

WHAT OTHER STATES ARE DOING TO EXPAND COVERAGE

Alabama Child Caring - Blue Cross Blue Shield of Alabama operates the **Alabama Child Caring** program, which provides health insurance for uninsured children who are ineligible for public coverage. Eligibility is coordinated between this private program and Medicaid and SCHIP in a number of ways. The programs share a uniform **application form** and coordinate applications between the public and private programs.

Alaska - Chronic and Acute Medical Assistance program (CAMA) - **CAMA** is a state-funded program designed to help needy Alaskans with specific illnesses (cancer, diabetes, mental illness, hypertension, seizure disorder and terminal illness) get the medical care they need to manage those illnesses. It is a program primarily for people age 21 through 64 who do not qualify for Medicaid benefits, have very little income, and have inadequate or no health insurance.

Arizona - Primary Care Program - The Arizona Department of Health Services operates a **Primary Care Program** (PCP) that provides access to primary care health services for uninsured, low-income Arizona residents of all ages. The program serves Arizona residents with family income no greater than 200 percent FPL, who are uninsured and ineligible for AHCCCS, KidsCare, and/or Medicare. The purpose of the program is to develop and maintain 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. The program provides funding for qualified contractors to provide primary and preventive care services, preventive dental services, and limited behavioral health care.

California - Access for Infants and Mothers (AIM) program - This state-funded program was established in 1992. **AIM** offers low-cost health coverage for pregnant women and their newborns. It has been designed for middle-income families who don't have health insurance and whose income is too high to qualify for no-cost Medi-Cal. AIM is also available to those who have health insurance if their deductible or co-payment for maternity services is more than \$500. This program provides coverage for those between 200 percent and 300 percent FPL. In 2004, the state began enrolling infants born of AIM enrollees into the Healthy Families Program, California's SCHIP program.

Connecticut Business and Industry Association's (CBIA) Health Connections - CBIA - a statewide, private, business organization - launched its purchasing cooperative, Health Connections, in 1995. **Health Connections** is designed for companies with 3 to 100 employees, allows small firms to take advantage of competitive premium rates, and allows employees a choice of health insurance. As of October 2005, Health Connections provides coverage to over 4,500 firms and covers more than 65,000 lives.

Husky B Buy-in - Connecticut's SCHIP program, called HUSKY B, allows uninsured children in families above 300 percent FPL the opportunity to buy-in to HUSKY B. The cost of the Husky B buy-in is not subsidized by the state; the family buy-in to the plan at a negotiated group rate. Benefits under the HUSKY B program are similar to those available to state employees. The Husky Plus program provides supplemental coverage for children in families with incomes below 300 percent FPL enrolled in Husky B with intensive physical or behavioral needs.

Delaware Community Healthcare Access Program (CHAP) - **CHAP** facilitates public coverage for low-income uninsured individuals. CHAP screens individuals for Medicaid eligibility and for those ineligible, but with family income below 200 percent FPL, CHAP links them with a volunteer or low-cost medical home. CHAP began in 2001 and as of June 15, 2005, 12,000 people have been served by the program.

Delaware Cancer Treatment Program - In May 2004, Delaware created and funded a \$4 million (FY'05) **annual program** to pay for treatment for the uninsured diagnosed with cancer. The state-funded program, administered by the Delaware Division of Social Services, provides treatment for uninsured individuals up to 500 percent FPL who meet eligibility criteria.

DC Healthcare Alliance - The **Alliance** provides free health care to uninsured District residents with family incomes below 200 percent FPL. The Alliance provides HMO-like coverage through a network of primary care "medical homes," with specialty and hospital services from participating providers. This program is funded solely by the District.

Hawaii - Prepaid Health Care Act (PHCA) - Hawaii's **Prepaid Health Care Act of 1974** requires nearly all employers to provide health insurance to their employees who worked 20 hours or more a week for four consecutive weeks. Employees must maintain the minimum of at least 20 hours a week to remain eligible. To date, Hawaii is the only state that has implemented an employer mandate and has one of the highest rates of individuals covered under employer-sponsored insurance. Starting in 2004, the Hawaii Department of Labor and Industrial Relations has conducted random compliance audits of employers to assure compliance with PHCA.

