3 Annual Report, October 1, 2004 – September 30, 2005*, November 8, 2007:

<http://www.cms.gov/medicaidstwaivprogdemopgi/mwddl/itemdetail.asp?itemid=CMS042935>

Minutes from Medicaid Advisory Committee – June 1, 2010:

www.maine.gov/dhhs/oms/pdfs_doc/stkhldrs/.../mac_notes_060110.doc

HealthChoice Primary Adult Care (PAC)

Overview

State Populations -

General	5,586,700	100%
Uninsured	730,700	13%
Medicaid	571,100	10%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Limited primary care health services.

Program Enrollment*-

Childless Adults	40,397*
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*FY 2010 Actual

Start Date: July 2007.

Annual Costs: FY 2009 budget \$70.2 million (\$35.1 million federal and \$35.1 million state general fund).

Funding Source: Federal budget neutrality required to cover the cost of care for childless adults is to be funded from savings expected to be realized through the implementation of managed care in the main Medicaid HealthChoice population.

Cost Sharing, Premiums, and Deductibles:

No premiums. Copayments are \$7.50 per prescription for brand-name drugs not on the preferred drug list (PDL), \$2.50 per prescription for generic drugs and those on the PDL. Waiver request includes denial of pharmacy products for failure to pay copayments.

Program Description

General and History: HealthChoice, a statewide health care reform program, began in June 1997. Under the HealthChoice program, the state enrolls demonstration-eligible individuals into a managed care organization, the Rare and Expensive Case Management (REM) program, the Primary Adult Care (PAC) program, or the Family Planning program. In July 2007, Maryland began providing a limited primary care health benefit package to uninsured adults through the PAC program.

One of Maryland's goals was to increase the number of covered individuals and their ability to access the medical care system, as well as to increase the number of persons covered under managed care.

Eligibility: Uninsured adults who are not otherwise eligible for Medicaid with incomes at or below 116% FPL are eligible for the program. Unlike full Medicaid, there is no retroactive eligibility in the PAC program.

Benefits and Services: Services for adults include the following:

- Substance abuse treatment (Community-based services added in 2010).
- Emergency room (added in 2010).
- Eye exams and glasses (covered for individuals with diabetes).
- Foot care (covered for individuals with diabetes).
- Family planning and birth control.
- Lab and x-ray (some services covered).
- Mental health and mental health case management (these services are provided under the waiver in a separate fee-for service system).
 - Physicians and clinics.
 - Physicals and preventive care (regular check-ups are covered).
 - Prescriptions (covered as are MD-recommended over-the-counter drugs).

The state intends to add to the benefits available to this population incrementally.

Current Status: Ongoing.

Evidence of Success: A 2010 marketing survey provides information on the members' ratings of and experiences with the medical care they receive. The survey provides feedback

on how the managed care organizations could improve the quality of care.

In 2010, the membership of the PAC is evenly divided between men and women. However, in the past two years women were a larger population. Most members are black and have completed high school or less education. The largest segment of the population is between 45 and 54 years of age (37%) and describe themselves as being in poor or fair health (40%). However, in the three years of data available, the percentage of members describing themselves as being in poor or fair health has slightly declined between 2008 and 2010. In 2010, the percentage of members who give the health plan a high rating is 57%, 56% give high ratings to the health care, and 71% said that they were getting the care they needed.

Sources and Additional Information:

Waiver renewal application: http://dhmh.maryland.gov/mma/html/pdf/2010/HealthChoice_Renewal_2010.pdf

Department of Legislative Services, Office of Policy Analysis, *Public Benefits for Children and Families*, December 2008: http://dls.state.md.us/data/polanasubare/polanasubare_heandhumser/Public-Benefit-for-children-and-Families_2008-Report.pdf

2012 Budget Proposal Document for the Department of Health and Mental Hygiene:
<http://www.dbm.maryland.gov/agencies/operbudget/Documents/2012/Proposed/hlthhosp.pdf>

WBA Market Research, 2010 Primary Adult Care Enrollee Satisfaction Survey Executive Summary, November 2010:
<http://www.dhmh.state.md.us/mma/healthchoice/pdf/CY2009/Executive-Summary-Adult-PAC-FINAL.pdf>

Commonwealth Care

Overview

State Populations -

General	6,514,900	100%
Uninsured	323,500	5%
Medicaid	1,216,900	19%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Medicaid funding to provide universal coverage.

Program Enrollment* -

Total	160,318
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*Enrolled FY 2010

Start Date: 2006

Annual Costs: \$822 M for SFY 2011.

Funding Sources: Revenue from the state general fund and revenue generated from a new increase in the tobacco tax of \$1.

Cost Sharing, Premiums, and Deductibles:

Premiums: No monthly premiums for adults earning 100% or less of the FPL and also up to 150% FPL if they choose the lowest-priced plan. The program charges the following monthly premiums: (1) \$39 for individuals earning between 150% and 199% FPL, (2) \$77 for individuals earning between 200% and 249% FPL, and (3) \$116 for individuals earning between 250% and 300% FPL.

Copays: For individuals with household incomes less than or equal to 100% FPL, there are only small copayments for prescription drugs (\$1 to \$3) with a maximum out-of-pocket for prescription copayments of \$200 per year.

For individuals with household incomes greater than 100% FPL but no more than 200% FPL, there are copayments for office visits, outpatient surgery, hospital visits, prescription drugs, mental health and substance abuse, and vision exams that vary from \$10 to \$50 with an annual maximum out-of-pocket of \$500 for medical benefits and \$750 for pharmacy benefits per year.

Program Description

General and History: The goal of the program is to provide near-universal coverage to the people of Massachusetts. Commonwealth Care is a subsidized program for adults who are not offered employer-sponsored insurance, do not qualify for Medicare, Medicaid, or certain other special insurance programs, and who earn up to 300% of the FPL.

Eligibility: Comprehensive benefits are provided to adults who are ineligible for Medicaid and whose incomes fall below 300% of the FPL.

Benefits and Services: All Commonwealth Care health plans include the following: outpatient medical care, inpatient medical care, mental health and substance abuse services (inpatient and outpatient), prescription drug benefits, rehabilitation services, vision care, dental care for people with incomes at or below 100% FPL, emergency care (including ambulance and out-of-state coverage), as well as wellness care (family planning, nutrition, prenatal and nurse midwife).

Current Status: The program is set to expire on June 30, 2011, but a renewal plan is currently under review by the CMS.

Evidence of Success: According to a report issued by the Pioneer Institute for Public Policy Research in 2010, the Commonwealth Care program (along with other programs included in MassHealth) has had an impact in decreasing the uninsured population. Two years after the Commonwealth Care program went into effect, the state's uninsured population dropped from 6.4% to 2.6%.

A 56% increase in insurance coverage in the state is attributable to Medicaid and Commonwealth Care. Since the end of 2007, Commonwealth Care enrollment has been the single largest contributor to the state's increase in health coverage. This large decrease in the uninsured population can be attributed, at least partially, to the state mandate that requires adults who can afford health insurance to purchase it.

The program has demonstrated some problems with churning. During an average quarter between October 2007 and December 2007, a total of 47,433 consumers joined Commonwealth Care, but 37,771 members' coverage ended when renewal forms were required. However, within five

months of losing coverage, 21% of these members reenrolled in the program.

The Pioneer Institute report also calls attention to the effect Commonwealth Care has had on preventive care utilization. The report found that although a greater proportion of Massachusetts residents have been receiving preventive treatment since the implementation of the program, the increase in preventive treatment is incremental. The Pioneer report also studies preventive care utilization as it relates to emergency department (ED) utilization. The report addresses preconceptions that if access to insurance is improved, a decrease in the utilization of ED services would consequently decrease. The study found that between 2006 and 2008, overall ED utilization rates increased in six assessed Massachusetts hospitals.

Successful factors were identified in the 2009 report from the State Health Access Data Assistance Center. These included data-driven eligibility and automatic enrollment into Commonwealth Care, use of an integrated system that uses information technology to seamlessly determine eligibility for multiple health subsidy programs, enlisting of providers and community-based organizations to complete application forms on behalf of consumers, and public education programs. These policies helped lower the per capita administrative costs for determining eligibility and enrolling consumers into subsidized coverage.

Sources and Additional Information:

Massachusetts Health Reform Facts and Figures, Spring 2011.

<https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Facts%2520and%2520Figures/Facts%2520and%2520Figures.pdf>

Health Connector: *Massachusetts Health Care Reform Overview*.

<https://www.mahealthconnector.org/portal/site/connector/menuitem.d7b34e88a23468a2dbef6f47d7468a0c/?fiShown=d>

Massachusetts Office of Health and Human Services: *MassHealth and Health Care Reform*.

http://www.mass.gov/?pageID=eohhs2terminal&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=MassHealth&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_masshealthandhealthcarereform&csid=Eeohhs2

Massachusetts Budget and Policy Center. Budget Monitor: *The FY 2009 Conference Committee Budget*.

http://www.massbudget.org/documentsearch/findDocument?doc_id=606&dse_id=507

MassResources.org. Consumer Information on Commonwealth Care.

<http://www.massresources.org/pages.cfm?contentID=81&pageID=13&Subpages=yes#benefits>

The Henry K. Kaiser Family Foundation. *Massachusetts Health Care Reform Plan: An Update*. June 2007.

<http://www.kff.org/uninsured/upload/7494-02.pdf>

Report to the Massachusetts Legislature: *Implementation of Health Care Reform for FY 2010*; Issued November 2010.

<https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/How%2520Insurance%2520Works/Connector%2520Annual%2520Report%25202010.pdf>

State Health Access Data Assistance Center, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*. November 2009. <http://www.rwjf.org/files/research/51368fullreport.pdf>

Lischko, Amy and Gopalsami Anand. The Pioneer Institute Public Policy Research. *An Interim Report Card on Massachusetts Health Care Reform Part 1: Increasing Access*.

http://www.pioneerinstitute.org/pdf/100113_interim_report_card1.pdf

Adult Benefits Waiver (ABW)

Overview

State Populations -

General	9,809,700	100%
Uninsured	1,250,600	13%
Medicaid	1,418,300	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Services provided through managed care through county-administered health plans and other provider networks.

Program Enrollment* -

Total (All Childless Adults) 61,000

*Approximate for SFY 2010.

Start Date: 2004

Annual Costs: The total budget for the five-year demonstration (from 2004 to 2009) was \$844 million (\$590 million federal share and \$254 million state general fund).

Funding Sources: The ABW was begun using unexpended federal funds available from the expansion of SCHIP up to 200% of poverty level. The nonfederal share came from state general funds that were appropriated to the community mental health system for mental health non-Medicaid services. \$40 million of a \$300 million pool was estimated to be used for mental health services to individuals who would qualify under the ABW. The money would draw federal funding at an enhanced match rate of 70%, leading to general fund cost savings.

Michigan's ABW waiver, with the funding paid from SCHIP dollars, was terminated, but the state was permitted to continue the program as a regular Medicaid waiver. The only change was a decline in the match rate.

Cost Sharing, Premiums, and Deductibles:

Co-pays are required pharmacy (\$1 per prescription); certain nonemergency outpatient services (\$3); physician, nurse practitioner, oral surgeon, and medical clinical services (\$3); physical, occupation, and speech therapy evaluation (\$3), and urgent care clinics (\$3).

Program Description

General and History: The ABW provides basic health insurance coverage to residents of Michigan with countable incomes at or below 35% of the FPL.

From the waiver application, the ABW services are provided to beneficiaries through a managed health care delivery system utilizing a network of county-administered health plans and Public Mental Health and Substance Abuse provider network. The programmatic goals for the ABW demonstration include the following:

- Improve access to health care
- Improve the quality of health care services delivered
- Reduce uncompensated care
- Encourage individuals to seek preventive care and choose a healthy lifestyle
- Encourage quality, continuity, and appropriate medical care.

Eligibility: The ABW provides a limited ambulatory benefit package to previously uninsured, low-income non-pregnant childless adults ages 19 through 64 years with incomes at or below 35% of the FPL who are not eligible for Medicaid.

An asset limit of \$3,000 is applied to beneficiaries who meet the income requirements.

Some services may require prior authorization from the county health plan or state.

Eligibility is redetermined every 12 months.

Services: Services for adults include the following: substance abuse treatment; emergency room; family planning; lab and x-ray for diagnostic and treatment purposes; limited medical supply and equipment; mental health through Community Mental Health Services Program; outpatient hospital for diagnostic and treatment services; certain pharmacy; physicians and clinics; physicals/preventive care; urgent care clinics; emergency medical transportation.

Current Status: The program was frozen in May 2009 due to state budget cuts and reopened in October 2010.

Federal approval of a request by the state converted the ABW program from a SCHIP waiver program to a

Medicaid waiver program with changes in financing occurred in 2010.

Evidence of Success: A November 2005 evaluation of the first 21 months of the ABW indicates that participants were using services (physician, outpatient hospital, and prescription drug) at a higher rate than Medicaid beneficiaries. In this review the population in the program was representative of the state population with the following population characteristics: participants were mostly male, 53.7% were white, and 80.6% were urban.

Sources and Additional Information:

Steve Angelotti, Senate Fiscal Agency.

CMS Waiver approval:

http://www.michigan.gov/documents/mdch/Medicaid_Nonpregnant_Childless_Adult_Waiver_ABW_Sec_1115_Aproved_315359_7.pdf

2005 Waiver Evaluation: http://www.ihcs.msu.edu/pdf/ABW_Evaluation.pdf

Senate Fiscal Agency Budget Overview:

<http://www.senate.michigan.gov/sfa/publications/approps/initial2011.PDF#page=50>

Senate Fiscal Agency Memo Concerning Health Care:

<http://www.senate.michigan.gov/sfa/publications/memos/memomifirsthealthcare.pdf>

Freeze Information News Story:

<http://www.wzzm13.com/news/story.aspx?storyid=135195>

Michigan Department of Health Services Enrollment in ABW:

http://www.michigan.gov/documents/dhs/Annual_30_339123_7.pdf

Brochure of covered services:

http://www.michigan.gov/documents/mdch/ABW-COVERAGES_340193_7.pdf

Request to transfer waiver from Title XXI to XIX:

http://www.michigan.gov/documents/mdch/ABW_Replacement_Waiver_2009_300722_7.pdf

New York Family Health Plus (FHPlus)

Overview

State Populations -

General	19,247,700	100%
Uninsured	2,778,900	14%
Medicaid	3,975,100	21%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Services provided through managed care plans and pharmacy through the Medicaid program.

Program Enrollment* -

Total 378,034

*CY 2010 statewide enrollment including adults living in families and adults not living in families.

Start Date: 2001

Annual Costs: \$1.57 billion in CY 2007 for all FHP enrollees.

Funding Sources: The demonstration is funded with Title XIX funds. Savings from managed care provision of services allow expansion of benefits to nontraditional Medicaid population.

Cost Sharing, Premiums, and Deductibles: There are no application costs or deductibles. However, copayments apply to some services.

From the waiver factsheet:

- Pharmacy:
 - \$6 for brand name prescriptions
 - \$3 for generic prescriptions
- Clinic - \$5 per visit
- Physician - \$5 per visit
- Dental - \$5 per visit with a \$25 maximum annual cap
- Lab Tests - \$.50
- Radiology (ordered ambulatory) - \$1
- Inpatient Hospital - \$25 per stay
- Non-Emergent Emergency Room - \$3

Program Description

General and History: FHPlus was added as an amendment to an existing 1115 demonstration waiver to expand coverage to adults between the ages of 19 and 64 who do not have health insurance and whose income and/or assets are too high to qualify for Medicaid. Health care in the FHPlus program is provided through managed care plans and pharmacy benefit obtained through the Medicaid Program.

Enrollment into FHPlus began in September 2001 for all areas other than New York City, which was delayed until February 2002 because of system problems due to the World Trade Center disaster. (Instead, potential FHPlus eligibles were enrolled in the temporary Disaster Relief Medicaid program in New York City through January 31, 2002, and transitioned to FHPlus or regular Medicaid over the next year.)

Eligibility: A personal interview is required to apply for FHPlus.

