Coverage Initiatives: Design and Effectiveness

Christine Chen and Lucien Wulsin

Insure the Uninsured Project

January 5, 2007

ITUP
INSURE THE UNINSURED PROJECT

Insure the Uninsured Project

Insure the Uninsured Project (ITUP) identifies, assists, and promotes new approaches to expand health care and coverage for California's uninsured. The project focuses on developing common ground and establishing connections among interested and influential parties, to bring about public and private health care reform.

Acknowledgements

ITUP would like to express its appreciation to The Blue Shield Foundation, The California Endowment, the California HealthCare Foundation, and LA CARE Health Plan for their generous support and leadership in covering California's uninsured.

TABLE OF CONTENTS

I. Introduction

With the number of uninsured soaring at 47 million nationwide and over 6.6 million in California, state and local governments and other interested organizations have begun to consider approaches to both universal and incremental health coverage. Various challenges to this process include economic limitations, difficulties achieving political consensus, and ways to ensure long-term sustainability. This paper examines how notable coverage initiatives addressed these issues through legislative design and program implementation. These include the Massachusetts Health Care Reform Act, The San Francisco Health Security Ordinance, Alameda Alliance Family Care, Financially Obtainable Coverage for San Diegans, SacAdvantage, Healthy New York, the Vermont Health Care Affordability Reform Act, and the Wisconsin BadgerCare program.

As California considers similar challenges and 6.6 million uninsured residents, we must confront demographic, financial, and political dynamics unique to our state. It is ITUP's hope that exploring mechanisms and solutions specific to other state and local coverage initiatives, will better equip our state to enact a coverage expansion model that is successful in providing affordable, accessible, and sustainable healthcare to California's uninsured.

Below are brief summaries of the initiatives included in this paper:

- *The Massachusetts Health Care Reform Act* offers universal coverage to Massachusetts' residents through a combination of individual and employer mandates. It seeks to expand access by creating new products, a subscriber pool to reduce the cost of private insurance, and providing full or partial subsidies to individuals with incomes up to 300% of the federal poverty line.

- *The San Francisco Health Security Ordinance* increases access to medical care for all uninsured San Franciscans using the framework of the county-sponsored health plan and safety net based delivery system. It will provide income-based, sliding scale premium subsidies to beneficiaries enrolled within the program. The ordinance also instituted a minimum health care contribution rate for medium and small businesses.

- *Alameda Alliance Family Care* was a pilot project designed to make health coverage more affordable for low-income families with children up to 300% of the federal poverty level. It offered subsidized premium assistance for health coverage through a safety net health plan established by the county.

- *Financially Obtainable Coverage for San Diegans (FOCUS)* was a pilot project that provided affordable health coverage for low to moderate-income employees (below 300% of the FPL) of small businesses and their families. The program was offered through an existing private health plan and was privately subsidized.

- *SacAdvantage* is a county funded nonprofit organization that provides access to employer sponsored health coverage for small firms and their employees through a small business purchasing pool. Sliding scale public subsidies are offered to employers, employees, and their families, if their family incomes are below 300% of the FPL.

- *Healthy New York* uses a market based approach to expand health coverage to state residents. New York State subsidizes the Healthy NY benefits package by paying for the catastrophic coverage component while mandating that private HMOs must participate in the program. It targets increasing health coverage among small low wage firms and low wage individuals.

- *The Vermont Health Care Affordability Act* expands health coverage to state residents by making the private health insurance market more accessible to the state's uninsured and expanding public coverage for the low income uninsured. It uses government subsidies and consolidation of the state's purchasing power to make insurance more affordable while providing government subsidies to uninsured low income employees with access to employer based coverage. It also institutes a mandatory employer assessment fee, expanding employer contributions to employee health care.

- *The Wisconsin BadgerCare program* is a government program for low-income families with children; it extends public health coverage to state residents through expanded income limits and making employer sponsored health coverage more financially obtainable through public subsidies.

II. Massachusetts Health Care Reform Act

Health Coverage Expansion

On April 12, 2006, the State of Massachusetts enacted a landmark healthcare bill, the Massachusetts Health Care Reform Act, which provides universal health coverage through a combination of employer and state mandates. The legislation is governed by a market-based universal health care system.[1]

The Massachusetts Health Care Reform Act is supported through a mix and match of public and private incentives, employer and individual mandates, and government subsidies to finance health coverage.

The individual mandate requires individuals who can afford private insurance to purchase it. If they do not, they will be penalized up to 50% of the cost of a health insurance plan. This is enforced through state income taxes. The legislation mandates that employers with more than 10 employees provide health insurance coverage or pay a "Fair Share" contribution (up to $295 annually per employee). A "Free Rider" surcharge is imposed on employers who do not provide health insurance and whose employees use free care. If an employee accesses free care more than three times, or if a company has five of more instances of employees receiving free care in a year, they will be required to pay a surcharge between 10% to 100% of the state's cost of providing services to those employees. The first $50,000 per employer is exempted. In theory, the Free Rider surcharge will provide an incentive to employers to encourage employees to purchase health coverage.

---

[1] The Washington Times, Universal Health Care Law Enacted In Massachusetts, Donald Lambro, April 13, 2006. www.washingtontimes.com/national/20060413-122853-3663r.htm

In order to ensure that health coverage is affordable to individuals and employers, the legislation creates a Commonwealth Health Insurance Connector. Essentially, the Connector is a public agency whose goal is to provide viable and affordable health insurance products.[2] The Connector will establish a framework within which private insurance companies will design new products and compete for customers.[3] The Connector permits individuals to tailor their purchase of individual coverage; the state gives new options to the standardized coverage in the Massachusetts individual insurance market.[4] This means that plans will become more affordable and better-fit individuals' health care needs. In addition, workers whose employers do not offer them health insurance can purchase insurance products from the Connector with pre-tax dollars.[5] Products will be offered at lower costs and health insurance will be affordable for individuals and small employers, many of whom are currently priced out. Approximately 215,000 residents are expected to purchase coverage through the Connector.[6]

The Connector will also administer the Commonwealth Care Health Insurance Program (CCHIP).[7] This program offers subsidized insurance to individuals with incomes up to 300% of the Federal Poverty Level (FPL) and who are ineligible for MassHealth, the state Medicaid program. Individuals with incomes less than 100% of the FPL will not be required to pay any premiums."[8]

Insurance plans offered through CCHIP will have no deductible and utilize managed care organizations that currently participate in the Medicaid program.[9] The Massachusetts Health Care Reform Act also provides a provision to expand the state's Medicaid program to cover all children up to 300% of the FPL.

Insurance reforms are also expected to make health coverage more accessible for Massachusetts's residents. The plan merges the individual and small-group insurance markets by July 2007.[10] This reform will reduce premium costs for individuals by approximately 24 percent.[11] The bill also "enables HMOs to offer coverage plans that are linked to Health Savings Accounts, which are more affordable than other plans."[12] Young adults will be able to stay on their parents' insurance plans for two years past the loss of their dependent status, or until they turn 25 (whichever occurs first)."[13] The Connector also allows insurance plans to limit their provider networks and exclude costly providers, therefore reducing the cost of health coverage

---

[2] Newshour with Jim Lehrer, Massachusetts Insures All, April 5, 2006. www.pbs.org/newshour/bb/health/jan-june06/massachusetts_4-5.html
[3] The Heritage Foundation, The Significance of Massachusetts Health Reform, Web Memo #1035, Edmund F. Haislmaier, April 11, 2006. www.heritage.org/Research/HealthCare/wm1035.cfm
[4] ibid
[5] Kaiser Family Foundation, Kaiser Commission on Key Facts: Massachusetts Health Care Reform Plan, April 2006. www.kff.org/uninsured/upload/7494.pdf
[6] ibid.
[7] Massachusetts State Congress, Health Care Access and Affordability Conference Committee Report, 4/3/2006. www.mass.gov/legis/summary.pdf
[8] Kaiser Family Foundation, Kaiser Commission on Key Facts: Massachusetts Health Care Reform Plan, April 2006. www.kff.org/uninsured/upload/7494.pdf
[9] ibid.
[10] Massachusetts State Congress, Health Care Access and Affordability Conference Committee Report, 4/3/2006. www.mass.gov/legis/summary.pdf
[11] ibid.
[12] The Heritage Foundation, Understanding Key Parts of the Massachusetts Health Plan, Robert E. Moffit and Nina Owcharenko, Web Memo #1045, April 20, 2006. www.heritage.org/Research/HealthCare/wm1035.cfm
[13] Massachusetts State Congress, Health Care Access and Affordability Conference Committee Report, 4/3/2006. www.mass.gov/legis/summary.pdf

for consumers.[14] The legislation allows insurers to offer plans to individuals between the ages of 19 and 26 that are subject to fewer costly state mandates and a two year moratorium on any new insurance mandates.[15] This permits young adults access to more affordable individual coverage.

The Political Agenda

Increasing health coverage for the uninsured was high on the political agenda for Massachusetts. Massachusetts' waiver was set to expire and if the state did not restructure its waiver it would lose federal funding for uncompensated care.[16] This provided sufficient bipartisan motivation to act on this issue. Politically, the issue arose fairly close to the November 2006 elections. The event provided legislators with high visibility and the media coverage to garner political capital. Governor Romney is also expected to run for the 2008 presidential election. Romney championed the bill that received national attention.

Political Support – Politicians, Voters and Interest Groups

The public has been supportive of Massachusetts' coverage expansion plan due to the use of preexisting charity care (uncompensated care pool) to support the program. This funding enables the state to avoid significant tax increases.[17] The bill has been introduced during a period of greater state fiscal wellness, therefore engendering greater support.

The bill promotes individual responsibility by requiring all individuals to obtain health insurance and providing government assistance to the needy through a sliding scale of affordability.

The Health Care Reform Act was created through a vast collaborative process that helped to decrease opposition. The authors solicited expertise from influential players and experts, such as state Democratic legislators, Governor Romney (a Republican), academics, insurers, hospitals, advocates for the poor (including religious leaders).[18] The political will, support, and opportunity for consensus was also driven by the federal government's threat to eliminate $385 million in federal Medicaid money unless the state reduced the number of uninsured.[19]

The November 2006 election placed additional pressure on major stakeholders (i.e. the business community and the health industry) to support the bill. The Mass ACT (Affordable Coverage Today) coalition was expected to place on the ballot an initiative that would require a much more substantial payroll-tax based contribution from employers.[20] Mass ACT consists of groups such as Health Care For All (HCFA) and Greater Boston Interfaith Organization (GBIO). Health Care For All is a highly respected state health organization. Their credibility, ties to the community, relationship with the media, and knowledge of policy kept the ACT coalition together and provided the coalition with political clout.[21] Mass ACT was able to collect the

---

[14] The Heritage Foundation, Understanding Key Parts of the Massachusetts Health Plan, Robert E. Moffit and Nina Owcharenko, Web Memo #1045, April 20, 2006. www.heritage.org/Research/HealthCare/wm1035.cfm
[15] ibid.
[16] ibid.
[17] Massachusetts-Style Coverage Expansion: What Would it Cost in California?
CHCF, April 2006. www.chcf.org/topics/healthinsurance/index.cfm?itemID=120742
[18] New York Times, Pam Belluck, Massachusetts Sets Health Plan for Nearly All, April 5, 2006.
www.nytimes.com/2006/04/05/us/05mass.html?ex=1156910400&en=c4a6130fbd889bc6&ei=5070
[19] ibid.
[20] Community Catalyst, Massachusetts Health Reform: What it Does; How it Was Done; Challenges Ahead, April 2006.
www.communitycatalyst.org/resource.php?base_id=1023
[21] ibid.

112,000 signatures needed to place the initiative on the ballot. [22] However, the organization chose to leverage the initiative to gain a voice in the Massachusetts' Universal Health Coverage. It informed the legislature that it would drop the initiative if a bill passed that met approval of the Mass ACT members.[23] This dynamic likely reduced opposition from the business community for the Massachusetts Health Care Reform Act. If the ballot passed, employers were likely to suffer economic loss. In contrast, the business community could maximize its welfare by working with legislators to create a bill that would allow the business community to influence the outcome to its best interest.

The availability of an array of potential policy solutions assisted in generating legislative support. "Blue Cross Blue Shield Foundation of Massachusetts' Roadmap to Coverage initiative commissioned the Urban Institute and others to create policy options that would achieve near universal coverage."[24] Legislators used these options (i.e. employer mandate, individual mandate, subsidized insurance, and Medicaid Expansion) as the foundation for the bill. [25] Legislators were willing to accept assistance from the Blue Cross Blue Shield Foundation because of its respected stature in the community and reputation as a field expert. Policy analysis are often costly to obtain due to time and resources required. The organization minimized legislator's cost in these areas and further reduced barriers to creating a working bill for universal coverage. Throughout the past three years, the Foundation worked to periodically convene stakeholders to generate discussions related to universal coverage and facilitate political support and compromise.[26]

Legislation's Structure

The final legislation bears the marks of bi-partisan efforts. Republican governor, Mitt Romney strongly advocated for an individual mandate; this reflects the conservative view of individual responsibility by ensuring people do not rely on "free care" through the public safety net. Conversely, the largely Democrat legislature believed that business should be responsible. This resulted in a blend of employer and individual responsibility[27]

The details of the legislation were also left fairly broad permitting legislators and interest groups room to maneuver after passage. It also sets in place multiple councils and advisory boards which allow for executive influence, balanced with interest group (particularly business and hospital networks and insurance companies) and bureaucratic influence.[28]

The structure of the bill was designed so that major stakeholders would have opportunity to shape policies and implementation. For instance, the council on healthcare quality includes among others, the commissioner of insurance, 7 persons to be appointed by the governor, a representative of the Massachusetts Chapter of National Association of Insurance and Financial Advisors, a representative of the Massachusetts Association of Health Underwriters. There is significant representation from the executive branch and business community. Similarly, the legislation creates a 12 member payment advisory board that includes an array of various internal and external groups. The MassHealth payment policy advisory board is required to conduct an

---

[22] ibid.
[23] ibid.
[24] ibid.
[25] ibid.
[26] ibid.
[27] Newshour with Jim Lehrer, Massachusetts Insures All, April 5, 2006. www.pbs.org/newshour/bb/health/jan-june06/massachusetts_4-5.html
[28] Massachusetts State Legislature, Health Care Reform Act, April 12, 2006. www.mass.gov/legis/laws/seslaw06/sl060058.htm

analysis of payment policies, make recommendations on rates, and assist in creating a plan of implementation of the policies. These various advisory boards and councils also serve as a source of information for legislators, making known the preferences of these influential groups at a low cost.

The influence of the business community can be seen in the reasonably low annual tax penalty and the free rider surcharge. The legislation requires businesses that do not provide health insurance to pay an annual tax of up to $295 per employee. It also applies a free rider penalty should a business' employee use of the public safety net exceed $50,000. Some experts believe that neither of these minimal penalties will impel employers to offer health insurance to their employees as the actual cost of health insurance far exceeds the maximum annual tax. Additionally, the free rider penalty may result in health discrimination in hiring as businesses that do not offer their employees health coverage may opt to hire only healthy employees to avoid the free rider surcharge.

Other facets of the bill also provide direct fiscal benefits to stakeholders. For instance, it addressed the concern that Medicaid underpays many of its providers by including a $90 million rate relief for Fiscal Years 2007-2009. It also addresses advocacy groups' demands for equity and quality of care requiring that rate increases be attached to specific performance goals of quality, efficiency, the reduction of racial and ethnic disparities, and/or improved health outcomes.[29] Additionally, the bill favors hospitals by stating a low maximum fine of $50,000 for failing to submit required data in a timely fashion. [30] This structure is favorable to both healthcare industry and the business community. By making these allowances within the bill, legislators also minimized opposition from benefiting groups.

Financing Structure and Cost Containment

The plan is estimated at a cost of $1.2 billion over the next three years. It redeploys current public funds previously distributed to providers for uncompensated care to the uninsured and the underinsured. Sources of financing include Medicaid payments previously paid to safety net providers and funds from the Free Care Pool.[31] Additionally it will come from employer and individual contributions and the state's General Fund revenue. General Fund contributions are expected at $308 million over three years. [32] Massachusetts "anticipates that no additional funding will be needed beyond three years." [33]

Critics believe that funding will be inadequate in the long-term, given the trend in rising health costs and the lack of cost controls. The legislation primarily focuses on controlling cost through the purchasing pool and risk pooling to drive down premium costs.

Legislators believe that the individual mandate will stabilize the health insurance risk pools by including more healthy people. The Connector would also reduce the likelihood of premium

---

[29] Health Care Access and Affordability Conference Committee Report, Conference Committee Report, April 3, 2006. www.mass.gov/legis/summary.pdf
[30] Massachusetts State Congress, Health Care Access and Affordability Conference Committee Report, 4/3/2006. www.mass.gov/legis/summary.pdf
[31] Kaiser Family Foundation, Kaiser Commission on Key Facts: Massachusetts Health Care Reform Plan, April 2006. www.kff.org/uninsured/upload/7494.pdf
[32] ibid.
[33] ibid.

increases by having plans with relatively high cost-sharing requirements and limited provider networks. [34]

High cost sharing shifts a proportion of medical costs to the beneficiary. In theory, individuals would consume more health care than they require if they do not suffer the financial consequences. This will cause beneficiaries to become more efficient and cautious consumers of medical care. An unintended consequence could be an under utilization of the health plan. Individuals with limited financial resources may choose not to access medical care until their conditions worsen. Those who will be most effected by this policy will be middle-income populations who do not qualify for governmental assistance, and those with greater health care needs. Through its limited networks, the Connector will prevent beneficiaries from utilizing high-cost providers. [35]

The reform plan does not address the following sources of rising health costs:

- Escalating costs of prescription medication
- Hospitals as a driver of increased costs
- Chronic disease management and preventative care

The Connector does not standardize benefit packages; this makes it challenging for purchasers to compare prices. Additionally, insurers may offer lower-cost policies that require higher out-of-pocket spending in order to attract low-risk and therefore lower cost populations. This will exacerbate the segmentation in the health insurance market by health care risk.[36] These patterns will not impact participants in CCHIP because these plans do not have deductibles and are expected to require standardized benefit packages. [37]

These cost saving efforts may prove inadequate at stemming rising health care premiums in the long-term because they do not address the major drivers of increases in health care expenditures. Should premiums become unaffordable for a growing number of the state's residents, the state may need to subsidize health coverage for a greater proportion of the population as well as increase its per capita contributions. Economic conditions may also affect an individual's ability to purchase health coverage without governmental assistance. Additionally, there is the issue of efficiency versus equity. While health plans containing high deductibles and cost sharing may be lower cost and therefore more affordable, expanding coverage with such plans may not enhance the currently uninsured's health outcomes due to underutilization and further risk segmentation.

Implementation

Massachusetts was able to pass this bill due to its efforts in consensus building. Yet stakeholders' significant influence in the implementation process may create inefficiencies in cost effectiveness and quality of care. The health industry may use its immense influence in

---

[34] [34] Health Affairs, Massachusetts Health Care Reform: A Look at the Issues, John Holahan and Linda Blumberg, Vol. 25, No. 6, September 2006, pp 432-44. content.healthaffairs.org/cgi/content/abstract/25/6/w432

[35] ibid.

[36] ibid.

[37] ibid.

determining standards of care and payments to its own gain rather than to improving patient welfare.

Additionally, the legislation requires the creation of a new government bureaucracy to administer the program rather than building on existing infrastructure. There are costs and benefits associated with a government bureaucracy purchasing coverage in the individual market. There is concern that this may make implementation costly due to the 'red tape' common to government bureaucracies and high overhead and administrative costs. An advantage to government participation is that it may be a signal to consumers that the product is trustworthy. By having a bureaucracy dedicated to this program, the government is better able to ensure that provisions are followed, rather than outsourcing to a private organization where accountability is often more difficult to assess due to communication barriers between the government and the contractor. The creation of a new government bureaucracy also minimizes the risk of overburdening an existing agency with additional responsibilities.

Governor Romney's support and commitment ensured the passage of the Massachusetts Health Care Reform Act. However, Governor Romney will likely leave office when his term ends to pursue presidential aspirations and therefore implementation will rely on the next governor. [38] While the legislation builds in provisions for gubernatorial influence, the next governor may not share his predecessor's vision or priorities and may not dedicate the time and resources necessary so that implementation will be successfully executed. Similarly, state legislators may overlook their commitment to the implementation process. Ultimately, implementation may be left to bureaucracies. Unless influential interest groups demand legislative attention, it is unlikely that legislators will be closely involved in the details of the process. Legislators have budgetary control of the program in the form of Ways and Means and Appropriation committees, which also permits them to exert influence over the organization charged with implementation and address interest group preferences and discontents.

Mandates present a challenge in that enforcement can become time consuming and organizationally taxing. The legislation addresses how individual mandates will be enforced. Beginning July 2007, the state will require residents to have health insurance. In order to ensure that residents comply with the individual mandate, residents must confirm their health coverage on state income tax forms filed in 2008. The legislation stipulates that coverage will be verified through a database of insurance coverage and that the Department of Revenue will enforce the requirement through financial penalties. Penalties begin with a loss of personal exemptions in tax year 2007 and increase to a portion of what an individual would have paid toward an affordable premium in subsequent years.[39]

The legislation designates a preexisting government bureaucracy to enforce the individual mandate. However, given the Department of Revenues' vast responsibilities, the Department may not have the resources or time to ensure compliance. The ambiguity of the legislation favors businesses over individuals by excluding specific details about the enforcement mechanism of employer mandates. This may be due to the influence that the business

---

[38] Galen Institute, The Massachusetts Health Plan: Proceed with Caution, Grace-Marie Turner, April 26, 2006. http://www.allhealth.org/BriefingMaterials/GraceMarieTurnerMassPlan-271.pdf

[39] Massachusetts State Congress, Health Care Access and Affordability Conference Committee Report, 4/3/2006. www.mass.gov/legis/summary.pdf

community had in writing the legislation. The vagueness permits businesses future flexibility in determining implementation. Additionally, not providing the Connector with its own enforcement unit and legal authority weakens the state's ability to ensure compliance with the mandates.

The individual mandate hinges on the affordability of the plans for moderate-income individuals and adequate government subsidies. The Massachusetts legislature did not define affordability and the subsidy schedule for low-income individuals and left this to the Insurance Connector.[40]

III. San Francisco Health Care Security Ordinance

Health Coverage Expansion

The San Francisco Health Care Security Ordinance was passed on June 18, 2006 and will be effective on July 1, 2007. The ordinance seeks to increase the uninsured's access to medical care through two measures. First, the ordinance creates the San Francisco Health Access Program (SF HAP) that will offer comprehensive healthcare services to uninsured San Franciscans and their employers at a reasonable cost. Secondly, it requires large and medium sized businesses to make minimal contributions towards employee health coverage.

