



Rebalancing Health Care IN THE HEARTLAND

A Compendium of State-Based Reform Initiatives

May 2007

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Introduction

Health care has never been more important to Americans than it is today. Expectations of the system have grown with advances in prevention, wellness, technology, research, and treatment. Longevity of our population demands recognition of a changed process of aging and adaptations in the health care system. Amid rapidly evolving expectations and abilities of the health care industry to meet these expectations come the realities of access and portability, cost and financing, quality, providers, and prevention.

The University of Iowa Health Sciences Policy Council is undertaking a series of three forums to examine health care issues and efforts at reform. In *Rebalancing Health Care in the Heartland* Forum 1, held on November 15, 2006, experts in publicly-funded health care from Iowa and the nation discussed issues facing the aging, children, disability services, and mental health in the context of access, cost, providers, and quality. This document builds upon the themes raised in Forum 1 and expands the review to state-based health care policy reform initiatives to be more fully discussed at Forum 2 on June 19, 2007. A third forum, scheduled later in 2007, on December 3 and 4, will elevate the discussion from the state level to the national level in context of the heightened attention to health care policy in the upcoming presidential campaign.

National health care policy reform is not imminent, though the profile of reform discussion is increasing. Meanwhile, Iowa is not alone in seeking solutions to health care issues for its residents and the public and private systems that support their health care. Other states across the United States, like Iowa, continue to wrestle with challenges in their systems and in meeting the changing needs and expectations of their residents. In the spirit of learning from one another, this Compendium was developed as a snapshot of state health care reform initiatives under active consideration, recently enacted, or in implementation phases across the country.

No matter one's niche in the health care realm, an understanding of the issues and potential solutions is necessary to craft Iowa's reform. This document serves as a resource guide to those interested in health care reform at the state level. Successes and lessons learned from each state are summarized concisely, with opportunities for the reader to seek additional information from the source. Recognizing that no research undertaking in this arena can ever be considered complete, the *Compendium of State-Based Initiatives* provides the status in each state as of mid-May 2007.

Overview of the Research and Findings

Rebalancing Health Care in the States – A Compendium of State-Based Reform Initiatives informs the discussion of state-based policy reform as part of Forum 2 of The University of Iowa health care policy series. It also serves as a resource document for those seeking summary information and resource links for each of the 50 states. With state-by-state research conducted and compiled in Spring 2007 by State Public Policy Group based in Des Moines, the Compendium is intended to provide a snapshot of each state’s legislative and/or executive branch initiatives in a concise summary. Four states receive additional attention: Iowa, Massachusetts, Oregon, and Tennessee. The three states, plus Iowa, are the focus of the Forum 2 program, with supporting data and context included in this Compendium.

State summaries in this document reflect state-level health care reform initiatives as of mid-May 2007. Information was sought about legislative and executive branch health care reform at the state level from varied sources. Universally, data and information were reviewed from the National Conference of State Legislatures (NCSL), National Governors Association (NGA), and the legislative and executive branches in each state. Personal contact was made with legislative staff in every state to assist in providing perspective and up-to-the-minute information. In the four states with in-depth focus at Forum 2, researchers spoke with the keynote speaker to ensure the data inform the reform and lessons learned for the Forum discussions. Suggested resources are included in each summary that allow interested readers to continue to follow initiatives in the states.

There was no consideration given to including non-government advocacy efforts or proposals in the summaries; rather, the summaries contain information directly relating to state government health care policy proposals. The summaries include what the researchers consider to be the most relevant and, in some cases, most promising ideas regarding health care reform. It is important to note that not all the activity in every state can be included in a summary document.

Given the scheduling dictates for this document, research was conducted in some states where legislatures had adjourned for the year; other states had not yet adjourned their session or are not scheduled to adjourn any time soon. For this reason, current status of active proposals is included in the summaries.

Common Findings Across States

Health care reform at the state level has been a popular topic of public policy debate in recent years. Many states have undertaken some kind of reform in past years. Successes and lessons learned are being applied in those and other states as policy change continues to be proposed. Nearly every state has at least one reform proposal under consideration this year, with varied levels of success in passage. There has been speculation for some time by followers of health reform efforts that states are moving into state-based health care reform because they can no longer afford to wait for Congress to address national reform. However, this research effort, conducted on a state-by-state level including talking with people involved in their states' processes, casts another view on the impetus for state-based health care policy initiatives. Simply put, states are motivated toward reform because each is interestingly unique for its own reasons, with context of culture, economics, tradition, and health care challenges moving states generally in the same direction – toward some level of health care reform – with distinct differences that “fit” with each state's circumstances. States are seeking health care reform to address their citizens' needs.

Drivers of state-level health care reform efforts will come as no surprise to Iowans who follow the issues. Soaring Medicaid budgets, State Children's Health Insurance Program shortfalls, high costs of insurance to employees and employees footing the bill, and growing elderly populations needing long term supports are the issues most often cited by states as motivating state health care policy reform.

Targeted reform in one or two areas is by far the most common approach. Few states are attempting comprehensive reform of health care policy this year. It appears that a wholesale revamping of health care policy was viewed as formidable and not likely to succeed in a single session or as a sweeping change developed over several sessions. Utah and Wyoming are addressing modest pieces of an intended multi-year reform in areas such as reducing the number of people in long-term care facilities or creating a preferred drug list. Legislators and Governors may have had early success in reaching agreement on broad elements of comprehensive reform proposals, but the details of individual components were a likely source of ultimate disagreement. New Hampshire, Georgia, Michigan, and Pennsylvania are examples of an initially comprehensive approach to reform.

Thus, an approach that addresses certain components independently of others is more likely to have met with success. Rather than taking a comprehensive approach that is implemented all at once or incrementally, most states are looking at their situation and addressing problems they believe will best balance high quality health care and cost. Cost, finding ways to fund reform, and gaining passage of funding mechanisms are slowing progress and outcomes for some states. Oregon's current State Children's Health Insurance Program (SCHIP) reform is tied to a proposed cigarette tax increase. The proposed cigarette tax received a simple majority of votes but did not receive the necessary three-fifths majority to become law, wiping out this option to help fund the state's “Healthy Kids” program.

In Arkansas, the Taxpayers Bill of Rights prevents government from implementing reforms that have a fiscal impact greater than “typical,” meaning a three-to-five year ballot initiative will be required to complete necessary reform. Illinois’ current proposals hinge on agreement on financing options.

Some of the more common reform efforts revolve around:

- Medicaid expansion
- SCHIP expansion
- Small business pooling/relief for small employers
- Long-term care supports for growing elderly populations
- Prescription drug programs
- Prevention
- Chronic disease management

Other initiatives were developed to address health care issues of significant impact in certain states. North Dakota’s expanses of sparsely-populated land steered efforts toward emergency medical services throughout the state as well as a study on long-term care that included geographic dispersion of services. Mental health reform is also a focus in several states, including North Carolina.

Maximizing coverage under Medicaid and in conjunction with SCHIP seems to be a cornerstone of many state reform efforts. Nebraska is undertaking a major Medicaid reform and Georgia is focusing on SCHIP, having had the largest SCHIP shortfall of all states that forced a freeze on new enrollments. Those states with strong Medicaid and SCHIP programs are working to include people on the fringes of those programs, such as Wisconsin’s new demonstration program to insure childless working adults.

Efforts to address the affordability of health coverage for small business seem to be taking the “carrot” approach, proposing tax credits or other kinds of incentives for offering coverage. Punitive measures if small business does not offer coverage are typically not in evidence. Oregon, Florida, Alabama, and Arizona are examples of states proposing a small business incentive. Montana implemented an small business incentive program and has had to create a waiting list given its popularity.

An emphasis on preventive care and chronic disease management is receiving more attention than in past years. It appears the increased cost of health care through both public and private sources has spurred policymakers to delve more deeply into the potential for prevention and chronic disease management to reduce or at least control costs while providing positive health impacts and improved quality of life for patients. Virginia has taken this approach. With 25 percent of Virginians currently using tobacco, the state sees clear, long-term cost savings for health care by investing now in prevention.

States that have undertaken reform in previous years continue to either enhance their reforms or expand upon them. Tennessee and Oregon are both taking on enhanced reform efforts. Hawaii, Kentucky, Idaho, and Maine are among states that have made some kind of reform prior to 2007.