FHPlus is available to single adults, couples without children, and parents. Participants must have limited income, be aged 19 to 64, a resident of New York State, and a United States citizen or fall under one of many immigration categories.

Allowed gross family income is up to 150% of FPL for households with children, and for adults without dependent children in their households, gross income can be up to 100% of FPL.

Individuals with health insurance through a federal, state, county, municipal, or school district benefit plan are not eligible.

Benefits and Services: The program provides comprehensive health insurance coverage through a health plan. Coverage includes physician services; inpatient and outpatient hospital care; prescription drugs and smoking cessation products; lab tests and x-rays; vision, speech, and hearing services; limited rehabilitative services; durable medical equipment; emergency room and emergency ambulance services; behavioral health and chemical dependence services; diabetic supplies and equipment; hospice care; radiation therapy, chemotherapy and hemodialysis; dental services (if offered by the health plan); and family planning and reproductive health services.

The Family Health Plus Premium Assistance program provides premium, deductible, coinsurance, and copayment assistance for individuals with employer–sponsored health insurance.

Current Status: Ongoing.

Evidence of Success: An evaluation of the FHPlus found that since 2001, FHPlus has successfully increased the rate of coverage for previously uninsured adults with over 518,000 adults who were uninsured and not eligible for Medicaid enrolled in the program at the end of 2007. The report also found slow growth in program enrollment of 2% between 2006 and 2007. It indicates that the imposition of an asset test may have led to the disenrollment of people recertifying for FHPlus in 2006. Based on 2006 and 2007 enrollment, it appears that childless adults were more likely to enroll in the program based on statewide data and that participants tended to be over 45 years old.

Sources and Additional Information:

Family Health Plus Website: <http://www.ins.state.ny.us/website2/hny/english/hnyfhch.htm>

Family Health Plus FAQ: http://www.healthplus-ny.org/data/FHP_QA.pdf

CMS Waiver Factsheet:

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/downloads/New%20York%20Partnership%20Plan%20Fact%20Sheet.pdf>

Delmarva Foundation for the New York Department of Insurance, *Interim Program Evaluation of Section 1115 Waiver Programs*, March 2009:

http://www.health.ny.gov/health_care/managed_care/appextension/waiver_extension/docs/interim_program_evaluation.pdf

Amerigroup website: https://www.myamerigroup.com/English/Medicaid/NY/Questions/Pages/FAQs_FAM.aspx

Fiscal analysis of FHP proposal: <http://www.ibo.nyc.ny.us/newsfax/nws58healthreform.html>

2007 Medicaid Expenditure Reports by Type of Service:

<http://www.health.state.ny.us/nysdoh/medstat/medicaid.htm#table2>

Oregon Health Plan (OHP)

Overview

State Populations -

General	3,821,800	100%
Uninsured	649,400	17%
Medicaid	462,100	12%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: State-developed priority list of conditions and treatments used to focus resources. Most services provided through managed care.

Program Enrollment -

Total OHP Standard*	26,857
Reservation List**	56,000

* Average monthly enrollment 10/2008 to 9/2009.

**Year-end CY 2009. Applications are sent to individuals on the reservation list through lottery selection.

Start Date: November 1, 2002.

Annual Costs:

OHP Standard***	\$180 million
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***FFY 2010

Funding Sources: Hospital provider tax revenue, beneficiary premiums, and federal Medicaid funds.

Cost Sharing, Premiums, and Deductibles:

Depending on eligibility, there may be a premium and a copayment for certain services. Vision exams are provided, but subject to a \$3 per visit per day copayment.

The OHP Plus and OHP with Limited Drug benefit packages have a \$3 copayment for restorative dental services. Diagnostic dental services do not have a copayment. Diagnostic services include oral examinations to identify changes in your health or dental status, routine cleanings, x-rays, lab work, and tests needed to make a diagnosis or treatment decision.

OHP Standard clients may pay monthly premiums of \$9 to \$20 per person depending on income. Those with income at or below 10% FPL do not pay premiums.

Program Description

General and History: On October 15, 2002, CMS approved Oregon's current section 1115 demonstration, Oregon Health Plan 2 (OHP 2), and began implementation on November 1, 2002. This demonstration included the Family Health Insurance Assistance Program (FHIAP)—a health insurance subsidy program designed to target low-income, uninsured Oregonians.

The current demonstration is scheduled to expire on October 31, 2013.

The state's primary objectives under the OHP 2 demonstration are:

- Health care coverage for uninsured Oregonians
- A basic benefit package of effective services
- Broad participation by health care providers
- Decreases in cost-shifting and charity care
- A rational process for making decisions about provision of health care for Oregonians
- Control over health care costs

OHP 2 makes Medicaid available to people living in poverty regardless of factors such as age, disability, or family status. Benefits are structured based upon a prioritized list of health care conditions and treatments, enabling Oregon to focus its resources on prevention.

Seventy-nine percent of enrollees receive medical services through managed care programs, and 91 percent of enrollees receive dental services through managed care programs. All mental health services are provided through managed care providers.

Eligibility: The OHP Standard program provides free or low-cost health care coverage to Oregon residents who have limited income, are ages 19 and older, and do not qualify for traditional Medicaid.

Eligibility is based primarily on income, which is averaged over a three-month period. Most adults with liquid assets of \$2,000 or more are not eligible. Generally, OHP eligibility is for six months at a time, compared to traditional Medicaid's month-to-month eligibility.

Benefits and Services: All OHP benefit packages are based on the Prioritized List of Health Services. The OHP Standard benefit package does not cover some services covered by the OHP Plus or OHP with Limited Drug benefit packages.

The OHP Standard benefit package only covers the following: a limited hospital benefit; physician services; emergency transportation by ambulance; prescription drugs; lab and x-ray services; some medical equipment and supplies; outpatient chemical dependency services; outpatient mental health; emergency dental; and hospice.

Current Status: On March 17, 2010, CMS approved the extension of OHP for November 1, 2010, through October 31, 2013.

Evidence of Success: The Oregon Division of Medical Assistance Programs (DMAP) monitors key performance measures in order to assess the effectiveness of OHP. When looking at the proportion of OHP clients (adults and children) receiving routine health care services annually, the general trend shows an increase from 2002 to 2007. During these years, the rate for adults increased from about 71% to 77%, and the rate for children increased from about 71% to 72%.

One of the goals of OHP is to reduce racial disparities. DMAP also looks at the proportion of clients receiving routine health care services generally in terms of racial and ethnic categories (African Americans, Native Americans, Asian/Pacific Islanders, Hispanic, and White). From 2002 to 2007, for all race and ethnic categories the rates have increased. As of April 2011, the majority of OHP participants were white and female.

Sources and Additional Information:

Oregon Health Plan 2, Section 1115 Quarterly Report for Federal Fiscal Quarter 4 (7/01/2010 – 9/30/2010):
http://www.oregon.gov/OHA/healthplan/data_pubs/quarterly/q2010/3qtr10-cmsrprt.pdf?ga=t.

Information about the Oregon Health Plan and Healthy Kids Application:
<https://apps.state.or.us/Forms/Served/HE9025.pdf>.

Oregon Health Plan Website: <http://www.oregon.gov/OHA/healthplan/index.shtml>.

Oregon Department of Human Services, *Oregon Health Plan Annual Report, Medicaid and State Children's Health Insurance Program Section 1115(a) Medicaid Demonstration Extension, 2009:*
http://www.oregon.gov/OHA/healthplan/data_pubs/quarterly/annual-0809.pdf.

Primary Care Network (PCN)

Overview

State Populations -

General	2,770,700	
Uninsured	389,400	14%
Medicaid	291,000	11%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Limited package of preventive and primary care services.

Program Enrollment* -

Total	18,248
Open enrollment May 2010	2,498

*Average monthly enrollment in FY 2010

Start Date:

Annual Costs: Total PCN claims for SFY 2010 were \$22.5 million.

Funding Source: Hospitals in Utah donated up to \$10 million in inpatient care for PCN patients in exchange for higher Medicaid rates. However, this arrangement ended in 2010. Inpatient services were not included in the PCN benefits.

In SFY 2010, \$440,000 was collected in premium revenue from participants.

Cost Sharing, Premiums, and Deductibles:

The yearly enrollment fee is \$50, \$25, or \$15, depending on income. The maximum amount of copays is no more than \$1,000 per person per year. The following copays apply: Primary care provider visit, immunization, eye exam, birth control, and generic prescriptions (\$5 each); OTC and brand name pharmaceuticals (25% of allowed amount); dental (10% of allowed amount); laboratory services (5% of amounts over \$50); x-rays (5% of amounts over \$100); medical equipment (10% for amounts over \$50); certain emergency room visits (\$30)

American Indians and Alaska Natives do not have a copay when receiving services at Indian Health Services or tribal facilities.

Program Description

General and History: PCN expands Medicaid coverage to certain able-bodied state plan-eligible individuals who are categorically or medically needy parents or other caretaker relatives. PCN provides a reduced benefits package and requires increased cost sharing. Savings from this state plan population funds a Medicaid expansion for up to 25,000 uninsured adults age 19 and older with incomes up to 150% of FPL. This expansion population of parents, caretaker relatives, and childless adults is covered for a limited package of preventive and primary care services.

Also, high-risk pregnant women whose resources made them ineligible under the state plan are covered under the waiver for the full Medicaid benefits package. The waiver was amended in October 2006 to offer assistance with payment of premiums for employer-sponsored health insurance (ESI) for up to 1,000 uninsured, low-income (up to 150% of FPL) working adults and up to 250 CHIP-eligible children of such adults.

The PCN covers services administered by a primary care provider on a fee-for-service basis.

Eligibility: Applications are only accepted during open enrollment periods, which are held when resources are available to cover more people. The federal government requires PCN to enroll more parents than people without children. Because of this, PCN may schedule separate enrollment times for parents and those without children.

To be eligible, an individual must meet the following qualifications:

- Between age 19 through 64
- U.S. citizen or legal resident
- Uninsured; not covered by any health insurance
- Not qualified for Medicaid
- Not have access to student health insurance, Medicare, or veterans' benefits

PCN reviews enrollment every 12 months.

Benefits and Services:

- Visits to a primary care provider
- Four prescriptions per month
- Dental exams, dental x-rays, cleanings, and fillings
- Immunizations
- Eye exam; no glasses or contacts
- Routine lab services and x-rays

- Emergency room visits, with restrictions
- Emergency medical transportation
- Birth control methods

Services not covered: hospital stays, MRIs, CT scans, etc.; visits to a specialist such as an orthopedist, cardiologist, ear nose and throat doctor, etc., are types of services that are not covered by PCN. Specialty care coordinators help enrollees find providers who will charge minimum copays for uncovered services.

Current Status: PCN enrollment is closed, but the program is ongoing.

Evidence of Success: An outcome evaluation of PCN reenrolling members in 2004 measured self-reported health outcomes, self-reported health care utilizations, and the enrollees' satisfaction with the program and providers after 12 months in the program.

Results included that minimal change was observed in physical health status of PCN enrollees, but PCN enrollees got more needed care after enrollment into the program. Enrollees who had received state medical assistance prior to PCN enrollment were less likely to receive routine care after enrollment into the PCN than those who had not had insurance prior to enrollment. The inability to access specialty care reduced the usage of specialty care when compared to levels of use prior to enrollment. This reduction was noted as a major problem in the report.

The report compared two groups; those that had been enrolled in Utah Medical Assistance Program (UMAP) and those who had been uninsured. Formerly uninsured PCN members indicated that they were more likely to be diagnosed with chronic conditions after they enrolled into the PCN than former UMAP clients.

Also observed in the study, a substantial number of PCN clients receive treatment in a hospital setting before receiving primary care. For those who receive treatment in a hospital setting, the total program cost is slightly higher than for those that have received primary care beforehand. In addition, many clients filling four or more prescriptions a month receive mental health and pain medications where there is a potential for inappropriate utilization, diversion, and abuse.

A disenrollment survey indicated that over one-third of the people who did not reenroll had health insurance through another source. Most (78%) did not have health insurance after disenrolling, and 29% indicated that 'finances' were their main reason for disenrolling. However, people who did not renew membership reported better health than those who did renew.

Sources and Additional Information:

PCN website: <http://health.utah.gov/pcn/faq.html>

PCN Brochure: <http://health.utah.gov/pcn/pdf/PCNBrochureEnglish.pdf>

2010 Legislative Report: <http://health.utah.gov/pcn/pdf/PCN2010LegislativeReport.pdf>

<http://health.utah.gov/hda/report/SCIJune04-PCN-RoundTable.pdf>

CMS Waiver:

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=2&sortOrder=ascending&itemID=CMS047650&intNumPerPage=2000>

Utah Department of Health, Center for Health Data, *Summary Report on the PCN*, January 12, 2005:
<http://health.utah.gov/hda/report/summaryEvaluations.pdf>

CMS Annual Report: http://health.utah.gov/medicaid/pdfs/annual_report2010.pdf

Vermont Health Access Plan (VHAP)

Overview

State Populations -

General	613,900	100%
Uninsured	59,000	10%
Medicaid	157,600	25%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Provides a plan similar to commercial health insurance for low-income individuals.

Program Enrollment* -

VHAP 37,383

*April 2011

Start Date: 1995

Annual Costs: Expenditures for the VHAP were \$89.9 million for SFY 2008; \$111.7 million for SFY 2009; and \$122.9 million for SFY 2010.

Funding Source: Initially, this program was funded solely from an increase in the state cigarette tax, but funding was ultimately integrated into the broader Medicaid program with a waiver that capped the maximum that Vermont could spend on Medicaid, but that allowed the state flexibility in program design.

Cost Sharing, Premiums, and Deductibles:

Monthly premiums for VHAP coverage are based on household income and family size, or for those with access to employer-sponsored insurance, the cost of the employee's portion of employer's health plan.

Possible copayment for prescriptions and emergency room visits.

VHAP has a \$25 emergency room fee (\$60 if it is determined the visit was not medically necessary). Depending on income and the prescription cost, a \$1 or \$2 copayment per prescription. There are no other out-of-pocket costs.

Program Description

General and History: VHAP was established through an 1115 demonstration waiver in 1995 and was approved for one extension by CMS, which continued the program through 2003. In 2005, Vermont entered a new 1115 waiver called Global Commitment to Health. The VHAP program was included in this waiver, which was renewed in December 2010 to run until December 2013.

Eligibility: The eligibility requirements for VHAP include being 18 years of age or older, a Vermont resident, having an income of 150% of the FPL or less, and one of the following:

Uninsured for at least 12 months.

Between the ages of 18 and 26 and currently on parents' health insurance plan.

Current insurance provides only hospital care or doctors' visits (but not both).

OR

Lost health insurance for one of the following reasons:

Retired, fired, quit, or have had working hours reduced.

Household's principle insurance policyholder died.

Divorce or dissolution of a civil union.

No longer receiving coverage as a dependent under the insurance plan of a parent or relative.

No longer qualifying for, or voluntarily choosing to end COBRA coverage.

College or university-sponsored health insurance is no longer available because of graduation, a leave of absence, or the termination of studies.

Victim of domestic violence.

Individuals can apply even if they are not a U.S. citizen or have had Medicaid or VHAP in the past 12 months, if the 12-month uninsured requirement is otherwise met. In addition, individuals whose income is at or below 75% of the FPL do not have to meet the 12-month uninsured rule.

Benefits and Services: VHAP enrollees receive a comprehensive benefit package similar to commercial health benefits packages offered to other Vermonters who are adequately insured in the private sector.

Current Status: Ongoing.

Evidence of Success: No information was available on the VHAP population.