SF HAP is a city-sponsored program that will provide affordable and accessible care for San Francisco's 82,000 uninsured residents. [41] SF HAP is not portable beyond the city and the county, does not cover services rendered by providers that are not in the provider network, and does not provide a comprehensive set of services.[42] The San Francisco Health Plan (SFHP), the county-sponsored health plan that currently provides health insurance to more than 50,000 low income Franciscans, will administer SF HAP. The uninsured would become plan members and would access care through existing SFHP's providers—20 public and nonprofit community health clinics, specialty care from SF General Hospital, and emergency room services from any San Francisco hospital.

As written, all of San Francisco's uninsured residents are eligible for the program regardless of employment or immigration status. The uninsured individual can enroll individually or be enrolled by an employer. Individual enrollees can pay an income-based sliding scale premium or employers can enroll employees as a group, by paying their premiums.[43] Individual and worker contributions and copayments will be based on a sliding scale, but have yet to be determined. If all 82,000 uninsured adult residents of San Francisco enrolled in the SF HAP, the approximate cost would be just over $200 per person, per month or $200 million annually.[44] Officials estimate that individual premiums will range from $3 per month at the lowest income levels to

---

[40] Health Affairs, Massachusetts Health Care Reform: A Look at the Issues, John Holahan and Linda Blumberg, Vol. 25, No. 6, September 2006, pp 432-44. content.healthaffairs.org/cgi/content/abstract/25/6/w432

[41] California Healthline, San Francisco Moves Forward With Health Access Plan, Lauer, George, August 9, 2006, http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=124104

[42] Universal Healthcare Council, Final Report to Mayor Gavin Newsom: San Francisco Health Access Program: Serving Uninsured Adults, June 23, 2006

[43] UC Berkeley Labor Center, San Francisco Health Care Security Ordinance Resources: Overview of the Ordinance with Questions and Answers, laborcenter.berkeley.edu/healthpolicy/index.shtml

[44] San Francisco Health Access Program website, Frequently asked questions, http://www.sfhp.org/sfhap/FAQ/?cid=0&qid=12&search=0#b12

greater than $200 per month for those at the highest income levels.[45] While all San Franciscans are eligible for SF HAP there will be an upper income level for subsidization, which is in the process of being determined.

To qualify for SF HAP individuals must be:

- Uninsured
- Residents of San Francisco
- Ineligible for other government subsidized health benefits programs, such as Medicare and Medi-Cal

The ordinance mandates large and medium businesses to spend a certain figure provide coverage to their employees; this is designed to deter employers from suspending existing coverage and forcing employees onto the public safety net. Large businesses are defined as having 100 or more employees and medium businesses as those with between 20-99 employees. These employers must make a minimum financial contribution, known as the 'health care expenditure rate,' on behalf of qualified employees. The money should be used to provide health care services for covered employees or to reimburse the cost of health care services.[46] Contributions can go to health savings accounts, insurance, a public program for the uninsured (i.e. Health Access Program), or direct reimbursement to employees for their health expenses.[47]

Large businesses will have a minimum financial contribution of $1.60 an hour worked per employee. For a full-time employee, "this is equivalent to 75 percent of the average amount that the 10 largest counties in California (other than San Francisco) spend on individual health coverage for their employees."[48] This rate will increase by 5 percent annually through 2009 and from 2010 and on, it will be indexed again to 75 percent of the 10-county rate.[49] Medium sized businesses will have a minimum financial contribution of $1.06 an hour worked per employee.[50] For a full-time employee, "this is equivalent to 50 percent of the average amount that the 10 largest counties in California (other than San Francisco) spend on individual health coverage for their employees."[51] The rate will increase by 5 percent annually through 2009 and from 2010 and on, it will be indexed again to 50 percent of the 10-county rate.[52]

---

[45] California Healthline, San Francisco Moves Forward With Health Access Plan, Lauer, George, August 9, 2006, http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=124104

[46] City of San Francisco, San Francisco Health Care Security Ordinance, Ordinance Number 219-06, July 17, 2006. www.ci.sf.ca.us/site/uploadedfiles/bdsupvrs/ordinances06/o0218-06.pdf

[47] UC Berkeley Labor Center, San Francisco Health Care Security Ordinance Resources: Overview of the Ordinance with Questions and Answers, laborcenter.berkeley.edu/healthpolicy/index.shtml

[48] ibid.

[49] City of San Francisco, San Francisco Health Care Security Ordinance, Ordinance Number 219-06 www.ci.sf.ca.us/site/uploadedfiles/bdsupvrs/ordinances06/o0218-06.pdf, July 17, 2006 and UC Berkeley Labor Center, San Francisco Health Care Security Ordinance Resources: Overview of the Ordinance with Questions and Answers, laborcenter.berkeley.edu/healthpolicy/index.shtml

[50] UC Berkeley Labor Center, San Francisco Health Care Security Ordinance Resources: Overview of the Ordinance with Questions and Answers, laborcenter.berkeley.edu/healthpolicy/index.shtml

[51] ibid.

[52] City of San Francisco, San Francisco Health Care Security Ordinance, Ordinance Number 219-06 www.ci.sf.ca.us/site/uploadedfiles/bdsupvrs/ordinances06/o0218-06.pdf, July 17, 2006 and UC Berkeley Labor Center, San Francisco Health Care Security Ordinance Resources: Overview of the Ordinance with Questions and Answers, laborcenter.berkeley.edu/healthpolicy/index.shtml

By utilizing hourly wages to determine contributions, the ordinance does not create an incentive for employers to reduce employees' hours.[53] Employees must also work at least two hours per week, be subject to the city's minimum wage law, and have worked for the employer for at least 90 days.[54] Employees who qualify for employer contributions are termed "covered employees."[55] Excluded employees include persons who are managerial, supervisory, or confidential employees, unless they earn under $72,450 annually in 2007.[56] Also exempt are employees who are eligible to receive benefits under Medicare or TRICARE/CHAMPUS (veterans' benefits), and those who are receiving health services through another employer.[57]

The ordinance exempts certain employers from making a minimum health care expenditure rate. These employers include small businesses, nonprofit corporations with less than an average of 50 employees, and nonprofit job training programs.[58]

The Political Climate:

It is consistent with San Francisco's progressive social history to develop a bold plan that provides uninsured with access to healthcare. In addition, the plan's release coincided with an election year for the board of supervisors and the upcoming mayoral election in 2007. This potentially generated greater attention and the political impetus necessary for change. The plan was also released at a time of economic prosperity for San Francisco that made government subsidies and support feasible.

The city has been actively involved in pursuing universal coverage through incremental steps. The City and County of San Francisco have had great success in passing incremental health coverage expansion efforts, such as SF Healthy Kids, Healthy Young Adults, coverage for home care workers and family home child care centers.

Currently, San Francisco continues to be involved in health coverage expansion. SFHP is working with the Department of Public Health to determine the best way to extend its services to over 50 percent of local taxi drivers.[59] The agency is also seeking to expand coverage to parents in families up to two times the federal poverty level.[60]

Political Support

The critical political support for the ordinance arose from San Francisco's mayor and liberal Board of Supervisors, fueled in part by the need to develop political support and ideological perspectives.

Businesses were not supportive of the ordinance due to the employer mandate. The measure required that businesses with 20 or more employees either provide health coverage to their workers or contribute to a fund that would pay for healthcare services within city limits to

---

[53] UC Berkeley Labor Center, San Francisco Health Care Security Ordinance Resources: Overview of the Ordinance with Questions and Answers, laborcenter.berkeley.edu/healthpolicy/index.shtml
[54] ibid.
[55] ibid.
[56] ibid.
[57] City of San Francisco, San Francisco Health Care Security Ordinance, Ordinance Number 219-06, July 17, 2006. www.ci.sf.ca.us/site/uploadedfiles/bdsupvrs/ordinances06/o0218-06.pdf
[58] ibid.
[59] San Francisco Health Plan, http://www.sfhp.org/about_us/inside_sfhp/looking_forward.aspx
[60] ibid.

uninsured residents. There was opposition from powerful business groups fearful that employer mandates could create another burden on smaller businesses that would reduce already small profit margins and possibly force them to close.

Despite the threat of this opposition, the plan rose on the political agenda because it garnered support from key politicians, unions, 11 Board Supervisors and, Mayor Newsom. The supervisors have long been known for their fairly liberal political position. On the other hand, Newsom has traditionally allied himself with the business community; his support was less foreseeable. The mayor's dedication to the initiative may be partly attributed to an effort to broaden his appeal to voters.

Other factors may have allayed Newsom's concern for the business community. The Office of Economic Analysis' released a report entitled, "The Economic Impact of the Proposed Worker Health Care Security Ordinance" which found a relatively neutral economic impact to the city economy.[61] In the short term, the report predicts that the primary burden will fall on businesses with 20-49 employees because they are less likely to provide health coverage and more likely to employ lower wage employees; however, these employers will eventually pass on the cost onto their employees through lower wage increases. In January 2005, San Francisco instituted an $8.62 living wage ordinance. Employers objected to the increase on the grounds that it would have adverse consequences on businesses and the economy. Yet, businesses continued to flourish even after the wage increase, undermining their capacity to predict the consequences of an employer mandate.

Newsom also increased the political feasibility of his plan by creating the Universal Health Council.[62] The council was a way to generate ideas from influential health industry organizations, experts, and advocates. By involving them in the process, the mayor minimized opposition by giving organizations and individuals a stake in the legislation. Additionally, the council provided valuable information and a workable policy solution, on which much of the ordinance is based, to address the city's uninsured population.

The mayor and the Board of Supervisors effectively framed the issue of universal access to the public. They made it politically viable by focusing on how the plan would better utilize public funds allocated to the care of the uninsured and reduce financial burdens on taxpayers. There was also a strong emphasis on the benefits to moderate-income residents who typically have incomes too high to qualify for subsidized government health care and yet, too low to purchase coverage.

Legislation – Power distribution

The Board of Supervisors and the mayor remain heavily invested in a program's outcome. The San Francisco Board of Supervisors only has 11 members. As a result, the public will be able to hold the local Board members more directly responsible for the program's performance. In order to ensure they are able to retain their elected position, board members must make certain

---

[61] San Francisco Office of Economic Analysis, Economic Impact Report of the Proposed Worker Health Care Security Ordinance, File No. 051919, June 23, 2006. www.sfgov.org/site/uploadedfiles/controller/oea/OEA_WrkHlthOrd0606.pdf

[62] Universal Healthcare Council, Final Report to Mayor Gavin Newsom: San Francisco Health Access Program: Serving Uninsured Adults, June 2006. laborcenter.berkeley.edu/healthpolicy/uhc_report.pdf

that SF HAP achieves its goals. The ordinance provides the board with the centralized authority to govern SF HAP's progress.

The Board of Supervisors will receive regular updates about the implementation process and have the power to make mid-course policy corrections. The City Controller and the Department of Public Health will be required to provide the Board with quarterly reports between July 1, 2007 through June 30, 2008 and every six months through June 2010. Through the report, the City Controller and the Department of Public Health can only make recommendations.[63] The Board will decide which actions to take. The Director of Public Health will also convene an advisory Health Access Working Group, which will provide expert consultation to the Department of Public Health and SFHP. [64] However, the Mayor and Board of Supervisors will have input in the consultation process, which allows them to influence and shape recommendations.[65]

These features of the ordinance leave agencies with little bureaucratic discretion, which may become problematic. The Board's goals may not be aligned with agency goals. As a result, board members may make decisions based on what is in their political interest rather than advice from experts at the government agencies who are more knowledgeable.

In order to ensure that their preferences receive priority, Board members also structured the ordinance in a very detailed manner. It gave highly specified time frames and instructions, such as the employer contribution schedule, leaving little room for interpretation and delay.

The ordinance leaves little room for business-based interest groups to exert influence and therefore weakens the employer mandate. Enforcement is placed under the Office of Labor Standard Enforcement (OLSE). OLSE performs functions such as ensuring that public works contractors comply with prevailing wage and other labor standard regulations, and administering and enforcing the City's Minimum Wage Ordinance, Minimum Compensation Ordinance, and Health Care Accountability Ordinance. The Board of Supervisors strategically placed enforcement within an agency that favors workers' welfare. The business community would probably have preferred to place the responsibility in an agency that was more receptive to business interests.

Employers must maintain records of health care expenditures.[66] If an employer fails to show adequate documentation of the health expenditures made or does not allow OLSE reasonable access to the records, it will be presumed that the employer is not in compliance with the mandate. By placing the burden of proof on the employer, the ordinance avoids disadvantaging employees.

Despite these considerations, ensuring employer adherence with the ordinance will be challenging. Investigations are often triggered through a complaint process. Employees may be reluctant to report employers because they fear losing their job or suffering consequences in the workplace. Most agencies do not have the resources to conduct compliance reviews to make

---

[63] City of San Francisco, San Francisco Health Care Security Ordinance, Ordinance Number 219-06, July 17, 2006. www.ci.sf.ca.us/site/uploadedfiles/bdsupvrs/ordinances06/o0218-06.pdf

[64] ibid.

[65] ibid.

[66] ibid.

sure that noncompliant employers alter their behavior. Another area of concern is that OLSE's legal authority is not housed within the agency. Instead, the OLSE relies on the City Attorney for legal consultation and action. The OLSE's limited authority may weaken its ability to punish uncooperative employers.

Financing and Cost Control

The program is expected to have an annual cost of $200 million. Approximately $104 million will come from pre-existing city funds for treating the uninsured, $28 million will be raised from employer contributions, and the remaining $56 million will come from participant premiums and related premiums. The cost is just over $200 per person, per month or approximately $2415 annually per person.[67]

SF HAP is expected to minimize costs by using the SF Health Plan, the county-sponsored managed care plan, as the administrator. Managed care plans are able to reduce costs using their market power to negotiate lower provider fees, restricting the services they provide, restricting the network to the most efficient providers and providing financial incentives to physicians to limit utilization.[68]

SF HAP is designed to reduce costs by adapting the uninsured's reliance upon the public health system, emergency care, into a more cost-efficient "medical home" model. The uninsured often utilize emergency care for conditions that could be treated more cost-effectively in primary care settings because this is their only guaranteed point of access. [69] In addition, having treated an uninsured person, the hospital emergency room has no defined place to send him or her for follow-up care.[70] The uninsured's patterns of utilization have enormous impacts on the health care delivery system and on taxpayers.[71]

The premise of the medical home model is that if each enrollee has direct access to one provider, he or she would have improved health outcomes and minimized later need for more costly medical services. The responsible provider will have centralized information about the patient's background and therefore be able to more efficiently treat the patient, avoiding duplicated services and diagnostic tests. The "medical home" model also allows the provider to increase the likelihood that patients will seek care and abide by prescribed regimens. As the main source of care, the provider would develop a relationship of trust with the beneficiary and provide ongoing health care such as preventative services. Uninsured individuals who enroll in SF HAP would change their care-seeking patterns and therefore avoid burdening local taxpayers with more expensive, untreated health problems in the long-term.

Promoting a focus on preventative care may have unintended pitfalls. This model may be highly attractive to individuals with chronic conditions. This population typically requires close monitoring and high levels of coordination of treatment in order to control their conditions.

---

[67] SF HAP Website, All Questions, Accessed October 2006, www.sfhap.org
[68] Rand Journal of Economics, How does managed care do it?, Cutler, David M.; McClellan, Mark and Newhouse, Joseph P., Vol. 31, No. 3, Autumn 2000, pp 526-548. www.economics.harvard.edu/faculty/dcutler/papers/cmn_rand_journal_autumn_00_reprint.pdf
[69] Universal Healthcare Council, Final Report to Mayor Gavin Newsom: San Francisco Health Access Program: Serving Uninsured Adults, June 23, 2006. laborcenter.berkeley.edu/healthpolicy/uhc_report.pdf
[70] San Francisco Health Access Program, Press Release dated February 1, 2006, Mayor Newsom Proposes Universal Health Care, www.sfhp.org/files/PDF/SFHAP/SFHAP_Release_2_1_06.pdf
[71] Universal Healthcare Council, Final Report to Mayor Gavin Newsom: San Francisco Health Access Program: Serving Uninsured Adults, June 23, 2006. laborcenter.berkeley.edu/healthpolicy/uhc_report.pdf

Providers find that organizing these resources is extremely time consuming and unprofitable given the current structure of insurance reimbursement. Many insurers provide low reimbursements for primary and preventive care and case management. Insurers generally do not compensate providers for the time they spend coordinating care with other providers, but rather based on specific procedures performed. [72] They also typically compensate providers at greater rates for acute care than for counseling and ongoing care.[73] Insurers may attempt to limit enrollment for individuals with chronic conditions out of fear that they will attract a greater number and share of the chronically ill. [74] The chronically ill will therefore have an incentive to self-select into SF HAP where they will receive a higher quality of care and greater attention to their medical needs. As a result, SF HAP may face the challenge of a high-risk pool and therefore greater than predicted per member costs.

The program is still in the midst of design and creation and may offset some of these potential issues by utilizing mechanisms such as chronic illness look back periods. Other cost-saving features may arise as implementers of the program iron out details about SF HAP's structure. Through utilizing the county-sponsored health access plan to expand coverage, the county has the flexibility to determine how the different facets of the program will be designed. It has the authority to develop other in-plan cost containing strategies such as bulk drug purchasing and tiered drug benefits.

There is little other consideration given to cost control, with the exception of focusing on preventative care, chronic care management, and using a managed care system. Instead, it attempts to addresses the stability of future finances through three financing mechanisms:

- Annual increases in employer expenditure rates
- Fund location and stipulations
- Maximization of state and federal reimbursements for patients

The ordinance addresses the rising costs of health care by building into the legislation an annual increase for employer health care expenditures. As previously discussed, health care expenditure rates are indexed for large businesses at 75 percent and for medium sized businesses at 50 percent of the average amount that the 10 largest counties in California (other than San Francisco) spend on individual health coverage for their employees. [75] Through creating these annual adjustments, the county protects itself and employees from rising health care costs.

The plan seeks to facilitate program financing by carefully stipulating the way employer contributed funds are collected and maintained. The ordinance states that the City Controller has the responsibility of requiring that required health care expenditures made by an employer to the county are kept separate and apart from general funds. [76] Additionally, these expenditures

---

[72] Health Affairs, Changing the Chronic Care System to Meet People's Needs, Anderson, Gerald and Knickman, James R, Vol. 20, No. 6, November/December 2001. content.healthaffairs.org/cgi/reprint/20/6/146.pdf
[73] ibid.
[74] ibid.
[75] City of San Francisco, San Francisco Health Care Security Ordinance, Ordinance Number 219-06, July 17, 2006. www.ci.sf.ca.us/site/uploadedfiles/bdsupvrs/ordinances06/o0218-06.pdf
[76] ibid.

are only to be used on the Health Access Program.[77] This protects SF HAP finances by ensuring that funds cannot be reallocated to unrelated programs in the future. This is strategic given that programs for disadvantaged populations do not fare well during difficult economic times. They often lose funding because they are not perceived as a political priority.

The ordinance also maximizes federal and state sources of reimbursement for its patients. It specifically designates the San Francisco Health Access Plan (SHAP) as access to medical care and not health coverage. Through utilizing this strategy, it maintains existing federal and state program contributions towards care to the uninsured."[78]

Implementation

The SF HAP Advisory Council was created by Mayor Newsom to oversee implementation and reduce opposition from various stakeholders. It consists of a 24 member panel comprised of a broad range of stake holders, which include Kaiser Permanente, SF Small Business Commission, including representatives from the Catholic Health Care West, SF Department of Public Health (DPH), Health Plan of San Mateo, CA Pacific Medical Center, SF Community Clinic Consortium, SEIU, UCSF Medical Center, Small Business Commission, Golden Gate Restaurant Association, Blue Shield Foundation, California HealthCare Foundation, San Francisco Organizing Project, Senior Action Network, and the SF Chamber of Commerce. The council will provide expert consultation for the DPH, the administering agency, in areas such as membership rates, designing benefits and services, researching utilization and costs, and program evaluation.[79] The council also serves as a way to access innovative ideas and high quality information at a low cost.

Additionally, the ordinance follows many of the politically strategic recommendations from the Universal HealthCare Council Report. The report provided recognition that there will be challenges in employer compliance and discontent in the business sector and recommended a means to mitigate these issues. As a result, the city is working with the Blue Shield of California Foundation to address these issues. The Blue Shield of California Foundation is considering supporting an employer focus group research study to facilitate the planning and implementation of the mandate.[80]

Implementation is also broken down into 3 implementation phases. This approach limits the pressure that SF HAP services may place upon the public health system and SF HP. The first phase-in period will serve as a program pilot and include employers with 50 or more workers and is scheduled to begin July 1, 2007. [81] During this period program details will be refined and adjustments will be made to financing projections:[82]

---

[77] ibid.
[78] Insure the Uninsured Project, Summary of San Francisco Health Plan: Initiative to Cover the Uninsured, July 25, 2006, http://www.itup.org/Reports/Solutions/SummarySFHealthPlan.pdf
[79] SF HAP Website, Press Release: Mayor Newsom Outlines Next Steps for Implementation of Universal Health Access Program for San Francisco's Uninsured, August 7, 2006. www.sfhp.org
[80] SF HAP Website accessed October 2006, SF HAP Update October 2006, www.sfhp.org
[81] California Healthline, San Francisco Moves Forward With Health Access Plan, Lauer, George, August 9, 2006, http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=124104
[82] SF HAP Website, All Questions, Accessed October 2006, www.sfhp.org

The pilot program presents a more manageable way to handle challenges such as pent up demand. The second phase of implementation will include employers with 20-49 workers and is expected to go into effect April 2008.[83]

The ordinance avoids using the private market to expand health access. Through the utilization of the public program, there will also be greater transparency of healthcare and administrative costs.