An important element of health care reform in a number of states is the appointment of a task force, commission, or blue ribbon panel to study the issues and recommend reforms and funding strategies to Governors and Legislatures. States believe they can learn from the reform of other states, more clearly set forth potentially-successful solutions, and give policy-making bodies a head start on the policy discussion. The appointed study group may be given a broad or more narrow charge. Colorado's Blue Ribbon Commission will receive and study reform proposals submitted by any interested party or organization. The Commission will study them and, from the input gained, bring forward elements of reform to be included in proposed legislation for 2008.

It seems as if states where there is strong leadership and support from the Governor are more likely to move components of health care reform in the legislature. Massachusetts, Indiana, Kansas, Pennsylvania, and Illinois are a few of the states that exhibit this type of executive branch involvement. Again, it is evident that it is difficult to achieve and sustain a level of support necessary for legislative success. Leadership and support from the state's executive leader contributes to the broader base of support needed for a successful reform initiative.

As residents and state governments increasingly face hardships tied to such issues as cost, access, quality, and providers, the impetus for undertaking health care reform has gained strength. Whether proposed policy change is a new undertaking for a state or earlier reform efforts are being expanded or tweaked, the stakes are high. The research shows that the risks of not addressing these difficult and politically-sensitive issues in states may now be greater than risks of making change. Lessons learned from across the country can serve as valuable tools for Iowa and other states seeking effective change, positive health impacts for citizens, and a tempering of health care costs for public and private sectors.

Navigating the Compendium

The state-by-state information is organized for ease of use by the reader. Three parts follow.

- 1. Quick Reference of Reform Elements** – For the reader who seeks to identify which states are adopting certain types of reforms, the Compendium includes a set of quick reference lists. Look for a reform, such as SCHIP, to find the states that have included this approach in their health policy reform initiatives. Reform topics included in this section are:
 - Business Mandate
 - Comprehensive Reform
 - Employer/Employee Assistance
 - High Risk Coverage
 - Individual Mandate
 - Information Technology
 - Insurance Company Mandate
 - Long-term Care
 - Medicaid
 - Medicare
 - Mental Health/Substance Abuse
 - Pharmaceuticals
 - Prevention/Wellness
 - Premium Assistance
 - Private Sector Reforms
 - SCHIP
 - Tax Credit
 - Universal Coverage
- 2. Focus: Iowa, Massachusetts, Oregon, and Tennessee** – Iowa and the three states highlighted in the Rebalancing Health Care in the Heartland Forum 2 are given special attention in the Compendium. Reform efforts are chronicled in greater detail to support and further illuminate the discussion of each state as part of the Forum 2 program. These states were selected for focus because of the significance of their past and current health care policy initiatives.
- 3. Summary of State-Based Reforms:** A concise summary of each of the 46 remaining states includes highlights of policy background and health reforms, 2007 legislation and study efforts, contact information and links, and a snapshot of coverage data. Each state summary includes the status of 2007 efforts as of mid-May. Bills included under “2007 Legislation and Study Efforts” must have advanced through at least one legislative committee by the status date indicated to be included in the snapshot.

Quick Reference of Reform Elements

Business Mandate

Arkansas
California
Hawaii
Maine
Massachusetts
Oregon
Pennsylvania
Vermont

Comprehensive Reform

Arizona
California
Connecticut
Hawaii
Illinois
Kansas
Maine
Massachusetts
Michigan
Minnesota
Oregon
Pennsylvania
Tennessee
Utah
Vermont
Virginia
Washington
West Virginia

Employer/Employee Assistance

Arkansas
California
Delaware
Florida
Illinois
Indiana
Kentucky
Maine
Massachusetts
Minnesota
Missouri
Montana
Nevada
New Hampshire
New Jersey
New Mexico
New York
Oregon
Pennsylvania
Rhode Island
South Carolina
Tennessee
Washington
Wisconsin

High Risk Coverage

Arizona
Maine
New Jersey
New Mexico
North Carolina
North Dakota
Oregon
South Dakota
Tennessee
Texas

Individual Mandate

California
Maine
Massachusetts
Minnesota
Pennsylvania

Information Technology

Alabama
Alaska
Delaware
Louisiana
Minnesota
New Hampshire
Oregon
Pennsylvania
Virginia
Washington

Insurance Company Mandate

Massachusetts
New Hampshire
New Jersey
Rhode Island

Long-term Care

Florida
Iowa
Kentucky
Nebraska
New York
North Dakota
Ohio
Oregon
Vermont
Virginia
Washington
Wyoming

Medicaid

Alabama
Alaska
Arizona
California
Colorado
Connecticut
Delaware
Florida
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Nebraska
Nevada
New Jersey
New Mexico
New York
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Texas
Utah
Vermont
Washington
West Virginia
Wisconsin
Wyoming

Medicare

California
Connecticut
Idaho
Oregon
Texas

Mental Health/Substance Abuse

Arkansas
Colorado
Connecticut
Delaware
Idaho
Indiana
Iowa
Maine
Nevada
North Carolina
Oregon
Texas

Pharmaceuticals

Alabama
Alaska
Arkansas
Colorado
New Hampshire
New York
Ohio
Oregon
South Dakota
Utah
Wisconsin

Prevention/Wellness

Delaware
Georgia
Indiana
Kentucky
Maine
Massachusetts
Minnesota
Oregon
Pennsylvania
Rhode Island
Tennessee

Premium Assistance

Hawaii
Illinois
Kansas
Louisiana
Massachusetts
Minnesota
Pennsylvania
Rhode Island
South Carolina

Private Sector Reforms

Arizona
Massachusetts

SCHIP

Alaska
Arizona
Colorado
Connecticut
Delaware
Florida
Hawaii
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maryland

Massachusetts
Minnesota
Mississippi
Montana
Nevada
New Jersey
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
South Carolina
Texas
Utah
Washington
Wisconsin
Wyoming

Tax Credit/Incentives

Alabama
Illinois
Indiana
Massachusetts
Minnesota
Montana
North Dakota
Pennsylvania
West Virginia

Universal Coverage

California
Colorado
Connecticut
Florida
Hawaii
Illinois
Kentucky
Maine
Massachusetts
Minnesota
Missouri
Montana
Pennsylvania
South Dakota

FOCUS:

Iowa, Massachusetts,
Oregon, and Tennessee

Focus: Iowa

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
2,982,085	9%	11%	6%	60%	7%	11%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Introduction and Background

Iowa has undergone changes in the past several years in the overall health care system that take gradual steps toward addressing some of Iowa’s most challenging issues. Those issues include rising Medicaid expenditures, an aging population in need of long-term care supports, geographic barriers because of the state’s rural makeup, impending workforce shortages, and an outdated system for mental health service funding and delivery.

The reform actions have required strong, experienced leadership willing to confront barriers and challenges and suggest innovative and bold ideas. Iowa has taken major steps to reform its mental health system, is working to “rebalance” long-term care supports by decreasing its reliance on institutional settings, has expanded options for community-based services, pioneered a Medicaid waiver program for childless adults, and created a path to direct the planning of improvements to the health care system in Iowa.

Additionally, Iowa is first in the nation in hosting the Presidential Caucuses, which affords individuals as well as Iowa and national groups the opportunity to garner attention from Presidential candidates on a host of issues. Several groups are active in the state in attempting to focus the national spotlight on health care for the 2008 election, including the American Association for Retired Persons (AARP) Divided We Fail Campaign, Wake Up Wal-Mart, the American Cancer Society, the American Alzheimers Association, and others.

Insurance and Population Characteristics

Iowa enjoys a relatively low uninsured rate with an overall uninsured rate of approximately 9 percent of the population. Uninsured children represent 6 percent of the uninsured population, and 64 percent of children are covered by employer-sponsored insurance. This is significantly higher than the US figure of 57 percent (State Health Facts: Iowa). Iowa’s residents are aging – the state ranks fourth in the nation for the number of residents over

the age of 65 (Older Iowans: 2007 1). This has significant implications for long-term care in the state, in terms of availability of service options for older Iowans, the impact on state funding of Medicaid and waivers, and ensuring a health care workforce is in place to address older Iowans' health care needs.

Iowa's Medicaid program provides coverage for working parents up to 29 percent of the federal poverty level (FPL) (the budget passed by the 2007 Legislature includes funding to increase this eligibility level); children ages 1 through 5 up to 133 percent of the FPL, and children ages 6 through 18 up to 100 percent of the FPL, as well as pregnant women up to 200 percent and infants up to 185 percent of the FPL. The Medicaid Expansion program covers children ages 6 through 18 between 100 and 133 percent of FPL and infants with family incomes between 185 and 200 percent of FPL. The State Children's Health Insurance Program (SCHIP), known as *hawk-i* (healthy and well kids in Iowa) covers children up to age 19 with family incomes between 133 and 200 percent of the FPL (State Health Facts: Iowa). Iowa is one of a dozen or so states facing a shortage of federal dollars for its SCHIP program – to the tune of about \$17 million. The state is expected to run out of funds sometime between July and September of 2007.