Sources and Additional Information:

VHAP website:

<http://www.greenmountaincare.org/vermont-health-insurance-plans/vermont-health-access-plan>

The Center for Health Policy, Planning, and Research at New England University, *Achieving Universal Coverage through Comprehensive Health Reform: The Vermont Experience*, September 2010:

http://www.shadac.org/files/shadac/publications/AchievingUniversalCoverageVTFinalReport_0.pdf

CMS website (does not contain most recent waiver document):

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual,%20data&filterValue=Vermont&filterByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS028357&intNumPerPage=10>

Report to CMS: <http://dvha.vermont.gov/global-commitment-to-health/gc-ffy11-qtr-1-report.pdf>

Robertson, Brian, Ph.D., Maurice, Jason, Ph.D., and Madden, Patrick, *2009 Vermont Household Health Insurance Survey: Comprehensive Report*: <http://www.bishca.state.vt.us/sites/default/files/VHHIS-2009.pdf>

Status of 1115 Demonstration Waivers: <http://www.cms.gov/apps/files/Section1115%20Demos-040111.pdf>

Comparison of Catamount Health and VHAP: <http://www.naswvt.org/project-insure-faq.pdf>

BadgerCare Plus Core Plan

Overview

State Populations -

General	5,551,800	100%
Uninsured	531,100	10%
Medicaid	807,200	15%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: State health care program using managed care services and Medicaid funding.

Program Enrollment -*

Total Childless Adults*	35,961
Waiting List**	89,412

*As of May 2011

**December 2010

Start Date: January 1, 2009.

Annual Costs: Budgeted for \$154 million annual expenditures for SFY 2010.

Funding Source: Nearly all of the state DSH allotment of approximately \$97 million is diverted to support Core Plan expenditures. Additionally, Milwaukee County provided \$6.8 million for SFY 2010. Federal HRSA grant of \$10 million per year for 5 years is available to support Core Plan expenditures.

Cost Sharing, Premiums, and Deductibles:

BadgerCare Plus Core Plan requires an annual nonrefundable application fee of \$60 for a tier one HMO and \$75 for a tier 2 HMO. Copayments are tiered by income levels; most notably, enrollees with income above 100% FPL but below 200% FPL may have higher copayments, with ER services being \$60. Copayments are annually capped at \$300 for those with incomes up to 100% FPL and \$500 for those with incomes between 100% and 200% of FPL.

Program Description

General and History: BadgerCare Plus initially combined SCHIP, Medicaid, and Healthy Start program dollars in addition to other funds to create one larger, more streamlined program with expanded eligibility guidelines. BadgerCare Plus Core Plan for Childless Adults was Phase II of the program and included the addition of childless adults. The program includes centralized eligibility and enrollment functions, a requirement to complete a health needs assessment, and the tiering of HMOs based on quality of care indicators.

The objective of BadgerCare Plus was to provide access to health insurance coverage to 98% of Wisconsin's population through BadgerCare Plus and related coverage expansions. The program relies on simplified eligibility and enrollment processes, seamless coverage across multiple programs, and expanded income eligibility rules.

Eligibility: Adults, 19 to 64 years of age, with incomes below 200% of FPL who have no dependent children, are not pregnant, disabled, or qualified for the Medicaid, Medicare, or SCHIP program. Applicants may not have been insured or eligible for employer-sponsored insurance for at least a year. Individuals enrolled in certain county general assistance medical plans were automatically transitioned to the Core Plan after January 1, 2009. This group was then transitioned to the managed care model.

All enrollees are required to complete a health needs assessment questionnaire related to basic health history and health conditions to assist the state in matching the applicant to the HMOs and providers that can serve their needs. All enrollees are required to obtain a history and physical the first year as a condition of continued enrollment in BadgerCare Plus. Qualified applicants remain eligible for BadgerCare Plus for 12 continuous months unless they become eligible for Medicaid or SCHIP coverage or no longer reside in the state.

Benefits and Services: Physician services; diagnostic services including laboratory and radiology; inpatient and outpatient hospital services; emergency outpatient services including emergency dental and ambulance transportation services; outpatient drugs per the Medicaid Pharmacy Benefit plan; physical, occupational, and speech therapy limited to 20 visits annually per discipline; durable medical equipment limited to \$2,500; and disposable medical supplies. Inpatient stays in an institution for mental disease or the psychiatric ward of an acute care hospital are

excluded. Dental services are limited to certain emergency services, and routine vision services are not covered.

Current Status: Enrollment in the Core Plan has been suspended, because the total number of applications exceeds the number of slots available. A waiting list was created for the program and people on the list receive program slots as they become available.

Evidence of Success: No evaluation of the childless adult population were uncovered.

Sources and Additional Information:

Wisconsin's BadgerCare Plus Coverage Expansion and Simplification: Early Data on Program Impact, Robert Wood Johnson Foundation, October 2009:

<http://www.rwjf.org/files/research/49948wisconsin.pdf>

State Coverage Initiatives, Robert Wood Johnson Foundation, October 2009, regarding enrollment suspension:

<http://www.statecoverage.org/node/2095>

State Health Access Program Grant Summary: Wisconsin, January 19, 2010:

http://www.shadac.org/files/shadac/SHAP_GrantSummary_WI.pdf

Report on BadgerCare Plus, Legislative Audit Bureau, May 2011:

http://legis.wisconsin.gov/lab/reports/11-badgercareplus_ltr.pdf

Evaluation of Wisconsin's BadgerCare Plus Health Care Coverage Program, University of Wisconsin, Public Health Institute, December 2010:

<http://uwphi.pophealth.wisc.edu/healthPolicy/badgerCarePlus/evaluation/98PercentFinalReport-6.pdf>

Enrollment Statistics

<http://www.dhs.wisconsin.gov/badgercareplus/enrollmentdata/pdf/BCStatewide511.pdf>

Expansion of the BadgerCare Plus Core Plan for Adults with No Dependent Children, Wisconsin Department of Health Services, June 2009:

<https://www.forwardhealth.wi.gov/kw/pdf/2009-33.pdf>

Primary Care Program

Overview

State Populations -

General	6,511,200	100%
Uninsured	1,273,300	20%
Medicaid	1,237,100	19%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: This program allows individuals to pay for care on a sliding scale to state-contracted providers.

Program Enrollment -

2006 Total	60,303
2007 Total	78,000

Start Date: 1995

Annual Costs: \$10 million in SFY 2006; \$13 million in SFY 2007; \$14.5 million in SFY 2008.

Funding Sources: Originally funded with an increase in the tobacco tax rate, program funding was transferred to the state general fund in 2004 after the tobacco tax revenue was dedicated to mental health programs.

Cost Sharing, Premiums, and Deductibles: Individuals pay for care based on a sliding fee schedule. The scale has a zero payment category for people under 100% of FPL.

Program Description

General and History: The Arizona Primary Care Program was originally known as the Tobacco Tax Primary Care Program.

The Primary Care Program develops and maintains an enhanced statewide capacity for delivery of comprehensive, community-based primary health care services to low-income, uninsured persons and other medically underserved Arizona residents. Payments are made by the Primary Care Program to qualified contractors for primary care provider visits.

As a result of the loss of state funds and American Recovery and Reinvestment Act (ARRA) funding ending in June 2010, the Arizona Primary Care Program terminated 19 contracts with 138 service sites throughout the state. Some of the sites are expected to close or scale back the availability of services to Arizona's uninsured population.

Eligibility: Services are available for persons of all ages who have a family income no greater than 200% of the FPL; are uninsured and not eligible for AHCCCS, KidsCare, or Medicare; and are residents of Arizona. A sliding fee scale is applied to all covered services based upon current FPL guidelines.

Benefits and Services: Primary and preventive medical and dental health services, prenatal care and family planning services, early periodic screening and diagnostic testing, lab and x-ray, pharmacy, radiology, outreach, health education and health promotion activities, medically necessary, nonemergency ground transportation, patient referral, tracking and follow-up, emergency stabilization services, and 24-hour medical coverage.

Current Status: The state funding for the Primary Care Program was dramatically reduced from \$12 million to \$2 million in SFY 2009. A one-time appropriation from Arizona's ARRA funding restored services in SFY 2010 for patients between 100% and 200% of FPL. However, the SFY 2011 state budget did not return funding to previous levels.

Evidence of Success: None available.

Sources and Additional Information:

Arizona Department of Health Services Primary Care Program Website:

http://www.azdhs.gov/hsd/primary_care.htm

Health Resources and Services Administration *State Title V Block Grant Narrative*, Application Year 2011:

<https://perfdata.hrsa.gov/mchb/TVISReports/Documents/2011/Narratives/AZ-Narratives.html#IB>

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<http://www.azcentral.com/arizonarepublic/news/articles/2010/03/24/20100324arizona-non-profit-clinics-cuts.html#ixzz1PXIP6FVz>

Arizona Association of Community Health Centers, *A Decade of Primary Care in Arizona*, Newsletter, October 2005, vol. 1, issue 5:

www.aachc.org/news/file/25

Community Healthcare Access Program (CHAP)

Overview

State Populations -

General	868,600	100%
Uninsured	105,900	12%
Medicaid	121,100	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Program Type: Program connects low-income uninsured individuals with physicians and provides limited services at reduced cost.

Program Enrollment -

Total* 22,241

*Number served over the nine year life of the program.

Start Date: 2001

Annual Costs: CHAP was appropriated \$1.05 million from the Tobacco Settlement Fund in SFY 2011. Appropriated funds pay for care coordination, enrollment, data management, customer service, program management, and evaluation. VIP participants cover the cost of voluntary and reduced-cost services.

Funding Sources: CHAP is administered by the Delaware Health Care Commission (DHCC) with funding support from the Delaware Tobacco Settlement Fund. VIP is administered by the Delaware Foundation for Medical Services, a supporting foundation of the Medical Society of Delaware, with funding support from the Delaware Foundation for Medical Services, the Medical Society of Delaware, and the DHCC.

Cost Sharing, Premiums, and Deductibles:

Participating hospitals and health centers offer services at reduced cost based on income.

Program Description

General and History: Started as a pilot program with a federal grant, CHAP connects low-income uninsured individuals with private doctors who participate in the Voluntary Initiative Program (VIP).

VIP is a network of about 520 private physicians statewide who accept CHAP patients into their practices and serve as their health home or provide medical subspecialty services. CHAP recipients receive discounted medical services based upon their income. Other medical services are provided through community hospitals and community health centers.

Eligibility: Patients with incomes below 200 % of FPL who are ineligible for other state or federal medical assistance.

Benefits and Services: CHAP offers reduced-cost physician services, prescription medication, physical therapy, radiology, and laboratory services.

Current Status: Ongoing.

Evidence of Success: Evaluations of CHAP focus on operational processes, health outcomes, chronic disease management, utilization, and program outreach.

According to a study of health outcomes for a sample of CHAP enrollees, CHAP patients show improvements in health outcomes, improved rates of screenings, fewer hospital emergency department visits, and improved control of chronic disease. (Source: Delaware Health Care Commission 2010 Report)

A 2004 report commissioned by the Delaware Health Care Commission has the following finding:

CHAP is an important statewide initiative that serves as a key mechanism for: facilitating access to health services for the state's low-income and uninsured residents; developing the foundation for more expansive coverage programs; and encouraging communication and collaboration across the components of the safety net.

In 2004, the majority (67%) of the 1,508 enrollees were female. The average age of a male applicant was 39, whereas female applicants were on average 37 years old. Only 48% of CHAP applications resulted in an enrollment, and the majority of those who were denied had access to other insurance.

The performance measure for CHAP established in the state budget was the number of the target population who became enrolled. The following information was presented for this target: For SFY 2009, the actual enrollment was 20,497; for SFY 2010, the budgeted enrollment was 22,341; and for SFY 2011, the recommended enrollment was 24,351.

Sources and Additional Information:

CHAP website: <http://dhss.delaware.gov/dhss/dhcc/chap.html>

Delaware Uninsured website: <http://www.delawareuninsured.org/>

Delaware Health Care Commission 2010 Annual Report:
http://dhss.delaware.gov/dhss/dhcc/files/dhcc_annual_report_2010.pdf

Progress Report to the Delaware Health Care Commission, July 20, 2005:
<http://dhss.delaware.gov/dhss/dhcc/files/chaprogressreportjuly2005.pdf>

Final Report: Analysis of Delaware's Safety Net, March 2004 - The Delaware Health Care Commission contracted with John Snow Inc. to analyze the health care safety net serving Delaware's low-income uninsured residents:
<http://dhss.delaware.gov/dhss/dhcc/files/johnsnowanalysisofsafetynet.pdf>

Gill, James, Fagan, Heather Bittner, Townsend, Bryan, Mainous, Arch G., *Impact of Providing a Medical Home to the Uninsured Evaluation of a Statewide Program*, *Journal of Health Care for the Poor and Underserved*, vol. 16, no. 3, August 2005, pp. 515-535.

General Assistance Medical Care (GAMC)

Overview

State Populations -

General	5,157,000	100%
Uninsured	450,100	8.7%
Medicaid	714,400	13.9%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Managed care with limited services.

Program Enrollment* -

Total	35,194
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*Average monthly enrollment

Start Date: Implementation 1976

Annual Costs: \$296 million in SFY 2010

Funding Sources: 100% state funding

Cost Sharing, Premiums, and Deductibles: \$25 copayment for nonemergency emergency room visits, and \$3 copay for brand-name prescriptions and \$1 per generic.

Program Description

General and History: GAMC, established in 1975, provides health care coverage to very low-income childless adults who do not qualify for other public health care programs. Funding was cut from the program in 2009, and after modifications the program once again received funding in 2010.

The program changed from a fee-for-service program to one operated through hospital-based coordinated care delivery systems (CCDS). The state contracts with hospitals for a 12-month period with 12-month renewals available. The hospital also contracts with other health care providers to ensure that 80% of the GAMC population has access to health care and preventive services.

Quarterly payments are made to hospitals based on the hospital's pro rata share of GAMC fee-for-service payments in FY 2008. All payments are capped by the funds appropriated to the program. The hospital reimburses any contracted providers.

A temporary uncompensated care pool reimbursed hospitals for services to GAMC participants who were not enrolled in a CCDS.

Eligibility: Individuals not eligible for Medical Assistance and either receiving General Assistance or Group Residential Housing; or a Minnesota resident with gross countable income less than 75% of federal poverty guidelines and nonexempt assets of \$1,000 or less.

Coverage begins from the date of application. Eligibility is redetermined every six months. A person who meets GAMC requirements is ineligible for MinnesotaCare.

Benefits and Services: CCDS provides either the standard set of services or an alternative set of services for which the minimum requirements are specified in law.

The standard set of benefits includes physician, inpatient, and outpatient services; services provided by Medicare-certified rehabilitation agencies; prescription drugs; equipment for insulin and diabetes; eye exams and eyeglasses; hearing aids; prosthetic devices; laboratory and x-ray services; medical transportation; some chiropractic services; some mental health services; podiatric and dental services; certain nurse practitioner services; certain public health nurse services; telemedicine consultation; some community health worker coordination and education services; and interpreters.

The minimum alternative benefits include emergency care, medical transportation, inpatient, outpatient, and physician services, preventive health services, mental health services, and prescription drugs administered in a clinical or other outpatient setting.

Current Status: The GAMC program ended on February 28, 2011. Childless adults at 75% of FPL who were in the GAMC program will qualify for Medical Assistance and automatically transfer on March 1, 2011. Medical Assistance is Minnesota's Medicaid program. It is jointly funded with state and federal funds. More than half of those on Medical Assistance are children and families, and the rest are people 65 or older and people who have disabilities.

Evidence of Success: A summary of 2006 roundtable discussions between hospitals providing GAMC services and members of the Minnesota House of Representatives provided some conclusions about GAMC enrollees and services, including the following.

The GAMC population is diverse with a varying ability to make and keep appointments, enroll in health care coverage, manage chronic conditions, and maintain stable housing. As an example of this diversity, hospitals are seeing many GAMC recipients who suffer from a traumatic brain injury incurred while fighting in the Iraq war or due to domestic violence in the home. Tailoring treatment to meet the unique and individual needs of GAMC recipients is a primary goal of hospitals seeking to provide effective care.

Hospitals provide financial counselors to assist [uninsured individuals with enrollment in public programs when the uninsured individual comes to the emergency department for services]. A major draw for enrolling individuals in GAMC is that the program provides retroactive coverage to the date of application allowing hospitals to receive payment for provided care. Without this retroactive coverage, hospitals would lose money and, along with it, the immediate financial incentive to help the uninsured secure health care coverage.