Despite these efforts, some employers will contest the legality of the mandate. The mandate may be subject to lawsuits under a provision of ERISA (the federal Employee Retirement Income Security Act). ERISA prohibits states from mandating or regulating the benefit packages of large self-insured multi-state employers.[84] Historically, the courts have interpreted the provision as prohibiting states from mandating employers to provide health coverage and these decisions have been upheld in the Supreme Court.[85] The business community is likely to request the courts to review whether the ordinance violates ERISA, and the Golden Gate Restaurant Association has already filed suit.[86]

IV. Alameda Alliance Family Care

Health Coverage Expansion

On July 1, 2000, Alameda Alliance for Health[87] began enrolling qualified individuals into its Family Care program, a 5-year pilot program designed to serve as a source of affordable health coverage for low-income families in Alameda County. Family Care enrollees had access to Alliance's network of more than 1,000 community physicians, 12 hospitals, 26 community health centers, and over 160 pharmacies within the county.[88]

Individuals were eligible based upon the following criteria:

- Low-income families in the county who are not otherwise eligible for public programs and were below 300% of the Federal Poverty Level (FPL).[89]
- Complete an application and statement of health;[90]
- Have a child enrolled in the Alliance through Healthy Families, MediCal or Family

---

[83] California Healthline, San Francisco Moves Forward With Health Access Plan, Lauer, George, August 9, 2006, http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID=124104

[84] Insure the Uninsured Project, Summary of San Francisco Health Plan: Initiative to Cover the Uninsured, July 25, 2006, http://www.itup.org/Reports/Solutions/SummarySFHealthPlan.pdf

[85] ibid.

[86] ibid.

[87] Alameda Alliance for Health is a local public nonprofit HMO that predominately serves Medi-Cal and Healthy Families members within Alameda County.

[88] Community Voices, Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity, Economic and Social Research Institute, November 2001. www.communityvoices.org/Uploads/nu2eq555sghyrq45gcxhn0ew_20020828081946.pdf

[89] Journal of Health Care for the Poor and Uninsured, Inclusion of Immigrant Families in U.S. Health Coverage Expansions, Jane Garcia, Ralph Silber, Ingrid Lamirault, Luella Penserga, Margo Hall, Vol. 17, 2006, pp 81-94. muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/v017/17.1Shirota.pdf

[90] Community Voices, Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity, Economic and Social Research Institute, November 2001. www.communityvoices.org/Uploads/nu2eq555sghyrq45gcxhn0ew_20020828081946.pdf

Care;[91]

- All children in the household without health coverage must be enrolled. [92]

The Alliance applied medical underwriting to its eligibility process in a very limited form, by relying on the availability of various self-reported medical conditions at the time of application.[93] This resulted in a denial of only 0.7 percent of applications in 2002.[94] Alliance was conscious that many of the county's uninsured are immigrants, some were undocumented.[95] Citizenship status was not a prerequisite for eligibility.

Monthly premiums ranged from $20 to $120 per month depending on age.[96] Alliance subsidized the other of the cost of health coverage through a portion of its reserve funds. Enrollees made copayments of $5-$15 for specified medical services. Although there was significant demand for the program, Alliance was forced to terminate Family Care as of July 2005 due to financial issues.

Program Development – Community support and input

Alliance Health maximized provider and community participation to develop a desirable benefit package, streamline enrollment, and effectively define its target population.

Alliance used focus groups to determine the preferences of the target population. The organization discovered that this group preferred comprehensive benefits to a more inexpensive primary care only plan.[97]

Alliance also benefited from its significant efforts to make the local safety net part of the development process and the group's dedication and organizational skills. The safety net organizations formalized their relationship through the creation of the Access to Care Collaborative. The Access to Care Collaborative's responsibilities included assisting, planning, decision making, and determining the direction of Family Care." [98] Members included Alliance, Alameda County Health Care Services Agency, Alameda Health Consortium, Alameda County Medical Center, and the Asian Health Services/La Clinica de la Raza Community Voices Project. [99]

This group's field experience provided information on health access and health care trends in the uninsured population who utilized the public safety net. It identified that a large proportion of parents and siblings of Medi-Cal and Health Families enrollees were without health coverage

---

[91] ibid.
[92] ibid.
[93] Health Affairs, Who Enrolls in Community-Based Programs for the Uninsured and Why do They Stay?, Erin Fries Taylor, Catherine G. McLaughlin, Anne W. Warren, Paula H. Song, April 11, 2005. content.healthaffairs.org/cgi/content/full/hlthaff.25.w183v1/DC1#6
[94] ibid.
[95] Journal of Health Care for the Poor and Uninsured, Inclusion of Immigrant Families in U.S. Health Coverage Expansions, Jane Garcia, Ralph Silber, Ingrid Lamirault, Luella Penserga, Margo Hall, Vol. 17, 2006, pp 81-94. muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/v017/17.1Shirota.pdf
[96] Health Affairs, Who Enrolls in Community-Based Programs for the Uninsured and Why do They Stay?, Erin Fries Taylor, Catherine G. McLaughlin, Anne W. Warren, Paula H. Song, April 11, 2005, content.healthaffairs.org/cgi/content/full/hlthaff.25.w183v1/DC1#6

[97] Community Voices, Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity, Economic and Social Research Institute, November 2001. www.communityvoices.org/Uploads/nu2eq555sghyrq45gcxhn0ew_20020828081946.pdf
[98] ibid.
[99] ibid.

and some were undocumented residents.[100] This information assisted Alliance in formulating Family Care's target population. Alliance's excellent relationship with the community providers within The Access to Care Collaborative also factored into the enrollment process.

Enrollment

Unlike several other local health expansion efforts, Alliance Family Care was extremely successful in enrollment and retention. Its success was based on utilizing Alameda Alliance for Health's established provider network, which was heavily used by the uninsured population for medical treatment.[101] A substantial amount of the recruitment of adults occurred as a result of a medical services referral from these providers during encounters for themselves or their children.[102] Alameda Alliance for Health enrolled a significant number of individuals at its culturally competent and linguistically accessible community health centers and school-based health centers.[103] These providers had gained the trust of people and were accessible. Demand outstripped financing. Within three years of implementation, approximately 3,000 people were on the waiting list.[104] According to a study by the Robert Wood Johnson Foundation, six months after enrollment, retention rates were approximately 62%.[105]

Financing and Cost Control

Family Care benefits from Alliance's cost savings from enrolling Medi-Cal and Healthy Families subscribers in managed care. Family Care did not have other unique approaches to control costs. Enrolling a family in one plan was meant to integrate the provision of health services and therefore improve health outcomes.

Despite high levels of enrollment, the program was discontinued due to a lack of funding. Its primary funding streams proved financially unsustainable in the long term. The vast majority of program funding came from Alameda Alliance for Health's own limited revenue stream. The nonprofit health plan contributed an estimated $20 million over a four-year period. The Alameda County Board of Supervisors also allocated $2 million per year of Tobacco Settlement funds and private foundations contributed approximately $4 million.[106] The program lacked a steady stream of financial support such as legislatively mandates or tax based funding that would remain reliable during economic and political change.

In FY 2003, Alliance was faced with a $13.6 million deficit. This was largely caused by state caps and cuts to the Medi-Cal and Healthy Families Program and growth in Alliance's health care expenditures that were not matched by increases in the state's premium rates.[107] This situation forced the health plan to make budget cuts to minimize these losses and ensure the health plan's

---

[100] ibid.
[101] ibid.
[102] Health Affairs, Who Enrolls in Community-Based Programs for the Uninsured and Why do They Stay?, Erin Fries Taylor, Catherine G. McLaughlin, Anne W. Warren, Paula H. Song, April 11, 2005. content.healthaffairs.org/cgi/content/full/hlthaff.25.w183v1/DC1#6
[103] Journal of Health Care for the Poor and Uninsured, Inclusion of Immigrant Families in U.S. Health Coverage Expansions, Jane Garcia, Ralph Silber, Ingrid Lamirault, Luella Penserga, Margo Hall, Vol. 17, 2006, pp 81-94. muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/v017/17.1Shirota.pdf
[104] ibid.
[105] Health Affairs, Who Enrolls in Community-Based Programs for the Uninsured and Why do They Stay?, Erin Fries Taylor, Catherine G. McLaughlin, Anne W. Warren, Paula H. Song, April 11, 2005. http://content.healthaffairs.org/cgi/content/full/hlthaff.25.w183v1/DC1#6
[106] Advancing Universal Health Insurance Coverage in Alameda County: Results of the County of Alameda Uninsured Survey, Ninez Ponce, Tomiko Conner, B. Patricia Barrera, Dong Suh, September 2001. www.healthpolicy.ucla.edu/pubs/files/alameda.pdf
[107] Alameda Alliance for Health, Provider Bulletin, Volume 31, Number 119, July 30, 2004. alamedaalliance.org/pdfs/0704bull.pdf

long-term viability.[108] As a result, Alliance became unable to provide ongoing financial subsidies to the program.

In 2004, the local economic environment made public funding and further foundation financing untenable. The county was faced with a $140 million budget deficit due to the state's efforts to reduce budget shortfalls. The County Board of Supervisors did not perceive funding the program as high on the political agenda. The President of the County Board of Supervisors stated that the problem of the uninsured was too expensive for local government intervention given the county's financial crisis.[109] It may have been assumed that the majority of county voters would not benefit directly from the program and therefore assigned the program a low priority given the economic situation. As a result, the County Board of Supervisors recognized that supporting the program at that time of competing budget priorities would jeopardize their political standing.

It should be noted that the financial problems were not the result of poor local planning. California received a SCHIP waiver to expand its SCHIP program to enroll parents of children enrolled Medi-Cal or SCHIP. Alameda Alliance for Health expected to enroll the parents and then transition the eligible parents into this new SCHIP program. Unfortunately, the state did not implement the parental expansion program as a result of the state's budget deficit. [110] With no other available sources of funding, Alameda Alliance Family Care was terminated in July 2005.

V. Small Business Health Insurance

Historically, small businesses are less likely to offer employer based coverage to their employees due to higher insurance costs relative to larger employers. They face various challenges in the insurance market that are unique to their circumstances. A significant portion of this phenomenon is explained by the fact that insurers typically charge small firms higher premiums and deductibles.[111] Very small firms often pay premiums that are about 10 percent higher than large firms even though their plans cover fewer benefits and require deductibles twice as high.[112] Medical underwriting is one reason behind these disparities in premium prices. Small firms are more likely to be subjected to medical underwriting although California law restricts the extent of underwriting. In this process, insurers charge firms based on assessing the health risk of their employees on a yearly basis. Since small firms have few employees, a high cost case could result in a significant increase in the average cost of insurance within the firm.[113] In California, the risk of these catastrophic costs is incorporated into the over-all premiums.[114] Additionally, due to the skewed distribution of benefits of pre-tax purchasing, low-wage and less-educated workers have always been much less likely to be offered and covered by employer plans than workers

---

[108] ibid.
[109] Alameda Alliance for Health, Daily Review, County Health Care Dropping 4,000 people, Rebecca Vesely, March 25, 2004. www.alamedaalliance.com/article25.html
[110] Robert Wood Johnson Foundation, Covering the Uninsured Parents of Public Insured Children, Debra Gorden, www.rwjf.org/newsroom/featureDetail.jsp?featureID=306&pageNum=5&type=3
[111] Robert Wood Johnson Foundation, Are Health Insurance Premiums Higher For Smaller Firms?, Jason Lee, 2004. www.rwjf.org/publications/synthesis/reports_and_briefs/pdf/no2_policybrief.pdf
[112] ibid.
[113] ibid.
[114] ibid.

who are better-paid and better educated.[115] Coverage initiatives arose to minimize these disparities and make health insurance more affordable for small businesses and low-income employees. Among these are Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) and Sac Advantage.

VI. Financially Obtainable Coverage for Uninsured San Diegans - FOCUS

Health Coverage Expansion

Enrollment in Financially Obtainable Coverage for Uninsured San Diegans (FOCUS) began in April 1999 as a partnership between Sharp Health Plan (a Medi-Cal, AIM and Healthy Families contractor) and the Alliance Healthcare Foundation.[116] The FOCUS pilot strived to provide subsidized health coverage for low to moderate-income employees of small businesses and their families. Enrollees purchased standard Sharp Health insurance plans.

San Diego based businesses with 50 or fewer employees who had not provided coverage within the last year were eligible to participate in the pilot. [117] Uninsured full-time employees with incomes up to 300% of the Federal Poverty Level (FPL) were eligible to enroll in the program.[118] They were also required to enroll all eligible uninsured dependents. [119] The FOCUS pilot was guaranteed funding for two years. [120]

Both employers and employees contributed to the monthly premiums. Employer contributions were fixed and ranged from $24.29 per month for employee only coverage to $48.70 per month for employee and family coverage. [121] Employee premium contributions were based on a sliding scale that reflected income and family size and typically ranged from $10 to $104 per month. [122] On average, employers and employees paid for about 50% of the full premium cost and Alliance Healthcare Foundation, The California Endowment, and the California HealthCare Foundation subsidized the remainder of the premiums; subsidies ranged from $0 to $175 per month.[123] Sharp Health Plan was responsible for administering this premium assistance program.[124]

While FOCUS was popular among small business and their employees, it was no longer able to provide participants with subsidies after 2002 due to lack of funding.

---

[115] Health Affairs, Covering The Low-Income Uninsured: The Case For Expanding Public Programs, Feder, Judith; Levitt, Larry; O'Brien, Ellen and Rowland, Diane, Vol. 20, No. 2, January/February, 2001. content.healthaffairs.org/cgi/reprint/20/1/27.pdf
[116] Alliance Healthcare Foundation, was created after the sale of the nonprofit Community Care Network to a for-profit entity.
[117] Community Voices, Community-Based Health Plans for The Uninsured: Expanding Access, Enhancing Dignity, Economic Social Research Institute, November 2001. www.communityvoices.org/Uploads/nu2eq555sghyrq45gcxhn0ew_20020828081946.pdf
[118] ibid.
[119] ibid
[120] ibid
[121] ibid
[122] ibid
[123] Community Voices, Community-Based Health Plans for The Uninsured: Expanding Access, Enhancing Dignity, Economic Social Research Institute, November 2001. www.communityvoices.org/Uploads/nu2eq555sghyrq45gcxhn0ew_20020828081946.pdf & The Effects of FOCUS on Employers, Kronick, Richard and Olsen, Louis. medicine.ucsd.edu/fpm/focus/
[124] Community Voices, Community-Based Health Plans for The Uninsured: Expanding Access, Enhancing Dignity, Economic Social Research Institute, November 2001. www.communityvoices.org/Uploads/nu2eq555sghyrq45gcxhn0ew_20020828081946.pdf

Enrollment

When the pilot began, FOCUS easily attracted participants and did not experience difficulty in filling its 2,000 available subsidy slots. The high levels of enrollment were due in part to effective marketing. Sharp utilized a media relations campaign and conducted strategic outreach to small business organizations such as the Chamber of Commerce and Economic Development Council. [125] This campaign included a one-hour television program, "Health Insurance Gap." about FOCUS featuring contact information about the program during the closing credits." [126]

More than 90% of eligible employers who inquired about the program actually enrolled.[127] Interested employers continued to contact the program long after marketing efforts ceased and months after FOCUS reached its enrollment cap.[128] Required employer contributions for employee and dependent coverage appeared to be affordable for most employers.[129] Additionally, clearly defined employer contributions and a simple payment process increased the attractiveness of the program for employers.

Program Development and Local Support

Sharp Health Plan and Alliance Healthcare Foundation began their effort to design a program to assist San Diego's uninsured population in 1997. Due to demographic trends, they concentrated their efforts on the county's small business employees.[130] Low-wage workers in small businesses are less likely to have access to employer-based health insurance. This situation was particularly problematic in San Diego, where 87 percent of businesses had fewer than 20 employees. [131]

Local partnerships were instrumental in FOCUS' ability to offer a more affordable health plan. Sharp Health Plan and Alliance Healthcare Foundation were fortunate to have a strong existing partnership with the private and public healthcare industries. In 1994, California mandated that private, nonprofit hospitals and healthcare systems play a greater role in addressing community health needs.[132] This resulted in the creation of Community Health Improvement Partners (CHIP), a collaboration of San Diego health care systems, hospitals, community clinics, insurers, physicians, universities, community benefit organizations and the County of San Diego.[133] The collaborative contributed to FOCUS' success by soliciting brokers to participate in the pilot without commission and asking providers to accept payment below market reimbursement rates. This allowed FOCUS to offer premiums that were much lower than standard commercial products.[134] Sharp Health Plan and Alliance Healthcare Foundation maintained their

---

[125] Institute for Health Policy Solutions, Background Data and Models for Expanding Health Insurance Coverage to Uninsured Children in Santa Clara County, Liane Wong, October 19, 2000. www.ihps.org/pubs/2000%20Dec%20SantaClaraExecSum.pdf
[126] ibid.
[127] ibid.
[128] The Commonwealth Fund, Expanding Employment-Based Health Coverage: Lessons From Six States and Local Programs, February 2001. www.cmwf.org/usr_doc/silow-carroll_6profiles_445.pdf
[129] Institute for Health Policy Solutions, Background Data and models for Expanding Health Insurance Coverage to Uninsured Children in Santa Clara County, Liane Wong, October 19, 2000. www.ihps.org/pubs/2000%20Dec%20SantaClaraExecSum.pdf
[130] ibid.
[131] ibid.
[132] Senate Bill 697 (SB 697).
[133] Community Health Improvement Partners website accessed November 2006, www.sdchip.org
[134] Institute for Health Policy Solutions, Background Data and models for Expanding Health Insurance Coverage to Uninsured Children in Santa Clara County, Liane Wong, October 19, 2000. www.ihps.org/pubs/2000%20Dec%20SantaClaraExecSum.pdf

collaboration through the development of a technical advisory committee, which reflected the makeup of CHIP. [135]

The FOCUS model also sought to improve health outcomes in low-income families by requiring that all eligible dependents be enrolled. Enrolling the entire family in the same health plan simplifies access to health services and promotes continuity of care.[136]

Financing and Sustainability

FOCUS was intended to be a two-year, $1.2 million demonstration project with an enrollment cap of 2,000.[137] Alliance Healthcare Foundation awarded the project a $1.2 million grant to subsidize insurance premiums. Later, The California Endowment contributed $400,000 for coverage for additional enrollees and to study FOCUS' impact on children who are undocumented immigrants.[138] Reduced provider reimbursement rates, limited insurance broker commissions, and Sharp Health Plan's donation of administrative services also indirectly subsidized premiums. [139]

Due to fixed resources and a low enrollment cap, FOCUS sought to limit coverage to families without any other source of insurance. It instituted a 12 month look-back period; employers and/or employees were only eligible if they did not have coverage within the last year.[140] The look-back period aimed to minimize crowd-out from the private market, discouraging individuals who would typically purchase private health coverage from enrolling in FOCUS' low-cost, subsidized insurance. However, there are difficulties associated with look-back periods. The criteria essentially penalize employers and employees who acted responsibly.[141] Look-back periods are difficult to enforce as needed information can be inconsistent and difficult to obtain from purchasers.[142]

FOCUS initially considered applying for government funds to help finance the program. In particular, Sharp Health Plan contacted the Managed Risk Medical Insurance Board to explore the option of wrapping around a preexisting public program.[143] This alternative presented some administrative challenges, potentially delaying implementation. [144] Obtaining public funding would also require appropriate legislation and waivers. The receipt of state and federal financing often necessitates compliance with numerous requirements and regulations. [145] It also requires a costly and time-consuming review process to ensure accountability of public funds.[146]

By using a combination of foundation grants, in-kind donations and price negotiations with providers, FOCUS secured adequate funding for the pilot, eliminating the need for government

---

[135] ibid.
[136] ibid.
[137] ibid.
[138] ibid.
[139] ibid.
[140] The Commonwealth Fund, Expanding Employment-Based Health Coverage: Lessons From Six States and Local Programs, February 2001. www.cmwf.org/usr_doc/silow-carroll_6profiles_445.pdf
[141] ibid.
[142] ibid.
[143] ibid.
[144] ibid.
[145] The Commonwealth Fund, Expanding Employment-Based Health Coverage: Lessons From Six States and Local Programs, February 2001, www.cmwf.org/usr_doc/silow-carroll_6profiles_445.pdf
[146] ibid.

funds. Furthermore, the program was not labeled as a public assistance program with the accompanying stigma.

However, in avoiding the complexities of public financing, FOCUS faced sustainability and feasibility challenges. FOCUS would be difficult to sustain or duplicate on a large scale or within another geographic region due to its limited financing streams and unique relationship with the local healthcare industry. FOCUS was heavily reliant on private foundation grants, which are often sensitive to fluctuations in the economy. In the long-term, foundations may be inclined to shift their financial resources to other programs that are more aligned with their interests or show new promise. Most foundations depend on a major donor(s) for funding. During economic downturns in the stock market and the economy, their ability to provide grants will be negatively affected. Foundations do not necessarily make long term funding commitments. Instead, many provide short-term grants and expect that further funding will be provided by other sources.[147]. As a result, foundation funding is better applied in the short-term to fund health program design, implementation, and evaluation. [148]

Additionally, agreements made with providers and insurance brokers to participate with below market reimbursement rates and no commissions, respectively, were not viable in the long term.[149] Program planners were aware that if the program expanded, FOCUS would have to raise provider reimbursement rates and provide brokers with some sort of commission. [150] Sharp Health Plan also made significant contributions during the pilot, donating one-third of its normal administrative costs of 15 percent, which is reflected in the premiums. [151] Sharp also carried out a greater amount of administrative and sales responsibilities than it would for a commercial group due to the absence of broker commissions.[152] If the program was enlarged, these extra duties might prove to be too great of a financial burden for Sharp Health Plan to shoulder.

In addition to the lack of long term financial sustainability, the applicability of FOCUS to the general uninsured population was uncertain. Only about 20-30% of uninsured Californians work full-time for a small business that does not provide employer-based health coverage or are dependents of such a worker. [153] Additionally, employers that typically do not offer health benefits may only be enticed to do so with a substantial subsidy. An assessment of the FOCUS program found that of employers offered a 50% premium subsidy, only about 20% of businesses chose to subsequently offer coverage.[154] The ability of the FOCUS model to reach large numbers of the uninsured is therefore limited and may not be the most comprehensive approach to reducing the number of uninsured.

---

[147] Helmut K. Anheier and Diana Leat, Creative Philanthropy, New York: Routledge, 2006, pp 12-13.
[148] Journal of Health Care for the Poor and Uninsured, Inclusion of Immigrant Families in U.S. Health Coverage Expansions, Jane Garcia, Ralph Silber, Ingrid Lamirault, Luella Penserga, Margo Hall, Vol. 17, 2006, pp 81-94.
muse.jhu.edu/journals/journal_of_health_care_for_the_poor_and_underserved/v017/17.1Shirota.pdf
[149] The Commonwealth Fund, Expanding Employment-Based Health Coverage: Lessons From Six States and Local Programs, February 2001. www.cmwf.org/usr_doc/silow-carroll_6profiles_445.pdf
[150] ibid
[151] ibid
[152] ibid
[153] California HealthCare Foundation, Step by Step: Local Coverage Expansion Initiative, Adult Coverage Programs – Conference Call Handouts, September 14, 2006. www.chcf.org/documents/insurance/RFPStepByStepConfCallHandout.pdf
[154] ibid.