Impacts of Health Care Costs

Iowa businesses and individuals face difficult decisions about rising health care costs. Research conducted as a result of the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services (HHS) 2004-2005 State Planning Grant by the Iowa Department of Public Health indicated that 92 percent of businesses in an Iowa survey reported that rising health care costs were hurting their company. Seventy-nine percent reported rising health care costs were creating a state of crisis for businesses in the state (Kinzel 11). According to the *2006 Iowa Employer Benefits Survey* (David P. Lind & Associates, L.L.C.), small employers are much less likely to provide health insurance than large employers. Among employers with less than 20 employees, 76.7 percent indicated they provided health insurance versus employers with 20 or more employees, which ranged from 90.2 percent (employers with 20 to 49 employees) to 100 percent (employers with 1,000 employees or more).

Individuals face different challenges, and a resident survey conducted with funding from the Iowa State Planning Grant revealed that as health care costs increase, individuals attempt to save on medical expenses, sometimes to the potential detriment of their own health (and potentially, at a financial cost to the state through unnecessary emergency visits and delivery of uncompensated care). Some of the measures Iowans reported taking when faced with increasing health costs:

- Stopped taking prescription (15 percent insured; 32 percent uninsured)
- Cut back on a prescription (15 percent insured; 35 percent uninsured)
- Did not fill a prescription (20 percent insured; 41 percent uninsured)
- Did not schedule a test (21 percent insured; 41 percent uninsured)
- Did not go to a doctor when needed to (29 percent insured; 63 percent uninsured)
- Waited longer to see a doctor when sick (53 percent insured; 75 percent uninsured)

Iowa is a major center for insurance and financial services and the state is well-regarded as a chief competitor in the national insurance market. The insurance industry in Iowa employs approximately 81,000 Iowans (Major Industries in Iowa 4). The substantial insurance presence in the state creates an opportunity to include major health insurers in discussions about next steps for Iowa's health care system.

Health Professional Workforce

Because of its rural nature, Iowa faces significant challenges in recruiting and retaining health care professionals. In 2005, the Center for Health Workforce Planning issued a report titled *A Report Prioritizing a Potential Shortage of Licensed Health Care Professionals in Iowa*, which cited some significant findings for planning for health care for its future citizens. Sixty-three percent of the 24 health professions studied estimated that more than 20 percent of their licensees would be age 55 or older in 2005. The top professions reporting large numbers of their professionals growing older were psychologists (47 percent projected to be 55 years of age or older by 2005) and health service providers (45 percent 55 or older by 2005), followed by marriage and family therapists, nursing home administrators, mental health physicians and counselors, and dentists (Center for Health Workforce Planning 4).

The University of Iowa recently released a report highlighting its findings from the convening of the Task Force on the Iowa Physician Workforce. Although Iowa's overall supply of physicians has increased by 54 percent since 1980, Iowa faces major challenges in recruiting and retaining physicians – mainly geographic and financial. The most common reason that physicians leave is to move to another state, and Iowa ranks 80th among the 89 Medicare payment localities in payment schedules, which creates an undesirable climate for physicians (Task Force on Iowa Physician Workforce 6). The mental health workforce is also impacted – only 32 of Iowa's 99 counties have at least one psychiatrist, which limits accessibility to mental health treatment statewide (Task Force on Iowa Physician Workforce 26). The Task Force generally recommended “1) increasing the supply of physicians, 2) improving the geographic distribution of medical services, and 3) retaining physicians for training, entry into practice, and continued practice” (Task Force on Iowa Physician Workforce 3).

Mental Health and Disability System

The mental health system in Iowa is county-based and creates inequities in the availability and funding of services across the state. As a result of legislation in 1996 that froze the funding counties could collect in property taxes for mental health and developmental disability services, county budgets reached a crisis point during the last couple of years and were faced with the real possibility of cutting programs or services. Mental health and disability expenditures have represented the largest growth categories in Medicaid spending since 2001. Overall, expenditures are increasing because of more availability of Medicaid services, but there have been no mandated or core services (Parks 1). The mental health and disability delivery and funding systems are undergoing a significant “rebalancing” effort, which will be described in more detail later.

Reform Efforts

Circumstances and timing are key elements of any reform implementation effort. Health care reform in Iowa has been defined and crafted based on the unique recent experiences of the state. For Iowa, crises in health and mental health funding have been a major impetus for change. They have also offered an unusual opportunity to introduce some initiatives that may not have otherwise been considered or adopted. In addition, reform efforts require strong leadership to guide the way, and Iowa has been fortunate to have many key players who not only advocated for change but worked hard to make it happen. The following information provides a summary of recent health care reforms in Iowa. Although it does not encompass all health care related efforts, it aims to highlight the most significant events that have impacted the way health care is delivered or funded in Iowa.

Innovations in Medicaid and SCHIP

In 2004-2005, the US Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services (CMS) notified Iowa that the federal government would no longer allow the state to utilize Intergovernmental Transfers (IGTs) the same way as it had in the past. This meant a projected loss of \$65 million in federal funds to the state annually, and approximately \$200 million total when considering the loss of state dollars. With the leadership of former Representative Danny Carroll (R, Grinnell) and support of the then Senate Co-President, Senator Mike Gronstal (D, Council Bluffs), the state was able to implement an innovative new waiver called the IowaCare program. The expert guidance and partnership of the Director of the Iowa Medicaid Enterprise (IME), Gene Gessow, and the Director of the Iowa Department of Human Services (DHS), Kevin Concannon, helped develop the IowaCare Act of 2005 (House File 841). The IowaCare program is an 1115 Medicaid waiver expansion program that covers nonelderly adults up to 200 percent of the FPL. An innovative solution to the IGT dilemma, the IowaCare waiver replaced the State Papers program, which was entirely state funded. Minimal premiums are due monthly and the network of providers is limited to Broadlawns Hospital in Des Moines, The University of Iowa Hospitals and Clinics in Iowa City, and any of the four state mental health institutions.

The IowaCare Act legislation implemented many more reforms beyond the waiver program. A major component of the reform effort was a focus on “rebalancing” long-term care services to place more emphasis on community-based care. This included changes to the criteria for nursing facility level of care to improve access to home and community-based services, development of a plan for case-mix reimbursement for services for individuals with mental retardation or developmental disabilities, a plan to enhance alternatives for community-based care for individuals who qualify for entry into an Intermediate Care Facility for Persons with Mental Retardation (ICF/MR), and state approval of a children’s mental health waiver to improve access to supports in the community.

Iowa is currently participating in several opportunities to increase the availability of choices for individuals seeking community-based care. Iowa's Cash and Counseling program, *Consumer Choices Option*, provides services to individuals eligible for one of six Home and Community Based Services (HCBS) waivers (Mental Retardation, Elderly, Physical Disability, Ill and Handicapped, Brain Injury, and AIDS/HIV). With assistance from the Robert Wood Johnson Foundation and the Centers for Medicare and Medicaid Services (CMS), the program provides a flexible monthly budget that allows the individual to direct and manage his/her own community-based services and supports.

Iowa is also a recent recipient of a *Money Follows the Person* Grant, which will assist the state in transitioning individuals from ICF/MRs into home and community-based services. The 2007 Legislature approved \$1.1 million for the state share of the grant. The Department of Human Services (DHS) has also applied for a *Demonstration to Maintain Independence and Employment (DMIE)* grant. If approved by CMS, DHS, in partnership with Iowa Workforce Development (IWD) would offer Medicaid coverage and work supports to individuals leaving the prison system. There were also extensive deliberations this year to attempt to eliminate or reduce the waiting lists for other HCBS waivers. However, the Children's Mental Health Waiver was the only waiver to receive increased funding to help alleviate the waiting list.

2006 legislation established the *Medicaid for Independent Young Adults (MIYA)* program, which provides Medicaid coverage to youth who "age out" of the foster care system. It is available for individuals who are under age 21, were in a foster care placement when they turned 18, and whose incomes are under 200 percent of the FPL. This program is paid for entirely with state dollars. The 2007 Legislature also established the Federal Family Opportunity Act to allow families with disabled children to buy into Medicaid coverage. This opportunity to expand Medicaid coverage availability was made possible through the Deficit Reduction Act of 2005. Also of significance, the 2007 Legislature passed funding to increase the earned income disregard under Medicaid, which will expand coverage to approximately 6,000 Iowa parents.