Sources and Additional Information:

Minnesota House of Representatives Research Brief:
<http://www.house.leg.state.mn.us/hrd/pubs/gamcib.pdf>

GAMC website:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006257

Minnesota Department of Human Services, *February 2011 Forecast*, February 28, 2011:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&noSaveAs=1&Rendition=Primary&allowInterrupt=1&dDocName=dhs16_144372

Minnesota Department of Human Services, Reports and Forecasts Division, *Family Self-Sufficiency and Health Care Program Statistics, Data for a series of 10 annual and 13 monthly periods, ending with April 2011*:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&noSaveAs=1&Rendition=Primary&allowInterrupt=1&dDocName=dhs_id_016338

House of Representative, *Summary of GAMC Statewide Hospital Visits*:
<http://www.house.leg.state.mn.us/comm/docs/SummaryofGAMCStatewideHospitalVisits.pdf>

*MinnesotaCare***Overview****State Populations -**

General	5,157,000	100%
Uninsured	450,100	8.7%
Medicaid	714,400	13.9%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Program uses managed care services.

Program Enrollment* -

Total Persons	148,610
Childless Adults	59,534
Childless Adults (transition)	12,696
Custodial Adults	73,357

*April 2011

Start Date: 1992

Annual Costs: CY 2010 total program costs were \$701.6 M, of which \$396.4 M was paid for adults.

Funding Source in 2010: \$ 445.8 M state share through the Health Access Fund from (1) a 2% tax on gross revenues of health care providers, hospitals, surgical centers, and wholesale drug distributors; and (2) 1% premium tax on health maintenance organizations and nonprofit health services plan corporations; \$183.7 M federal waivers*; \$35.9 M enrollee premiums and cost-sharing

Minnesota's waiver allowed expansion of this program to children and custodial adults using SCHIP funds. These federal funds may not be expended for childless adults.

Cost Sharing, Premiums, and Deductibles:

Copayments for Adults –

- Inpatient hospital services yearly limit of \$10,000 with 10% copay
- \$3 per prescription and nonpreventive care visit
- \$25 per pair of eyeglasses
- \$3.50 for nonemergency visits to hospital emergency rooms

Premiums for adults are sliding scale based on the federal poverty guidelines ranging from \$4/month to 7.2% of gross monthly income.

Program Description

General and History: Created in 1992 to make health insurance available to very low-income individuals who do not qualify for state health care programs or have access to affordable private health insurance. In July 1996, MinnesotaCare began converting certain groups of enrollees to managed care health plans. By January 1997, all MinnesotaCare enrollees were converted to and continue to receive their services through managed care health plans.

Eligibility: Single adults and households without children-

- Gross household income cannot exceed 250% of FPL
- Total asset limits of \$10,000 for a one-person household, and \$20,000 for a household of two or more persons
- No access to employer-subsidized coverage, defined as health insurance coverage for which an employer pays 50% or more of the premium (18-month restriction if an employer terminates health care coverage as a benefit)
- No other health insurance
- 180-day residency requirement with the intent of living in Minnesota permanently and not having moved to Minnesota to seek medical care

Benefits and Services: Services for adults include adult mental health rehab/crisis; alcohol/drug treatment; chiropractic; limited dental; emergency room; eye exams and glasses; family planning; hearing aids; some home care; hospice care; hospital stay to \$10,000; immunizations; interpreters; lab and x-ray; medical supply and equipment; mental health and mental health case management; outpatient surgical center; physicians and clinics; physicals/preventive care; prescriptions; rehabilitative therapies; and emergency medical transportation.

Current Status: MinnesotaCare will be terminated by August 31, 2011, and adults without children with incomes at or below 75% of the federal poverty guideline will be qualified for and moved to Medical Assistance starting March 1, 2011.

Transfer will be prioritized based on medical need, enrollees will continue to go to their health plan providers, and Medical Assistance benefits will be retroactive to March 1, 2011.

Evidence of Success: A 2002 report indicated that about one-third of the enrollees disenroll each year from MinnesotaCare. The report examined the reasons that enrollees left the MinnesotaCare subsidized health insurance

program. A mail survey of former MinnesotaCare enrollees found that 77% of the disenrolled had health insurance and that the disenrolled reported being in good health and had good opinions of the program. Also according to the report, most respondents thought the premium level was reasonable.

However, the rate of uninsurance among disenrollees was 23%, or four times more than the statewide rate at that time. The respondents indicated that “failure to pay” and “other reasons” were the primary reasons for disenrolling.

The report notes that failure to pay may not indicate that the household is unable to afford the premium, but rather that the member may not be able to afford the premium for a specific period of time and that other reasons for disenrolling may include general confusion about program coverage.

Sources and Additional Information:

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Minnesota Department of Human Services, *2010 Managed Care Public Programs: Consumer Satisfaction Survey Results*, July 2010: <https://edocs.dhs.state.mn.us/lfserver/public/DHS-5541B-ENG>

adultBasic

Overview

State Populations -

General	12,286,700	100%
Uninsured	1,310,000	11%
Medicaid	1,775,800	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Program provides limited-benefit health care coverage.

Program Enrollment* -

Total*	42,783
Waiting List**	478,785
Full-cost participants***	1,052

*Average annual enrollment CY 2010
 **December 2010
 ***June 2010

Start Date: July 1, 2002

Annual Costs: \$166 million in CY 2010

Funding Sources: Originally funded with the state’s tobacco settlement money, currently the Blue Cross/Blue Shield Plans provide funding under a Community Health Reinvestment agreement.

Cost Sharing, Premiums, and Deductibles:

Premium of \$36 per month for participants; people on the waiting list can purchase coverage at full cost, which in March 2010 jumped from \$330 to \$600 per month. (Participation dropped from 3,500 to 1,052 after the price increase.)

Copays increased in 2010 by \$5 to \$10 for primary care provider visit; by \$10 to \$20 for specialist visit; and by \$25 to \$50 for emergency room visit.

A 10% coinsurance with a \$1,000 maximum per calendar year for all services requiring coinsurance payments.

Program Description

General and History: adultBasic was established and exclusively used Tobacco Settlement funds from its start in 2002 through 2005. In February 2005, a six-year Community Health Reinvestment agreement was established between the state and Blue Cross/Blue Shield Plans. The agreement called for the Plans to make expenditures equal to a percentage of health insurance premiums sold less any insurance premium taxes paid for for-profit entities in exchange for tax-exempt status. The BC/BS Plans, through the Community Health Reinvestment commitments, became the primary funding source for the program, although some Tobacco Settlement funds were still used. Administrative costs have been funded with state general fund dollars.

Eligibility: The following are required of program participants:

- Between 19 and 65
- No other health care coverage (including Medicaid or Medicare)
- Without health insurance for 90 days prior to enrollment, except if health insurance coverage was lost due to job loss
- Family income is below certain income limits
- Resident of Pennsylvania for at least 90 days prior to enrollment
- U.S. citizenship or permanent legal alien status

Benefits and Services: Inpatient hospital care (including maternity care, two stays per year); short procedure unit care; emergency room care (including transportation); primary and specialist care; surgery; obstetrics; lab and pathology tests; x-rays; routine mammograms; occupational and speech therapy (total of 15 visits per year, combined); skilled nursing care (in lieu of inpatient hospitalization, 60 days per calendar year); diabetic supplies and injections; routine gynecological care; cardiac rehabilitation (36 sessions for a 12-week period); chemotherapy, dialysis, or radiation; pulmonary rehabilitation (18 sessions per calendar year); respiratory therapy (18 sessions per calendar year); inpatient rehabilitation therapy (45 days per calendar year).

Dental care, vision, hearing, and mental health services and most prescription drugs are not covered by adultBasic.

Current Status: Coverage for adultBasic ended on February 28, 2011.

Evidence of Success: The state reports the following program statistics for June 2010: The majority of enrollees are white (almost 70%), women (almost two-thirds), 46 to 55 years old (33%), and the largest group earns between \$10,000 and \$20,000 per year.

A review of length of enrollment found long-term participation with about 32% having been enrolled for five years or more. Additionally, 76% had been enrolled for two years or more, and more than 75% of enrollees have been on adultBasic for more than two years.

Almost 50% of adultBasic enrollees have retained their coverage for more than four years, leaving little room for people on the waiting list to be offered subsidized coverage.

Of those with coverage through a state-sponsored health insurance program, one-third have been enrolled more than five years, while 28.5% enrolled during the past 12 months.

Sources and Additional Information:

Wood, Michael; Chen, Alison; and Ward, Sharon, "adultBasic Sings the Blues," PA Health Access Network: www.pahealthaccess.or

Archived state documents on adultBasic including the 2010 Annual Report: http://www.portal.state.pa.us/portal/server.pt/community/health_insurance/9189/adultbasic_archived_program_information/822119

Basic Health (BH)**Overview****State Populations -**

General	6,574,400	100%
Uninsured	838,600	13%
Medicaid	950,000	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Premium assistance to individuals.

Program Enrollment* -

Total	56,394
Wait List	136,571

*December 2010

Start Date: 1987 as pilot program; 1993 permanent status.

Annual Costs: In SFY 2010, benefits costs were \$180.2 million and administrative costs were \$7.6 million.

Funding Sources: Originally, the BH was funded with state general fund dollars. In 2010, the BH was financed by the Health Services Account. The account received funding from cigarette and tobacco products taxes, alcohol taxes, a health insurance premium tax, hospital business and occupation taxes and Tobacco Settlement funds. However, the fund was abolished and the balance transferred to the state General Fund on July 1, 2009. As an 1115 demonstration waiver program, (status that began in January 2011), federal funds will provide about 40% of the overall program funding.

Cost Sharing, Premiums, and Deductibles:

Monthly premium based on age, income, number of people in family, health plan selected, and location.

There is a \$250 annual deductible and \$1,500 out-of-pocket maximum per person per calendar year that applies to certain services. Once the annual deductible is met, the health plan pays the 80% coinsurance for certain benefits. The deductible counts toward the out-of-pocket maximum.

Program Description

General and History: Created in 1987 as a pilot project to provide access to health insurance for low-income Washington residents, BH was made permanent in 1993. This state-sponsored program helps eligible Washington residents pay for health insurance through state subsidies.

Everyone participates financially; BH is an insurance program, not an entitlement. The state contracted with insurance companies that were not active in commercial markets but rather run health care clinics or provide Medicaid managed care services.

Additionally, an 1115 Medicaid waiver has been approved by CMS to make BH a transitional bridge to Medicaid expansion under the Affordable Care Act. As a result, only 70% of the existing enrollees are estimated to qualify at the reduced family income levels and required custodial or covered diagnosis status.

Eligibility: The following eligibility requirements applied prior to conversion to an 1115 waiver.

Washington residence
U.S. citizenship or qualified noncitizenship
Between the ages of 19 and 64
Have gross family income at or below 200% of the FPL
Have gross monthly income per family up to 133% of FPL

People who are eligible for Medicaid or other medical care services from the state, free or purchased Medicare, or enrolled in the Washington Health Program are not eligible. A full-time student who has received a temporary visa to study in the United States and individuals institutionalized at the time of enrollment are not eligible as well.

Benefits and Services: BH does not provide dental coverage, but does cover doctor and hospital care, including preventive care, emergency services, and prescription drugs.

Current Status: A 2011 supplemental budget reduced BH's funding and limited eligibility. After March 1, 2011, only enrollees who could be transitioned into the 1115 Medicaid demonstration waiver or who are foster parents are eligible for BH. To meet the new budget appropriations, BH disenrolled about 17,000 members and is transitioning about 1,700 children to Apple Health for Kids, effective April 1, 2011.

Evidence of Success: A 2006 evaluation of BH found that 85% of the enrollees were between the ages of 19 and 64, 60% were female, and 54% were below the FPL. The report found that 33% of enrollees had been enrolled for less than a year and that another 38% had been enrolled between two and five years. Most enrollees had not had insurance for three years prior to enrolling in BH, and the high cost of health insurance was the primary reason that enrollees had not had insurance. For those who were employed, 80% of employers did not offer health insurance.

A telephone survey of enrollees found that nearly 90% of respondents had a doctor and that 62% rated their health good or very good. The percentage responding that they were in very good health exceeded the statewide general population survey results. Sixty-eight percent of respondents indicated that they a chronic health condition. The majority of chronic health conditions fell in the other category, but low back pain topped the specific conditions identified. Hypertension, arthritis, and depression were next on the list, each with 18% to 19% of the respondents identifying the condition.

A 2002 report for the Washington State Health Care Authority concerning the BH program indicated that 47.9% of enrollees had been enrolled one to three years, 41.9% had been enrolled four to six years, 7.9% had been enrolled seven to nine years, and 2.3% had been enrolled ten or more years. On average, respondents had been enrolled in BH for three years and ten months. According to the *2010 BH Annual Report*, 2,000 members disenroll monthly due to income determination at recertification, nonpayment of premiums, or no longer needing health insurance.

Further evidence of low turnover rates comes from the CMS for the 1115 demonstration waiver application. The study indicates that new cost sharing increased the turnover in the program. However, with the few options for other coverage the turnover rate returned to around 1%. The application indicates that this is little churning and that there is no indication that the lowest income band of enrollees are leaving the program to be replaced by individuals in higher income bands.

Sources and Additional Information:

Dennis Martin, Director, Policy and Legislative Relations, Health Care Authority, (360) 923-2831.

Basic Health website: <http://www.basichealth.hca.wa.gov/>

Washington State Health Care Authority, *Basic Health 2010 Annual Report*:

<http://www.basichealth.hca.wa.gov/documents/2010AnnualReport.pdf>

Fiscal information for Health Basic Plan Administration:

<http://fiscal.wa.gov/FRViewer.aspx?Rpt=Monthly%20Monitoring%20Monthly%20Expenditure%20Program%20Variance>

State Auditor report on Washington State Health Care Authority:

<http://www.sao.wa.gov/auditreports/auditreportfiles/ar1003719.pdf>

CMS Transitional Program 1115 waiver application:

<http://hrsa.dshs.wa.gov/MedicaidHealthCareReform/pdf/1115WaiverCover7710.pdf>

State of Washington Health Care Authority, *A Study of Washington State Basic Health Program*, June 2002:

<http://www.statecoverage.org/files/A%20Study%20of%20Washington%20State%20Basic%20Health%20Plan.pdf>

Joint Legislative Audit and Review Committee, *Basic Health Plan Study – Part 2: Who Is Enrolled? What Services Do They Use?*, Briefing Report 06-9, November 29, 2006:

<http://www.leg.wa.gov/JLARC/AuditAndStudyReports/2006/Documents/06-9RegularPaper.pdf>

Health Services Account Funding Information: <http://apps.leg.wa.gov/documents/WSLdocs/2009-10/Pdf/Bill%20Reports/Senate%20Final/5073-S.E%20SBR%20FBR%2009.pdf>

Washington Health Program

Overview

State Populations -

General	6,574,400	
Uninsured	838,600	13%
Medicaid	950,000	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Unsubsidized state-sponsored insurance.

Program Enrollment* -

Total 5,573

*Enrolled June 2011

Start Date: 2010.

Annual Costs: The program is unsubsidized, and is paid entirely by member contributions; \$17 per member per month is collected to pay administration fees totaling approximately \$600,000 for SFY 2011.

Funding Sources: Insurance costs are covered by program participants.

Cost Sharing, Premiums, and Deductibles:

Premium rates vary based on age of each covered family member, the annual benefit limit selected, tobacco use, and county of residence. Members pay all premiums, coinsurance, and deductibles (in-network per person deductible of \$500, coinsurance of 30%). Maximum out-of-pocket expenses total \$3,000 per person (The maximum amount includes coinsurance costs only. Co-pays and deductible charges do not count toward the out-of-pocket maximum). The annual benefit limit per person is either \$75,000 or \$100,000, depending on which plan is selected.

Program Description

General and History: Washington Health was developed primarily for individuals on the waiting list to participate in Washington's Basic Health Program. The waiting list for that program exceeds 122,000 people. Washington Health's benefits and services are similar to the Basic Health Program, but Washington Health does not offer subsidies to participants and does not have any income requirement.