VII. SacAdvantage

Health Coverage Expansion – Sac Advantage

SacAdvantage began enrolling eligible employers and employees in October 2002 and provides incentives to small businesses to offer health coverage to their employees. It represents the state's first program using public funds to subsidize health benefits at private firms.[155] SacAdvantage is a tax-exempt nonprofit organization sponsored by Sacramento County.[156] It is not a government program, but is run by the community with the county as a partner.[157]

SacAdvantage is available to small businesses in Sacramento County that employ between 2 and 50 workers. The employer prerequisites for enrollment are: 1) employers did not offer health coverage to any of their employees within the last 6 months; 2) 70% of the business' eligible employees must enroll (employees enrolled in Medi-Cal do not count towards the number of a group's eligible employees. For groups of 2-3 employees, 100% of employees must enroll.; participating businesses must have been in operation for at least 12 months; and employers' primary place of business must be located in Sacramento County.

The eligibility requirements for employees and their dependents are: 1) employees must work a minimum of 30 hours per week for the employer; 2) employees must not have been insured for the past three months and employees and dependents are not eligible for public health coverage.

Subsidies are available to employers and employees. Employees and their families are eligible for subsidies for a two-year period if their family incomes are below 300% of the Federal Poverty Level.[158] Subsidies vary between 40-65% of the full premium for the lowest-cost plan offered, depending on the employee's income level. [159] Employers and workers split the remaining premium equally. Workers have the option of paying more out of pocket for plans with greater benefits or a wider network of physicians and hospitals.[160]

Originally, SacAdvantage was able to offer small businesses affordable health plans through its partnership with PacAdvantage, a nonprofit, small business purchasing pool. Through this pooling mechanism, participating small businesses held the purchasing power to obtain the same health care benefit packages that larger employers provide at reasonable rates.[161] However, PacAdvantage recently announced that it would close its health insurance operations after December 31, 2006 due to shrinking voluntary participation of California's major health plans.[162] Most participating health plans were not able to continue offering plans through PacAdvantage due to their financial losses in the program and lack of profitability. [163] Currently, Western

---

[155] Institute for Health Policy Solutions, Using Premium Assistance to Expand Coverage through Small Firms, January 2004.
[156] Insure the Uninsured Project, Directory of Local Efforts to Expand Healthcare Access for California's Uninsured, January 2006
[157] Harvard School of Public Health Conference, Public Private Partnerships: Strategies for Reaching the Uninsured – Amerish Bera, October 20, 2006. www.hsph.harvard.edu/uninsured/speakers.html
[158] Institute for Health Policy Solutions, Using Premium Assistance to Expand Coverage through Small Firms, January 2004.
[159] ibid.
[160] California Healthline, Sacramento County To Launch Program To Help Small Business Employees Purchase Health Insurance, October 30, 2002. www.californiahealthline.org/index.cfm?Action=dspItem&itemID=93091&classcd=CL350
[161] County of Sacramento, Department of Health & Human Services, Sac Advantage Website, www.sacdhhs.com
[162] PacAdvantage website, copy of letter to employer. www.pacadvantage.org/documents/brokers/Final-PA-ER-COPY.pdf
[163] ibid.

Health Advantage is the only available option for employer groups to maintain their subsidy through SacAdvantage.[164]

Enrollment

Relative to FOCUS, SacAdvantage has been less successful in soliciting participation. Sacramento County expected to enroll 500 individuals in approximately 100 businesses in the program within the first year.[165] As of June 30, 2005, SacAvantage had 26 active employers participating in the program and provided subsidies to 123 employees and family members.[166]

There is speculation that this trend is the result of subsidy structure. Employers face uncertainty in their contribution rate. According to SacAdvantage's rules and regulations, employer contributions are dependent on employees' family incomes. This information is not readily available to employers, and employees' may have unwillingness to provide it.[167] Many employees view it as an intrusion into their personal lives and do not want their peers or supervisors to have knowledge about their financial situation.[168] As a result, employers cannot effectively determine their upfront costs without knowledge of their employees' family income.[169] Although family income is needed to determine contribution and subsidy amounts, the administrative barriers may be a disincentive to participate for employers and employees.

Program Design and Financing

To some degree, political pressure contributed to Sacramento County exploring ways to reduce the county's number of uninsured. Sacramento Area Congregations Together (ACT), a grassroots organization, along with other community leaders, "challenged the county to use windfall [from the tobacco settlement in 2000] as an investment in the future of its struggling health care system." [170]

The county played a substantial role in the development and implementation of SacAdvantage. Sacramento County provided $100,000 to analyze the problem, assess and test models, build consensus, and market the selected model.[171] SacAdvantage used a mix of federal and county funds to finance the implementation of the program. Sacramento County established The Health Care for Uninsured Fund in FY 2000-2001 using $2 million annually of Tobacco Litigation Settlement funds as a means to fund "innovative programs and approaches to provide basic health care for the uninsured residents of Sacramento County."[172] Through the fund, the County's goal was to work with a variety of health care and human services communities to expand and enhance health services to the working poor and other needy county residents. [173] The county uses The Health Care for Uninsured Fund to finance local match requirements for

---

[164] Western Health Advantage Website. westernhealth.com/brokers/bulletin_issue_10.pdf
[165] Pacific Business Group on Health, Newsletter, Spotlight, Vol 1, Issue 2, December 2002. www.pbgh.org/news/eletters/2002-11-12.htm
[166] County of Sacramento California, Memo to the Board of Supervisors from the Department of Health and Human Services, Report Back – Transfer of $500,000 SacAdvantage Funds to "Cover The Kids by 2006," September 15, 2005. www.co.sacramento.ca.us/Budget/information-annoucements/fy2005-2006/reports-back/docs/Report-Back-DHHS-Cover-the-Kids-TLS.pdf
[167] Institute for Health Policy Solutions, Using Premium Assistance to Expand Coverage through Small Firms, January 2004
[168] ibid.
[169] ibid.
[170] PICO, A Training Manuel on Health Care Organizing, www.piconetwork.org/linkeddocuments/MFH-English.pdf
[171]Harvard School of Public Health Conference, Public Private Partnerships: Strategies for Reaching the Uninsured – Amerish Bera, October 20, 2006. www.hsph.harvard.edu/uninsured/speakers.html
[172] Sacramento County, FY2002-2003 Budget, www.co.sacramento.ca.us/Budget/information-annoucements/fy2002-2003/final-budget-book/pdf/SectionI.pdf
[173] ibid.

federal grants. For instance, in FY 2003-04, SacAdvantage received a federal grant of $695,450 for the implementation process and received a local match allotment of $133,000 from the Healthcare/Uninsured Reserve. [174] The matching dollars for that federal grant funded the Department of Health and Human Services administrative staff work that is related to SacAdvantage. However, the Healthcare/Uninsured Reserve monies are not solely tied to SacAdvantage, and the Board of Supervisors has the discretion to shift funds to other projects that meet certain guidelines. [175] In FY 2001-02, the Board of Directors assigned the responsibility and authority to plan, develop, and implement a program which would provide insurance coverage to working adults and their families to the Department of Health and Human Services. [176]

In partnering with PacAdvantage to offer affordable health coverage to small businesses, the program was able to keep costs low and reduce administrative complexities. Using PacAdvantage's existing infrastructure, SacAdvantage simplified subsidy administration and reduced administrative overheads.[177] It also benefited from PacAdvantage's established negotiated products and relationships with brokers. [178]

The County Board of Supervisors strategically created SacAdvantage as a nonprofit organization so it could continue to request funding from the state and federal governments in addition to private foundations once the initial tobacco funds are exhausted.[179] Additionally, the Board avoided creating a new bureaucracy and tangling itself in a long-term commitment to the organization. As a nonprofit organization, the Board maintains the flexibility, given the right political and economic climate, to fund SacAdvantage. This arrangement also allows the Board to extricate itself if the program fails to meet its objectives. Once tobacco funds run dry, SacAdvantage may be in a vulnerable position soliciting government and foundation funds. Relying on foundation grants would not be ideal for long-term sustainability.

SacAdvantage utilizes a three month look-back period for employees and a six month look-back period for employers and limits subsidies to those ineligible for public programs in an effort to reduce crowd out. However, verification can be difficult. Employers provide self-certification and declaration on the SacAdvantage application, which are subject to random audits.[180] A preference of using this honor system was due to the higher cost of verifying enrollment eligibility.[181] Employees receiving a SacAdvantage subsidy submit income documentation at the time of initial application and at the employer's annual renewal with SacAdvantage/PacAdvantage. [182] With termination of the PacAdvantage pool and slower than expected enrollment, it remains to be seen how SacAdvantage will progress.

---

[174] ibid.
[175] ibid
[176] ibid.
[177] Institute for Health Policy Solutions, Using Premium Assistance to Expand Coverage through Small Firms, January 2004.
[178] Harvard School of Public Health Conference, Public Private Partnerships: Strategies for Reaching the Uninsured – Amerish Bera, October 20, 2006. www.hsph.harvard.edu/uninsured/speakers.html
[179] California Healthline, Sacramento County To Launch Program To Help Small Business Employees Purchase Health Insurance, October 30, 2002
[180] SacAdvantage Website
[181] Conference at Harvard School of Public Health, Public-Private Partnerships: Strategies for Reaching the Uninsured, October 20, 2006, http://www.hsph.harvard.edu/uninsured/files/summary.pdf
[182] ibid.

VIII. Healthy New York

Health Coverage Expansion

On December 30, 1999, New York Governor George Pataki signed the New York Health Care Reform Act (HCRA) of 2000 into law. Healthy New York, a state subsidized health benefits package, was one of three new programs - the others being Family Health Plus (FHP) and Direct Pay Fund - created to provide affordable and comprehensive health coverage to New York State's uninsured population.[183] Healthy NY is private market-based and is predominately geared towards small businesses and their employees, sole proprietors and working individuals. In particular, it seeks to assist those who do not qualify for public coverage but whose incomes make purchasing coverage in the private market prohibitively expensive.

Small businesses, sole proprietors, and individual workers may be eligible to purchase a Health New York policy if they meet certain requirements. Small employers are eligible if 1) they have 50 or fewer employees, 2) they have not offered group health insurance for the past 12 months, and 3) one-third of their employees earn $34,000 or less (adjusted annually for inflation).

Participating employers must pay at least 50% of the employee premiums and 50% of employees must participate. A sole proprietor is eligible if he or she has been uninsured for the past 12 months and has a household income that does not exceed 208% of the FPL.

Individuals may enroll in a Healthy NY policy if they 1) reside in New York State, 2) have been uninsured for at least the past 12 months or have lost coverage due to a qualifying event 3) do not have access to an employer group health plan 4) are ineligible for Medicare, and 5) have a net family income that does not exceed 200% FPL.

Healthy NY uses several mechanisms to make health insurance more accessible and affordable to low-income individuals. Many of these techniques provide benefits and pose challenges for low-income beneficiaries and program sustainability. Mechanisms include:

- High cost sharing
- A mandate that all HMOs offer qualifying small businesses and individuals a Healthy NY benefit package as of January 1, 2001
- Providing participating insurers with "stop loss" coverage
- Requiring insurers to charge the same premium across small businesses, sole proprietors and individuals

Gaining a Place on the Political Agenda

A combination of factors allowed Healthy NY to gain a place on the state's political agenda. During the 1990s, uninsurance was a visible and growing problem in New York. In 1999, more

---

[183] Senate Committee, www.sen.ca.gov/ftp/SEN/COMMITTEE/STANDING/HEALTH/_home/NEW_YORK_HEALTH_CARE_SUMMARY.DOC

than two million non-elderly residents lacked health coverage.[184] In 1998, nearly 30% of residents in New York City were uninsured, the third highest rate among urban areas in the United States. In the same year, nearly 32% of individuals with incomes below the federal poverty line had no health coverage, compared to 6% in 1994.[185]

The momentum for expanding health coverage began during the 1990s when a strong coalition of stakeholders and strong public support brought uninsurance to state attention.[186] They helped to apply the necessary pressure on the state legislature to begin incrementally addressing the uninsured population. During the mid-1990s, the coalition focused primarily on children. Through a combination of Medicaid expansions and the implementation and extension of the state-sponsored Child Health Plus (CHPlus) program, New York gradually provided the state's low-income children with access to health coverage.[187] These achievements were boosted by New York's historically progressive attitudes on health and social welfare issues.[188] Despite many fiscally conservative actions under Governor Pataki and slowing budget growth, spending on health care and progressive health policy was sustained.[189] With a strong public health care available for children, Healthy NY addressed the next step in reducing the size of New York's uninsured population by providing coverage to adults.

At the same time that momentum was growing around covering the uninsured, policymakers recognized the significant link between the burden of rising health care costs for small businesses and the growing number of uninsured. Small businesses became less and less able to afford group coverage for their employees. Over the past decade, the state dedicated modest resources to devising a solution to this issue. It created a series of programs to investigate ways to make health insurance more affordable to small businesses and their employees. Two programs in particular, the New York State Health Insurance Partnership Program (NYSHIPP) and the Individual Subsidy Program, set a precedent for Healthy NY through their five pilot programs.

NYSHIPP became operational in 1997 and was phased out in 2003 to make way for Healthy NY.[190] Premium subsidies were provided to businesses with 50 employees or less and sole proprietors with gross income below 222% of FPL.[191] To be eligible, a business had not offered group insurance coverage to any employee during the 12 months prior to application.[192] These businesses received subsidies of up to 45% of the premium costs.[193] Employers could pay for the remainder of the premium or ask employees to contribute part of the premium; employee

---

[184] The Urban Institute, Recent Changes in Health Policy: Low-Income People in New York, Teresa A Coughlin and Amy Westpfahl Luzuky, State Update No. 22, March 2002. www.urban.org/UploadedPDF/310439.pdf
[185] ibid.
[186] Kaiser Family Foundation, New York: A Case Study in Childless Adult Coverage, State Report, Silow-Carroll, Sharon (Economic and Social Research Institute), August 2004. www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46184
[187] The Urban Institute, Recent Changes in Health Policy: Low-Income People in New York, Teresa A Coughlin and Amy Westpfahl Luzuky, State Update No. 22, March 2002. www.urban.org/UploadedPDF/310439.pdf
[188] Kaiser Family Foundation, New York: A Case Study in Childless Adult Coverage, State Report, Silow-Carroll, Sharon (Economic and Social Research Institute), August 2004. www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46184
[189] The Urban Institute, Recent Changes in Health Policy: Low-Income People in New York, Teresa A Coughlin and Amy Westpfahl Luzuky, State Update No. 22, March 2002. www.urban.org/UploadedPDF/310439.pdf
[190] Commonwealth Fund, State and Local Initiatives to Enhance Health Coverage for the Working Uninsured, Economic and Social Research Institute, November 2000. www.cmwf.org/usr_doc/silow-carroll_initiatives_424.pdf
[191] West Virginia State, Closing the Gap, Insuring the Uninsured in West Virginia, Literature Review on State Activities Related to Employer-Sponsored Insurance (ESI), prepared by Alfreda Dempkowski, February 2003. www.wvhealthpolicy.org/reports/ESI%20Lit%20Review.pdf
[192] ibid.
[193] Commonwealth Fund, Healthy New York, Making Insurance More Affordable for Low-Income People, Katherine Swartz, November 2001. www.cmwf.org/usr_doc/swartz_healthyny_484.pdf

contributions were limited to 10% of the full premium.[194] Due to limited enrollment capacity, preference was given to low wage businesses, and by 1998, there was a waiting list.[195]

The Individual Subsidy Program established the Regional Pilot Project (RPP) in 1989. RPP was a group of demonstration projects in limited geographic areas that paid 50% of the premiums for businesses with up to 20 employees that had not previously provided health insurance.[196] The employer paid the other 50 percent of the premium and employees were not required to contribute.[197] The project provided subsidies to individuals who had not had health insurance for at least 6 months and had family incomes below 200% of the FPL.[198]

Although there are conflicting sentiments about the success of these programs, both received national attention and set a foundation for state subsidies for employer-based health insurance. NYSHIPP and the Regional Pilot Project also served as laboratories for testing solutions, and their evaluation revealed ways to increase the effectiveness subsidy programs. Healthy NY would use some of these program features as its building blocks.

Political Feasibility

The political and economic environment of New York State in the mid-1990s was conducive to a significant health care expansion. Major interest groups, such as consumer advocates and health workers unions were focused on developing and supporting the Family Health Plus initiative.[199] Simultaneously, Governor Pataki worked to elevate Healthy NY to legislative consideration. His desire to assist small business and employees in gaining greater access to private insurance resulted in the formulation of Healthy NY.[200] Pataki took on the role of policy champion building the political will to bring the program to the political forefront.

During economic downturns, political support for expansion programs generally wanes. The general public would prefer to allocate scare resources to more imperative issues. Healthy NY came about during a time of economic and government prosperity when New Yorkers would be more receptive to such an expansion. New York was in the midst of a booming economy, although that would quickly change after the terrorist attacks on September 11, 2001. At the end of 1999, the state had a budget surplus of over $1 billion.[201] Additionally, the state was coming into its $500 million tobacco settlement.[202] (double check it is millions)

Healthy NY subsidies utilize a combination of tobacco settlement funds and proceeds from a 55-cent per pack cigarette tax increase. The tax gained political support following a scandal involving some legislators and an influential tobacco company.[203] The tobacco lobby had a traditionally powerful influence on New York State policy markers, but their stronghold on

---

[194] West Virginia State, Closing the Gap, Insuring the Uninsured in West Virginia, Literature Review on State Activities Related to Employer-Sponsored Insurance (ESI), prepared by Alfreda Dempkowski, February 2003. www.wvhealthpolicy.org/reports/ESI%20Lit%20Review.pdf
[195] ibid.
[196] ibid.
[197] ibid
[198] ibid.
[199] ibid.
[200] Kaiser Family Foundation, New York: A Case Study in Childless Adult Coverage, State Report, Silow-Carroll, Sharon (Economic and Social Research Institute), August 2004. www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=46184
[201] New York State, Governor George E. Pataki's State of the State Address, January 6, 1999. www.ny.gov/governor/keydocs/sos99.html
[202] State Coverage Initiatives, New York Continues Tradition of Ambitious Health Care Reform: Reforms Seek to Expand Adult Coverage Through the Individual and Employer-based Markets, November 2000. statecoverage.net/pdf/scinews1100.pdf
[203] ibid.

legislators was weakened during a scandal over Philip Morris. In 1999, Philip Morris admitted to giving thousands of dollars worth of illegal gifts to state legislators and staff. Legislators, desiring to repair their tarnished reputations, became more willing to pass a tax increase on tobacco products and use tobacco settlement funds for new health coverage expansions. [204]

Pataki strategically piggybacked the Healthy NY legislation onto the proposed Executive Reauthorization of the Health Care Reform Act. The Health Care Reform Act (HCRA) provides legislative underpinning for many of the State's health care financing, supporting a number of important programs (i.e. hospital reimbursements, bad debt/charity care, Graduate Medical Education, and Child Health Plus), and provides substantial financial relief to the General Fund by supporting programs typically financed by the state's General Fund. [205] The Health Care Reform Act was originally established in 1996 and comes under executive and legislative review approximately every three years. By including the Healthy NY program as an amendment to the Health Care Reform Act, Governor Pataki minimized the political opposition typically faced by new legislation. Legislators had diverse and vested interests in the renewal of HCRA as it controls many of their pet projects. Therefore they were more willing to compromise on passage of Healthy NY in order to protect these interests and pass the reauthorization. Support grew for the amendment, which was relevant to the HCRA renewal and viewed as a natural extension of the Child Health Plus Program.

Legislation – Structure and Power Distribution

The HCRA is reauthorized approximately every three years. By linking it to the HCRA, Healthy NY is not subject to annual legislative review. Thus the program has more independence and leeway in pursuit of its mission and goals without frequent pressure from the legislature.

Healthy NY relies heavily on program structure to drive down premium costs and therefore make health insurance more affordable for the target population. The HCRA provides extremely detailed guidelines for the structure leaving little room for compromise on issues related to cost and affordability. Compromise may not allow for the savings needed to achieve success. A clear plan also reduces the likelihood of delays in implementation.

However, the legislation leaves some flexibility for programmatic changes as needed. Although the New York State Insurance Department is responsible for implementation, only the Superintendent has the latitude to make program improvements.[206] The Superintendent is nominated by the Governor and must undergo a confirmation process by the New York State Senate. The executive branch typically nominates appointees that share its goals and will be receptive to its directives. By centralizing authority with the Superintendent, the governor maintains oversight and influence over the program. This is particularly important for Governor Pataki given that he was a key author and advocate of Healthy NY and therefore must take measures to ensure its success. Centralized control of the program allows the agency to act quickly and efficiently.

---

[204] ibid.
[205] New York State, Health Care Reform Act (HCRA): The Need to Restore Accountability to Taxpayers, Office of Comptroller. April 2003. www.osc.state.ny.us/reports/health/hcra.pdf
[206] State of New York, 9093, 1999-2000 Regular Sessions in Assembly, An act to enact the New York Health Care Reform Act of 2000, December 21, 1999.

The Superintendent is also required to order an annual study of the Healthy NY program, which is submitted to the Governor, the Superintendent, the temporary President of the Senate and the Speaker of the Assembly. [207] The report includes an examination of employer participation, an income profile of covered employees and qualifying individuals, claims experience, and the impact of the program on the uninsured population.[208] The report ensures transparency and accountability of public funds. It also offers an excellent opportunity to regularly assess the program on a large scale and improve the program's effectiveness.

Health Care Financing and Cost Containment

Healthy NY takes multiple approaches to reducing administrative and premium costs. Healthy NY will only reimburse providers who are a part of its network. These providers have agreed to negotiated fees below market reimbursement rate.[209] By limiting beneficiaries to these service providers, insurers can manage costs more efficiently, thereby reducing costs and premiums.[210]

The benefit package also includes a pre-existing condition limitation. If an applicant has a medical condition that he or she has been diagnosed with or treated for in the last six months, his or her insurer may choose not to provide services to treat this pre-existing condition for up to a year.[211] Certain exceptions are made – the pre-existing condition limitation will be reduced or waived if the applicant had prior health coverage and has not had a break in coverage that was longer than 63 days. These limitations are designed to discourage high-cost individuals from self-selecting into the program and thereby raising costs to insurers, who in effect pass them on to plan beneficiaries in the form of higher premiums. Healthy NY's participation rules also attempt to minimize adverse selection by requiring 50% of employees to participate.[212]

By passing on a significant portion of financial responsibility for their medical expenses to consumers, consumers become more cost conscious and will not seek more medical care than they require. However, Healthy NY's cost sharing features are unrelated to a beneficiary's ability to pay and may disadvantage low-income individuals. In order to meet cost-sharing requirements, low-income beneficiaries that utilize specific medical resources will be required to spend a significant proportion of their income.[213] High cost sharing form some services - $500 co-payment for inpatient visits and $200 or 20% co-payment for surgeries[214] - may be detrimental to low-income individuals and the chronically ill. Due to their financial constraints, these members may not seek costly but needed medical care until their conditions further deteriorate, resulting in poorer health outcomes and even greater costs to the patient and the system.