The financial dilemma of the *hawk-i* program was the source of much discussion during the 2007 Iowa General Assembly. Iowa legislators put a safety plan in place in case SCHIP funding is not reauthorized before Iowa runs out of funds. The state plans to use 100 percent of state funds by borrowing from the Emergency Fund and the Senior Living Trust Fund, which will allow Iowa to maintain the program through May of 2008. The Legislature also set priorities for the state's SCHIP funding if Congress reauthorizes more than is currently allocated to Iowa. If additional resources are available, they would be spent first to expand coverage to pregnant women, children of state employees, legal immigrant children, and children up to age 21 or 23 if they are in school.

Health Care System Planning and Funding

One of the overarching issues of the 2007 legislative session was definitely health care. The passage of SF 128 – a \$1 per pack tobacco tax increase – was a major victory for Governor Chet Culver (D) and many other groups that had advocated for the increase for several years. Governor Culver made it part of his FY 2008 budget and strongly urged the Legislature to pass the tax to improve the health of Iowans. The legislation, signed by the Governor on March 15, 2007, also created the Health Care Trust Fund into which revenues from the tobacco tax are to be deposited.

Senator Jack Hatch (D, Des Moines) and his co-chair on the Joint Appropriations Subcommittee on Health and Human Services (HHS), Representative Ro Foege (D, Mount Vernon) were instrumental in the passage of health care reform efforts this year. Senator Hatch and Representative Foege identified health care reform as a priority for the Subcommittee early in the 2007 Session and held numerous hearings and presentations on the various components of the Democrats' health care reform proposal. The major legislation that passed as a result of their hard work was the creation of the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families. The Commission is charged with reviewing and analyzing individual mandates, health insurance coverage for all children in the state, the most effective ways to cover the uninsured and underinsured, and research on various strategies to reduce costs. The Commission is expected to hold its first meeting in June, and recommendations are due to the General Assembly in December of 2007. The Health Care Data Research Advisory Council was also created to assist the Commission in carrying out its duties.

Mental Health and Disability Services

In 2005, Iowa joined the ranks of many other states by implementing mental health parity that mandates health insurance coverage (only impacting state-regulated plans) of biologically-based mental illnesses. Attempts have been made during the last two legislative sessions to expand the definition to include substance abuse and/or eating disorders, but they have failed. In 2006, the Iowa General Assembly focused much attention on the crisis facing the inequitable, county-based mental health system. The Mental Health and Disability Services Division was also re-established within the Iowa DHS. The Legislature also took steps to eliminate “legal settlement” in Iowa, an outdated means of determining who pays the costs for individuals who need publicly-funded mental health or disability services. Eventually, the county of residence, not the county of legal settlement, will be responsible for all aspects of a person's service needs – eligibility determination, authorization of services, and payment.

The 2007 General Assembly appropriated \$350,000 to the Mental Health and Disability Services Division to improve the state's mental health system. Through partnerships with its stakeholders, the Iowa DHS will prepare implementation plans for the General Assembly regarding mental health system improvements, alternative county funding distribution formulas, increased state responsibility for community mental health centers, core mental health services, co-occurring mental health and substance use disorders, evidence-based practices, and information sharing.

Counties at imminent risk of eliminating mental health and disability services and programs were provided some relief by the 2007 General Assembly. Five million dollars was allocated in additional allowed growth funding and an additional \$12 million was included for counties that had a low fund balance and had maximized their levy authority. An additional \$460,000 was included for a risk pool to assist counties with additional funding challenges.

Challenges

Iowa in general, and the Legislature in particular, tends to cautiously approach change, with a well-informed and thoughtful approach to decisions. Any type of comprehensive change effort, then, requires time and deliberation. Legislators do have a big job – balancing a tight budget with many competing priorities. The Iowa legislators also face the typical dilemmas faced by all policymakers – the need to consider public opinion, as well as the need to compromise and reach consensus with their colleagues on issues. The IowaCare Act was the result of a crisis situation that actually forced Iowa to make some innovative and significant changes to its health care system. However, it required the threat of a loss of funding to drive the effort. The problems with the historically inequitable county-based mental health system have been evident for years, but the extreme complexity of the system and sometimes competing state and county interests (and even competing interests among counties) make it a very difficult issue to tackle.

Long-term care in this country is slowly shifting more toward a focus on meeting individuals' health and other needs in their homes and communities. Older people are demanding access to these types of services, and states are realizing the savings when investing in more home and community-based services and less institutional services. Iowa spends over \$400 million per year on nursing home care, but only about \$350 million per year on services provided through all of its eight Medicaid waivers (Concannon). The nursing homes and hospitals in Iowa have a strong advocacy presence, and while they are supportive of a continuum of care, they are also naturally protective of investments in their core services. It will continue to be a challenge to try to strike a balance among the different levels of care, and to provide incentives for providers to participate in a diversity of services.

Consumers are at the center of the debate about health care system reform. However, in Iowa, there is not a strong consumer lobby. While there are certainly many groups that represent different populations of health care consumers, they do not command a huge force at the Capitol (Concannon). It is definitely a challenge to lead a health care reform effort without significant partnership with and support from those who are being directly impacted by the change.

Summary and Next Steps

The health care reform efforts outlined here have positioned Iowa well for continuing positive change into the future. The next several years will likely prove to be very challenging as policymakers in Iowa try to address the really big questions of what elements make a cost-effective, efficient, and equitable health care system for all residents. The Legislative Commission on Affordable Health Care Plans for Small Businesses and Families will meet during the summer and fall of 2007 and will likely recommend legislation for the 2008 session. Meanwhile, the Iowa Department of Human Services will continue to participate in several innovative approaches to increasing the availability of community-based services for individuals who would otherwise receive institutional-based care (through various waivers and grants).

Major changes to the mental health and disability services system will need to occur. The 2007 Legislature provided funding to study improvements to the system. Basic changes that are likely to happen within the near future are an increased involvement in the state to ensure equitable treatment and access, development of core services available to all individuals in the system, and increased emphasis on reducing the state's reliance on institutional-based care.

Ultimately, the percentage of Iowa's population that is aging will continue to increase, and barriers to statewide access and funding will constantly be a challenge in such a rural state. In spite of the challenges and barriers, Iowa has taken steps to create innovative solutions that positively impact Iowans' health while also considering the financial well-being of the state. The right mix of timing and circumstances to create future change is difficult to predict, but policymakers in Iowa have set a course to continue to tackle some of the big picture issues impacting the state.

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Resources

Iowa General Assembly
www.legis.state.ia.us

Iowa Department of Human Services
www.dhs.state.ia.us

Iowa Medicaid Enterprise
www.ime.state.ia.us

Center for Health Workforce Planning – IDPH
http://www.idph.state.ia.us/hpcdp/workforce_planning.asp

Focus: Massachusetts

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
6,437,193	10%	14%	5%	60%	4%	14%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Introduction and Background

In 2006, the state of Massachusetts enacted comprehensive health care reform designed to provide access to affordable health care coverage for all Massachusetts residents. Since passage of reforms, the state has been aggressively implementing provisions of the legislation. Iowa, like the rest of the country, has been watching closely and trying to capture lessons learned from the reforms as well as the process to achieve reforms.

Massachusetts has implemented a series of health reforms over the last twenty years that paved the way for the 2006 reform. In 1985, the Massachusetts Legislature created the Uncompensated Care Pool to distribute the costs of care for the uninsured. A commission was also created to make recommendations for a system that would provide health insurance for all Massachusetts residents. The recommendations led to the passage of a universal health care law, signed by Governor Michael Dukakis in 1988. The universal health care law included programs to provide health insurance for disabled adults and children, pregnant women, uninsured workers, and a requirement that college students have health insurance. The 1988 law also included an employer mandate that was never implemented due to opposition from the business community and an economic recession (Affordable Care Today).

Rising health care costs and a growing uninsured population led to the next series of major reforms in the 1990s. In 1995, Massachusetts was awarded a demonstration waiver from the Centers for Medicare and Medicaid (CMS) to redesign the state's Medicaid program. The redesigned Medicaid program, called MassHealth, made health insurance available to a number of previously uninsured individuals including the unemployed, the working and non-working disabled, low-income workers and their families, individuals with HIV, and women with cervical and breast cancer. Since the demonstration began, the number of MassHealth members has increased by 46.5 percent to include over 800,000 members. MassHealth also provided incentives for employers who offer health insurance and pay at least 50 percent of employee premiums (Centers for Medicare and Medicaid Services, Fact Sheet).