Illinois - Three-Share - Illinois has several active "three-share" programs, which combine contributions from the employer, the employee, and some public subsidy to create a lower-cost product traditionally aimed at small business. Illinois has active programs in Winnebago (Rockford) and Macoupin counties.

Funded by the Health Resources and Services Administration (HRSA) pilot grant, the grant team developed a "three-share" **program for St. Clair County**. The product is designed for low wage, small business (3-50 employees) that currently do not offer insurance. The new program is scheduled to begin enrollment in early 2006.

Kansas - MediKan - **MediKan** is a health program that covers adults with disabilities who do not qualify for Medicaid, but are eligible for services under the **State's General Assistance program**. MediKan provides limited benefits to adults whose applications for federal disability are being reviewed by the Social Security Administration. Health benefits include the provision of medical care in acute situations and during catastrophic illness.

Overall, the scope of services covered by MediKan is similar to that covered by Medicaid, but a number of restrictions and limitations apply. A majority of the individuals who qualify for MediKan are in the process of applying for the federal Supplemental Security Income (SSI) program. After these individuals qualify for SSI, they will transfer to the Medicaid program.

Maine - Dirigo Health Reform Act - This comprehensive state-wide health system reform addresses costs, quality, and access to health care with the goal of establishing universal coverage within six years. The Act includes a number of cost-containment initiatives, including system-wide health planning, public price disclosure, simplification of administrative functions and reductions in paperwork, and voluntary limits on the growth of health insurance premiums and health care costs.

The Act creates the Maine Quality Forum, which will promote quality of care initiatives and educate providers and consumers about medical practices and other quality of care indicators. The Act created **DirigoChoice**, which is an affordable health insurance option to small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance that offers discounts on monthly payments and reductions in deductible and out-of-pocket costs on a sliding scale to enrollees with incomes below 300 percent FPL.

Funding for the Dirigo Health Plan will combine a variety of funding streams: employer contributions, individual contributions, state general and federal Medicaid matching funds (pursuant to a CMS approved managed care contract) for those individuals who are eligible. Funding for premium discounts is generated through the recovery of bad debt and charity care.

Maryland - The **Maryland Health Insurance Plan** became operational in 2003 and as of the end of 2004 there were 5,078 persons enrolled. The program is financed by premiums and an assessment on hospitals.

Limited-Benefit Plan - The Minimum Benefit Legislation (**SB 570**), enacted in 2004, requires carriers who insure > 10 percent of the covered lives in the small group market to offer a limited-benefit plan. Other carriers may offer if they choose. The actuarial value of the limited plan cannot exceed 70 percent of the actuarial value of the comprehensive standard health benefit plan. The limited-benefit plan is only open to small employers with an average employee wage of less than 75 percent of the state average annual wage and who have not offered health benefits within the last 12 months. Limited-benefit plans became available to qualified small employers beginning July 1, 2005.

Maryland AIDS Drug/Insurance Assistance Program - MADAP is a statewide program which helps low-to-moderate income Maryland residents who are HIV-infected. The MADAP formulary covers a range of medication used to treat HIV infection and to treat, prevent, or relieve certain conditions associated with HIV infection. The income guidelines for MADAP, and MADAP-Plus, are based on 500 percent FPL. The income guidelines for MAIAP (Insurance) are based on 300 percent FPL.

Hospital All-Payor Rate Setting System - Since 1977 Maryland has operated a hospital all-payor system. Under this system the **Maryland Health Services Cost Review Commission** (HSCRC) sets rates that Maryland's hospitals may charge. This payment system distributes the cost of hospital uncompensated care among all purchasers including Medicare, Medicaid, commercial carriers, and self-paying patients. Medicare is required to pay these state-established rates for hospital services under a unique federal waiver.

Massachusetts Uncompensated Care Pool - The Massachusetts legislature established the **Uncompensated Care Pool** in 1985 to help ensure access to needed health care services to individuals with no other source of health care coverage. The pool makes payments to acute care hospitals and community health centers for eligible services provided to low-income uninsured and underinsured individuals,

Insurance Partnership - Massachusetts operates the **Insurance Partnership** as part of its Medicaid program under an 1115 waiver. The Partnership helps small employers (<50) offer insurance and helps low-income workers afford premiums. Small employers can have part of their cost paid for premiums paid on behalf of qualified employees. Workers with family income below 200 percent FPL qualify for premium assistance through the MassHealth program.