Eligibility: Washington residents are eligible for Washington Health if they are ineligible for Medicare and the Washington State Health Insurance Pool and are not receiving Medicaid or subsidized Basic Health benefits. Individuals who are confined to an institution are not eligible.

Benefits and Services: Benefits and services include alcohol/drug treatment; diagnostic imaging and laboratory services; emergency medical transportation; emergency room; home care; hospice care; hospital care; immunizations; mammograms (covered in full); maternity services; medical supply and equipment; mental health care; organ transplants; physicals and preventive care (covered in full); prescriptions; rehabilitative therapies; and skilled nursing facility.

Preexisting conditions occurring during the six months immediately before coverage begins are not covered during the first nine months of participation in the program. The policy does not apply to maternity care, prescription drugs, or to children up to the age of 18.

Current Status: Ongoing.

Evidence of Success: No formal evaluation of the program is planned or has been completed.

Sources and Additional Information:

Washington Health Program website:
<http://www.washingtonhealth.hca.wa.gov/>

Crystal Chilman, (360) 923-2892

Washington

State-Funded

BadgerCare Plus Basic Plan

Overview

State Populations -

General	5,551,800	100%
Uninsured	531,100	10%
Medicaid	807,200	15%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Premium payments and limited health care benefits package.

Program Enrollment -*

Childless Adults 5,714

*Total enrolled on March 19, 2011, when enrollment was suspended.

Start Date: July 1, 2010.

Annual Costs: \$5.0 million for the first eight months of operation. (Average monthly cost per enrollee was \$273 for July through December of 2010.)

Funding Source: Premium payments and any available federal grant funding.

Cost Sharing, Premiums, and Deductibles:

Premium payments were initially established at \$130 per month. Beginning with June 2011 coverage, premiums will be increased to \$200 per month

Most services have a copayment of \$10 per visit or per item. Emergency and ambulatory hospital services have a \$60 copayment. Inpatient and outpatient hospital services allow full coverage for a defined number of services – after the limit, a \$7,500 deductible applies. Prescription drugs require a \$5 copayment for generic drugs and a \$10 copayment for brand-name drugs.

Program Description

General and History: Wisconsin established the BadgerCare Plus Basic Plan, which provides temporary, unsubsidized health insurance for childless adults on the waiting list for the BadgerCare Plus Core Plan. The Basic Plan was proposed in 2009 in response to a flood of 25,000 applicants added to the BadgerCare Plus Core Plan waiting list after that program's enrollment was closed in 2006 due to over-enrollment.

Eligibility: Adults are eligible for the program if they are 19 to 64 years of age, have incomes below 200% of FPL, have no dependent children, and are not pregnant, disabled, or qualified for the Medicaid, Medicare, or SCHIP program. Applicants may not have been insured or eligible for employer-sponsored insurance for at least a year. Enrollees must be on the waiting list for the BadgerCare Plus Core Plan.

Benefits and Services: Services for adults include the following: adult mental health and substance abuse services provided by a psychiatrist; emergency-only dental services; emergency room (full coverage limited to two visits per year); hospice care; first hospital stay covered with \$7,500 deductible for additional inpatient and outpatient stays; immunizations with \$10 copay; interpreters; lab and radiology; medical supply and equipment including durable medical equipment up to \$500 per year; certain outpatient surgical centers; 10-visit physician services limit applies to chiropractors, nurse practitioners, and physician assistants, physicians, podiatrists, and optometrists; generic-only formulary drug benefit limited to 10 per calendar month; rehabilitative therapies limited to 10 visits per therapy discipline per year; and emergency medical transportation.

Current Status: In response to concerns regarding sustainability of the Basic Plan, 438 high-cost enrollees were transferred to the Core Plan in December 2010. Enrollment in the Basic Plan was suspended in March 2011 due to concerns about sustainability. Monthly premiums will be increased from \$130 to \$200 beginning with June 2011 coverage.

Evidence of Success: In a May 2011 study, the majority of enrollees are white (84.8%), female (53.1%), and between 50 and 64 years of age (52.4%). Overwhelmingly, the enrollees have never been insured (98.2%) and are unemployed (73.7%). Most have no household income (41.9%).

The study found that 79.5% of enrollees utilized services and that the most frequently used services were professional, pharmacy, and outpatient services.

Sources and Additional Information:

Report on BadgerCare Plus Basic, Legislative Audit Bureau, May 2011:

http://legis.wisconsin.gov/lab/reports/11-badgercareplus_ltr.pdf

Informational Paper on Medical Assistance & BadgerCare, Legislative Fiscal Bureau, January 2011:

http://legis.wisconsin.gov/lfb/Informationalpapers/44_MA%20BadgerCare%20Plus,%20SeniorCare,%20and%20Related%20Programs.pdf

DeLeire, Thomas and Friedsam, Donna, *Evaluation of Wisconsin's BadgerCare Plus Health Care Coverage Program, Report #1, Executive Summary*, December 2010

<http://uwphi.pophealth.wisc.edu/healthpolicy/badgerCarePlus/evaluation/executiveSummaryFinalReport-1.pdf>

Report on BadgerCare Plus, Legislative Audit Bureau, May 2011:

http://legis.wisconsin.gov/lab/reports/11-badgercareplus_ltr.pdf

*ARHealthNetworks***Overview****State Populations -**

General	2,831,900	100%
Uninsured	526,400	17%
Medicaid	692,300	24%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Limited healthcare coverage to employees of small businesses regardless of income.

Program Enrollment* -

Total	13,512
Childless Adults	7,372
Custodial Adults	6,140

*Ever enrolled during March 2011

Start Date: October 1, 2006.

Annual Costs: SFY 2010 \$17.6 million; SFY 2011 budget \$31.9 million; SFY 2011 to date (05/26/2011) \$21.4 million.

Funding Sources: Medicaid 1115 Waiver, SCHIP, Arkansas tobacco funds.

Cost Sharing, Premiums, and Deductibles:

Premiums: \$25 per month (\$35 for self-employed) for employees earning less than 200% of FPL (over 90% of participants). Employees earning more than 200% of the FPL, who are not Arkansas residents or who are not U.S. citizens may participate, but must pay the unsubsidized premium amount of \$255 per month.

Employers are required to pay an annual enrollment fee for each participating employee, but are not required to pay a portion of the premium.

Deductible: \$100 annual deductible (not applicable to office visits and prescriptions); 15% coinsurance after deductible has been reached; \$1,000 out-of-pocket maximum annually, including deductible.

Program Description

General and History: ARHealthNetworks was developed to combat high uninsured rates among small business employees. The program aims to be a safety net, offering limited health care coverage to employees of small businesses regardless of income.

Eligibility: This program covers employees of small-to-medium-sized businesses (2 to 500 employees) who have not offered group health insurance for the previous 12 months. For a business to be eligible to participate, all uninsured employees from the business must participate (100% participation can be waived in certain circumstances). To be eligible, individuals must work at least 30 hours a week or be self-employed. Spouses of eligible employees may also be eligible. Employees with family incomes below 200% of the FPL receive subsidized premium rates.

Enrollment caps were initially set at 15,000 and were subsequently raised to 50,000. Participation in the program has never exceeded 15,000.

Benefits Services: Services covered annually include

- 7 inpatient days
- 2 major outpatient services, including emergency room and major services performed in the office
- 6 physician office visits
- 2 prescriptions (per month)
- Maximum annual benefit of \$100,000
- No exclusions for preexisting conditions

Current Status: The current Medicaid 1115 waiver program period continues through September 2011.

Evidence of Success: There is an evaluation plan for the program, but the evaluation has not yet been completed. The planned evaluation will measure program success by comparing the effect of having insurance coverage with no coverage. The four program goals that will be measured include (1) lowering the number of uninsured workers, (2) ensuring 100% participation from each employer signed up for the program, (3) demonstrating that program participants have access to preventive care that they didn't have before and that they are accessing this care, and (4) showing that the program improved access to health care for program participants.

The program has been successful in insuring individuals who had not had insurance during the past year; however,

enrollment has been lower than anticipated. Enrollment caps set at 15,000 during the first couple of years of the program have never been reached, despite the cap amount being increased to 50,000. Participant turnover hovers around 3% per month.

Sources and Additional Information:

ARHealthNetworks websites: <http://arhealthnetworks.com/index.php>

<http://www.achi.net/ARHealthNet.asp>

Beverly Mercer, Program, Budget, and Analysis Team, (501) 681-1889

Access to Health Insurance (AHI)**Overview****State Populations -**

General	1,518,700	100%
Uninsured	234,100	15%
Medicaid	212,500	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: The program provides premium assistance to employees of small businesses that provide employer-sponsored health plans.

Program Enrollment* -

Total	511
Childless Adults	108
Custodial Adults	302
Children	101

*Enrolled April 2011

Start Date: 2006

Annual Costs: \$502,797 in FFY 2010.

Funding Sources: Medicaid 1115 waiver, CHIP 1115 waiver, state premium tax fund (tax on insurance).

Cost Sharing, Premiums, and Deductibles:

Employers must cover at least 50% of premium; state covers \$100 per month per person to a maximum of \$500; the employee covers the remainder of the premium and any necessary copays or deductibles.

Program Description

General and History: The program was created to lower the number of people uninsured in Idaho. AHI offers monthly premium assistance to employees of small businesses and their families to help them afford to participate in employer-sponsored health plans.

Eligibility: Eligible employees are over 18, work for a participating small business, and do not have health insurance at the time of application. In addition, they must have a family income of 185% or less of the FPL. To be eligible, employees must work 30 or more hours a week, live in Idaho, and be U.S. citizens or legal residents.

To be eligible, participating small businesses must employ between 2 and 50 workers, must not currently offer insurance, and must have at least one employee who meets the income requirements. To participate, the employer must begin offering a health plan and be willing to pay at least 50% of the employees' health insurance premiums.

Participation in the program is capped at 1,000 adults, including both small-business employees and their spouses. An estimated 400 to 500 employees participate each year.

Benefits and Services: Premium assistance to help cover the employees' cost of health insurance premiums. Participating individuals are eligible for up to \$100 per month per person for themselves, their spouse, and children, up to a maximum of \$500 per family each month.

Current Status: Ongoing.

Evidence of Success: No formal evaluation of the program has been completed. Each year the program has successfully allowed several hundred Idahoans to obtain health insurance who otherwise would not be able to afford it and has successfully encouraged several small businesses to begin to offer group coverage. The program impacts only a small portion of the uninsured in Idaho, and there is some concern that the administrative burden, cost, and reporting requirements are onerous compared to the scope of the program.

The program's turnover rate has not been measured; however, turnover occurs regularly as people change jobs and staffing requirements change in participating small businesses.

Sources and Additional Information:

AHI website: <http://www.healthandwelfare.idaho.gov/Medical/AccessToHealthInsuranceAHI/tabid/122/Default.aspx>

Robin Pewtress: CHIP Director, (208) 364-1892

Janie Jackson: Eligibility, (208) 528-5982

Insurance Partnership (IP)**Overview*****State Populations -***

General	6,514,900	100%
Uninsured	323,500	5%
Medicaid	1,402,500	22%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Premium assistance to small businesses and employees.

Program Enrollment* -

Total	13,369
Participating Businesses	4,628

*Enrolled June 2010

Start Date: 1999

Annual Costs: SFY2011 budget, \$58.2 million; SFY2010 costs, \$52.1 million.

Funding Sources: Medicaid 1115 demonstration waiver, SCHIP, state general funds.

Cost Sharing, Premiums, and Deductibles:

Employers are required to pay at least 50% of health premiums for participating employees. The state will reimburse the employers a portion of the premium cost (up to \$1,000 per year per employee) and will subsidize the employee's premium (based on income, up to \$150 monthly for each covered adult and \$227 for each covered child).

Employees are responsible for the remaining premium payments, copays, and deductibles required by their health plan.

Program Description

General and History: The IP program provides premium assistance for eligible employees of small businesses to help them obtain health insurance by subsidizing the premium cost for employer-sponsored health insurance.

Eligibility: To be eligible for the IP program, a small business must employ 50 or fewer employees, offer or plan to offer comprehensive health insurance, pay at least 50% of the insurance premium, and have at least one uninsured employee.

To be eligible, employees of participating employers must be between the ages of 19 and 64, residents of Massachusetts, and meet citizenship requirements. They must not have been offered insurance through their current employer during the last six months and must not be eligible for insurance through their spouse's employer. They must also meet income requirements (family income of 300% FPL or less). Self-employed individuals are also eligible if they meet the requirements. Spouses and children are also eligible.

Based on the enacting statute, the eligibility and income requirements can be changed during the program in order to maintain budget neutrality and prevent the program from surpassing funding levels.

Benefits and Services: Participating employees receive up to \$150 per month for premium assistance for an employer-sponsored health plan for themselves, up to an additional \$150 per month for their spouse, and up to \$227 per month for each covered child.

Current Status: Ongoing.

Evidence of Success: Based on a survey of eligible businesses completed in 2003, participating businesses are most likely to be sole proprietors and located outside of Boston. The self-employed are the group most likely to participate in the IP program because they receive premium assistance for both the employer and employee portion of the premium. Businesses not participating in the program are likely not to have heard of the program (76.5%) or are likely to be concerned about the cost of the program; 44% of participating businesses offered insurance for the first time through the IP program.

Sources and Additional Information:

The IP website: <http://www.insurancepartnership.org/index-html.asp>

Employer Subsidies for Health Insurance Premiums: Massachusetts' Unique Experiment, January 2009, authored by Janet B. Mitchell, Joseph Burton, and Deborah Osber
<http://www.benthamsience.com/open/tohspi/articles/V002/10TOHSPJ.pdf>

Using Medicaid/SCHIP to Insure Working Families: The Massachusetts Experience, Spring 2002, authored by Janet B. Mitchell, Ph.D. and Deborah S. Osber, M.P.H.
<http://www.cms.gov/HealthCareFinancingReview/Downloads/02springpg35.pdf>

*State Coverage Insurance (SCI)***Overview****State Populations -**

General	1,967,900	
Uninsured	449,000	23%
Medicaid	501,300	25%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Subsidized health insurance for employees of small businesses.

Program Enrollment* -

Total	44,295
Childless Adults	27,961
Custodial Adults	16,334

*Enrolled March 2011. Program enrollment peaked in November 2009 with 53,187 participants. The program's waiting list began that month.

Start Date: July 2005

Annual Costs: SFY2010 funding: \$83.8 million in state funding, \$331 million in federal funding.

Funding Sources: Medicaid 1115 waiver, SCHIP, state general funds.

Cost Sharing, Premiums, and Deductibles:

Copays and premiums differ depending on income. Individuals with household earnings less than 100% FPL pay no premiums or copays. Those earning 101%-150% FPL pay a premium of \$20 per month and mostly \$5 copays. Employers pay a monthly per employee premium of \$75. For individuals earning 151%-200% FPL, the employee pays \$35 monthly premium and mostly \$7 copays. The employer pays a monthly per employee premium of \$75. Individuals who are not part of a group plan pay both the employee and employer premium amount.

Program Description

General and History: SCI provides health insurance coverage for eligible employees of participating small businesses at a subsidized cost. The goals of the program are to reduce the number of uninsured in the state and provide access to needed medical care for all eligible individuals.

Eligibility: Participating small businesses employ 50 or fewer employees and must not have voluntarily canceled group health insurance for its employees during the last 12 months. If an employer has fewer than ten eligible employees, 75% of eligible employees must be willing to participate in the program. If an employer has ten or more eligible employees, 50% of eligible employees must be willing to participate.

To be eligible, employees must be between 19 and 64 years of age, New Mexico residents, and U.S. citizens or permanent residents. Their household income must be below 200% of FPL, they must be ineligible for other public insurance programs, and they must not have voluntarily canceled their health insurance during the last six months. The self-employed and other low-income adults are also eligible for the program without employer participation, but are required to pay both the employer and employee portion of the premiums.

The program has reached its maximum capacity (at approximately 45,000 adult participants). All new employers, employees, and individuals wanting to participate in the program are being placed on a waiting list.