Approaching 2005, Massachusetts was still faced with an uninsured population of approximately 10 percent and pending expiration of the Medicaid demonstration waiver, creating a need and opportunity for the comprehensive 2006 reforms. In April 2006, the Massachusetts General Court enacted “An Act Promoting Access to Affordable, Quality, Accountable Health Care” (Chapter 58 of the Acts of 2006). The law was designed to provide universal health insurance coverage to residents of Massachusetts through a combination of Medicaid expansions, subsidized private insurance programs, and insurance market reforms. The law places shared responsibility for health insurance on individuals, businesses, and state and federal government.

Major Drivers of Reform

The timing was right for health care reform in Massachusetts. Political leaders and reform advocates made the best of an opportunity for comprehensive reform. Massachusetts has an uninsured rate of approximately 10 percent or 650,000 people. In comparison to the national rate of uninsured, which is 15 percent, Massachusetts has the fourth lowest uninsured rate in the country (State Health Facts: Massachusetts). The number of uninsured does not make the challenge of health care coverage less urgent, but more manageable given the state’s history with reforms and strong investment in the health care.

Medicaid 115 Demonstration Waiver

There was a sense of urgency in Massachusetts regarding the renewal of the of the Medicaid 1115 Demonstration Waiver, under which the MassHealth program was created. The waiver, awarded in 1995, was set to expire in 2005. Governor Mitt Romney successfully negotiated with CMS for an extension pending program changes that would discontinue Massachusetts’ current financing system for charity care, safety net providers, and intergovernmental transfers. These program changes meant a potential loss of federal funds (Sachs 5). As outlined in the Massachusetts Waiver Amendment submitted to CMS, the health care reform law built upon the MassHealth demonstration and accomplished key goals of the extension, including improving the fiscal integrity of the MassHealth program, directing more federal and state health care dollars to individuals and less to institutions, and subsidizing the purchase of private insurance for low-income individuals to reduce the number of uninsured (Centers for Medicare and Medicaid Services, Waiver Amendment).

The Uncompensated Care Pool

The Massachusetts Uncompensated Care Pool, created in 1985, provided another reason for reform. Prior to reform, hospitals received payments from the Pool for the cost of caring for the uninsured. Under this system, some hospitals received higher reimbursements from the Uncompensated Care Pool than from the state Medicaid program, MassHealth. The pool resulted in a system that encouraged uninsurance and escalated costs of uncompensated care. Redirecting the state’s investment from uncompensated care to an

insurance-based model was a major tenet and financing mechanism for the 2006 reform (Centers for Medicare and Medicaid Services, Waiver Amendment).

Political Leadership and Compromise

The leadership and compromise behind the Massachusetts health care reform were defining factors in its successful passage. During the 2005-2006 Legislative Session, multiple health care reform bills were introduced. While each had a different approach to reform, they had a similar goal of expanding access to health insurance to residents of Massachusetts. Governor Romney, the House, and the Senate all had proposals on the table for consideration. The difficult process to reach consensus led to the creation of a conference committee to negotiate key differences in provisions of the House and Senate bills. The committee reached a compromise after weeks of discussion and issued a conference report that received near unanimous support in the House and Senate. Governor Romney vetoed eight sections of the bill, all of which were overridden by both chambers.

Advocates

Health care reform advocates played a key role in influencing the development and passage of the 2006 reform. The Blue Cross Blue Shield Foundation of Massachusetts launched an initiative called the *Roadmap to Coverage* to inform the debate about how to provide health coverage for the uninsured in Massachusetts and generate a roadmap for achieving that goal. The initiative, in its third report in a series, outlined coverage options that shaped the development of the Massachusetts reform. Demonstrating citizen support for reform, a coalition of health care, religious, business and grassroots community leaders conducted a ballot initiative campaign, known as MassACT!. The coalition collected over 82,000 signatures of registered voters from across the Commonwealth in support of health reform. Another influential advocacy group, Health Care for All, convened a broad coalition of stakeholders to form a new organization, the Affordable Care Today (ACT!) Coalition, dedicated to advancing health reform in Massachusetts.

Massachusetts Health Care Reform

The Massachusetts Health Care Reform bill (Chapter 58 of the Acts of 2006) was designed to provide nearly universal access to health insurance coverage to residents of Massachusetts through a combination of Medicaid expansions, subsidized private insurance programs, and insurance market reforms. The major elements of the reform are described in this section.

Commonwealth Health Insurance Connector

The Commonwealth Health Insurance Connector is a new agency responsible for connecting individuals and small businesses (50 or fewer employees) with health insurance products. Individuals who are employed are able to purchase insurance using pre-tax dollars. The Connector allows for portability of insurance as individuals move from job to job, and

permits more than one employer to contribute to an employee's health insurance premium. The Connector will set subsidy levels for the Commonwealth Care program, set the affordability standards for individual mandate, and decide what insurance plans can be offered through the Connector. The Connector is overseen by a separate, appointed Board of private and public representatives.

Insurance Market Reforms

Non-group (individual) and small-group health insurance markets will be merged to reduce premium costs. Health plans are required to offer family coverage to young adults for two years after they lose their dependent status or up to age 25, whichever occurs first. The Connector will also offer specially designed, lower-cost products for 19-26 year-olds. The bill also imposes a moratorium on the creation of new health insurance mandated benefits through 2008.

Subsidized Health Insurance

Commonwealth Care Health Insurance

The Connector will administer a subsidized insurance program called the Commonwealth Care Health Insurance Program for individuals who earn less than 300 percent of the federal poverty level (FPL) and are not eligible for MassHealth, the state Medicaid program. Premiums for the program will be set on a sliding scale based on household income and will not have deductibles. Individuals who earn less than 100 percent FPL (raised to 150 percent by the Connector Board) will not be charged premiums. The program is operated by the Connector.

Medicaid Expansions, Restorations, Enhancements

Medicaid coverage is expanded to the uninsured by providing \$3 million for comprehensive community-based outreach programs to reach people who are eligible for Medicaid but not yet enrolled, expanding eligibility for children from 200 percent to 300 percent FPL, and increasing the enrollment cap on MassHealth Essential (unemployed), CommonHealth (people with disabilities), and HIV programs. The bill also restores MassHealth benefits that were cut in 2002, including dental and vision services, and creates a two-year pilot program for smoking cessation treatment for MassHealth enrollees. MassHealth will allow lower cost sharing responsibilities for individuals that demonstrate healthy behaviors such as smoking cessation, diabetes screening, teen pregnancy prevention, cancer screening and stroke education.

Insurance Partnership Program

The reform expands eligibility for employee participation in the current Insurance Partnership program from 200 percent to 300 percent FPL, in order to provide another option for small businesses who want to offer health care to their employees. The Insurance Partnership Program provides small employers (less than 50 employees) with an incentive payment for contributing at least 50 percent toward the cost of health insurance coverage

for their low-income employees, and provides employees with subsidies towards the purchase of employer-sponsored insurance.

Individual Mandate

Beginning in July 2007, Massachusetts residents will be required to obtain health insurance. Individuals for whom affordable products are not available will not be penalized for not having insurance coverage. A sliding “affordability scale” will be set annually by the Board of the Connector. Residents will confirm that they have health insurance coverage on their state income tax forms filed in 2008. The Department of Revenue will enforce this provision with financial penalties beginning with a loss of the personal exemption for tax year 2007 and then increasing to a portion of what an individual would have paid toward an affordable premium for subsequent years.

Employer Mandate

Fair Share Contribution

Employers with 11 or more employees who do not provide health insurance will be required to make a “fair and reasonable contribution” toward premiums for their employees or pay a per-employee contribution. The Division of Health Care Finance will define “fair and reasonable” and establish per-employee contributions.

Section 125 Plans

Section 125 plans or “cafeteria plans” allow an employer to offer health insurance to employees on a pre-tax basis. Employers with more than 10 employees will be required to offer this pre-tax benefit to employees.

Free Rider Surcharge

The Free Rider surcharge will be imposed on employers who do not provide health insurance and whose employees use free care. The surcharge will be triggered when an employee receives free care more than three times, or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10 percent to 100 percent of the state’s costs of services provided to the employees, with the first \$50,000 per employer exempted.

Health Safety Net Office and Fund

The Uncompensated Care Pool is eliminated and replaced with the Health Safety Net (HSN) Fund. The Fund is administered by a newly-created Health Safety Net Office located within the Office of Medicaid. The HSN Office will develop a new standard fee schedule for hospital reimbursements, replacing the current charges-based payment system.