Children's Medical Security Program (CMSP) - **CMSP** is a health-insurance program for children under the age of 19 who are Massachusetts residents, who do not qualify for MassHealth (except MassHealth Limited), and do not have access to primary and preventive health care. Children covered by CMSP with family incomes up to 400 percent FPL are also eligible for wrap-around care via the Uncompensated Care Pool at Massachusetts acute hospitals for inpatient services not covered by CMSP. Premiums for CMSP are based on a sliding-scale according to income and a deductible, based on family size and income, is required for inpatient care.

Adult Medical Security Plan - The **Medical Security Plan**, run by the Division of Unemployment Assistance, helps laid-off workers and their families who receive unemployment insurance payments. Depending on the workers' circumstances, the program either provides direct, state-based coverage or helps pay the cost of coverage available through former employers. This is a short-term program that serves a relatively healthy population and is available to families who have family incomes up to 400 percent FPL. The state's 1115 waiver provides federal Medicaid matching funds for all enrollees.

Minnesota - Limited-Benefit Plan - In 1999, the Minnesota legislature passed SF 84 which allowed for benefit plans that may alter or eliminate coverage that is required by law, other than the requirement that care provided for covered services such as osteopaths, optometrists, and chiropractors be reimbursed on a nondiscriminatory basis. No carriers ever sold the plans and the law was allowed to expire in 2003.

In 2005, the Minnesota legislature enacted a new law that allows health plans to sell "small employer flexible benefit plans" that does not include any of the benefit mandates (except maternity).

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MinnesotaCare - In 1992, **MinnesotaCare** was established to provide health coverage to the growing number of uninsured. It is funded through a tax on health care providers and enrollee premiums, and since 1995 receives federal funds for some eligible individuals under the state 1115 waiver. There have been several expansions in eligibility over the years and the program currently enrolls families with children up to 275 percent FPL under Medicaid and childless adults up to 175 percent of FPL. In 2003, coverage for adults without children was limited to a defined set of benefits and an annual cap of \$5000 on non-inpatient services.

New Jersey - Family Care Coverage - As part of New Jersey's FamilyCare program, the state covers childless adults up to 100 percent FPL with state-only funds.

Oregon - Family Health Insurance Assistance Program (FHIAP) - The FHIAP program was created in 1997 with state-only dollars to address the needs of families who do not qualify for Medicaid or Medicare. In 2002, the program was included in the Oregon Health Plan 2 Waiver and began to receive federal matching funds. FHIAP provides a premium subsidy on sliding scale to individuals (families and adults without children) with income below 185 percent FPL. Members enroll in their employer's group insurance if one is available; otherwise they enroll in an individual plan in the private market.

Pennsylvania - adultBasic Program - In June 2001, the Health Investment Insurance Act (Act 77 of 2001) was signed into law. Act 77 was an initiative that invested the proceeds of the state's tobacco settlement in the health of Pennsylvania consumers. The program created as a result of this legislation, adultBasic, was designed to provide health insurance for adults with incomes up to 200 percent FPL who do not have health care coverage. It is administered by the Pennsylvania Insurance Department. adultBasic offers basic benefits including preventative care, physician services, diagnosis and treatment of illness or injury, in-patient hospitalization, out-patient hospital services, emergency accident, and medical care .

In early 2003, the tremendous response to the program quickly outstripped the allocated funding, and a waiting list was created. In 2005, nearly 38,000 Pennsylvanians are enrolled in the adultBasic program monthly with approximately 110,000 people on the waiting list. To ensure that the program continues to offer adultBasic coverage to the maximum number of people, every month an assessment of the total adultBasic expenditures is performed in conjunction with the budget and a determination is made as to whether sufficient funding is available to add new enrollees. Offers are made as funding is available and people are enrolled on a first-come, first-served basis.