Benefits and Services: Alcohol/drug treatment; diabetes treatment, equipment, supplies, and management; diagnostics; emergency room; home care; inpatient hospital medical and surgical care; maternity care; medical supply and equipment; outpatient surgical center; pre/post natal care; physicians and clinics; physicals/preventive care; prescriptions; and rehabilitative therapies.

The maximum annual benefit is \$100,000; individuals who reach the maximum have the option to transfer to the New Mexico Medical Insurance Pool, the state's high-risk insurance pool.

Current Status: The program is ongoing; however, it has reached its maximum capacity. All new employees and employers wanting to participate are currently being placed on a waiting list. The waiting list for individuals began in

November 2009; the list for employers began in December 2009. As of March 2011, approximately 30,000 individuals were on the waiting list.

Evidence of Success: Between January and March 2011, 1,611 individuals disenrolled from the SCI program, or 3.6% of the individuals who were enrolled as of December 2011. Of the individuals who disenrolled in the program during that period, 37% became eligible for full Medicaid benefits and 27% became eligible for Medicare. The low turnover rate may be a result of the large waiting list; if an individual leaves the program it would be very difficult to get back in the program. Also, only 9% of participants are participating through their employer, so a job change would only affect coverage for a small minority of participants.

Compared to the large number of small businesses in the state, participation by eligible businesses has been low. In March 2011, 91% of program participants enrolled without employer sponsorship. Businesses that decide to participate in the program tend to have more employees, higher operating budgets, and tend to be in operation longer than employers who inquired about the program but decided not to participate. Businesses with few low-wage workers are unlikely to participate in the program. According to survey results of businesses who inquired about the program but who did not participate, the cost of the program and the complication of the enrollment and renewal process has kept some employers from participating.

Participants report that the SCI program has improved their access to health care; 73% of survey respondents strongly agreed that SCI has improved their ability to get regular or routine care; 81% strongly agreed that SCI coverage has improved their ability to get care when they have been sick or injured. Nearly three-quarters of respondents strongly agree that having health insurance has improved their ability to afford health care. Program participants tend to be older (47 years old on average) and more likely to be female (74%) than the overall New Mexico population. When asked what they would do for health insurance if they were not participating in the SCI program, 75% replied that they would have no coverage.

Sources and Additional Information:

New Mexico State Coverage Insurance Website: <http://www.insurenwnewmexico.state.nm.us/SCIHome.htm>

New Mexico State Planning Grant Insure New Mexico! Initiative, Final Report, September 2007, New Mexico Human Services Department, Medical Assistance Division
<http://www.insurenwnewmexico.state.nm.us/Inm/documents/HRSA2007NewMexicoStatePlanningGrantFinalReport.pdf>

Second Phase of the HIFA Evaluation Study: Final Report on the Two-State Enrollee Survey, University of Minnesota, July 1, 2010, authored by Kathleen T. Call, Adam J. Atherly, Bryan E. Dowd, and Robert F. Coulam

Second Phase of the HIFA Evaluation Study: Supplementary Report on the Two-State Enrollee Survey, University of Minnesota, April 2, 2010, authored by Kathleen T. Call, Adam J. Atherly, Bryan E. Dowd, and Robert F. Coulam

Small Business Participation in the New Mexico State Coverage Insurance Program: Evaluation Results, The Hilltop Institute, January 2010, authored by Anna S. Sommers, Laura Spicer, Asher Mikow, Jean Abraham, Charles J. Milligan, Jr., and Mari Spaulding-Bynon
<http://www.hilltopinstitute.org/publications/SmallBusinessParticipationInNMSCIProgram-January2010.pdf>

State Coverage Insurance Quarterly Narrative and Reporting Grid, quarter ending March 31, 2011
http://www.hsd.state.nm.us/mad/pdf_files/SCI/CMS%20SCIQuarterlyreport_0311-final.pdf

Pam Champion, Insure New Mexico, (505) 827-7717

*Insure Oklahoma***Overview****State Populations -**

General	3,576,200	100%
Uninsured	578,500	16%
Medicaid	719,200	20%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Two-part program with employer-sponsored insurance and a state-sponsored health insurance program for individuals.

Program Enrollment* -

Total	32,735
ESI Adults	18,830
ESI Children	337
IP Adults	13,413
IP Children	115

*Enrolled May 2011, ESI=Employer-Sponsored Insurance, IP=Individual Plan

Start Date: ESI began in November 2005; IP began in January 2007.

Annual Costs: Total cost: \$97.1 million in SFY 2010 (ESI: \$48.7 million, IP: \$48.4 million)

Funding Sources: Medicaid 1115 waiver, state tobacco revenue.

Cost Sharing, Premiums, and Deductibles:

Premium costs for the ESI program are split between the state (60%), the employer (25%), and the employee (15%). The employee is responsible for any copays or deductibles required by their employer-sponsored health plan.

Individuals participating in the IP plan pay a monthly premium of \$0-\$119.62, based on income. The state subsidizes the remaining premium cost. Participants are responsible for copays between \$5 and \$30. Annual out-of-pocket expenses are limited to 5% of household income.

Program Description

General and History: Insure Oklahoma has two parts, the Employer-Sponsored Insurance program (ESI) and the Individual Plan (IP). The ESI program provides premium assistance for small business employees of low to moderate income. Premium costs are subsidized for employees who participate in a qualifying employer-sponsored health plan. The IP program allows individuals access to affordable health care through a subsidized state-sponsored insurance program.

Eligibility: ESI Program: Participating employers must be located in Oklahoma, have 99 or fewer employees, and must be enrolled or in the process of enrolling in a qualifying private health insurance plan. Private health plans qualify if they meet certain benefit and cost requirements. Employers must contribute a minimum of 25% of premiums.

Eligible employees must be Oklahoma residents, U.S. citizens, or permanent residents, and 19 to 64 years old. In addition, they must be ineligible for any other public health care program and must have a household income below 200% of FPL. Both full-time and part-time workers are eligible.

IP Program: If an eligible business decides not to participate in the ESI program, its employees are eligible for the IP program. The self-employed are also eligible for the IP program as long as they do not carry insurance that would qualify under the ESI plan. In addition, unemployed individuals who qualify for unemployment benefits are eligible, as are workers who do not qualify for their employer's health insurance plan, individuals who are disabled and have a "ticket to work" from the Social Security Commission, and college students between the ages of 19 and 22. The IP program also covers children whose family incomes are between 186% and 200% of the FPL (The state has waiver approval to cover children up to 300% FPL, but due to budget constraints, has not yet implemented the change).

In order to be eligible for the IP program, individuals must be Oklahoma residents, U.S. citizens or permanent residents, 19 to 64 years old, within program income guidelines (household income of <200% FPL), and ineligible for any other public insurance program.

Spouses may be eligible if they are not working, work for an employer who meets participation requirements, but who is

not participating, or works part time.

The enrollment target for Insure Oklahoma is 50,000 participants.

Benefits and Services: Services for the ESI program include premium assistance for qualifying employer-sponsored health insurance premiums.

Services for the IP program include alcohol/drug treatment; anesthesia; chemotherapy and radiation; dental (limited treatment for pregnant women only); diabetes supplies; diagnostic tests and screenings; dialysis; emergency room; family planning; immunizations; inpatient hospital care; lab and x-ray; maternity care; medical supply and equipment; mental health treatment; outpatient surgical center; physicians and clinics; physicals/preventive care; prescriptions; rehabilitative therapies (outpatient only); smoking cessation products; and surgery. The maximum benefit is \$1 million.

Current Status: Ongoing.

Evidence of Success: An evaluation completed in December 2008 by Burns & Associates highlighted the following successes and challenges.

Early in the formation of the program, stakeholders offered strong support for the program including legislators, the executive branch, insurance carriers, the chamber of commerce, and the medical society. The legislature has expressed continued support for the program and its expansion.

The program has a dedicated source of funding through state tobacco revenue. This provides reliable funding for the program; however, anticipating future program costs has been a challenge because the state pays a percentage of the premium costs, rather than a certain dollar amount for each covered individual.

Program enrollment has increased rapidly over the last several years, but seems to be leveling off. Between May 2010 and May 2011, enrollment in the IP program rose 9% while the ESI program increased 2%. For the same time period, the enrollment in the IP program increased 87% while ESI program enrollment rose 41%. Program staff attribute the rapid growth in the program to a successful outreach campaign.

The program has been successful in decreasing the number of Oklahomans without health insurance. Based on a survey of ESI participants conducted by Burns & Associates in 2008, 51% of ESI program participants had been uninsured for two or more years prior to participation in the program, and 45% responded that they would be uninsured if they were not participating in the program. In addition to increasing the insurance rate of participants in the IP and ESI programs, many of the small businesses participating in the ESI program are offering insurance to all of their employees for the first time, increasing the insurance rate for their employees who are ineligible for Insure Oklahoma due to income.

Participants in the IP program tend to be older than the ESI participants; 52% of IP participants are over 40 years of age, compared with 39% of ESI participants. As of December 2008, the average length of program enrollment was just under 8 months for ESI participants and just below 5 months for IP participants. The monthly disenrollment rate has varied between 1% and 6.5%. According to the Burns & Associates evaluation, much of the ESI disenrollment is attributed to individuals switching jobs, while the IP disenrollment is attributed to individuals failing to pay premiums or because they obtained insurance elsewhere.

Sources and Additional Information:

Insure Oklahoma website: <http://www.insureoklahoma.org/>

Independent Evaluation of the Insure Oklahoma Program: Final Report, December 11, 2008, Burns & Associates, Inc. <http://www.insureoklahoma.org/IOaboutus.aspx?id=4172>

Annual Report, Oklahoma Health Care Authority, 2010 Fiscal Year:
<http://www.okhca.org/research.aspx?id=84&parts=7447>

Oregon Family Health Insurance Assistance Program (FHIAP)

Overview

State Populations -

General	3,821,800	100%
Uninsured	649,400	17%
Medicaid	462,100	12%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Premium assistance program for low-income, uninsured individuals through employer's insurance or state-sponsored insurance.

Program Enrollment* -

Total	7,787
Children (Ages 0-18)	2,110
Adults (Ages 19 +)	5,677

*Enrollment as of June 13, 2011.

Start Date: November 1, 2002

Annual Costs:** \$20 Million

**SFY 2009

Funding Source: State tobacco tax and federal Medicaid funds.

Cost Sharing, Premiums, and Deductibles:

FHIAP pays 50% to 95% (100% for children up to age 19) of the cost of health insurance coverage for individuals or families who qualify. Members pay deductibles, copayments, and other costs of health plans.

Program Description

General and History: In October 2002, the Oregon Health Plan was reauthorized by the CMS. This demonstration included the FHIAP – a health insurance subsidy program designed to target low-income, uninsured Oregonians. Prior to the reauthorization, FHIAP was a state-funded program only.

FHIAP pays 50% to 95% of the premium for Oregonians who are uninsured and meet income and other guidelines. Individuals and families use FHIAP subsidies to pay for insurance at work or to buy individual health plans if insurance is not available through an employer.

FHIAP applicants who have access to employer-sponsored insurance must enroll in that coverage if the employer plan meets certain qualifications. Once approved, premiums are withheld from employee paychecks. FHIAP reimburses the employee after receiving a copy of the pay stub showing that the premium was withheld. FHIAP also will subsidize premiums for part-time employees who are allowed to buy health insurance through the employer, but must pay the entire premium themselves.

Eligibility: In order to be eligible for FHIAP, applicants and/or their dependents must be uninsured for the prior two months (with some exceptions), meet income requirements (from 0% up to 185% FPL), be Oregon residents and U.S. citizens or qualified non-citizens, and not be eligible for or receiving Medicare.

Benefits and Services: Services for adults include the following: adult mental health rehab/crisis; alcohol/drug treatment; chiropractic; limited dental; emergency room; eye exams and glasses; family planning; hearing aids; some home care; hospice care; hospital stay to \$10,000; immunizations; interpreters; lab and x-ray; medical supply and equipment; mental health and mental health case management; outpatient surgical center; physicians and clinics; physicals and preventive care; prescriptions; rehabilitative therapies; and emergency medical transportation.

Current Status: On March 17, 2010, CMS approved the extension of the Oregon Health Plan for November 1, 2010, through October 31, 2013.

Evidence of Success: In a study completed by the University of Minnesota, 75.5% of a sample of FHIAP enrollees had not had insurance for one year or more before enrolling, and

83.9% of respondents indicated that they expected they would have no insurance coverage without the FHIAP. The study also reported that 61.2% of respondents strongly agreed that having health insurance has improved their ability to receive regular and routine care, and 70.2% strongly agreed that health insurance has improved their ability to receive care when sick or injured. About 53.0% of respondents reported that their quality of health care was improved by having health insurance, and 63.6% reported that they strongly agreed that having health insurance improved their ability to afford health care. In addition, of the 91.8% of respondents reporting that they had to recertify their eligibility for FHIAP, 33.7% found the process “very easy” and 38.5% found the process “somewhat easy.”

In June 2011, the majority of FHIAP participants were white and female. In May 2011, the average length of enrollment for all FHIAP participants was 30 months, while the average enrollment for terminated lives was 19.9 months. In May 2011, there were 93 (1.2%) terminations, and through the life of the program there were 39,704 terminated.

Sources and Additional Information:

State of Oregon Family Health Insurance Assistance Program:
<http://www.oregon.gov/OHA/OPHP/FHIAP/index.shtml>

Office of Private Health Partnerships: *Summary Snapshot as of June 13, 2011:*
http://www.oregon.gov/OHA/OPHP/docs/ophp_snapshot.pdf

State of Oregon Office of Private Health Partnerships, *Annual Performance Progress Report for Fiscal Year (2008-2009)*, 2009: http://oregonhealthauthority.com/OHA/OPHP/docs/perf_measures.pdf?ga=t.

Call, Kathleen T.; Atherly, Adam J.; Dowd, Bryan E.; and Coulam, Robert F., *Final Report on the Two-State Enrollee Survey*, Revised, July 1, 2010, University of Minnesota, Medicare/Medicaid Research and Demonstration Task Order Contract HHSM-500-2005-000271, T.O. 2.

Call, Kathleen T.; Atherly, Adam J.; Dowd, Bryan E.; and Coulam, Robert F., *Supplementary Report on the Two-State Enrollee Survey*, April 2, 2010, University of Minnesota, Medicare/Medicaid Research and Demonstration Task Order Contract HHSM-500-2005-000271, T.O. 2.

Utah Premium Partnership (UPP)

Overview

State Populations -

General	2,770,700	
Uninsured	389,400	14%
Medicaid	291,000	11%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Premium assistance to small businesses employees.

Program Enrollment* -

Total	724
Childless Adults	29
Custodial Adults	271
Children	424

*Enrolled April 2011

Start Date: October 30, 2006.

Annual Costs: Budget of \$300,000 for child participants and \$450,000 for adults in SFY 2011. Through May 2011, \$275,916 has been spent on children, and \$214,000 on adults in the program.

Funding Sources: Medicaid 1115 Waiver, CHIP, tobacco funds.

Cost Sharing, Premiums, and Deductibles: Employer must pay at least 50% of monthly premium. Employee is responsible for any copays, coinsurance, and premiums minus the amount reimbursed under UPP.

Program Description

General and History: The mission of UPP is to make health insurance more affordable for low-income employees and their families. The program offers monthly premium assistance to low-income employees to help them afford to participate in health insurance plans sponsored by their employers.

Eligibility: Individuals and their families are eligible if they are employed, between the ages of 19 and 64, currently uninsured, and their employer offers group health coverage. They must also meet income guidelines (approximately 150% of FPL for adults to participate and 200% of FPL for children to participate) and the current cost of their least expensive option for health coverage must be more than 5% of family income. To be eligible they must be U.S. citizens or legal residents of the state.

Adult enrollment in UPP is capped when the funding limit is reached, the equivalent of 1,000 adults receiving the full \$150 per month. There is no cap on the number of children who can be enrolled in the program. To date, they have never had to cap the program or stop open enrollment.

Benefits and Services: UPP covers premium assistance for employer-sponsored health plans and COBRA. Eligible individuals will be reimbursed for monthly premium costs of up to \$150 for each adult and \$120 for each child, which includes premium assistance for dental care for children of \$20 per month.