Provider Rates

The reform also includes support for some providers in the form of MassHealth rate increases, with a stipulation that hospitals meet performance goals related to quality, efficiency, the reduction of racial and ethnic disparities, and improved patient outcomes in order to obtain rate increases.

Challenges

Affordability

Because the Massachusetts law mandates coverage for all residents, affordability is a major consideration. The mandate is only enforceable if affordable products are available. The Massachusetts legislation left the responsibility of defining affordable coverage to the Connector. The Connector Board has worked amid scrutiny to define affordability as well as adequate coverage. Four plan types have been established for Commonwealth Care with the same basic benefits, but different contributions and out-of-pocket costs. The Board has also received a second round of bids from private insurers for Commonwealth Choice, the unsubsidized program for residents and small businesses that will offer coverage from private insurance carriers. The first round of bids created considerable concern that plans were going to be unaffordable, with bids for premiums as high as \$380 per month. The resubmitted bids were 5 to 18 percent below original proposals (Raymond 15-18).

Achieving Compliance

The individual mandate requires residents to obtain health insurance by July 1, 2007 or face tax penalties. Marketing, outreach, and education about the law and about employer and individual responsibilities are necessary to ensure successful implementation. The Connector has established an affordability schedule, waiver, and appeal process as components of the individual mandate to help increase compliance. The Board also increased the threshold for individuals who will not be charged premiums from 100 percent as written in the bill to 150 percent FPL (Raymond 20).

Employer Insurance

Questions remain regarding the impact of the employer responsibilities on employer sponsored coverage. The Kaiser Commission specifically raised questions about the Fair Share Contribution. It was estimated that employers would pay approximately \$295 per employee if they do not offer health insurance coverage. However, that may not be an incentive if the contribution is less than the cost of providing insurance (Kaiser Commission).

Adequate Funding and Long Term Cost

The Massachusetts health care reform is financed through re-direction of existing funds from the Uncompensated Care Pool described earlier and Disproportionate Share Hospital Payments. New funding includes a general fund appropriation, the employer fair share and free rider surcharges, and federal Medicaid matching funds. Total projected cost for the program was \$1.2 billion for FY07 (Blue Cross Blue Shield 9). At a forum convened in May by the Blue Cross Blue Shield Foundation of Massachusetts, participants expressed concern that the price tag will be as high as \$1.7 billion and cited the need for cost savings and efficiencies to ensure long term success (Dembner 15 May). The employer fair share contribution and free rider surcharge, important state-level financing mechanisms for the program, went into effect in late 2006 but have not yet been collected (Dembner 10 May). Given the limited commitment of new funds from the state and rising health care costs, long-term costs for the reforms will be a challenge.

Implementation Progress and Next Steps

The Massachusetts health care reform legislation included an aggressive timeline for implementation of each reform element. In a report to the Massachusetts General Court on the one year anniversary of the signing of the health care reform legislation, Governor Deval Patrick and Secretary of Health and Human Services JudyAnn Bigby outlined the progress toward implementation.

Commonwealth Care was successfully launched on October 1, 2006 for individuals below the federal poverty level. The program was expanded to individuals up to 300 percent of the federal poverty level on January 1, 2007. In a May 10 report to the Connector Board, state officials reported that nearly 70,000 members have already enrolled in Commonwealth Care (Commonwealth Connector).

Commonwealth Choice was launched on May 1, 2007. Individuals are able to enroll in insurance coverage with the Connector “seal of approval.” Insurance coverage will begin on July 1, 2007. Small businesses can begin enrollment on October 1, 2007. To meet these deadlines, the Connector accomplished difficult tasks of defining minimum credible coverage and affordability (Raymond 12).

MassHealth, the state Medicaid program, implemented an increase in the income limit for the Insurance Partnership to 300 percent FPL, increasing coverage by 3,071 people. As of July 1, 2007, MassHealth completed the expansion of coverage to children to 300 percent FPL increasing enrollment by more than 13,000 and increased the enrollment cap for MassHealth Essential from 44,000 to 60,000 (Patrick 6).

The Connector has engaged in aggressive outreach activities to explain how the law impacts individuals and businesses. The Connector participated in a series of forums across the state hosted by Associated Industries of Massachusetts, produced an employer handbook, and responded to inquires through a public information unit. Outreach is also being coordinated

through providers, community health centers, community-based organizations, private contractors, advocacy organizations, and information technology including the new Connector website, www.mahealthconnector.org. In May 2007, the Connector announced a public information campaign with the Boston Red Sox to encourage residents to obtain health insurance.

The individual mandate requires residents to obtain health insurance by July, 1 2007, or face tax penalties. The Connector is working with the Department of Revenue on enforcement of the mandate. As described previously, the Connector Board has successfully established an affordability schedule, waiver, and appeal process as components of the individual mandate to help increase compliance. The Board also increased the threshold for individuals who will not be charged premiums from 100 percent as written in the bill to 150 percent FPL.

The Massachusetts experience in developing, passing, and now implementing sweeping health care reform offers policymakers and advocates across the country an opportunity to learn as they work to develop their own reforms. The Massachusetts reforms are a significant undertaking and the state has successfully met major implementation milestones. As the state works to complete implementation and enforce the individual and employer components, the story of Massachusetts health care reform is really just beginning.

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Resources

Affordable Care Today
www.hcfama.org

Blue Cross Blue Shield Foundation of Massachusetts, Road Map to Coverage
<http://roadmaptocoverage.org/>

Commonwealth Connector
www.mahealthconnector.org

Commonwealth of Massachusetts
www.mass.gov

The General Court of the Commonwealth of Massachusetts
<http://www.mass.gov/legis/>

Focus: Oregon

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
3,700,758	16%	21%	11%	53%	6%	12%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Introduction and Background

The state of Oregon has been a leader in health care policy since the 1990s. Over time, the health care system in Oregon has continued to evolve, given an ever-changing population and economic landscape. These changes have encouraged the state to continue to make adjustments to the way that health care policy is structured to ensure that consumers are accessing quality health care in an affordable and sustainable way. Oregon has worked to identify unmet health care needs, explore opportunities for public-private partnerships, and expand coverage to members of Oregon’s most vulnerable populations. The series of adjustments and an early look at the need for health care reform provided lessons that will continue to assist the state as it looks for ways to increase the sustainability of the health care system and meet new and changing demands.

Critical junctures in the policy process tend to provide a climate for the success of certain issues. Oregon’s first juncture occurred in the 1980s with a substantial change in the long-term care system. In 1985, budget issues in the state forced a market shift in revenue, and advocates for older Oregonians lobbied for alternatives to nursing homes. Oregon’s willingness to try new things allowed the state to invest more public dollars into home-like settings right out of the hospital. Future reforms were based on a strong, process-oriented approach that included grassroots advocacy efforts from consumers of health care services.

Kevin Concannon, Director of the Iowa Department of Human Services and former Director of the Oregon Department of Human Services, commented on the climate that led to the implementation of the Oregon Health Plan. Early in the 1980s, the Oregon Business Council conducted extensive polling and individual interviews around the state regarding health care and tax policy. Findings indicated that people did not mind paying into the system if it was not wasteful. In 1987, the case of a child needing bone marrow transplant services, a service which had been eliminated to provide pre-natal care services, dominated news headlines. The attention provided the profile needed to forge debate and decisions about treatment

options and prioritization. The issue of children and the health care services that they are able to access versus expectant mothers forced debate and a further discussion of the importance of preventive medicine and the prioritization of services, as well as the Oregon Health Plan (Concannon).

As in many states, it is important to note Oregon's population trends and demographics as drivers of health care costs. The state currently has a population of just over 3 million, a slight jump from almost 2.9 million in 1990 (Office for Oregon Health Policy and Research 1). The state's population has and continues to change significantly in age, racial and ethnic makeup, and economic status. Oregon's population is aging, with an expected increase in Medicare spending as these individuals move from employment-based health care to publicly-funded programs. Between now and the year 2013, the fastest growing segment of the population of Oregonians are those 70 to 74 years of age, with projected growth of 45 percent. Currently, Oregon's health care dollars are primarily spent on hospital care, physician services, and prescription drugs. Acute care services also are a high-cost item in serving the health care needs of Oregon's citizens, with a projected cost of \$19.3 billion by 2008 (Office for Oregon Health Policy and Research iii-v).

New medical technology has been identified as one of the most important, long-term drivers of increased health care costs. The Office for Oregon Health Policy and Research reports that "new medical technology accounts for one-half to two-thirds of the increase in health care spending in excess of the general inflation (Office for Oregon Health Policy and Research iii)." Other costs, such as waste and inefficiency, medical errors, medical liability, and structural issues of the insurance system were also identified as significant cost drivers.