In February 2005, Pennsylvania Governor Edward G. Rendell announced a landmark agreement with Pennsylvania's four Blue Cross/Blue Shield plans for an ongoing annual commitment of funds for Annual Community Health Reinvestment (ACHR). Overall, this represents a commitment of nearly \$1 billion over the life of the agreement. In its first year, more than \$85 million of the nearly \$150 million in committed ACHR was used to provide affordable basic health care coverage for thousands of low-income and uninsured Pennsylvanians. The remainder was committed to other health care-related services in the community.

The Blue Plans agreed that a certain percentage of their premiums, based on a formula, will go toward providing health care for low-income Pennsylvanians. For the next six years, 60 percent of those funds will be dedicated to providing health insurance through state-approved programs for both low-income and uninsured persons through programs like adultBasic.

Virginia - Indigent Health Care Trust Fund - The Virginia General Assembly created the Indigent Health Care Trust Fund in 1989 as a public-private partnership involving the state government and private acute care hospitals. The purpose of the fund is to help offset some of the charity care provided by Virginia's private acute care hospitals. The fund reimburses hospitals for the cost of charity care provided to any person whose annual family income is equal or less than 100 percent FPL.

State and Local Hospitalization Program (SLH) - SLH provides funding for hospital costs incurred by indigent persons. It differs from the Trust Fund because while the Trust Fund reimburses hospitals based upon an overall amount of charity care provided by each hospital, the SLH program is "claims-based" - specific claims incurred by eligible indigent persons are approved for payment. SLH assistance is available to persons who are not enrolled in Medicaid and have incomes at or below 100 percent FPL.

Washington - Created in 1988, Basic Health (BH) is a state-sponsored program that provides health care coverage to Washington State residents with family incomes below 200 percent FPL. Monthly premiums are based on family size, income, age, and health plan choice, with a sliding scale state subsidy. Member cost-sharing comes in the form of copays, coinsurance, and deductibles. A standardized benefits package is offered through private insurance carriers offering a "managed care plan." To qualify, applicants must meet BH's income guidelines, live in Washington state, not be eligible for Medicare, not be a full-time student in the United States on a student visa, and not be institutionalized at the time of enrollment. As of September 2005, the program covered approximately 100,000 subsidized enrollees. BH and Medicaid coordinate coverage to support family unity for low-income families, enrolling children in Medicaid (Basic Health Plus) and their parents in BH. Medicaid coverage is delivered through BH contracted health plans.

In addition, there are several small sub-programs included in BH. The "financial sponsors" program allows a third party to pay the BH premium. As of September 2005, about 25,000 BH enrollees had financial sponsors. Employers may also sponsor coverage for their employees who meet BH eligibility criteria. As of September 2005, about 300 BH enrollees were enrolled in the employer-sponsored program. BH is also available to foster parents and homecare agency workers or individual providers employed by clients of the state's Medicaid Aging and Disability program. As of September 2005, about 1,000 Basic Health enrollees were enrolled in these three programs.

Coverage for Non-Citizen Children - In January 2006, the Washington State Children's Health Program (CHP) is being re-instated in Medicaid to provide health coverage for a limited number of non-citizen children in families up to 100 percent of poverty level.

West Virginia Small Business Plan - Created by the 2004 legislative session through passage of [Senate Bill 143](#), the Small Business Plan is a set of criteria, or rules, under which the private insurance companies, the West Virginia Public Employees Insurance Agency (PEIA), and the physicians and health care providers in the state work together with the goal of bringing lower cost health insurance to eligible small businesses.

The new law created a private-public partnership between the [West Virginia Public Employees Insurance Agency \(PEIA\)](#) and insurance companies that choose to offer the plan. [West Virginia's Small Business Plan](#) allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly. Program enrollment began in January 2005 and, as of September 2005, more than 500 were enrolled, representing 100 businesses.

Wisconsin - General Assistance Medical Program (GAMP) - The [GAMP](#) is a community safety-net system for uninsured residents in Milwaukee County. To be eligible for coverage an individual must be uninsured and have a family income below 125 percent FPL, depending on family size. GAMP covers services such as primary care and clinic services, inpatient and outpatient hospital care. GAMP is funded by state and federal Medicaid revenues as well as Milwaukee County tax levy. In 2004, GAMP provided access to over 30,000 individuals.

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