Healthy NY builds upon the private health insurance market to increase access to participants. The HCRA mandates that as of January 1, 2001, all HMOs offer qualifying small businesses and

---

[207] ibid.
[208] ibid.
[209] Commonwealth Fund, Healthy New York, Making Insurance More Affordable for Low-Income People, Katherine Swartz, November 2001. www.cmwf.org/usr_doc/swartz_healthyny_484.pdf
[210] ibid.
[211] State of New York, Healthy New York – Benefits Package, www.ins.state.ny.us/website2/hny/english/hnybp.htm
[212] State Coverage Initiatives, Issue Brief: The Role of Reinsurance in State Efforts to Expand Coverage, Deborah Chollet,, Vol. 5, No. 4, October 2004. statecoverage.net/pdf/issuebrief1004.pdf
[213] Health Affairs, Income-Related Cost Sharing in Health Insurance, Rice, Thomas and Thorpe, Kenneth E., Spring 1993
[214] Healthy NY website. www.ins.state.ny.us/website2/hny/english/hnybp.htm

individuals the Healthy NY benefit package.[215] The mandate approach may help to spread risks among insurers while increasing plan options for participants and increasing the probability of the program's long-term viability. Additionally, by mandating HMO participation, it allows Healthy NY to employ managed care concepts and reduces administrative costs of contracting with health plans.[216] With applicants applying directly to the HMOs, there is no need for a new bureaucracy to enroll eligible individuals or and reduces the burden on the administrating state agency.

Health coverage is made more accessible and affordable under Healthy NY through the use of community rating. Small businesses, sole proprietors and individuals are pooled together and pay the same premium rate, although rates may vary by health plan and by rating region.[217] Community rating minimizes risk segmentation by limiting the extent to which insurers can price discriminate according to health risk. The classification of risk is limited to government specified characteristics "even though other characteristics may be better predictors of risk."[218] Without mandated community rating, insurers in effect charge higher premiums to those that will have higher expenditures.[219] Community rating particularly promotes affordability of health coverage for those with high-risk conditions. While some believe that price discrimination is an unfair practice, community rating may also result in equity problems and adverse selection. Community rating essentially imposes the same premiums regardless of risk level, saddling low-risk populations with higher than actuarially fair premiums and lower than the actuarially fair premiums for high risks populations.[220] This may lead young, low risk individuals to exit the policy and continue to remain uninsured, resulting in a market increasingly dominated by high-risk individuals. In response, insurers increase premiums to cover the costs of providing care to this costly population. Without certain government safeguards, this would also leave insurers vulnerable to financial difficulties.

Subsidies, which are invisible to enrollees, come in the form of "stop loss" coverage. Healthy NY's stop loss provision is a state subsidized reinsurance mechanism that reimburses insurers for 90% of high-cost claims between $30,000 and $100,000 made on the behalf of an enrollee.[221] In July 2003, the legislature changed the stop loss corridor to $5,000 and $75,000 due to lower than expected claim activity; this adjustment resulted in a premium reduction of 17%.[222] The subsidies are financed by a portion of the tobacco settlement funds and a 55-cent per pack increase in the state's cigarette tax. This mechanism is intended to protect insurers against the financial risk associated with adverse selection of high-risk individuals into the pool. Premiums become more affordable for participating businesses and individuals because the stop loss provision eliminates the premium impact of high cost claims.[223] It decreases insurers' risk in

---

[215] New York State Legislature, Senate Committee, The New York Health Care Reform Act of 2000. www.sen.ca.gov/ftp/SEN/COMMITTEE/STANDING/HEALTH/_home/NEW_YORK_HEALTH_CARE_SUMMARY.DOC

[216] New York State Insurance Department Health Bureau, Healthy NY Powerpoint Presentation, Patricia Swolak, September 12, 2006. statecoverage.net/0906/ReinsuranceInstitute.ppt

[217] New York State Senate Standing Committees on Insurance and Health, Statement of New York Insurance Department, June, 6, 2006

[218] Commonwealth Fund, Healthy New York, Making Insurance More Affordable for Low-Income People, Katherine Swartz, November 2001. www.cmwf.org/usr_doc/swartz_healthyny_484.pdf

[219] Health Services Research, Redistributional Consequences of Community Rating, Dana P. Goldman, Arlene Leibowitz, Joan L. Buchanan and Joan Keesey, Vol. 32, No. 1, April 1997. www.pubmedcentral.nih.gov/picrender.fcgi?artid=1070170&blobtype=pdf

[220] Health Affairs, Market Watch, Community Ratings and Sustainable Individual Health Insurance Markets in New Jersey, Alan C. Monheit, Joel C. Cantor, Margaret Koller, Margaret Kimberly S. Fox, Vol. 23, No. 4, July/August 2004. content.healthaffairs.org/cgi/content/abstract/23/4/167

[221] Robert Wood Johnson Foundation, Profiles in Coverage: Healthy New York, January 2005. statecoverage.net/newyorkprofile.htm

[222] ibid

[223] New York State Senate Standing Committees on Insurance and Health, Statement of New York Insurance Department, June, 6, 2006

providing coverage to the Healthy NY enrollees by protecting them from excessive and catastrophic claims. HCRA enforces gains by requiring health plans to "factor this stop loss reimbursement into their premium rates for the Healthy NY product." [224] Stop loss spending was expected to be approximately $58 million in 2005 and $71 million in 2006.[225]

Healthy NY policies are also less costly due to looser requirements than those in the state's heavily regulated private health insurance market. While the state's regulation is intended to protect consumers by mandating coverage for certain services among other requirements, it often leads to higher premium rates.[226] Healthy NY is allowed to circumvent some state regulations by exempting its policy carriers from providing services such as chiropractic, hospice care, mental health services, and alcohol and substance abuse treatment and allowing co-payments to be charged for most services. [227]

Healthy NY continues to pursue options to increase the affordability of health insurance. In 2003, it authorized a no-drug option. The initial result was a 12% reduction in premiums and even greater savings today by eliminating increasingly costly prescription drugs from the benefit package.[228] Effective January 1, 2007, a consumer-driven high deductible health plan designed to be used with a tax advantaged Health Savings Account (HSA) will be available.[229] Insurance companies offering Healthy NY must provide an option with a deductible of $1150 per individual and $2,300 per family, subject to the policy's out-of-pocket maximums.[230] Out-of-pocket expenses, including the deductible and co-payments are to be capped at $5,250 for individual coverage and $10,500 for family coverage for the plan year.[231] Enrollees can then set up tax advantaged HSAs for no more than the deductible in order to cover that cost. [232] Current Superintendent of Insurance, Howard Mills, expects this option, which promotes cost consciousness among consumers, to produce an estimated 20-25% premium savings annually. [233] Because consumers will need to use their own funds to pay for medical care up to the deductible, they will only consume the medical services they need. This will result in fewer unnecessary procedures and therefore reduce administrative and service costs.[234]

Experts have conflicting views about the impact of HSAs in combination with high deductible plans. Some claim that it will disproportionately attract the healthy because of their low demand for health care. They believe that Healthy NY would benefit from this increasing healthier pool of beneficiaries because it would lead to lower premiums. Others contend that chronically ill

---

[224] ibid.
[225] State New York Insurance Department, Report on the Healthy NY Program 2005, EP&P Consulting Inc., December 31, 2005. http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf
[226] United States General Accounting Office, Report to the Honorable James M. Jeffords, U.S. Senate: Health Insurance Regulation, Varying State Requirements Affect Cost of Insurance, August 1996
[227] New York State Legislature, Senate Committee, The New York Health Care Reform Act of 2000. www.sen.ca.gov/ftp/SEN/COMMITTEE/STANDING/HEALTH/_home/NEW_YORK_HEALTH_CARE_SUMMARY.DOC
[228] NYS Insurance Department Health Bureau, Healthy NY Powerpoint Presentation, Patricia Swolak, September 12, 2006. statecoverage.net/0906/ReinsuranceInstitute.ppt
[229] New York State Insurance Department website accessed November 2006, Press Release, Mills Announces New High Deductible Healthy NY Plan, Issued October 30, 2006. www.ins.state.ny.us/press/2006/p0610301.htm
[230] New York State Insurance Department, Third Amendment to Regulation No. 171 (11 NYCRR 362) The Healthy New York Program. www.ins.state.ny.us/r_emergy/pdf/re171a3t.pdf
[231] ibid.
[232] New York State Insurance Department website accessed November 2006, Press Release, Mills Announces New High Deductible Healthy NY Plan, Issued October 30, 2006, http://www.ins.state.ny.us/press/2006/p0610301.htm
[233] ibid.
[234] The Heritage Foundation, An Examination of the Bush Health Care Agenda, Robert Moffit and Nina Owcharenko, October 12, 2004. www.heritage.org/Research/HealthCare/bg1804.cfm

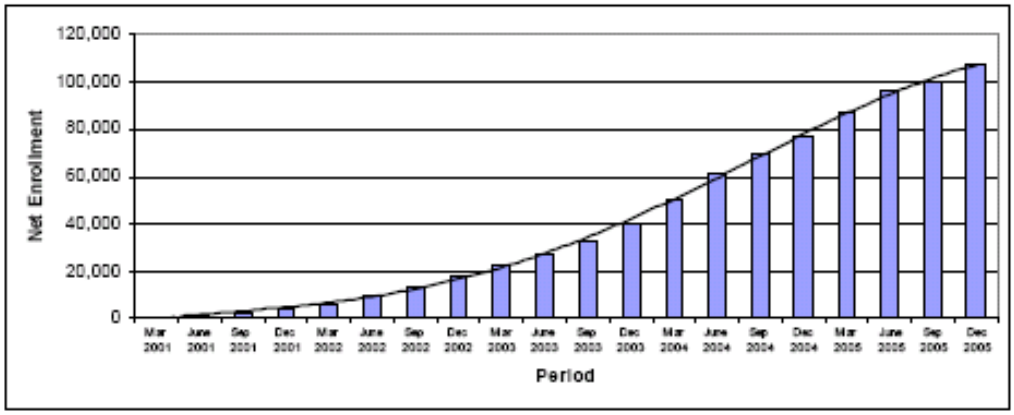
individuals would be drawn to the program because they are likely to spend well beyond the deductible in any case. As a result, HSAs and high deductibles are not likely to reduce consumption of health services and costs for this population.[235]

There are some challenges in the way Healthy NY is financed. It receives financial support for the Tobacco Control and Insurance Initiative Pool. This pool is financed through a 55-cent per pack increase in the State's cigarette tax and the Tobacco Settlement Fund. Healthy NY shares this pool with numerous other programs. Since these financing streams are not dedicated solely to Healthy NY, its future funding may be threatened if legislators shift monies to other programs. [236]

Enrollment and Program Implementation

The Healthy NY program in combination with other programs has effectively decreased New York State's uninsured population. In September 2005, active enrollment rose above 100,000 members and gross enrollment exceeded 200,000. [237]

Exhibit II-1a
Net Enrollment Since Program Inception



Source: Report on the Healthy NY Program 2005, Prepared by EP&P Consulting Inc. for the State of New York Insurance Department, December 31, 2005

The US Census Bureau's Current Population Survey (CPS) found that unlike most states, New York's uninsurance rate experienced a reduction – decreasing from 14.2 percent in 2003-2004 to

---

[235] The Urban Institute, New Healthcare Tax Proposals: Costly and Counterproductive, Leonard E. Burman, February 13, 2006. www.urban.org/publications/1000876.html
[236] New York State, Health Care Reform Act (HCRA): The Need to Restore Accountability to Taxpayers, Office of Comptroller. April 2003. www.osc.state.ny.us/reports/health/hcra.pdf
[237] New York State Insurance Department, Report on the Healthy NY Program 2005, EP&P Consulting Inc., December 31, 2005. http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf, based on the 2002-2003 average found in a Kaiser Commission study of the uninsured

13.3% in 2004-2005 – a trend that may be attributed in part to Healthy NY's success.[238] New York has an uninsurance rate lower than the national average of 15.7%.[239]

Healthy NY has had relatively low disenrollment rates. Almost all of the participating health plans stated that disenrollment rates were lower form the program than their commercial products.[240] This was contrary to initial beliefs that Healthy NY would "serve more as a 'stop gap' insurance product when individuals are in between jobs that offer insurance or some other break in coverage."[241]

The state is largely responsible for developing public interest in enrollment. The majority of health plan representatives state that they do no marketing for the program. It advertises the Healthy NY program through a variety of mediums. Since 2003, the Department of Insurance has promoted Healthy NY in television and radio advertisements featuring Governor Pataki.[242] The 2005 annual report found that greater than one-third of surveyed Healthy NY members heard about the program through a family member of friend, one-quarter learned of the program through the television advertising campaign, and 11 percent cited the internet option as their primary source of information.[243] To facilitate public interest, the Department also instituted a toll-free telephone line, which is "accessible 24 hours a day, seven days a week."[244]

The Department of Insurance also utilizes interagency partnerships with already established contacts and resources for small businesses and the uninsured to broaden its enrollment efforts.[245] In October 2002, it conducted outreach and training sessions for local Medicaid caseworkers to enable them to effectively refer applicants not qualifying for Medicaid to the Healthy NY program.[246] The Department also works with the Mayor's Office of Health Insurance Access in New York City, local Chambers of Commerce, the Medical Society of New York State and individual medical societies throughout the state, medical establishments, the Business Council of New York State, the National Federation of Independent Business, and other organizations.[247] Staff from the Insurance Department has also participated at conferences and fairs to promote the program among individuals and small businesses."[248]

Healthy NY is believed to be responsible for the decrease of uninsurance in low-income households. Between 2001 and 2003, the uninsurance rate among households with incomes less than 200% of the FPL declined from 39.3% to 38.1% while the national average of uninsurance

---

[238] US Census Bureau, Percentage of People Without Health Insurance Coverage by State Using 2- and 3-Year Averages: 2003 to 2005, http://www.census.gov/hhes/www/hlthins/hlthin05/hi05t10.pdf
[239] ibid.
[240] New York State Insurance Department, Report on the Healthy NY Program 2005, EP&P Consulting Inc., December 31, 2005. http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf
[241] ibid.
[242] ibid.
[243] ibid.
[244] ibid.
[245] State Coverage Initiatives, Profile In Coverage: Health New York, January 2005. www.statecoverage.net/pdf/healthynewyork.pdf
[246] New York State Insurance Department, Report on the Healthy NY Program 2003, The Lewis Group and Empire Health Advisors, December 31, 2003. http://www.statecoverage.net/statereports/ny24.pdf
[247] State Coverage Initiatives, Profile In Coverage: Health New York, January 2005. www.statecoverage.net/pdf/healthynewyork.pdf
[248] ibid.

rose among all income groups during this period.[249] Despite this progress, 38% of non-elderly uninsured adults below 200% of the federal poverty levels remain uninsured.[250]

There has been a limited crowd out of employer based coverage and other sources of health insurance. According to the survey, sixty-five percent of Healthy NY members would not have had health insurance without Healthy NY.[251] Approximately 33 percent of respondents would have purchased health coverage from another source or through another family member.[252]

Despite the pre-existing condition waiting period, adverse selection may be increasing. In 2003, the percentage of the population that reached the $5,000 to $75,000 stop-loss threshold was 3.3%.[253] In 2004, that figure rose to 5.9%.[254] It appears that more individuals with needs for higher levels of medical care may be self-selecting into the program due to more affordable premiums.

While the state reduces the need to create a new government bureaucracy by utilizing private health plans, an inevitable consequence of this public-private program is the lack of fluidity in the transference of information. For instance, all health plans indicated that the administrative burden of Healthy NY was comparable to their product offerings, although most plans found the administrative costs of Healthy NY to be less than State-sponsored products such as Family Health Plus, Child Health Plus, and Medicaid.[255] Health Plans cited several reasons for this additional administrative burden, including the lack of application specificity on the website - requiring them to expend additional resources to "communicate with potential members and correct any inconsistencies, resource intensive process of stop-loss tracking and reporting systems.[256]

IX. Vermont Health Care Affordability Act of 2006 - Catamount Health and the Employer Sponsored Premium Assistance Initiative

Health Coverage Expansion

In May 25, 2006, the Vermont Governor Jim Douglas signed the 2006 Health Care Affordability Act into law. This piece of legislation is intended to make quality health care affordable to all Vermonters.[257] The goal is to directly reduce the number of the uninsured Vermonters through the creation of a new state subsidized health insurance program, Catamount Health Care Plan, and the Employer Sponsored Premium Assistance Initiative. Catamount Health will launch on October 1, 2007.

---

[249] State New York Insurance Department, Report on the Healthy NY Program 2005, EP&P Consulting Inc., December 31, 2005. http://www.ins.state.ny.us/website2/hny/reports/hny2005.pdf
[250] ibid.
[251] ibid.
[252] ibid.
[253] ibid.
[254] ibid.
[255] ibid.
[256] Report on the Healthy NY Program 2005, Prepared by EP&P Consulting Inc. for the State of New York Insurance Department, December 31, 2005
[257] The Vermont Legislature, 2006 Health Care Reform Initiatives – The Details2006 HEALTH CARE REFORM INITIATIVES—THE DETAILS, http://www.leg.state.vt.us/HealthCare/2006_Health_Care_Constituent_Information_Sheet.htm

Catamount Health pairs public and private approaches to health expansion. Catamount Health fills in some gaps in Vermont's public healthcare system, expanding coverage to those adults who are between 150-300% of FPL but ineligible for Medicaid or the Vermont Health Access Plan (VHAP).[258]

Unlike the Massachusetts plan, Catamount Health uses a carrot approach to expand private market health coverage, although the Health Care Affordability Act does permit the state legislature to institute an individual mandate in 2011 if under-enrollment becomes an issue and fewer than 96 percent of state residents are uninsured at the beginning of 2010.[259] It develops a new private insurance market for uninsured Vermonters who do not have adequate insurance available to them from an employer or public programs.[260] Catamount Health will encourage uninsured Vermonters to purchase health insurance through the availability of subsidies and lower cost health plans.

The legislation defines an uninsured person as an individual who:[261]

- Does not qualify for Medicare or Medicaid and its extended programs (Vermont Health Access Plan (VHAP) and Dr. Dynasaur)

- Has not had private or employer-sponsored insurance that includes both hospital and physician services for the last 12 months. If a person has only catastrophic coverage for hospital care, for example, he or she is defined as uninsured for the purposes of Catamount Health and does not need to wait 12 months

- Has lost private or employer-sponsored coverage during the last 12 months due to a loss of employment, death of the principal insurance policyholder, divorce or dissolution of a civil union, no longer qualifying as a dependent under a parent's or caretaker relative's plan, no longer qualifying for COBRA, VIPER or other state continuation coverage

- Lost college or university-sponsored health insurance because of graduation, leave of absence or otherwise termination of otherwise termination of studies

An individual 18 or older who is claimed on a tax return as a dependent of a resident of another state is not eligible for the program.

The program will offer enrollees one standard plan which reflects the typical insurance plan available in Vermont's current market, with a few exceptions:

- It will make it as easy as possible for people to get the care they require, and

- There will be no cost to the patient for preventative care (i.e. mammograms and

---

[258] Families USA, Fact Sheet: Vermont Health Reform Law, September 20, 2006. /www.familiesusa.org/resources/publications/fact-sheets/vermont-health-reform-law.html?print=t

[259] Vermont Public Interest Research Group, The 2006 Vermont Health Care Affordability Act: Frequently Asked Questions, www.vpirg.org/campaigns/healthCare/documents/06.06.27_FINALCatamountQA.pdfhttp://www.leg.state.vt.us/HealthCare/Comparison.htm

[260] The Vermont Legislature, 2006 Health Care Reform Initiatives – H.861 Committee of Conference – May 5, 2006, www.leg.state.vt.us/HealthCare/H861_Two_Pager.htm

[261] ibid.

recommended services for chronic illnesses) [262]

Benefit packages will include primary care, preventative and chronic care, acute episodic care, and hospital services. [263] Catamount Health will provide sliding scale subsidies to uninsured Vermonters whose incomes are below 300% of the FPL and not eligible for adequate coverage through employment. [264]

The employer sponsored insurance initiative provides uninsured Vermonters with the financial assistance to purchase the health insurance plan offered by their employer.[265] The state assists a qualifying employee to pay for his or her share of the premiums and cost sharing for care associated to chronic conditions. Individuals who are eligible for the employer sponsored insurance (ESI) initiatives are those who are:

- Currently eligible or enrolled in the Vermont Health Access Plan (VHAP) or
- Uninsured Vermonters with incomes under 300% of the Federal Poverty Level (FPL) who are eligible for Catamount Health Assistance.[266]

According to state guidelines, a person is eligible for VHAP if he or she is an uninsured Vermonter with an income under 150% of the FPL. Additionally, the legislation requires persons enrolled in or applying for VHAP to purchase their employer-sponsored health insurance plan if the plan meets certain provisions. The plan must be as good as the typical plan of the four largest insurers in the small group and association market. [267] The State of Vermont will conduct an analysis to determine whether providing the individual with the financial assistance to enroll in the employer's plan is more cost-effective to the state relative to enrolling the person in VHAP.[268]

Individuals eligible for Catamount Health may receive subsidies for purchasing an employer-sponsored plan if that plan is equivalent to Catamount Health, although there is some flexibility to the extent the employer's plan covers chronic care before January 1, 2009. Additionally, the state also determines whether it is more cost effective to subsidize the person's enrollment into the employer's (rather than Catamount Health).[269] Those eligible for the ESI initiative will pay a monthly premium that is commensurate to their income, as illustrated below.