Chronic diseases typically result in higher utilization and cost of health care services. The state has recognized the importance of primary health care in the design and implementation of the Oregon Health Plan. In Oregon, over one-third of adults reported having a chronic disease such as arthritis, asthma, heart attack, coronary heart disease, stroke, or diabetes. In 2005, 23.8 percent of adults in Oregon were obese, and 59.7 percent were either overweight or obese. Obesity is linked to a wide range of diseases including cardiovascular disease, some cancers, and diabetes. In Oregon, cigarette sales have declined, but the number of people using tobacco products has remained the same for several years. According to an Oregon physicians report, tobacco-related deaths contributed to 23 percent of deaths in Oregon in 2005 (Office for Oregon Health Policy and Research 85).

The Office for Oregon Health Policy and Research report notes that it is critical to understand the dynamic nature of the uninsured to best meet their needs for coverage and access in the future. Oregon's uninsured population is made up 43 percent of adults 18 to 64 years of age who earn less than 100 percent of the federal poverty level (FPL) and 35 percent of adults who earn less than 200 percent of FPL. Sixteen percent of Oregonians are currently uninsured (Office for Oregon Health Policy and Research v). Changes in the health care system in Oregon have had significant impacts on the health care for all Oregonians, but especially on the uninsured, who are more vulnerable to systematic and economic changes. Young adults are most at risk to be without health insurance, and those without a high school diploma are four times more likely to be uninsured. Also, racial and ethnic disparities

are notable in Oregon, with Hispanic populations twice as likely to be without health insurance as their white counterparts (Office for Oregon Health Policy and Research 63). The costs of being uninsured can be high, both in terms of health and financial considerations as many people do eventually seek care in expensive acute care settings like emergency rooms.

The need for access to care for Oregon's uninsured is met by Oregon's Health Care Safety Net, instituted in 2004 by Oregon's Health Care Safety Net Policy Team. The Health Care Safety Net serves as a mechanism to provide services to Oregonians who have limited access to health care and have special circumstances that increase their vulnerability. Oregon's Health Care Safety Net includes Federally Qualified Health Centers (FQHC), Tribal Health Centers, county health departments, migrant health centers, School-Based Health Clinics (SBHC), Veteran's Administration Clinics, volunteer and free clinics, and hospital emergency departments as well as some private providers (Office for Oregon Health Policy and Research 71). The state also has a shortage of available health care providers in rural areas, but a 1998 study of primary care capacity conducted by the Office for Rural Health in 102 rural areas found that 35 percent of these areas had less than 25 percent of their primary care needs met. In contrast, only about 14 percent of the rural areas had more primary care capacity than needed (Office for Oregon Health Policy and Research 73).

History of Reform Efforts

The Oregon Health Plan

The state of Oregon has been implementing health care reforms since the 1990s in the form of the Oregon Health Plan, the Oregon Prescription Drug Program, the Medical Assistance Pool, and the Family Health Insurance Assistance Program. The changes also created an opportunity for small business and other groups to participate in public discussions about the state's health care reform efforts.

This effort was made possible in large part by former Governor, Dr. John Kitzhaber, who served as the President of the Oregon Senate at that time. Many leaders in the state have recognized that the leadership that these programs have provided the state has not eliminated the need for continued reform efforts to meet future challenges for the state's health care system. Kitzhaber recognized and publicized the notion that although it may not seem fair, health care is rationed every day. With that in mind, he encouraged Oregon to explicitly prioritize health care, and do so in a way that capitalizes on opportunities to stop paying for expensive and lower-priority procedures and to serve additional people in the system (Concannon).

Challenges identified by the Office for Oregon Health Policy and Research and others include:

- If health care cost growth rates are not curbed, the state will not be able to cover the uninsured.
- Premiums paid by the insured will continue to be negatively influenced by the costs of uncompensated care for hospitals and other acute care facilities.

- Transparency and the opportunity for consumer choice must be available in determining health care needs.
- Prevention and public health programs are vital to health care reform in Oregon.
- Disparities in income and opportunities for racial and ethnic minorities, residents of rural areas, and others must be addressed as a barrier to health care.

The most common types of health care coverage are employer-sponsored and commercial insurance; however, approximately 910,000 Oregonians are covered by Medicare, Medicaid, or both (Office for Oregon Health Policy and Research 19). Oregon's Medicaid program, the Oregon Health Plan (OHP) was a model program started in 1987, touted as first in the nation providing basic health coverage to more people by implementing a "Prioritized List of Health Services." The list was compiled by a collaboration of researchers and an outside evaluator. At the time of OHP's initiation, 18 percent of Oregon residents were uninsured and the employment rate was at 5.7 percent. The 2007 uninsured rate is 16 percent and unemployment rate is 5.2 percent (State Health Facts). Oregon applied for, and the United States Department of Health and Human Services approved, Section 1115 Waivers for the OHP Demonstration for a five-year period, beginning on February 1, 1994. It includes three key features: 1) expanded eligibility, 2) prioritization of health care benefits, and 3) managed care. The demonstration was designed to be cost effective, so that the expansions cost no additional Medicaid dollars. On September 28, 1994, additional waivers were approved to include aged, disabled, and foster care children. The waivers also allowed mental health and chemical dependency services to be included in the plan (*Medicaid State Waiver Program Demonstration Projects: General Information*).

Major components of the original OHP included:

- **Medicaid Reform:** One of the greatest reforms included an innovative approach to creating a basic benefit package that expanded public coverage to 100 percent of the FPL for families and adults, built upon a managed care system with prioritization of health services and integration of mental, physical, and dental health care services. In 2007, the OHP covers: low income adults up to 100 percent of the FPL, children (under 19 years of age) up to 185 percent of the FPL, and pregnant women up to 185 percent of FPL (Office for Oregon Health Policy and Research 21-22).
- **Insurance for Small Business:** This component created the Insurance Pool Governing Board (now called the Office of Private Health Partnerships) that was charged with encouraging private sector group health insurance with little public investment. This led to the 1997 creation of the Family Health Insurance Assistance Program (FHIAP), which offers premium subsidies for persons up to 185 percent of the FPL accessing coverage.
- **High-Risk Medical Insurance Pool:** This pool was created in 1987 by legislative action to provide health insurance to persons denied coverage due to preexisting medical conditions.
- **Employer Mandate:** The Oregon Legislature recognized that even after the implementation of the Oregon Medical Insurance Pool providing high-risk coverage many employees and their families were still left uninsured. The OHP legislation in 1989 contained language for a "pay or play" option that would require all employers to offer full-time permanent workers and their dependents with insurance and set an implementation timeline for July

of 1995. This option provided cost shifts and additional support for effectively addressing the ongoing issue of paying for uncompensated care. Due to political and leadership changes in the Legislature, implementation of the mandate for businesses was delayed, and the mandate was repealed in its entirety in 1996 after a self-imposed deadline for securing the required Congressional exemption to implement the mandate was not obtained.

In 2003, the state of Oregon faced challenges to serving residents with appropriate health care options, with a soaring unemployment rate and budget deficit. The state took advantage of the Health Insurance Flexibility Act offered through the Centers for Medicare and Medicaid Services (CMS) that encouraged new comprehensive state approaches to increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources to reevaluate and restructure the state's 1115 Waiver.

The state's changes in the program are contained in a waiver known as OHP2, which separated the Medicaid program into two benefit packages: OHP Plus and OHP Standard. The changes also moved the FHIAP, previously financed entirely by state dollars, under Medicaid so it could begin to receive federal match funding. The OHP2 program was designed to expand coverage to 185 percent of the FPL for children, pregnant women, and adults through savings accrued by implementing a leaner program for OHP Standard that serves the expansion population (adults 19 to 64 years of age up to 100 percent of the FPL). Included in the leaner OHP Standard benefit package were a decrease in benefits, co-pays, and an increase in premiums. The OHP program was adjusted as the state's budget shortfall intensified, and coverage was increased to 185 percent of the FPL for pregnant women and children, but not for adults (Office for Oregon Health Policy and Research 23).