To be eligible, an employer-sponsored plan must meet the following criteria: cover physician visits, well-child exams, hospital inpatient services, child immunizations, and pharmacy. The plan must have a deductible of \$2,500 per person or less and a lifetime maximum of \$1,000,000 or more. The plan must pay 70% of inpatient costs after the deductible. Employer plans that cover abortions, except in limited cases, are ineligible.

Current Status: Discussions are currently underway to expand the program to include individual private insurance.

Evidence of Success: No formal evaluation has been done on the program. Program managers look at the data on an ad hoc basis to investigate, for example, unexplained drops in enrollment or why certain individuals and families who are eligible for the program choose not to use it.

Individuals participating in the program have been very satisfied with it; however, enrollment is much lower than originally anticipated, leaving an eligible segment of the population unaware or unable to participate in the program. Increased marketing is needed to reach the eligible population, and an increase in the staff determining eligibility is needed to process additional claims.

Sources and Additional Information:

UPP Website: <http://www.health.utah.gov/upp/index.htm>

Leigha Rodak, Health Program Specialist, (801) 538-6806

*Catamount Health***Overview****State Populations -**

General	613,900	
Uninsured	59,000	10%
Medicaid	157,600	25%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Health insurance coverage to low-income individuals without access to health insurance.

Program Enrollment* -

Total	12,997
With Premium Assistance	10,375
With No Premium Assistance	2,622

*April 2011

Start Date: 2006

Annual Costs: \$38.6 million in SFY 2010.

Funding Sources: Medicaid 1115 waiver; cigarette tax; assessment on employers who do not offer health insurance; state general funds. State general funds have been used to make up any funding shortfalls. Without further legislative action in 2010, the balance in the fund would have been negative. Long-term funding remains a concern.

Cost Sharing, Premiums, and Deductibles:

Premiums: \$454 to \$513 per month for single coverage, no premium assistance; \$1,339 to \$1,492 for a family plan, no premium assistance. With premium assistance, the lowest income group pays \$60 to \$173 per month for single coverage.

Annual in-network deductible: \$500 individual, \$1,000 family.

Coinsurance: 20% until the out-of-pocket maximum has been reached (\$1,050 for single coverage, \$2,100 for family coverage).

Copays: \$10 per office visit, \$10 for generic drug prescription, \$35 for brand-name drug prescription.

Program Description

General and History: Catamount Health is one of several Vermont programs working to make affordable and comprehensive care available to all Vermonters. The program is meant to cover people who do not have insurance coverage through their employers and who are not currently eligible for Medicaid.

Eligibility: Individuals over 18 are eligible if they have been uninsured for at least a year, currently have insurance with a high deductible (at least \$7,500 for a single person, \$15,000 for a family), or have insurance that only provides hospital care or doctors' visits (but not both). Individuals are also eligible if they lost their health insurance due to a qualifying event (retirement, job loss, job change, divorce, death in the family, etc.). In addition, they achieve eligibility if they are no longer eligible for coverage as a dependent, or under COBRA or a college- or university-sponsored plan. Victims of domestic violence are also eligible. In order to participate, individuals must not be eligible for any other state health plan.

Participants with incomes under 300% of the FPL receive subsidized premium rates. Participants with incomes over 300% FPL pay the full premium cost; however, they are ineligible for the program if their employer offers health coverage.

A provision in the enacting legislation allows enrollment to be capped if funding is exhausted. To date, a cap has not been used.

Benefits and Services: Services include the following: Alcohol/drug treatment; chiropractic; chronic disease management care (out-of-pocket costs are waived for chronic managed care); preventive dental (children only); diabetes equipment and supplies; diagnostic tests and screenings; emergency room; home care; hospice care; inpatient hospital care; immunizations; lab and x-ray; maternity care; medical supply and equipment; mental health care; outpatient surgical center; physicians and clinics; physicals/preventive care (preventive care is covered at 100%); prescriptions; rehabilitative therapies; surgery; transplant services; basic infertility; abortion/sterilization; and emergency medical transportation.

Current Status: Ongoing.

Evidence of Success: All evaluation information cited below is from the September 2010 report by the Center for Health Policy, Planning, and Research titled “Achieving Universal Health Coverage through Comprehensive Health Reform: The Vermont Experience –Report of Findings.”

The level of enrollment in Catamount Health has remained fairly steady; however, individuals do not remain in the program long term. The average length of enrollment in the program is 7 to 8 months. The level of turnover raises concerns among Vermont staff about increased administrative costs and continuity of care.

Vermont’s health reform programs have been successful in increasing the number of Vermonters with health insurance. Through 2009, insurance coverage across the state has increased by 2.2%; however, the insurance coverage rate has not hit the goal set by legislators to reach 96% coverage by 2010.

Enrollment in public insurance programs rose 4.4% through 2009, while enrollment in private insurance decreased 1.9%. Most of the increase in public insurance programs provided new coverage for the uninsured; however, the decrease in the private insurance rate shows some possible crowding out of the private sector. Over the same period, the national average decrease in private coverage was 1.5%.

Program outreach has successfully increased enrollment in Catamount Health as well as in other public insurance programs.

Sources and Additional Information:

Catamount Health website: <http://www.greenmountaincare.org/vermont-health-insurance-plans/catamount-health>
<http://www.catamounthealth.org/catamount-health-information.html>

Evaluation report: “Achieving Universal Health Coverage through Comprehensive Health Reform: The Vermont Experience –Report of Findings”, September 2010.
http://www.shadac.org/files/shadac/publications/AchievingUniversalCoverageVTFinalReport_0.pdf

Betsy Forest, Department of Health Access, (802) 879-5918.

Vermont Health Access Plan (VHAP ESI)**Overview****State Populations -**

General	613,900	100%
Uninsured	59,000	10%
Medicaid	157,600	25%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Provides premium assistance to employees.

Program Enrollment* -

VHAP ESI	890
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*April 2011

Start Date: 1995

Annual Costs: Expenditures for VHAP ESI were \$0.6 million in SFY 2008; \$1.5 million in SFY 2009; and \$2.4 million in SFY 2010.

Funding Source: Initially, this program was funded solely from an increase in the state cigarette tax, but funding was ultimately integrated into the broader Medicaid program with a waiver that capped the maximum that Vermont could spend on Medicaid, but that allowed the state flexibility in program design.

Cost Sharing, Premiums, and Deductibles:

Monthly premiums for VHAP coverage are based on household income and family size, or for those with access to employer-sponsored insurance, the cost of the employee's portion of employer's health plan.

Program Description

General and History: The VHAP was part of an 1115 Medicaid demonstration waiver, which was renewed in December 2010 to run until December 2013. The VHAP includes another related program called VHAP ESI for childless adults with incomes between 150% and 200% of the FPL. The program provides assistance for employee purchase of employer-sponsored insurance.

Eligibility: VHAP ESI requires that the employee meet the eligibility requirements for VHAP; household income is less than 300% FPL for one person; the employer's plan has comprehensive benefits; and the cost of providing premium assistance is less than the cost of providing premium assistance to enroll in Catamount Health (see Catamount Health on pg. 75) or the VHAP.

Benefits and Services: For VHAP ESI, the employer pays the full insurance benefit and the employee receives a payment from the state agency administering the program.

Current Status: Ongoing.

Evidence of Success: No information was available on the VHAP population.

Budget documents indicate that in April 2011 most frequently enrollees in the VHAP ESI were between 100% and 150% of the FPL (48%) and the majority was female (64%). Most enrollees (35%) were between the ages of 36 and 45. Other age groups strongly represented in the report were enrollees between 25 and 35 years of age (30%) and between 46 and 55 years of age (25%).

Sources and Additional Information:

VHAP website:

<http://www.greenmountaincare.org/vermont-health-insurance-plans/vermont-health-access-plan>

The Center for Health Policy, Planning, and Research at New England University, *Achieving Universal Coverage through Comprehensive Health Reform: The Vermont Experience*, September 2010:

http://www.shadac.org/files/shadac/publications/AchievingUniversalCoverageVTFinalReport_0.pdf

CMS website (does not contain most recent waiver document):

<http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/itemdetail.asp?filterType=dual.%20data&filterValue=Vermont&filter>

[ByDID=2&sortByDID=2&sortOrder=ascending&itemID=CMS028357&intNumPerPage=10](#)

Report to CMS: <http://dvha.vermont.gov/global-commitment-to-health/gc-ffy11-qtr-1-report.pdf>

Robertson, Brian, Ph.D., Maurice, Jason, Ph.D., and Madden, Patrick, *2009 Vermont Household Health Insurance Survey: Comprehensive Report*: <http://www.bishca.state.vt.us/sites/default/files/VHHIS-2009.pdf>

Status of 1115 Demonstration Waivers: <http://www.cms.gov/apps/files/Section1115%20Demos-040111.pdf>

Comparison of Catamount Health and VHAP: <http://www.nasvvt.org/project-insure-faq.pdf>

Insurance Coverage Affordability and Relief to Small Employers (ICARE)

Overview

State Populations -

General	4,262,400	100%
Uninsured	688,000	16.1%
Medicaid	711,500	16.7%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: State-funded reimbursement toward employer's cost of health insurance premiums with minimum employer contribution.

Program Enrollment -*

Total	1,000
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* Reported employer-based health insurance enrollment

Start Date: Enacted in 2006.

Annual Costs: \$15 million over four-year period.

Funding Sources: General fund appropriation of the General Assembly.

Cost Sharing, Premiums, and Deductibles:

Program Description

General and History: ICARE was enacted as a pilot program to encourage small businesses to retain health care insurance. Under the supervision of the Kentucky Department of Insurance, this program reimbursed employer's cost of health insurance premiums.

ICARE is a two-tier program –

Employer has not offered health insurance in last 12 months: ICARE provides \$40 per eligible employee per month, decreasing \$10 each subsequent year of the program.

One employee with a high-cost condition*: ICARE provides \$60 per eligible employee per month, decreasing \$15 each subsequent year of the program.

*High-cost conditions include anoxic brain injury, ascites, limited back disorders, brain tumor, limited burn, limited cancer, cirrhosis of the liver, limited endocrine disorder, limited heart condition, hemophilia, hypersomnia with sleep apnea, limited lung condition, limited kidney condition, morbid obesity, multiple sclerosis, organ or tissue replaced by transplant, psychotic disorder, rhabdomyolysis, stroke, or limited trauma.

Insurers had to provide health risk assessment for eligible employees to encourage prevention and early treatment and offer a healthy lifestyle discount.

Eligibility: Employer that has between 2 and 25 full-time or full-time-equivalent employees; pays at least 50% of employee's premium for single coverage; and pays an average annual salary of less than \$54,930, not including owners and ineligible employees. Also, business must be located in Kentucky.

Benefits and Services:

Current Status: Program discontinued. Applications were no longer accepted and approved after June 15, 2010.

Evidence of Success: None available.

Sources and Additional Information:

ICARE website:

http://insurance.ky.gov/Home.aspx?Div_ID=8

Insurance Journal, *Kentucky Aids Small Businesses with Health Insurance Costs*, December 13, 2006:
<http://www.insurancejournal.com/news/southeast/2006/12/13/74921.htm>.

Success of ICARE Subsidies Prompts Governor to Propose Program Expansion:

<http://www.healthtransformation.net/galleries/StateKY/Success%20of%20Icare%20Subsides%20Program%20Governor%20to%20Propose%20program%20expansion.KY.pdf>

Insurance Coverage Affordability and Relief to Small Employers (ICARE):

<http://www.benefactorins.com/img/~www.benefactorins.com/icarefactsheet012609.pdf>

Tamera Pyles, Kentucky DOI, 502-564-3630

*DirigoChoice***Overview****State Populations -**

General	1,305,300	100%
Uninsured	134,700	10%
Medicaid	350,100	27%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Subsidized health insurance for low-income individuals and employees of small businesses.

Program Enrollment* -

Total	7,474
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*Enrolled November 2010. At the beginning of 2011, 590 small businesses were participating in the program. In June 2008, 12,050 people were enrolled in the program.

Start Date: 2003

Annual Costs: \$52 million in SFY 2010.

Funding Sources: Access Payments (2.14% tax on insurance policies), Fund for Healthy Maine, working capital advance from the state general fund, and Savings Offset Payment (SOP). The SOP was the initial funding mechanism for the program, based on health cost savings due to Dirigo health reforms. The SOP never produced the level of funding anticipated and was controversial from the outset. The Access Payment replaced the SOP as the main source of program funding. The Federal Health Coverage Tax Credit provides subsidies for the group affected by trade adjustments.

Cost Sharing, Premiums, and Deductibles:

Unsubsidized deductibles vary based on selected plan: \$1,250; \$1,750; or \$2,500.

Premium rates vary based on location and household size. Employers are responsible to pay at least 60% of the premium for employees. Participants with household incomes below 300% FPL are eligible for premium and deductible discounts of 20-80%.

Program Description

General and History: DirigoChoice was created in 2003 as part of comprehensive health reform to create quality and affordable care for all Maine residents. The program provides private health insurance for individuals and employees of small businesses, subsidized for individuals with incomes below 300% FPL. Beginning in January 2008, DirigoChoice partnered with Harvard Pilgrim Health Care (HPHC) to provide and administer the insurance program.

Eligibility: Small employers (50 or fewer employees) and sole proprietors are eligible to participate in the program. Small proprietors and small employers must contribute 60% of the premiums for their employees. Individuals without an employer sponsor who are unemployed, who are working but do not have coverage options through their employer, or work part-time are also eligible. Individuals with preexisting conditions who have been uninsured for six months or more are also eligible for the program.

Individuals of all income levels may participate in DirigoChoice; however, individuals with household incomes below 300% FPL receive discounted premiums and deductibles.

Individuals who have lost their coverage or their job due to trade adjustments are also eligible for DirigoChoice and receive an 80% subsidy from the federal government. These people either receive Trade Adjustment Assistance benefits or receive pension payments from the Pension Benefit Guaranty Corporation.

Currently, the program is open for enrollment; however, due to cost constraints, new enrollment in the program has been suspended several times, beginning in 2005.

Benefits and Services: Alcohol/drug treatment; chiropractic care; emergency room; hearing aids; hospice/home health care; immunizations (for children); inpatient/outpatient services; maternity care; mental health services; physicians and clinics; physicals/preventive care; prescriptions; rehabilitative therapies; smoking cessation programs; well-child care; emergency medical transportation; domestic partner coverage; extensive provider network; out-of-network coverage (at higher out-of-pocket cost); and no referral necessary to see a specialist.

Current Status: Ongoing, although in recent budget proposals, the program's major source of funding, Access

Payment tax on insurance policies, will decrease in the next several years and will be discontinued in 2014. The insurance exchanges created by the Patient Protection and Affordable Care Act will take the place of this program.

Evidence of Success: Program cost per participant has been higher than anticipated, partially due to low participation by small businesses and high demand by individuals and sole proprietors. In November 2010, 34% of participants were small group participants. Individual and self-employed participants tend to be older and more expensive than small business participants. Also, nearly 80% of participants receive premium and deductible subsidies. Two-thirds of the individual members receive the full 80% subsidy.

The required employer contribution may prohibit many small businesses from being able to participate in the program. In a survey of small businesses, cost was the deciding factor for half of the firms who had considered offering DirigoChoice but decided against offering the program; 90% of firms who did not offer any insurance responded that premiums for the program were too high. In 2007, the high cost for employers led to the development of high-deductible plans for small businesses which are more affordable for employers. This change, however, may make the program more affordable to businesses, but less affordable to their employees.

DirigoChoice has successfully provided insurance for individuals and employees who were previously uninsured. In 2007, 49% of the small businesses participating in DirigoChoice were offering insurance for the first time. Of enrollees in 2006, 31% reported being uninsured during the year prior to enrolling in the program.

In 2005, 18% of enrollees either disenrolled or did not renew their coverage under DirigoChoice; 40% of individuals left because they either changed jobs or their employer dropped the coverage. High cost was the most common reason cited as to why people left the program voluntarily.