---

[262] ibid.
[263] State of Vermont, A Summary of the 2006 Health Care Affordability Act – Presented by Representative Harry Chen House Health Care Committee. www.une.edu/com/chppr/pdf/ps_summaryhcaact.pdf
[264] The Vermont Legislature, 2006 Health Care Reform Initiatives – H.861 Committee of Conference – May 5, 2006, www.leg.state.vt.us/HealthCare/H861_Two_Pager.htm
[265] The Vermont Legislature, 2006 Health Care Reform Initiatives – Quick Overview, www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Leddy_Summary.htm
[266] State of Vermont, A Summary of the 2006 Health Care Affordability Act – Presented by Representative Harry Chen House Health Care Committee, www.une.edu/com/chppr/pdf/ps_summaryhcaact.pdf
[267] ibid
[268] ibid
[269] ibid

Income by federal poverty level (One person/annual in 2006)	Approximate Monthly Premium Cost
Below 50% FPL ($4,900)	$0.00
50-75% ($4900-$7350)	$7.00
75-100% ($7,350 – $9,800)	$25.00
100-150% ($9,800 – $14,700)	$33.00
150-185% ($14,700 – $18,130)	$49.00
Over 185% ($18,138)	Premiums and cost-sharing to be determined

Source: State of Vermont, A Summary of the 2006 Health Care Affordability Act – Presented by Representative Harry Chen House Health Care Committee, http://www.une.edu/com/chppr/pdf/ps_summaryhcaact.pdf

Political Agenda

Major healthcare reform rose to the top of the political agenda due to the state of Vermont's healthcare and proximity of the 2006 elections. Vermont is in the midst of a health care crisis. Approximately 11% of its residents are uninsured and 15% or more have such inadequate coverage that a costly illness would essentially bankrupt them.[270] In Vermont, health costs are rising by more than 10% a year and the state is expected to spend over $4 billion annually on health care in the year 2008, a substantial burden in a relatively small state. [271]

Vermont's Medicaid program spent about $900 million in the last fiscal year. The deficit in the state's Health Care Trust Fund is expected to grow to more than $247 million by 2009 and its Medicaid deficit was estimated at $78 million in 2006.[272] Although per capita health costs are lower in Vermont than the national average, the spending gap has been narrowing since 1999. Health care spending growth rates in Vermont have exceeded the national average for each of the last six years.[273] These factors pointed to the need for comprehensive reform.

Democrats retook control of Vermont's legislature in 2004. [274] They used health care as one of their primary political platforms and in order to maintain their creditability and reputation, they sought to fulfill their campaign promise of health care reform.[275] Key legislators such as "Speaker Gaye Symington and House and Senate Health Chairs John Tracy and James Leddy

[270] Vermont Public Interest Group website, Health Care for All Vermonters, www.vpirg.org/campaigns/healthCare/index.php
[271] ibid.
[272] Office of the Secretary of Administration and the Office of the Secretary of Human Services, Saving Medicaid, The Douglas Administration's Plan for Saving the Vermont Medicaid System, January 19, 2005. www.ovha.state.vt.us/docs/savingmedicaid.pdf and National Federation of Independent Businesses, Vermont 2006 Legislative Action. www.nfib.com/object/IO_26173.html
[273] State of Vermont, 2004 Vermont Health Care Expenditure Analysis, Department of Banking, Insurance, Securities, and Health Care Administration, January 2006. www.bishca.state.vt.us/HcaDiv/Data_Reports/expenditure_analysis/2004EAReport.pdf
[274] Community Catalyst, Understanding the Health Reform in Vermont, December 2006. www.communitycatalyst.org/resources/VermontFinal.pdf?PHPSESSID=0e5b95ba0a2eca1bea4648cbe16e8fd8
[275] ibid.

played a leadership role in crafting legislation." [276] Pete Welch, President of the Senate, also championed major health reform; this amassed significant political capital for his campaign for a Congressional seat.[277]

During the 2005-2006 legislative session there was significant political momentum to address this issue; however setbacks occurred due to tensions between the Democratic controlled legislature and the conservative Republican Governor. The state legislature passed a sweeping health care reform bill in 2005 that would have established a government-run, taxpayer-financed health care system, but the Governor vetoed the measure in late 2005 citing concerns about cost and his preference for a privately based system. [278] Both sides held fast to their positions and were unable to come to a compromise. Although this measure did not succeed, the effort set the groundwork by placing the issue of comprehensive health reform on the table, building consensus within the legislature, educating the public, and organizing a group of stakeholders.

Political Support – Politicians, Voters and Interest Groups

Interest groups played a significant role in the passage of the Health Care Affordability Act. Soon after the Governor's veto, the largest coalition in the state's history was formed in January 2006 to restart the movement for reform. The new coalition was called the Vermont Campaign for Health Care Security, which claimed to represent 200,000 constituents. [279] The coalition was comprised of 40 organizations that included several labor unions and influential health care and advocacy groups. Among the members were Vermont Health Care For All, AARP, America's Agenda, the Vermont Public Interest Research Group, and Vermont Businesses for Social Responsibility.[280] They assisted in developing the necessary public influence and political consensus, creating a highly public debate through advertisements, media, grassroots movements, and participation in major junctures of the debate. America's Agenda was responsible for bringing the expert assistance of respected health care economist Dr. Kenneth Thorpe to Vermont legislators.[281] Thorpe became a consultant to the Health Care Committee and played a key role in directing the conversation and promoting compromise. The House Health Care Committee originally considered simply modifying the 2005 health care reform package and reintroducing it into the legislature. Thorpe helped committee members to understand that without significant compromise, another veto from the Governor was probable.[282] He was also instrumental in shifting the debate away from the politically charged question of how to finance the initiatives towards a more productive discussion of improving medical care delivery and developing greater cost-effectiveness. [283]

---

[276] ibid.
[277] Community Catalyst, Understanding the Health Reform in Vermont, December 2006.
www.communitycatalyst.org/resources/VermontFinal.pdf?PHPSESSID=0e5b95ba0a2eca1bea4648cbe16e8fd8
[278] Rutland Herald, Politicians Still Debating Merits of Catamount Health Plan, Louis Porter, October 1, 2006.
www.rutlandherald.com/apps/pbcs.dll/article?AID=/20061001/NEWS/61002001/-1/healthcare
[279] Rutland Herald, Health Care Reform So Close, and Yet So Far, Kevin O'Conner, March 12, 2006.
www.rutlandherald.com/apps/pbcs.dll/article?AID=/20060312/NEWS/60312001/-1/healthcare
[280] Vermont Public Interest Research Group, New coalition attacks Douglas on health care reform proposal, John Zicconi, January 11, 2006.
www.vpirg.org/pubs/1.11.06TAUHC.php
[281] America's Agenda, 'While Washington dithers . . .' First Massachusetts. Now Vermont. States lead fight for universal health care.
www.americasagenda.org/health1.html
[282] Rutland Herald, Health Care Reform So Close, and Yet So Far, Kevin O'Conner, March 12, 2006.
www.rutlandherald.com/apps/pbcs.dll/article?AID=/20060312/NEWS/60312001/-1/healthcare
[283] America's Agenda, 'While Washington dithers . . .' First Massachusetts. Now Vermont. States Lead Fight For Universal Health care,
www.americasagenda.org/health1.html

There was also a healthy constituent participation in the process, helping to motivate legislators to action. Vermont has a "tradition of direct democracy," in part due to a "small population in a relatively compact area." [284] Residents were able to communicate their perspectives to their representatives through public hearings and town halls sponsored by the nonpartisan Snelling Center for Government. [285]

With this energy building around health care reform, Governor Douglas was also more eager to reach an agreement than before. Although Douglas was a popular governor, polls showed that his approval rating declined significantly after a broadcast and media campaign challenged his initial refusal to sign the reform bill in 2005.[286] It was clear that Vermonters wanted health care reforms. With the November 7, 2006 gubernatorial election approaching, the Governor was more motivated to respond. Races in the state legislature may also have facilitated the compromise as legislators increasingly voiced their support for reform and their desire to address the needs of their constituents. The legislature also knew that they needed to find common ground with the Governor because they did not have the votes to overturn a veto. [287] Pressure mounted from the opposition as well. The insurance industry, the Chamber and the Roundtable voiced considerable resistance on behalf of a large constituency.[288] Despite this, the Governor was willing to compromise.

Passage of the Massachusetts Health Care Reform Act of April 12, 2006 further motivated compromise in Vermont. Legislators were inspired by the achievement, as it was the first time a Democrat controlled legislature and Republic Governor agreed on a goal for universal health care.[289] It helped to revive stalled efforts and place pressure on Governor Douglas and Democratic lawmakers to come to an agreement.

Financing and Cost Control

Catamount Health will have multiple funding streams. Enrolled individuals will pay a sliding scale premium based on income. [290] Employers are required to pay an assessment based on the number of their employees who are uninsured.[291] Uninsured employees fall into three categories: 1) employees of businesses who do not offer health coverage to any employee, 2) employees who are not eligible for their employer's health sponsored insurance and 3) employees who are eligible for insurance through their employer but choose not to enroll. [292] Employers will pay $365 annually per full time equivalent (FTE) uninsured employee. An FTE is an employee who works 40 hours per a week for 13 weeks (520 hours). [293] The assessment will be calculated quarterly and the formula is based on full time equivalents. Assessments for part

---

[284] Community Catalyst, Understanding the Health Reform in Vermont, December 2006. www.communitycatalyst.org/resources/VermontFinal.pdf?PHPSESSID=0e5b95ba0a2eca1bea4648cbe16e8fd8
[285] ibid.
[286] America's Agenda, 'While Washington dithers . . .' First Massachusetts. Now Vermont. States Lead Fight For Universal Health care. www.americasagenda.org/health1.html
[287] Rutland Herald, Health Care Reform So Close, and Yet So Far, Kevin O'Conner, , March 12, 2006. www.rutlandherald.com/apps/pbcs.dll/article?AID=/20060312/NEWS/60312001/-1/healthcare
[288] Health Care For All, 2006 Legislative Updates, April 30, 2006. www.vthca.org/legupdate22.php
[289] United Health Care Action Network, State in the Lead: Initiatives for Health Care Reform, Rachel De Golia, June 2006. www.uhcan.org/files/states/stateslead.html
[290] The Vermont Legislature, 2006 Legislative Action on Health Care, Catamount Health: The 2006 Health Care Affordability Act: 2006 Health Care Reform Initiatives, Questions & Answers. www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Details_Leddy.htm
[291] ibid.
[292] ibid.
[293] ibid.

time employees will be determined by dividing their actual hours worked by 520.[294] In 2007 and 2008, employers are exempt from paying an assessment for 8 FTEs. In 2009, the exemption is limited to 6 FTEs and in 2010 the exemption will be limited to 4 FTEs.[295]

Catamount Health is also financed by new revenues from increases in the tobacco tax. The state tobacco tax will increase:[296]

- $0.60 per pack of cigarettes on July 1, 2006
- $0.20 additional for a total of $0.80 per pack on July 1, 2008
- Little cigars, roll-your-own tobacco will be taxed as cigarettes
- Snuff tax will be changed to a per-ounce tax and the tax will be increased on July 1, 2008 by 17 cents[297]

The legislation plans to fund Catamount and the Employer-Sponsored Insurance Premium Assistance Program through the Global Commitment (Vermont's §1115 Medicaid waiver). It requires the Agency of Human Services to seek federal approval to include these programs in the Global Commitment to Health Medicaid 1115 Waiver.[298] However, there is a concern that extending these funds to Catamount and the employer initiative may create financial instability for the state Medicaid program and/or the expansion programs. The Global Commitment waiver includes an overall cap that limits the amount of federal financing that the state may draw down during the five-year life of the waiver. At the time the waiver was negotiated, the cap appeared to be generous, allowing the state to spend up to a total of $4.7 billion on Medicaid (compared to the $4.2 billion that the state estimated it actually needed to operate the program during the five-year period). The danger is that if the state spends more than these "extra" funds on the expanded programs and has greater than expected Medicaid costs; it may have to cut Medicaid benefits or eligibility levels, especially since the state cannot receive any additional funding from the federal government.[299]

The Health Care Affordability Act aims to control health costs through offering health insurance to all Vermonters and establishing an effective chronic care system.[300] Chronic care management is an important feature of the legislation as individuals with chronic conditions consume approximately 80% of all health care dollars.[301] With proper medical care and treatment, this system can prevent expensive complications often associated with chronic conditions translating to lower premiums in the private market. Catamount Health seeks to improve chronic care management through its design structure and financial incentives. The

---

[294] ibid.
[295] ibid.
[296] ibid.
[297] State of Vermont, A Summary of the 2006 Health Care Affordability Act – Presented by Representative Harry Chen House Health Care Committee. www.une.edu/com/chppr/pdf/ps_summaryhcaact.pdf
[298] ibid.
[299] Families USA, Fact Sheet: Vermont Health Reform Law, September 20, 2006. www.familiesusa.org/resources/publications/fact-sheets/vermont-health-reform-law.html?print=t
[300] State of Vermont, A Summary of the 2006 Health Care Affordability Act – Presented by Representative Harry Chen House Health Care Committee. www.une.edu/com/chppr/pdf/ps_summaryhcaact.pdf
[301] AARP, Coverage for All: Two States have enacted universal health care plans. Are they leaders or simply anomalies?, Patricia Barr, July-August 2006. www.aarp.org/bulletin/yourhealth/health_care_for_all.html

Catamount Health policies must have a chronic care management program and it waives cost-sharing for chronic care beneficiaries participating in the program.[302] Additionally, preventative care is a required benefit and cost-sharing is waived for such services.

Uninsured individuals would otherwise be eligible for Vermont's nongroup health insurance market but are either unable or unwilling to purchase health coverage from the private individual market due to high premiums and cost sharing. [303] Catamount Health aims to make purchasing health insurance in the individual market more affordable for these individuals by consolidating this population into a single state pool.[304] Catamount Health will invite insurers to offer their products on this market and use this increased purchasing power to negotiate more reasonable prices with private insurers. [305] Prices are not yet known; however, Blue Cross Blue Shield and MVP Health Insurance have already indicated their intention to participate.[306] If using private insurers does not prove cost-effective, the state may administer Catamount Health as a self-insured product. [307]

Catamount Health also addresses the problem of "cost-shifting" in driving private health care costs. Cost shifts occur when uninsured or underinsured individuals require medical care and cannot afford to pay the bill or when public programs do not compensate providers for the full cost of treatment. [308] Providers shift a large portion of these uncompensated costs to individuals with private insurance through higher prices for services.[309] Catamount Health will be able to minimize the "cost shift" by reducing the number of uninsured and underinsured Vermonters and through adequate provider reimbursement rates. Under Catamount Health, providers reimbursement rate for medical services is equal to 110% of the Medicare reimbursement rate. [310] These compensation rates are lower than commercial rates but higher than Medicare. These mechanisms will help to slow the growth in health care premiums.

There is debate as to whether Catamount will be able to achieve these cost shavings. Criticism of its cost control aspect questions the ability of chronic care management to obtain promised cost savings. Experiences in Florida and California point to the potential problems of this mechanism, insurance companies are leaving the chronic care market because of the lack of profitability and lack of savings.[311]

Additionally, these programs may disproportionately attract chronically ill members, resulting in adverse selection. Self-selection of high-risk individuals into Catamount Health policies because of strong chronic care management programs may drive up premiums. However, the "look back" period for chronic illnesses may minimize this type of self-selection.

---

[302] State of Vermont, Act No. 191 – An Act Relating to Health Care Affordability for Vermonters (H.861). www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT190.HTM
[303] Vermont Public Interest Research Group, The 2006 Vermont Health Care Affordability Act, Frequently Asked Questions. www.vpirg.org/campaigns/healthCare/documents/06.06.27_FINALCatamountQA.pdf
[304] ibid.
[305] ibid.
[306] The Vermont Legislature, 2006 Health Care Reform Initiatives – H.861 Committee of Conference, May 5, 2006. www.leg.state.vt.us/HealthCare/H861_Two_Pager.htm
[307] Vermont Public Interest Research Group, The 2006 Vermont Health Care Affordability Act, Frequently Asked Questions. www.vpirg.org/campaigns/healthCare/documents/06.06.27_FINALCatamountQA.pdf
[308] ibid.
[309] ibid.
[310] ibid.
[311] Rutland Herald, Catamount Bill a Sham: Commentary by Cornelius Hogan, March 2, 2006. rutlandherald.com/apps/pbcs.dll/article?AID=/20060302/NEWS/603020317/1039/OPINION03

The Employer Sponsored Initiative will produce cost savings for the state by shifting some of the cost of insuring individuals from the public to the private sector, particularly those enrolled in VHAP. This increases the state's access to private funds thus reducing Medicaid's mounting financial burdens for the state.[312] Similar to Catamount Health, elements in the initiative will also address the issue of chronic care in an effort to control costs.

The legislation also allows for cost containment in the form of an enrollment cap. If the state emergency board, which consists of four "money" chairs and the Governor, deems that Catamount Health's appropriated funds are "insufficient to meet the projected costs of enrolling new program participants," than the emergency board has the authority to suspend new enrollment or "restrict enrollment to eligible lower income individuals." [313]

Legislation's Structure

The Health Care Affordability Act reflects the dispute and compromise that occurred between Governor Douglas and the Democrat-controlled legislature. In 2005, both sides were unable to come to an agreement. The General Assembly held fast to its vision of a government run universal health care system while the Governor had a strong preference for reform utilizing a market model. Governor Douglas threatened to veto the bill and only agreed to sign it after inclusion of a three-step process for offering Catamount Health.[314] The program will first provide private insurers and carriers the opportunity to offer their policies on the Catamount Health Market. In the event that there is no participation by insurers or no carrier's policy forms, the state will subsequently mandate that private insurers offer Catamount. If the Health Care Reform Committee does not deem the second approach cost-effective after two years the state has authority to administer the program as a self-insured product.

Compromise was facilitated by a number of trade-offs by the Governor and Legislature on the Health Care Reform Act. While the Governor accepted the cigarette tax to help fund Catamount, he was not as receptive to the idea of employer assessment to finance the health insurance program. The Governor was committed to inclusion of his Common Sense Initiatives, S.310, in the legislation.[315] The Democrats saw the opportunity to use this issue as leverage on the employer assessment issue. [316]

The Health Care Affordability Act assigns the Secretary of Administration the responsibility of coordinating the health care system reform among executive branch agencies, departments, and offices. [317] However, much of the actual authority to design and direct the Catamount Health program is held by the legislature. In this role, legislators will exercise direct oversight of the program to appropriately adjust the program and ensure its success.

---

[312] Office of Secretary of Administration and the Office of the Secretary of Human Services, Saving Medicaid: The Douglas Administration's Plan for Saving the Vermont Medicaid System, January 19, 2005. www.ovha.state.vt.us/docs/savingmedicaid.pdf
[313] State of Vermont, Act No. 191 – An Act Relating to Health Care Affordability for Vermonters (H.861). www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT190.HTM
[314] National Conference of State Legislatures, Vermont Approves "Catamount Health," Chronic Care Initiative, Christina Kent, Vol. 27, Issue 467. www.ncsl.org/programs/health/shn/2006/sn467.htm
[315] Health Care For All, 2006 Legislative Updates: April 30, 2006. www.vthca.org/legupdate22.php
[316] ibid.
[317] State of Vermont, Act No. 191 – An Act Relating to Health Care Affordability for Vermonters (H.861), www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT190.HTM

The Human Services Agency is responsible for establishing the employer-sponsored insurance premium assistance initiative. It is required to report monthly to the Joint Fiscal Committee, and Health Access Oversight Committee, and the Commission on Health Reform on: enrollment figures; income levels of participants; approved employer-sponsored plans, the percentage of the premium and cost-sharing amounts paid by employers whose employees participate in the premium assistance program; and the net savings or cost of the program.[318]

While the Health Care Affordability Act requires the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) to adopt rules for Catamount Health, potential rules must go through a series of reviews.[319] After a public review period, the Department is required to file final proposed rules with the legislative Committee on Administrative Rules.[320] Within 14 days, Committee will approve or object to the final proposed rules. If approved, the Department will properly file the final proposed rule.[321] This system also serves to limit executive branch control by housing rule making authority in the legislature.

Legislators also engage in active surveillance of program progress through the Cost Shift Task Force. The Task Force is made up of legislators and stakeholders charged with determining how to ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums. Stakeholders have the opportunity to voice their perspectives on the success of program elements and the General Assembly benefits from this first-hand information. Unlike the Massachusetts Reform Plan, external agents - such as the health care industry, business community, and advocacy groups - are given a limited role in shaping the implementation and development of the health care initiatives. Massachusetts allows their involvement in crucial areas such as healthcare quality and payment policy.

The General Assembly's involvement in the plan design, implementation and oversight was partially driven by legislators' concerns over the state's growing Medicaid deficit. Predicted to reach $43 million in 2008, a deficit of that magnitude threatens the viability of the program.[322] Working to achieve maximum cost savings in the expanded programs serves to prevent future cuts to Medicaid.

The legislation creates the Commission on Health Care Reform to monitor the reform initiatives under the Health Care Affordability Act and to provide recommendations to the General Assembly on actions needed to attain health reform. Part of the Commission's responsibility is to monitor the development, implementation, and ongoing operation of Catamount Health. The Speaker of the House and President Pro Tempore of the Senate will appoint the Commission's co-chairs. The Speaker of the House will appoint four representatives, the Committee on Committees will appoint four senators, and the Governor will appoint two nonvoting members. No seats are explicitly dedicated for representatives from advocacy, community, or insurance groups. While the executive branch will have influence in the process, its appointees represent only a fraction of the total commission membership. Similarly, the influence of the Commission

---

[318] ibid.
[319] ibid.
[320] ibid.
[321] ibid.
[322] State of Vermont, Joint Fiscal Office, FY 08 Medicaid Deficit Update, October 2006. www.leg.state.vt.us/jfo/Healthcare/Medicaid%20Deficit%20Issue%20Brief%2010-2006.pdf

is limited to making recommendations. It will receive monthly progress reports from the Agency of Administration or designee, the Agency of Human Services, and BISHCA on Catamount Health and the Catamount Health assistance program. [323]

By detailing the structure of these provisions, the current state legislature also sought to protect them from interpretation by future state legislatures that had different political views and the influence of external stakeholders. The business community has little room to alter provisions in the ESI. The legislation clearly delineates employer assessments and while it does not outline who will enforce these employer contributions, the high level of legislative influence suggests that it will be effectively carried out.

The legislation avoids creating new government bureaucracies to implement Catamount Health and ESI by distributing responsibilities among the Human Service Agency, BISHCA, and the Agency of Administration. Given this fragmentation, the various monthly reports become a crucial means of agency accountability and integrating these various efforts. Yet, asymmetric information among different agencies and the distribution of responsibilities may lead to inefficiencies in communication and the implementation process.

Implementation:

Although the Health Care Affordability Act required compromise between the executive and legislative branches, the state legislature created legislation that would favor it with generous amounts of direct oversight. State legislature's high level of influence may result in an efficient implementation process, reducing time lags and reducing the ability of opposing stakeholders from weakening the provision. The submission of the detailed and time oriented five year strategic plan to the legislature on November 30, 2006 suggests that the creation of Catamount Health and ESI are well on their way.[324] However, the centralization of authority within the legislature may endanger the effectiveness of the legislation. It may result in a trade off in effectiveness by allowing the legislature's preferences to take precedence over those of more experienced bureaucrats.