Sources and Additional Information:

DirigoChoice website: http://www.dirigohealth.maine.gov/Pages/dirigo_choice.html

DHA Monthly Dashboard November 2010 (SFY 2011 Month 5 of 12)
http://www.dirigohealth.maine.gov/Documents/Numbers_November10.pdf

Leading the Way? Maine's Initial Experience in Expanding Coverage through Dirigo Health Reforms: Final Report, Mathematica Policy Research, Inc., December 2007, authored by D. J. Lipson, J. Verdier, L. Quincy.
<http://mathematica-mpr.com/publications/PDFs/dirigooverview.pdf>

Understanding Disenrollment from DirigoChoice: Results of a Survey and Telephone Interviews with Former Members of Maine's State-Sponsored Health Insurance Program, November 2006, authored by Nathaniel Anderson and Taryn Bowe http://www.dirigohealth.maine.gov/Documents/DisenrolleeReport_Final_June07.pdf

Shirrin Blaisdell, Bureau of the Budget, (207) 624-7806

Insure Montana

Overview

State Populations -

General	970,900	100%
Uninsured	153,500	16%
Medicaid	114,100	12%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Two-part program aimed at small employers providing tax credits and incentive payments for employer-funded health insurance.

Program Enrollment* -

	Purchasing Pool Option	Tax Credit Option
Businesses	672	700
Employees	1,862	2,436
Covered Lives	3,632	4,098

*on January 5, 2009

Start Date: 2005

Annual Costs: In SFY 2008, Purchasing Pool Option - \$5.6 million; Tax Credit Option - \$4.0 million.

In SFY 2010, total expenditures were \$10.3 million, with \$9.6 million for benefits and \$0.7 million for administration.

Funding Sources: In 2009, funding was provided from tax revenue from certain tobacco products.

Cost Sharing, Premiums, and Deductibles: Employers receive a tax credit or payment for premium costs, and employees may receive premium assistance, in certain cases.

Program Description

General and History: Insure Montana is a two-part program designed to make health insurance affordable to small businesses, regardless of whether they previously offered health insurance.

Businesses that currently offer health insurance - Small businesses with 2 to 9 full-time employees are eligible for refundable tax credits in the amount of \$100 per employee per month. If the average age of employees is 45 or older, the tax credit per employee increases to \$125. Additionally, an employer may receive \$100 per spouse per month and \$40 per dependent per month.

Businesses that do not currently offer health insurance - Small businesses with 2 to 9 full-time employees receive a premium incentive payment up to half of the employer portion of health insurance costs, and employees receive premium assistance payments depending on their family income. These businesses can apply for coverage through the Insure Montana purchasing pool or one of the qualified association plans.

Insurance under the purchasing pool is made available through two Blue Cross/Blue Shield plans.

Eligibility: A small business must employ 2 to 9 eligible employees and not pay any employee more than \$75,000 in gross wages per year, excluding owners. An eligible employee works the number of hours specified by the employer (between 20 and 40 hours per week) and has satisfied the waiting period established by the employer. All eligibility standards must be applied uniformly.

An employee must not receive more than \$75,000 in gross wages per year from this business or any related business and must meet the requirements for eligibility set by the employer.

For the purchasing pool option, a small employer may not have offered group health insurance in the past 24 months.

Benefits and Services: Tax credits for employers and premium assistance to both employers and employees for the purpose of incentives to provide insurance benefits.

Current Status: Slots for coverage are currently filled; however, the program continues to receive applications because coverage is available on a first-come, first-served basis. A May 2009 report indicated that there was a waiting

list with about 600 businesses waiting for premium assistance or incentives and 65 businesses on the waiting list for tax credits.

Evidence of Success: The Montana State Auditor’s Office found that businesses scheduled to receive up to \$300,000 of benefits were not actually eligible for the program and recommended verification of business’s self-reported eligibility qualifications.

Sources and Additional Information:

Insure Montana website: <http://www.sao.mt.gov/insuremontana/index.asp>

Murdo, Pat, Office of Research and Policy, Legislative Services Division, “Facing the Gordian Knots of Health Care Reform,” http://leg.mt.gov/content/Publications/committees/interim/2007_2008/2009healthcarereform.pdf

Legislative Audit Division, State Auditor’s Office, Insure Montana Program, December 2010:
<http://leg.mt.gov/content/Publications/Audit/Report/10P-09.pdf>

*Healthy NY***Overview****State Populations -**

General	19,247,700	100%
Uninsured	2,778,900	14%
Medicaid	4,954,600	26%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: State-sponsored health insurance and reinsurance program.

Program Enrollment* -

Total	165,891
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*Enrolled September 2010

Start Date: January 2001

Annual Costs: In CY 2010, the state paid \$157 million to participating health providers in reinsurance payments (for medical costs incurred in 2009). Providers had requested payment for \$179 million in eligible costs. 2010 was the first year the state did not pay 100% of requested reinsurance amounts.

Funding Sources: New York Tobacco Settlement Fund

Cost Sharing, Premiums, and Deductibles:

Premiums: Premium costs vary by location and provider. The median premium rate as of July 2010 was \$303 per month. Employers must pay at least 50% of the premium for the employee. Employers are not required to pay a portion of premiums for spouses or children.

Deductibles: There is no deductible for the Healthy NY plan without prescription drug coverage. With prescription drug coverage, the deductible is \$100 per calendar year. The high deductible plan has a \$1,200 deductible for single coverage and \$2,400 for family coverage.

Copays: Copay rates vary from \$10 for prenatal services to \$500 for inpatient hospital care.

Program Description

General and History: Healthy NY provides lower-cost options for health insurance for individuals with a family income below 250% of FPL. Private insurance carriers offer the Healthy NY plans; premium rates vary depending on location and provider. The program is able to offer lower premiums due to reinsurance and fewer services being offered than other commercial plans (services such as ambulance service and mental health services are mandated for commercial insurance plans). Under the reinsurance program, providers are reimbursed for 90% of the cost of annual medical claims for individual members between \$5,000 and \$75,000.

Eligibility: To be eligible, sole proprietors and individual applicants must be residents of New York, must have worked during the last year, and were not offered insurance through their employer. In addition, uninsured individuals are eligible who have been uninsured for a year or more or who have lost their insurance due to a specific qualifying event, such as the loss of a job, death of a family member, discontinuation of a group plan, aging off of a parent's plan, etc. Eligible individuals must meet income requirements (family income below 250% of FPL), and be ineligible for Medicare.

Employees of participating small businesses are eligible if they work 20 or more hours per week and make \$40,000 or less per year.

Small employers with 50 or fewer employees are eligible to participate. Participating employers must have not offered group health insurance for their employees during the last year, have paid less than \$50 in premiums per employee (\$75 in higher cost areas), or have offered insurance plans that didn't cover both doctor and hospital care. They must offer participation to all employees working 20 or more hours per week and earning less than \$40,000 per year (they must assure that at least one employee making under \$40,000 enrolls). Either half of employees must sign up for the program or show that they have other coverage.

Benefits and Services: The plan benefits include: Anesthesia; diabetes equipment, supplies, and education; diagnostic, lab and x-ray; emergency room; home health care; immunizations; inpatient hospital services; maternity care; medical supply and equipment; outpatient services; physicians and clinics; physicals/preventive care; prescriptions (if selected); rehabilitative therapies; surgical

services; therapeutic services including radiological services, chemotherapy, and hemodialysis; well-child visits.

Current Status: Ongoing.

Evidence of Success: Evaluation information comes from the “Independent Report on the Healthy NY Program for Calendar Year 2010” prepared by Burns & Associates, Inc.

Healthy NY has experienced substantial turnover since the program’s inception. In September 2010, 165,891 members were enrolled in the program; more than three times that many people participated in the program at some point between July 2006 and July 2010. Over the same period, enrollment rates ranged from 3.9% to 8.6% and disenrollment rates ranged from 3.5% to 7.3%. This data may overstate program turnover, however, because a member switching from one Healthy NY provider to another is captured dropping their coverage and reenrolling with a different provider.

The program has shown success in insuring individuals who would otherwise be uninsured. Burns & Associates, Inc. conducted a survey of sole proprietors and working individuals enrolled in Healthy NY as of March 2010. According to survey data, over 60% of participants had been uninsured for less than three months prior to enrolling in the program, while 24% had been uninsured for more than a year. When asked what they would have done for health insurance if Healthy NY were not available, 60% said that they would have gone without health insurance, while approximately 35% indicated that they would have purchased health coverage elsewhere.

In a similar survey of the participating small businesses, 78% indicated that they had not offered health insurance coverage prior to their participation in Healthy NY. Over 70% of the small businesses who responded indicated that they chose to participate so they could offer reasonably priced health insurance for their employees, something they had not been able to do previously.

Because the state reimburses providers 90% of annual individual health claims between \$5,000 and \$75,000 through its reinsurance program, providers are able to offer lower premiums than they are able to offer for other health coverage. In 2010, for the first time, the state was only able to reimburse the providers for 88% of their eligible costs. Each health plan received payment on a pro rata basis. By paying a lower proportion of eligible costs, the reinsurance program may lose some of its effectiveness in keeping premiums low going forward.

Even with the reinsurance program, premium rates for Healthy NY have been rising in recent years. While the program is still less expensive than most other health insurance options, premium rates have increased 8% to 12% each year from 2006 through 2010. In addition, 34% of respondents indicated that they were very concerned about their ability to stay in the program when it came time for renewal, and 37% of the written comments also expressed concern about the cost of the program.

Sources and Additional Information:

Healthy NY website: <http://www.ins.state.ny.us/website2/hny/english/hny.htm>

Evaluation website: “Independent Report on the Healthy NY Program for Calendar Year 2010”, Burns & Associates, Inc. <http://www.ins.state.ny.us/website2/hny/reports/hny2010rep.pdf>

CoverTN**Overview****State Populations -**

General	6,171,200	
Uninsured	947,200	15%
Medicaid	1,447,100	23%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: State-sponsored insurance providing limited-benefit health care coverage for employees of small businesses.

Program Enrollment* -

Total	19,118
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*Enrolled April 2011

Start Date: 2007

Annual Costs: \$17.3 million in SFY 2010. The budget for the program has been reduced in recent years due to statewide budget reductions.

Funding Sources: State general funds.

Cost Sharing, Premiums, and Deductibles:

Premium: Premium costs are shared equally by CoverTN, the employer, and the employee. Individual monthly premiums range from \$37-\$109, and are dependent on age, weight, and tobacco use. Self-employed individuals and local county governments pay two-thirds of the premium costs. The employer is not required to pay a portion of the premium cost for spouses.

Deductibles: None

Co-pays: The individual is responsible for co-pays ranging from \$5 for diabetic supplies to \$100 for outpatient surgery.

Program Description

General and History: CoverTN is one of four programs created to help meet the health care needs of the uninsured in Tennessee. The program offers affordable, portable, limited-benefit health care coverage to employees of small businesses, the self-employed, and individuals with low incomes.

Eligibility: Eligible employers must be located in Tennessee and employ 50 or fewer workers, half of whom earn less than \$55,000 per year. The business must offer participation to all of its employees, and must agree to pay one-third of the premium. In addition, eligible employers either have not offered health insurance during the last six months, or have offered insurance, but paid less than 50% of the premium. Local county governments are eligible to participate if they meet the requirements; however, they must pay two-thirds of the premiums for their employees.

Participating employees must be over the age of 18, work at least 20 hours, must not have had insurance during the last six months, and are U.S. citizens or qualified legal aliens. Employees working for participating employers agree to pay one-third of the premium. If an individual works for an employer who does not participate, is self-employed, or has been unemployed during the previous six months, the individual is still eligible for the program, but must agree to pay two-thirds of the premium cost and must earn less than \$55,000 per year.

Spouses are also eligible to be covered by the program if they meet eligibility requirements. No children are covered under the program, but are able to receive coverage under the state program CoverKids.

The initial program budget could accommodate 23,000 participants; however, program appropriations have declined over the past several years. In December 2009, no new enrollees have been accepted into the program, except for new employees of businesses already participating in the program.

Benefits and Services: Annually, CoverTN will cover

- 12 primary doctor visits
- 1 free adult physical
- 1 free woman well visit including a mammogram
- 5 specialist visits
- \$10,000 or \$15,000 maximum for inpatient services
- 2 emergency visits

- 2 outpatient surgical visits
- 3 outpatient diagnostic consultations
- \$500 maximum for durable medical equipment (not covered under both plans)
- prescription drugs up to a quarterly maximum of \$75 or \$250 (depending on which plan is selected)
- insulin and diabetic test strips and diabetic supplies
- \$25,000 maximum annual benefit amount per individual

CoverTN provides no coverage for preexisting conditions that existed in the six months before coverage begins for the first 12 months of enrollment.

Current Status: In December 1, 2009, the program reached its funding capacity, and new enrollment in the program was suspended, other than allowing participating employers to add new employees.

Evidence of Success: No formal evaluation for CoverTN has been completed. Internal audits of the program have been conducted, which only cover administration and financing of the program. No findings were reported.

Sources and Additional Information:

CoverTN website: <http://www.covertn.gov/>

Shaunalynn Brenmeyer, Communications Liaison, (615) 532-4598

Lance Iverson, Analyst, Division of Budget, (615) 741-5045

Legislative Report: <http://www.covertn.gov/web/report10.pdf>

Health Insurance Partnership (HIP)**Overview*****State Populations -***

General	6,574,400	
Uninsured	838,600	13%
Medicaid	950,000	14%

Source: statehealthfacts.org, Health Insurance Coverage of the Total Population, states (2008-2009), U.S. (2009)

Brief Description: Premium Assistance for small business employees.

Program Enrollment* -

Individuals	67
Small Business Sponsors	16

*Enrolled June 2011

Start Date: Legislation creating the program passed in 2007, with an anticipated start date of 2009. Due to budget issues the program did not start until the state was awarded a grant from the federal State Health Access Program (SHAP) in 2010 with coverage beginning in January 2011.

Annual Costs: Five-year grant funding of \$35 million. \$800,000 was spent on the program in CY 2010, approximately \$2 million was budgeted for 2011 with just under \$10 million expected for the following three years. However, grant funding for the program was cut as of August 31, 2011.

Funding Sources: Federal grant from the U.S. Department of Health and Human Services State Health Access Program.

Cost Sharing, Premiums, and Deductibles: Employers pay at least 40% of the premiums for employees only. Employees are offered a subsidy of up to 90% of the remaining premium cost.

Premiums, copays, and deductibles vary based on which health plan is selected.

Program Description

General and History: The Washington HIP is a premium assistance program geared toward low-income employees of small businesses. Due to budget difficulties, the program has experienced difficulty getting and keeping funding. Enacting legislation creating the program passed in 2007, but due to budget constraints, coverage under HIP did not begin until January 2011. The federal grant which supports the program was not renewed, and funding for the program will end at the end of August 2011.

Eligibility: Eligible employers have 50 or fewer employees, do not offer health insurance at the time of application to the program, and at least half of their employees have household incomes below 200% FPL. Eligible businesses may then choose a health plan offered through HIP. Approved health plans take employee premium payments on a pre-tax basis. At least 75% of eligible employees must participate for an employer to offer the coverage, and the employer must pay at least 40% of the premium for employees only.

Employees eligible for a subsidy must be Washington residents and have a household income of 200% FPL or less.

Benefits and Services: HIP participants may enroll in one of 16 different insurance plans. Benefits and services vary between the plans, from comprehensive care to basic coverage.

Current Status: Enrollment in HIP has been suspended. The federal grant which funds the program was not renewed in the most recent federal budget. Current participants can continue their coverage until the end of August 2011. Funding beyond that point is uncertain.

Evidence of Success: Due to a loss of funding, the program will run only eight months and provide coverage for 67 small business employees.

Sources and Additional Information:

HIP website: <http://www.hip.hca.wa.gov/>

Washington State Health Insurance Partnership Board
Preliminary Report, December 2008

http://www.hca.wa.gov/documents/legreports/E2SHB1569_HIP_Prelim_Report.pdf

Beth Walter, Program Director, (360) 923-2942