The business community has little room to alter provisions in the ESI. The legislation clearly delineates the monetary contributions that employer must make but does not explicitly state the method of enforcing the assessment. However, the Department of Labor is responsible for establishing rules for the administration and premium collection of the employer assessment.[325] As an agency that is favorable to workers, the Department of Labor is likely to work strongly to enforce the assessment.

There is also concern that the court may strike down the employer assessment, a pay or play model, under ERISA. Employers would not have to wait until implementation of the assessment to challenge its legality. [326] ERISA is a federal pension law that prohibits that state from regulating employee benefit plans (i.e. health plans) directly. Experts believe that the

---

[323] State of Vermont, Act No. 191 – An Act Relating to Health Care Affordability for Vermonters (H.861). www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT190.HTM

[324] State of Vermont Agency of Administration, Vermont Health Care Reform , Five-Year Implementation Plan, December 1, 2006. www.adm.state.vt.us/pdf/hcr5-yearstrategicplan.pdf

[325] ibid.

[326] State of Vermont, General Assembly, Commission on Health Care Reform Minutes, August 26, 2006. www.leg.state.vt.us/CommissionOnHealthCareReform/09-26-06%20HCRCMinutes.HTM

judicial system will not be favorable to the challenge against the employer assessment as "workers are eligible for the public program regardless of whether their employers have paid the fee."[327] The judicial system is also unlikely to strike down a law that allows employers the flexibility of funding worker health care or paying the assessments and does not require that employer health plan meet specific standards or spending thresholds. [328]

X. Low Income Working Families

Low income families are susceptible to higher rates of uninsurance. Approximately two-thirds of the nation's uninsured are low-income individuals and families, having incomes less than 200% of the FPL. [329] The uninsured rate among the poor, those with family incomes between those less than 100% of the FPL, is about 36% and among the near poor, those with incomes between 100% and 199% of the FPL, the rate is 30%.[330] These rates are significantly higher than that of the national average of 18%.[331]

Contrary to popular perception, most of the low-income uninsured are hard-working members of society. Of families with incomes below 200% of the FPL, 36.7% have two full time workers and another 40% have one full-time worker.[332] Unfortunately, many of these working families have less access to employer sponsored health coverage and private health coverage, because they are low-wage workers.

Low wage workers are less likely than high wage workers to have access to employer based health care. Of the 31 million workers in the United States not eligible for employer based health coverage or do not work for employers who offer health insurance, more than half earn less than $10 an hour. [333] Low wage workers are also less likely to be able to accept employer sponsored insurance due to financial constraints. They often do not opt to enroll in employer provided health plans because high premiums and co-payments make it unaffordable. Those that do take up employer-based coverage tend to spend a greater proportion of their income on premiums relative to high wage workers.[334] Their employers are less likely to offer coverage due to the high cost of health benefits combined with the skewed distribution of the benefits of pre-tax purchasing. Additionally, private individual insurance is typically prohibitively expensive, out of reach for most low wage families. Public coverage, while available to a large and growing percentage of children, is largely inaccessible to adults. As a result, a significant proportion of low-income working families and individuals must rely on the public safety net for care.

State programs, such as Wisconsin' BadgerCare, are making health coverage more affordable and accessible for low-income families by raising income limits and subsidizing employee contributions for low-wage workers with access to employer sponsored health coverage.

---

[327] State Coverage Initiatives, ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland "Fair Share Act" Court Decision, Patricia Butler. statecoverage.net/SCINASHP.pdf
[328] State of Vermont, General Assembly, Commission on Health Care Reform Minutes, August 26, 2006, http://www.leg.state.vt.us/CommissionOnHealthCareReform/09-26-06%20HCRCMinutes.HTM
[329] Kaiser Family Foundation, The Uninsured: A Primer, Key Facts About Americans Without Health Insurance, January 2006. http://www.kff.org/uninsured/upload/7451.pdf
[330] ibid
[331] ibid
[332] ibid
[333] ibid.
[334] ibid

XI. Wisconsin BadgerCare

Health Coverage Expansion

BadgerCare was enacted in 1997 and began enrollment in July of 1999. The program uses a combination of public health insurance and an employer sponsored health insurance subsidy program to extend coverage to adults and children in low income families with minor children.[335] It was designed to assist those with incomes in excess of Medicaid limits and those without the financial means to access employer sponsored health insurance.

BadgerCare utilizes preexisting Medicaid eligibility, provider and reimbursement systems but is run as a "program wholly separate from Medicaid." [336] Prior to the introduction of BadgerCare, Medicaid covered children aged 6-14 with family incomes up to 100 percent of the Federal Poverty Level (FPL) and children aged 15-18 and parents below approximately 57 percent of the FPL.[337] Additionally, Medicaid's Healthy Start Program covered children younger than 6 and pregnant women with family incomes less than 185% of the FPL. BadgerCare extends coverage to a greater number of low income families through more generous requirements. Qualifying families are those families with children under age 19 with incomes at below 185% of the FPL[338]

Additionally, individuals receiving BadgerCare may continue on the program until their income exceeds 200% of the FPL, and there is no asset limitations associated with the program.[339] Individuals covered by a health insurance must fulfill a three-month waiting period after their insurance ends before they can enroll in BadgerCare, unless the insurance is lost for a "good cause."[340]

Premiums are based on a sliding scale and dependent on family income. Families with incomes below 150% of the FPL pay no premium. [341] Those with family income exceeding 150% of FPL will pay a monthly premium no greater than 5% of their family income. [342] No co-payment is required for children under age 18 or those enrolled in a BadgerCare HMO.

BadgerCare also makes health coverage more affordable for low-income working families through its Health Insurance Premium Payment (HIPP). The program allows BadgerCare to enroll qualified families in their employer-sponsored health insurance plan if the plan is more cost effective than BadgerCare. [343] The cost of employer health insurance includes the family's monthly premium, coinsurance, deductibles, and "BadgerCare covered services not covered by

---

[335] State Coverage Initiatives, Case Study: Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage, Alberga, Jeremy, January 2001 and Economic Research Initiative on the Uninsured, Working Paper Series: Extending Health Care Coverage to the Low Income Population: The Influence of the Wisconsin BadgerCare Program on Insurance Coverage, Barbara Wolfe, Thomas Kaplan, Robert Haveman, and Yoon Young Cho, June 2004. www.umich.edu/~eriu/pdf/wp18.pdf

[336] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill Marsteller, David G. Stevenson, Susan Wall Wallin, Susan Wall, September 1, 1998. www.urban.org/publications/307575.html

[337] Economic Research Initiative on the Uninsured, Working Paper Series: Extending Health Care Coverage to the Low Income Population: The Influence of the Wisconsin BadgerCare Program on Insurance Coverage, Barbara Wolfe, Thomas Kaplan, Robert Haveman and Yoon Young Cho, June 2004. www.umich.edu/~eriu/pdf/wp18.pdf

[338] Wisconsin BadgerCare Fact Sheet, Health Coverage for Working Families. www.dhfs.state.wi.us/badgercare/factsheets/hc-work-fam.htm

[339] Wisconsin BadgerCare Fact Sheet, Health Coverage for Working Families, http://www.dhfs.state.wi.us/badgercare/factsheets/hc-work-fam.htm

[340] Good cause includes loss of job (unless the individual quits the job), end of COBRA continuation, coverage ended due to reduced hours of employment, and health benefits ended by employer for all employees. Source of information is Wisconsin BadgerCare Fact Sheet, Health Coverage for Working Families. www.dhfs.state.wi.us/badgercare/factsheets/hc-work-fam.htm

[341] Wisconsin BadgerCare Fact Sheet, Health Coverage for Working Families. www.dhfs.state.wi.us/badgercare/factsheets/hc-work-fam.htm

[342] ibid.

[343] ibid.

the family health plan through BadgerCare fee for service."[344] The conditions of HIPP enrollment are: [345]

- The employer sponsored plan must be a major medical plan that offers at least physician services.
- Family members must not be covered by any employer-sponsored family health plan.
- The employer must pay between 40% and 80% of the monthly premium
- The cost of coverage employer sponsored health insurance for the family less than the cost of BadgerCare HMO coverage for the family."[346]

Through the mechanisms of HIPP and expanding income limits, BadgerCare makes both public and private health insurance more accessible for low-income families and workers.

The Political Agenda

In the years leading up to the creation of BadgerCare, health care was not high on the political agenda. Instead, the state legislature pursued other policy initiatives due to a combination of factors. Wisconsin's state health care system was stable in comparison to most other states; characterized by a strong and healthy private insurance market and a fairly extensive Medicaid program with "liberal eligibility standards and a rich benefit package."[347] Wisconsin's population had low incidences of poverty and unemployment, groups that typically lack health coverage. [348] In 1998, Wisconsin spent $5,032 per Medicaid enrollee, far exceeding the national average of $3,882.[349] Despite its generosity, it spent a small percentage of its budget relative to other states due to the state's low uninsurance rates. [350] The state also had a high rate of employer-based health coverage, augmented by a strong union presence. [351] Due to these factors, uninsurance did not draw strong media or constituency pressure.

The welfare reform efforts of the mid 1990s were largely responsible for creating a window of opportunity for the state to expand coverage to low-income families. The Federal government enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1990 (PRWORA).[352] PRWORA replaced the Aid to Families with Dependent Children (AFDC) program with the block grant program Temporary Assistance to Needy Families (TANF). [353]

---

[344] Wisconsin Medicaid, Wisconsin BadgerCare Fact Sheet: Health Insurance Premium Payment (HIPP) Program, http://dhfs.wisconsin.gov/medicaid1/recpubs/factsheets/phc10095.htm
[345] ibid.
[346] ibid.
[347] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa A. Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, Susan Wall, September 1, 1998. www.urban.org/publications/307575.html
[348] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.
[349] Kaiser Family Foundation, Kaiser State Health Facts Online, 2003. statehealthfacts.kff.org & Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.

[350] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.
[351] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa A. Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, Susan Wall, September 1, 1998. www.urban.org/publications/307575.html
[352] Journal of Law-Medicine, Working on the Puzzle: Health Care Coverage for Low-Wage Workers, Louise G. Trubek, Vol. 12, No. 1, pp 157-79, Winter 2002. wage.wisc.edu/uploads/Articles/trubek-louise_working.pdf
[353] ibid.

TANF was intended to foster self sufficiency among needy parents through the promotion of job training, work, and marriage. [354] TANF placed a five year limit on the receipt of federally funded assistance and gave states a large amount of autonomy to structure their own TANF program within the confines of broad federal guidelines.[355] Prior to the introduction of PRWORA, individuals receiving cash assistance through AFDC were "automatically eligible for health insurance under Medicaid."[356] TANF separated Medicaid from government income assistance. [357]

State officials believed implementing TANF would be problematic if no provision was made for offering health insurance to working low-income families. TANF requires parents and caretakers receiving program benefits to work; however, they may be reluctant to maximize their earnings/productivity because it may lead to a loss of Medicaid coverage for themselves and their children because Medicaid eligibility is determined on a household income basis. Those that value the health coverage more than additional earnings above the Medicaid income threshold may refrain from optimal levels of productivity.

There was also concern that TANF would leave significant numbers of beneficiaries uninsured. TANF promotes work that may cause individuals to exceed the Medicaid threshold, making them ineligible for the program while lacking access to employer sponsored health insurance. Due to their social-economic status, these individuals are more likely to be low-wage laborers. This wage category of workers is less likely to be able to offered employer sponsored health insurance and even when offered health coverage by an employer, they are less able to afford employee contributions relative to higher wage counterparts. Without access to either employer sponsored health coverage or public health insurance, these individuals may have poorer health outcomes for this population, negatively affecting job retention and thereby increasing the likelihood of re-entrance into the TANF system. [358] It would also place significant pressure on the public safety net. By bolstering the TANF with access to healthcare, states will minimize welfare reliance and facilitate the transition from traditional welfare into the workforce, increasing the success of the TANF program. Although Wisconsin, by federal law, maintained its Medicaid eligibility for low-income families on AFDC eligibility standards, these standards were still well below 100% of the FPL. [359]

The success of TANF was of central importance to then Governor Tommy Thompson. Governor Thompson was a major champion of policies favoring work and self reliance and an author and heavy proponent of Wisconsin Works (W-2), the Wisconsin version of the TANF program that began in September of 1997 and was completely implemented by the end of March 1998. [360] W-2 was the key piece of his political platform and the pinnacle of his long stream of efforts to "re-shape welfare in his state."[361] Thompson had a strong incentive to ensure the

---

[354] ibid.
[355] ibid.
[356] ibid.
[357] ibid.
[358] Center on Budget Policy Priorities, Assuring That Eligible Families Receive Medicaid When TANF Assistance is Denied or Terminated, Liz Chott and Cindy Mann, November 5, 1998. www.cbpp.org/11-5-98mcaid.htm
[359] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, September 1, 1998. www.urban.org/publications/307575.html
[360] The Urban Institute, Recent Changes in Health Policy for Low-Income People in Wisconsin, Brian K. Bruen and Joshua Weiner, State Update No. 25, March 2002. www.urban.org/uploadedpdf/310437.pdf & State of Wisconsin, Wisconsin Works (W-2). AFDC and TANF: Comparisons and Contrasts in Welfare Assistance, April 1998. www.legis.state.wi.us/lrb/pubs/wb/98wb4.pdf
[361] Online News hour, Wisconsin Works?, May 21, 1996. www.pbs.org/newshour/bb/welfare/welfare_5-21.html

success of W-2, as he desired to "use his gubernatorial record as a springboard to national office." [362] All eyes were on Wisconsin's W-2 program as it was one of the first states to implement the TANF program. With W-2 serving as a national model for welfare reform, Thompson had the incentive to ensure that the program was accompanied by reasonable access to health coverage to maximize participant productivity. As a result, Thompson is largely credited with bringing health expansion to the forefront of Wisconsin's political agenda during the late 1990s.

The window of opportunity was also facilitated by the economic climate. During the late 1990s, Wisconsin, similar to the rest of the nation had a strong economy.[363] The healthy economy produced high tax revenue and significant budget surpluses, increasing the political plausibility of expanding public programs. [364]

Political Feasibility

The creation of BadgerCare was the result of a long and contentious political process between state and federal interests, delaying program implementation by approximately one year. The delay was the result of politics, the lack of precedent in using SCHIP funds to cover parents, and the relatively new use of Medicaid waivers. Through dedication and the recognition of the interests of an involved federal agency, state officials were able to obtain their desired outcomes.

In addition to bringing healthcare expansion to the top of the governmental agenda, Thompson devoted much of his political will to the issue. Healthcare was one of the original components of W-2, facilitating the transition from traditional welfare into the workforce. [365] The intent of the W-2 healthcare provision was to eliminate Medicaid entitlement for AFDC populations while making them eligible for healthcare through the W-2 program. W-2 health coverage would be comparable but less comprehensive than the preexisting Medicaid program, while expanding eligibility to a greater number of uninsured individuals. [366] The program would also require enrollees to contribute a monthly premium regardless of income.[367] State officials believed that mandatory premiums would further promote the idea of self responsibility.[368]

The Governor's W-2 plan received support from the state legislature but was denied the federal Medicaid Section 1115 waiver necessary to permit the reform.[369] Governor Thompson's ability to maneuver the legislation through the state political system was due to a combination of factors. Historically, the Governor's office leads the policy making process, in large part because the state's constitution provides the office with significant authority. [370] Wisconsin's Governor has the most powerful veto in the United States.[371] Consequently, the Governor is largely

---

[362] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.
[363] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, September 1, 1998. www.urban.org/publications/307575.html
[364] ibid.
[365] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.
[366] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, September 1, 1998. www.urban.org/publications/307575.html
[367] ibid.
[368] ibid.
[369] ibid.
[370] ibid.
[371] Wisconsin State Legislature, Governing Wisconsin: The "Separation of Powers" Doctrine: Why Do We Separate the Powers of Government?, LRB, November 2005. www.legis.state.wi.us/LRB/gw/gw_7.pdf

responsible for developing policy initiatives while the legislature responds.[372] Thompson's ability to pressure the legislature to pass the legislation was due in part to his popularity[373] – indicated by his four terms as governor. Governor Thompson was also able to rely on party affiliation to pass the legislation as Republicans dominated both the state Assembly and Senate.[374] Although the legislature enacted the W-2 program in April of 1996, the W-2 program required Congressional approval to obtain the waiver necessary to conduct the proposed Medicaid restructuring.[375]

The W-2 health plan did not receive federal approval. Some say the proposed waiver was "not comprehensive enough."[376] The Thompson administration may have miscalculated the situation at the federal level. The W-2 piece drew national attention and was absorbed into the national debate as Congress and President Clinton were engaged in a contentious debate about changing Medicaid from an entitlement into a block grant, devolving more authority to state governments.[377]

Critics pointed to the W-2 health plan as an example of the detrimental consequences of such devolution.[378] Congress did not approve transitioning Medicaid from an entitlement to a block grant and shortly after the W-2 health plan was rejected. The political environment at the national level was significantly different than that at the state level. The authors of the W-2 plan may not have anticipated the national debate, perhaps resulting in unpropitious timing or a less politically palatable proposal that did not minimize opposition.

Undeterred, the Thompson administration charged Joe Lean, Wisconsin's secretary of Health and Family services, with the responsibility of developing a new plan that would appeal to Congressional interests.[379] The Thompson administration sought to bring in groups from the entire political spectrum into the dialogue, from the Chamber of Commerce to advocacy groups, minimizing opposition at the state and federal level.[380] Additionally, the planning group included advocates, moderates and conservatives, providing the plan with legitimacy.[381] Although final negotiations on the plan's elements were held in internal government meetings, the planning group did circulate waiver and concept papers to major stakeholders. Concessions were made to facilitate consensus. For instance, some public officials and insurance companies were unwilling

---

[372] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, September 1, 1998. www.urban.org/publications/307575.html

[373] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.

[374] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, September 1, 1998. www.urban.org/publications/307575.html

[375] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.

[376] The Urban Institute, Recent Changes in Health Policy for Low-Income People in Wisconsin, Brian K. Bruen and Joshua Weiner, State Update No. 25, March 2002. www.urban.org/uploadedpdf/310437.pdf & The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[377] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.

[378] ibid.

[379] The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[380] ibid.

[381] ibid.

to support the program if it did not include premiums. [382] It was not in the administration's interests to prolong the creation of a plan, which would eventually become BadgerCare, as the W-2 welfare reform piece was already being implemented. Although the state sought to maintain many elements of the W-2 healthcare program within the creation of BadgerCare, compromises were made to develop a program that would focus on expansion and smooth out contentious aspects that were problematic to the W-2 health plan.[383]

Even with these concessions, the process of obtaining federal consent due to conflicting interests between the state and the federal Health Care Financing Administration (HCFA) – now CMS - proved to be contentious. BadgerCare was originally designed to take advantage of the newly created S-CHIP, approved by Congress in 1997 as a component of Title XXI. S-CHIP funds were primarily to be used to expand coverage for children. Under SCHIP legislation, funds were only to be extended to covering parents "if very strict cost-effectiveness conditions were met." [384] Wisconsin sought to use part of its received federal SCHIP funds to cover parents of eligible children and to use the premium payments by enrollees as part of the state match.[385] After dialoging with HCFA, state officials were under the impression that this was an acceptable means of financing the BadgerCare program.[386] Unfortunately, there was miscommunication between state officials and the HCFA.

HCFA approved the Title XXI State Plan to expand "Medicaid coverage using SCHIP funding for children age 15 through 18 in May of 1998" but denied the Title XXI waiver request to cover adult family members in August of 1998. [387] HCFA determined that the use of SCHIP funds to cover parents of eligible children was against legislative intent. [388] HCFA was concerned that acting against Congress' preferences would lead to Congressional scrutiny of agency actions.[389] Federal agencies are accountable to Congress and must operate within the constraints of legislative interests. Agencies typically desire to avoid legislative intrusion that may result in reduced agency discretion, in the form of detailed and time consuming procedural requirements. Legislators may also admonish an agency that is not fulfilling their preferences through the appropriations process. State officials may not have conducted an assessment of HCFA's interests. HCFA also claimed that the process was stalled because granting SCHIP expansion

---

[382] CMS, Evaluation of BadgerCare Medicaid Demonstration, Health, Social, and Economics Research, July 2002. www.cms.hhs.gov/Reports/downloads/badgercare_2002_5.pdf

[383] The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, September 1, 1998. www.urban.org/publications/307575.html

[384] The Urban Institute, Recent Changes in Health Policy for Low-Income People in Wisconsin, Brian K. Bruen and Joshua Weiner, State Update No. 25, March 2002. www.urban.org/uploadedpdf/310437.pdf & The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[385] The Urban Institute, Recent Changes in Health Policy for Low-Income People in Wisconsin, Brian K. Bruen and Joshua Weiner, State Update No. 25, March 2002. www.urban.org/uploadedpdf/310437.pdf & The Urban Institute, Health Policy for Low-Income People in Wisconsin, Teresa Coughlin, Joshua Wiener, Jill A. Marsteller, David G. Stevenson and Susan Wall Wallin, September 1, 1998. www.urban.org/publications/307575.html

[386] The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[387] Wisconsin Department of Health and Family Services, BadgerCare Evaluation, July 2004. dhfs.wi.gov/aboutDHFS/OSF/Evaluation/BadgerCare07-04.pdf

[388] The Urban Institute, Recent Changes in Health Policy for Low-Income People in Wisconsin, Brian K. Bruen and Joshua Weiner, State Update No. 25, March 2002. www.urban.org/uploadedpdf/310437.pdf & The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[389] The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

waivers was a brand new issue in a brand new program.[390] Politics was also believed to have contributed to the complexity of obtaining the appropriate waivers. Some believed that the Clinton Administration was hesitant to assist the program because of its links to Wisconsin's Republican Governor.[391]

The state and federal government were able to hammer out a compromise on the waiver. On January 22, 1999, the Thompson administration obtained a waiver to expand eligibility for parents as a Medicaid demonstration (Title XIX).[392] The state preferred SCHIP to a Title XIX waiver because Title XIX waiver is an entitlement, which could require Wisconsin "to raise the eligibility level for Medicaid permanently." A Title XXI (SCHIP) waiver would have avoided this trap and reimbursed the state at a higher rate relative to Medicaid. [393] As a concession, HCFA allowed an "enrollment trigger," which places lower income limits on applicants if the program's appropriated funds ran dry after reaching the projected enrollment. [394]

The state actively developed Congressional support to overcome HCFA's reluctance to use SCHIP funds for adult coverage. State officials cultivated cross party relationships with Wisconsin's Congressional members to place pressure on the U.S. Department of Health and Human Services (HHS), which houses HCFA. Wisconsin Congressman Tom Barette is attributed with developing the unanimous support amongst the state's Congressional members. Congressman Barette was a Congressional insider and a respected figure among his Congressional peers. Consequently, Wisconsin's federal legislators, consisting of seven Democrats and four Republicans signed a letter requesting HHS Secretary Donna Shalala to consent to the Title XXI waiver, permitting Wisconsin to use SCHIP funds to cover parents. [395] Wisconsin was also assisted by the national health care agenda as President Clinton announced in January 2000 "he would request funding for a program to insure families as a way to reach more children." [396] These factors contributed to Wisconsin's obtaining its desired XXI waiver to cover parents on January 18, 2001, just as the Clinton Administration left office.

Program Implementation

Since its introduction, BadgerCare has been a highly popular program. The program was implemented in 2 phases; on April 1, 1999, the program began enrolling teens aged 15-18 with family incomes below 100 FPL and then all remaining eligible families in July 1, 1999.[397] Within one year, more than 66,000 individuals were enrolled in the program, 28% were children and 72% adults. [398] By 2004, 108,634 individuals were enrolled in the program, including 34,957

---

[390] ibid
[391] ibid
[392] The Urban Institute, Recent Changes in Health Policy for Low-Income People in Wisconsin, Brian K. Bruen and Joshua Weiner, State Update No. 25, March 2002. www.urban.org/uploadedpdf/310437.pdf & The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html
[393] The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html
[394] ibid.
[395] ibid.
[396] ibid.
[397] Wisconsin Department of Health and Family Services, BadgerCare Evaluation, July 2004. dhfs.wi.gov/aboutDHFS/OSF/Evaluation/BadgerCare07-04.pdf
[398] Ibid.

children.[399] BadgerCare's popularity exceeded even the expectations of state officials who believed that the program would be a success.

BadgerCare uses a variety of approaches to attract its targeted population. It employs a family-based approach to facilitate enrollment of uninsured children. Studies show that parents are more likely to enroll their children in a program if they are also extended coverage. Family-based Medicaid expansions increase the enrollment of children who are eligible but not enrolled in Medicaid.[400] Economic theory dictates that parents considering applying for Medicaid coverage for their child, consciously or unconsciously conduct a cost benefit analysis. Parents may incur costs in the form of the expenses such as of taking time off from work and the administrative hassles of the application process.[401] Benefits are often represented as fewer out of pocket medical expenses and a feeling of security.[402] The benefits are maximized if the whole family can obtain health insurance through a single application.[403]

Numerous studies also show that insuring parents increases the probability that an insured child will access medical care. An analysis of the 1999 National Survey of America's Families found that children of insured parents were "more likely to have seen a health care provider and had a well-child health visit."[404] A study on the 1996 Medical Expenditure Panel Survey concluded that "43 percent of children who were covered by Medicaid, but whose parents were uninsured," had a well-child visit while "67 percent of the children whose parents also were covered by Medicaid had a well child visit."[405] Expanding child health insurance is ineffective if it is not accompanied by utilization in order to improve child health outcomes.

Wisconsin embarked on an aggressive and multifaceted enrollment campaign, creating more than 80 outstation application sites that placed eligibility workers at health facilities and other community oriented areas.[406] The state hired a private contractor to train hundreds of workers about basic Medicaid/BadgerCare eligibility.[407] These workers came from a wide breadth of employment, including "schools, public health agencies, dental providers, utility companies, legal services, food pantries, and homeless shelters," all likely to come in contact with eligible individuals.[408]

Other outreach efforts included the distribution of 850,000 brochures in English, Spanish, and Hmong to health care providers, public health departments, community organizations, and school systems. Public health officials took advantage of an immunization program for children to educate parents about the state's new insurance program.[409] Some school districts offered a

---

[399] Department of Health & Family Services, BadgerCare Enrollment, dhfs.wisconsin.gov/medicaid8/caseload/enrollment/pdf/04bc.pdf
[400] Center on Budget and Policy Priorities, The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms, Leighton Ku and Matthew Broaddus, September 5, 2000, www.cbpp.org/9-5-00health-rep.pdf
[401] ibid.
[402] ibid.
[403] ibid.
[404] Inquiry, The Effect of Parents' Insurance Coverage on Access to Care for Low-income Children, Amy Davidoff, Lisa Dubay, Genevieve Kenney and Alshadye Yemane, Vol. 40, pp 254-268, Fall 2003.
[405] Elizabeth Gifford, Robert Weech-Maldonado, Pamela Farley Short, "Low-income Children's Preventive Service Use: Implications of Parents' Medicaid Status," Health Care Financing Review, 26(4):81-94, Summer 2005.
[406] Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Health Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html & State Coverage Initiatives, Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage, Jeremy Alberga, January 2001
[407] Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Health Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html
[408] ibid.
[409] ibid.

sign-off on free or reduced lunch programs. The schools attached a Medicaid application to the lunch application form and mailed them to 50,000 families. Approximately 4,000 application forms were returned from new families enrolling in Medicaid or BadgerCare."[410] The state also established was a toll-free number to provide case-specific assistance, multilingual posters, fact sheets, radio and TV ads, and a website. [411] BadgerCare facilitates retention using a mail-in re-certification process, reducing barriers to continuing enrollment. [412]

Program structure was an important factor in the simpler enrollment process. BadgerCare made its benefit package comparable to that of Medicaid, making it more "understandable and accepted by low-income families."[413] BadgerCare was not promoted as a welfare program in order to minimize stigma as a public assistance program.[414] Premium payment was also used as a means to differentiate the program from being typecast as a public assistance program. [415]

The state government overcame institutional barriers in the enrollment process. The program encountered difficulties due to the interagency conflict between the Department of Family and Health Services (oversees BadgerCare and Medicaid programs) and the Department of Workforce Development (administers W-2 and operates CARES). These agencies were required to encourage individuals to become less reliant on public cash assistance programs but were also charged with the conflicting responsibility to ensuring that all eligible individuals receive public health coverage.[416] The problem was overcome through "intensive training of workers who came into contact with BadgerCare applicants." [417] Institutional culture, often heavily engrained in agency behavior on multiple staff levels, can make policies ineffective if not thoroughly addressed

There are multiple reasons why building BadgerCare on Medicaid resulted in a more effective implementation process. By using the preexisting provider, application, and reimbursement system, the program minimized the implementation time. Additionally, it avoids creating a new government bureaucracy to manage the program. Through the use of the same application processing system, the state also maximizes applicant welfare. County workers enter BadgerCare applicant information in the state's Client Assistance for Reemployment and Economic Support (CARES) system, which determines eligibility for W-2, food stamps, Medicaid, and BadgerCare. While an applicant may not be eligible for BadgerCare, CARE will automatically check if individual may be eligible for other governmental assistance programs. The program's use of CARE also assists beneficiary retention. Medical providers have access to CARE, allowing them to check the status of the patients' health coverage prior to appointment to ensure that "patients arrive for appointments with their papers in order." If a patient has been disenrolled from the

---

[410] Wisconsin Department of Health and Family Services, BadgerCare Evaluation, July 2004. dhfs.wi.gov/aboutDHFS/OSF/Evaluation/BadgerCare07-04.pdf

[411] State Coverage Initiatives, Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage, Jeremy Alberga, January 2001

[412] Wisconsin Department of Health and Family Services, BadgerCare Evaluation, July 2004. http://dhfs.wi.gov/aboutDHFS/OSF/Evaluation/BadgerCare07-04.pdf

[413] State Coverage Initiatives, Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage, Jeremy Alberga, January 2001

[414] The State of New Mexico, House Bill 955 Comprehensive Study: On Health Care and Health Care Costs in New Mexico, Legislative Health and Human Services Committee, December 2004. http://legis.state.nm.us/LCS/lcsdocs/153454.pdf

[415] CMS, Evaluation of BadgerCare Medicaid Demonstration, Health, Social, and Economics Research, July 2002. www.cms.hhs.gov/Reports/downloads/badgercare_2002_5.pdf

[416] The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[417] ibid.

program, medical providers can assist them to reenroll, which be done as simply as through a phone call. [418]

While it is more administratively efficient to base the program on the Medicaid structure, it places strains on the provider networks. There are already a limited number of medical providers willing to accept Medicaid recipients. Due to the low supply of these providers and the high demand by beneficiaries of various Medicaid programs, it is no surprise that BadgerCare beneficiaries reported difficulty finding a primary care provider that would accept a new BadgerCare member. [419]

Legislation's Structure

BadgerCare was enacted as part of the executive budget act (1997 Wisconsin Act 27). The legislation was concise in nature, outlining major program eligibility requirements already discussed in the health coverage expansion section, and giving the Department of Health and Family Services (DHFS) authority to implement the program.

The legislation is silent on much of the implementation process and does not make many provisions for mandatory legislative participation in the creation or maintenance of the program. One of the few that does requires DHFS to submit for review and approval any proposed schedule of contribution that exceeds 3 percent of family income to the Joint Committee on Finance. This may be attributed to pressure from advocacy groups that were concerned that a higher contribution rate would be detrimental to low-income families. SCHIP guidelines allowed a maximum of premium cost of 5 percent of the family income for families win incomes between 150 percent and 200 percent of the FPL, BadgerCare set up initial provisions at 3 percent for families with incomes between 150 and 200 percent of the FPL.[420] Introduced later through an amendment in January 2000, were the enrollment trigger and the requirement for DHFS to obtain the prior approval from the Joint Committee of Finance in order to institute it.[421]

Vague legislation is often beneficial for the most prominent stakeholders, who can exert their influence on legislators and administrators to achieve their missions outside the legislative spotlight, BadgerCare's legislation used Medicaid's infrastructure and benefits from Medicaid's preexisting standards of quality, provider reimbursement, and other procedures, reducing the need to create committees staffed with legislative and external stakeholders to ensure that the DHFS adheres to their preferences.

Housing the program within DHFS also allows it to be operated by bureaucrats who are highly knowledgeable about providing insurance to low-income individuals and avoids the inefficiency that often arises by fragmenting responsibilities.

By law, SCHIP funds may not crowd out employer sponsored insurance but may be used to subsidize it for the uninsured. To use SCHIP funds for this purpose, the state must enact

---

[418] ibid.
[419] CMS, Evaluation of BadgerCare Medicaid Demonstration, Health, Social, and Economics Research, July 2002. www.cms.hhs.gov/Reports/downloads/badgercare_2002_5.pdf
[420] CMS, Evaluation of BadgerCare Medicaid Demonstration, Health, Social, and Economics Research, July 2002. www.cms.hhs.gov/Reports/downloads/badgercare_2002_5.pdf
[421] Wisconsin Legislative Reference Bureau, BadgerCare Revised, January 2000. www.legis.state.wi.us/lrb/pubs/budbriefs/00bb2.pdf

"crowd-out prevention measures, cost-effectiveness rules, employee cost-sharing limits, and benefit levels." To meet these requirements, states must often scrutinize each case.[422]

Financing and Cost Containment

The program relies on state general purpose revenues (GPR), federal funds (FED), Program Revenues (PR) – primarily participant contributions. For the timeframe of 2007-2008, Department of Health and Family Services (DHFS) requested $82,639,000 (GPR) 149,480,400 (FED) and $12,396,600 (PR) - an increase of $28,273,000 (nearly 12%) from the previous year. [423]

The federal government reimburses parents with incomes below 100% at the Medicaid rate of 59% and parents with incomes above 100% of the FPL at the SCHIP reimbursement rate of 71%. [424] Children in families with incomes above Medicaid levels are also reimbursed at the SCHIP rate. [425] Besides providing higher matching rates than Medicaid, SCHIP allows states to create more restrictive benefits than those permitted under Medicaid reimbursement. Also allowed are cost-sharing requirements and an enrollment cap, both of which are not permissible under Medicaid.[426]

BadgerCare is not an entitlement program, the state and federal government's share of BadgerCare funding is not open-ended. Unlike Medicaid, SCHIP funding does not "automatically increase to cover everyone who is eligible."[427] Instead, eligible states receive a set allocation of SCHIP funds, so states can face shortfalls in SCHIP funding.[428] In theory, its "enrollment trigger" financially protects the state.

DHFS may enact the enrollment trigger if the funding appropriated for BadgerCare is inadequate to cover BadgerCare costs based on projected enrollment levels, allowing DHFS – with the approval of the state legislature – to lower the program's maximum income eligibility levels to "no greater than necessary to ensure the amounts appropriated are sufficient to cover projected costs." [429] The catch to this provision is that changes in eligibility levels would only apply to new applicants.[430] State coverage of already enrolled individuals would not be affected by these new arrangements.[431] Additionally, if Wisconsin was to utilize its enrollment trigger, federal reimbursement for parents with incomes above 100% FPL would revert to the Medicaid

---

[422] National Health Policy Forum, Using SCHIP to Subsidize Employer-Based Coverage: How Far Can This Strategy Go?, June 2000. www.nhpf.org/pdfs_bp/BP_SCHIP_6-00.pdf
[423] State of Wisconsin Legislature, Biennial Budget Request 2007-2009, Health and Family Services. www.legis.state.wi.us/lfb/2007-09budget/agencyrequest/dhfs.pdf
[424] Wisconsin Department of Health and Family Services, BadgerCare Evaluation, July 2004. dhfs.wi.gov/aboutDHFS/OSF/Evaluation/BadgerCare07-04.pdf
[425] ibid.
[426] Journal of Health Politics, Policy and Law, States and the Politics of Incrementalism: Health Policy in Wisconsin during the 1990s, Michael Sparer, Vol. 29, No. 2, April 2004.
[427] Office of Governor Jim Doyle, Doyle, Media Release, Mendez Urge Action on Children's Health Care Crisis Failure by Republican Congress Threatens the Health Care of Over 600,000 Children Nationwide, September 27, 2007. www.wisgov.state.wi.us/journal_media_detail_print.asp?prid=2345&locid=19
[428] Office of Governor Jim Doyle, Doyle, Media Release, Mendez Urge Action on Children's Health Care Crisis Failure by Republican Congress Threatens the Health Care of Over 600,000 Children Nationwide, September 27, 2007. www.wisgov.state.wi.us/journal_media_detail_print.asp?prid=2345&locid=19
[429] Wisconsin Legislative Fiscal Bureau, Medical Assistance, BadgerCare, SeniorCare, and Related Programs, Informational Paper 43, January 2005. www.legis.state.wi.us/lfb/Informationalpapers/43.pdf
[430] ibid.
[431] ibid.

rate.[432] This provides a disincentive for Wisconsin to carry out its enrollment trigger, which would be particularly detrimental to vulnerable populations during an economic downturn. It may also create financial hardship on the state during economic downturns, when individuals, due to job loss, turn to public health insurance, increasing enrollment and state costs.

BadgerCare has instituted multiple cost containment and savings measure, some were a part of its original program structure and others were added in response to the economic climate. BadgerCare reduces costs by enrolling most members into an HMO, unless it is more cost effective to subsidize premiums to enroll families in their employer-sponsored health insurance plan.[433] In theory, HMOs reduce costs by limiting access to services through the use of gatekeepers. HMOs may also promote the use of preventative services, avoiding the need for more costly medical care in the future.

The program attempts to limit costs to the state by instituting multiple provisions designed to minimize the crowd out of private employer sponsored health insurance. BadgerCare utilizes a pre-established tracking system, which is run by Electronic Data Systems (EDS), a private organization.[434] Wisconsin law requires insurance carriers to provide information that lists all currently enrolled individuals with private health coverage to the Medicaid program. With this information, the program can identify individuals and dependents that are enrolled or may be eligible for private employer based coverage. [435] A complication of this approach is that due to the lag time prior to the posting of the data, circumstances may change, and an individual may no longer be covered by employer sponsored health coverage due to job loss, resulting in incorrect denials. [436]

State officials made improvements to minimize the substitution of public health insurance for private coverage. In 2004, the program implemented measures that required recipients and applicants to verify their income and access to employer based coverage by having their employers fill out and return an Employer Verification of Health Insurance (EVF-H).[437] Prior to this, information provided by applicants was accepted based on the honor system.[438]

BadgerCare instituted a three month look back period that denies coverage to individuals with access to employer sponsored health plan that pays for more than 80 percent of the monthly premium. [439] While this may deter unwanted applicants it can be detrimental for families that have "bare-bones [private] coverage, often at a considerable cost, because of poor health." [440]

---

[432] Wisconsin Department of Health and Family Services, BadgerCare Evaluation, July 2004. dhfs.wi.gov/aboutDHFS/OSF/Evaluation/BadgerCare07-04.pdf

[433] Department of Health & Family Services, Wisconsin BadgerCare Fact Sheet: Health Care Coverage for Working Families. www.dhfs.state.wi.us/badgercare/factsheets/hc-work-fam.htm

[434] The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[435] State Coverage Initiatives, Wisconsin BadgerCare Program Offers Innovative Approach for Family Coverage, Jeremy Alberga, January 2001

[436] CMS, Evaluation of BadgerCare Medicaid Demonstration, Health, Social, and Economics Research, July 2002. www.cms.hhs.gov/Reports/downloads/badgercare_2002_5.pdf

[437] Department of Health and Family Services, Office of Strategic Finance, Program Evaluation and Audit Section, Evaluation of BadgerCare Employer Verification Process, September 2005. dhfs.wisconsin.gov/aboutDHFS/OSF/Evaluation/BadgerCareEVP9-05.pdf

[438] Coving Kids & Families, CKF Policy Primer #6: Raising the Bar and Reducing Access: Analysis of BadgerCare Income Verification Policy, February 2006. www.ckfwi.org/documents/PP6-Raisingthebarandreducingaccess.doc

[439] The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

[440] CMS, Evaluation of BadgerCare Medicaid Demonstration, Health, Social, and Economics Research, July 2002. www.cms.hhs.gov/Reports/downloads/badgercare_2002_5.pdf

Individuals with substantial financial disadvantages and requiring constant medical care cannot afford to drop their inadequate private coverage. [441]

In 2003, the Wisconsin legislature authorized DHFS to implement measures to control the cost of drugs under BadgerCare and several other Medicaid related programs, including establishing a preferred drug list and entering agreements with pharmaceutical companies in exchange for supplemental drug rebates. [442]

The state increased subscriber premiums to supplement program funding. [443] During the economic difficulties of 2003, Wisconsin raised monthly premiums from 3 percent of family income to 5 percent, the maximum allowed by federal law.[444] It also increased co-payments for all families with incomes at above 100% of FPL. During 2002, Wisconsin "zeroed out" its outreach budgets. [445]

Early on, program costs exceeded budgetary allocations. In the early stages of the program, BadgerCare enrollment grew more rapidly than expected, resulting in a projected funding deficit of $13.5 million between 1999-2001. [446] Another noteworthy cause of this financial situation was the higher than anticipated parent to child enrollment ratio.[447] Adults are more expensive to insure due to higher health costs.[448] High costs in the early years were also due to pent up demand for adult coverage.[449] Wisconsin found that insurance for low-income families, such as BadgerCare, was more likely to draw in adults than the traditional Medicaid program.[450]As a forerunner in expanding coverage to adults, BadgerCare encountered great challenges in projecting costs and enrollment.

XII. Conclusion

Governmental and nongovernmental organizations are creating a broad and innovative array of initiatives to address the uninsured. Critical lessons can be learned about the examined legislation and programs that may contribute valuable insight for future coverage initiatives.

Many policy solutions wait for years for a window of opportunity, a moment made ripe through an optimal economic and political climate and sufficient community and governmental interest. Experts, advocacy groups, bureaucrats, government officials and other crucial actors dedicate valuable resources to pave the way for extending health care to the insured by making policy solutions available and assisting in the creation of political and public consensus. As important

---

[441] ibid.
[442] Family Studies, Wisconsin Family Impacts Seminar and the University of Wisconsin Population Health Institute, Medicaid: Who Benefits, How Expensive Is It, and What are States Doing to Control Costs, October 2005. learningstore.uwex.edu/pdf%5CBFI22.pdf
[443] ibid.
[444] The Urban Institute, Squeezing SCHIP: States Use Flexibility to Respond to the Ongoing Budget Crisis, Series A, No. A-65, Ian Hill, Holly Stockdale, and Bridgette Ourtot, June 2004. www.urban.org/uploadedPDF/311015_A-65.pdf
[445] Ibid.
[446] The Urban Institute, Recent Changes in Health Policy for Low-Income People in Wisconsin, Brian K. Bruen and Joshua Weiner, State Update No. 25, March 2002. www.urban.org/uploadedpdf/310437.pdf
[447] Wisconsin Budget Project, Badger Care Coming of Age: Promise and Reality, www.wccf.org/pdf/bc.pdf
[448] Ibid.
[449] CMS, Evaluation of BadgerCare Medicaid Demonstration, Health, Social, and Economics Research, July 2002. www.cms.hhs.gov/Reports/downloads/badgercare_2002_5.pdf
[450] The Milbank Memorial Fund, The Origins and Implementation of BadgerCare: Wisconsin's Experience with the State Children's Insurance Program (SCHIP), Coimbra Sirica, January 2001. www.milbank.org/010123badgercare.html

as developing the broad consensus that is often necessary to pass legislation are the details within the legislation that affect program implementation, such as where enforcement authority is housed and the degree of legislative oversight. These details will have significant impacts on implementation and program outcomes.

Enrollment success is indicative of program outcomes. Programs with high levels of enrollment were typically accompanied by family based enrollment, outreach efforts facilitated by trusted organizations within the targeted community, participant privacy, organizations with the trust of and access to targeted populations, and clear upfront outreach costs and program benefits.

Both high enrollment rates and ensuring financial sustainability are both crucial means of demonstrating program success. Programs without a stable source of long-term funding, such as a new mandate, tax, or fee for program financing, are highly vulnerable to economic downturns and shifting priorities. Sources of funding, such as foundation support, are better suited for short-term activities like those found in program development and implementation.

Programs are enlisting a variety of mechanisms to contain costs and make healthcare more affordable to targeted populations. Some hope to achieve broad cost savings by drastically altering medical utilization patterns for those with chronic disease. Many programs employ more conventional provisions that include reducing crowd out, building on a managed care system, promoting cost effective treatments. Most programs vary their approach with consideration to their geographic strengths and weaknesses.

Coverage to the uninsured is a multi-faceted political and policy challenge. This examination of these varied coverage expansion initiatives only begins to touch upon the wealth of creative state and local approaches to coverage of the uninsured. ITUP hopes that this paper will help engender discussion and provide insight into the design and implementation challenges that lay ahead for California.

2444 Wilshire Blvd., Suite 415

Santa Monica, CA 90403

Telephone: **(310) 828-0338**

Website: **www.itup.org**

ITUP

INSURE THE UNINSURED PROJECT