Attempts to address budget shortfalls accounted for program changes in 2003 and 2004. In early 2003, optional Medicaid benefits for outpatient mental health and chemical dependency were eliminated for the OHP Standard population, but were reinstated in 2004. The same year, prescription drug benefits were also eliminated, then reinstated two weeks later due to public demand. The OHP standard co-payments, which were instituted in the OHP2 waiver changes, were challenged in *Spry v Thompson* in early 2003. The litigation resulted in a ruling that OHP Standard co-payments violated federal law. These were eliminated June 19, 2004, in compliance with the court order. Currently, OHP Standard operates without General Fund resources, and uses provider taxes from hospitals and managed care organizations. This program is currently closed to new enrollment as the program serves a reduced number of individuals based on availability of provider tax and premium revenue, along with federal matching funds. Several smaller adjustments have been made to the OHP Plus and Standard benefit packages regarding coverage (Office for Oregon Health Policy and Research 22, 24, 25).

Impacts of the OHP2 policy changes have been identified and the challenges experienced have informed some new reforms. The largest impact occurred due to the implementation of premiums and administrative lockout on OHP enrollment. In a study conducted by the Oregon Health Research and Evaluation Collaborative, evaluators saw enrollment in the OHP Standard benefit package drop by 80 percent from July of 2002 to July of 2006.

Premium cost was the most commonly-mentioned reason for leaving the program, but the elimination of outpatient behavioral health and chemical dependency, along with the two-week loss of prescription drug coverage was also commonly cited (Office for Oregon Health Policy and Research 31). Persons no longer served by OPH were more likely to experience a need for unmet care, skip filling a prescription, and/or access emergency department care (Office for Oregon Health Policy and Research 32).

Drivers of Reform

Oregon is on the path to making additional changes to continue to build upon the successes of the past and institute lessons learned to create a sustainable health care system for the state. Aside from small business, a strong grassroots consumer advocacy network, and needs to improve upon past successes, internal policy leadership plays a substantial role in the reform efforts. Major persons and organizations that serve as drivers of this effort include those described in this section.

Governor Ted Kulongoski (D), who has been serving the state in this capacity since 2003, has made health care reforms a top priority for his agenda in 2007. Governor Kulongoski's political career began in 1974 when serving in the Oregon House of Representatives for two terms and the Oregon Senate until 1983. Governor Kulongoski was elected to serve as Oregon's Attorney General in 1993 and aimed to reform the state's juvenile justice system. As Governor, he has focused on cutting Oregon's deficit and implementing health care reform that covers every child under the age of 19 and provides health care for all under the Healthy Kids Plan. Governor Kulongoski's agenda calls for improved health care access for all citizens of Oregon, to buy only the care that works, to improve quality of the health care workforce, and prevention. The Governor has proposed short-term solutions in the form of the Healthy Kids Plan, which would provide all children with affordable health coverage. He has also proposed to expand coverage availability to low-income families. Governor Kulongoski's long-term goals for health care reform include the guarantee of affordable health insurance for all Oregonians. He has charged the Oregon Health Policy Commission to prepare a blueprint for a sustainable system that provides access to care for every Oregonian. The Governor has noted that his priority is the Healthy Kids Plan, which he proposed to be funded through an increase of 85 cents per pack on cigarettes. If the plan is approved, the state of Oregon would subsidize health coverage on a sliding scale for children younger than 19 in families of four with a maximum income of \$70,000 and fully subsidize health care for children in families of four with annual incomes less than \$40,000. The Governor has also supported Mental Health Services Transformation for Oregon Youth and the Children's Wraparound Steering Committee.

Former Governor, Dr. John Kitzhaber (D) recently launched the Archimedes Movement, an organization that works to "create awareness about the growing health care crisis in Oregon (Archimedes Movement)." A former emergency room physician, Dr. Kitzhaber's political career started in 1978, when he was elected into one term at the Oregon State House of Representatives. In 1980, he was elected to the Oregon State Senate and in 1985 became Senate President. As Senate President, Dr. Kitzhaber was a critical player in the

implementation of the new Oregon Health Plan. This work is often noted to be the mechanism that eventually helped him win the gubernatorial election twice. Dr. Kitzhaber now serves as President of the Estes Park Institute.

The Archimedes Movement was formed in 2006. The organization's mission is "to create not only the vision for a more equitable and sustainable system but also the tension necessary for its realization (Archimedes)." According to Dr. Kitzhaber, one of the main problems with the health care system today is that it focuses on emergency care instead of preventive care and that there is a need for greater comprehensive reforms. The Archimedes Movement encourages health care to focus more on health promotion, disease prevention, wellness, and health education. During the 2007 session, the Archimedes Movement has concentrated advocacy efforts on supporting the Oregon Better Health Act (Senate Bill 27). This bill would allow Oregon to receive exemptions from the federal government to use federal and state dollars to fund programs that the state determines to be the highest priority, providing a "core benefit" of essential health care services to Oregon residents.

The Office for Oregon Health Policy and Research (OHPR) provides analysis, technical, and policy support to the Governor and Legislature on issues relating to health care costs, utilization, quality, and access, and serves as the policy making body for the Oregon Health Plan. The Office for Oregon Health Policy and Research also provides staff support to the Oregon Health Policy Commission, the Health Resources Commission, the Health Services Commission, the Advisory Committee on Physician Credentialing, and the Medicaid Advisory Committee.

The Oregon Legislature in 2003 passed House Bill 3653, creating the Oregon Health Policy Commission (OHPC), to develop and oversee health policy planning for the state. The Commission identifies and analyzes health care issues affecting the state and makes policy recommendations to the Governor and Legislature. The Commission partners with health care experts and stakeholders around the state to develop projects focused on improving Oregonians' health status and access to effective and efficient health care services.

Oregon Legislators have been key drivers in recent reform efforts. Senator Alan Bates (D) serves as the Oregon Senate's Special Committee on Health Care Reform Chair, Chair of the Senate Interim Commission on Health Care Access and Affordability, and the Senate Majority Whip. Senator Ben Westlund (D) serves as Chair of the Oregon Senate's Special Committee on Health Care Reform. Senator Bates and Senator Westlund are co-sponsors of Senate Bill 329, which establishes the Oregon Health Fund program. In support of SB 329, the Senators held 21 town hall meetings throughout the state during the month of March. The **Hope for a Healthy Oregon Tour** engaged Oregonians who shared their ideas, concerns, and experiences about Oregon's health care system.

The Northwest Health Foundation funds projects and engages in issues related to health and health care. The Foundation also supports the Oregon Health Reform Collaborative, which is convened jointly along with the Oregon Health Policy Commission (OHPC).

The Oregon Health Reform Collaborative has been meeting since February 2006 to find ways to support each other's efforts and enter the legislative session with a common vision and message. The Oregon Health Reform Collaborative released a *Report to Legislators and a Consensus Statement on Health Reform*, which has been endorsed by a number of Oregon organizations that are collaborating on the issue of health care reform.

The Office for Oregon Health Policy and Research (OHPR), under its Robert Wood Johnson Foundation State Coverage Initiatives Grant, brought together state agencies and researchers in December of 2002, to form the Oregon Health Research and Evaluation Collaborative (OHREC). The OHREC is a statewide organization that includes health services researchers from Oregon's distinguished universities and state and county agencies, as well as representatives of managed care, behavioral health and advocacy organizations, hospital systems, and a variety of other stakeholders.

The Oregon Business Council (OBC) is made up of over forty business executives that focus efforts on a variety of public issues. The OBC is a nonpartisan and independent organization, and its policy agenda is broader than the interests of individual businesses or industries. Since it was founded, OBC has worked on a variety of issues related to business, and has recently weighed in on health care reform discussions. In the OBC's report, *A New Vision For Healthcare: Draft White Paper*, short-term recommendations for Oregon's health care system are identified. Recommendations include noting the importance of access, restructuring the entire system to accommodate access, and for all the stakeholders – consumers, employers, providers, health plans, and government – to collaborate and work within their defined roles and responsibilities. The white paper also recommends the health care system be privately delivered and to create steps in order to fix the system entirely in the long term. The OBC's final recommendation is that businesses drive improvements because they are the primary purchaser of benefits (Oregon Business Council).

Recent Reform Efforts

In the last year, incremental reform efforts have been implemented, and the Legislature, expected to adjourn in July, has been working diligently to process Commission reports and legislation that has been introduced to reform Oregon's health care system.

Oregon began enrolling participants in its new prescription drug program at the end of 2006. This program provides discounts to all state residents who lack prescription drug coverage and is projected to cover about 600,000 state residents. It was approved by a 77 to 23 percent margin. Current reform efforts in Oregon have been fueled by the release of commission reports, by a variety of stakeholders, and by the introduction of several pieces of legislation aimed at overhauling Oregon's health care system.

The Oregon Health Policy Commission identifies and analyzes significant health care issues affecting the state and makes policy recommendations to the Governor, the Oregon State Legislature, and the state Office for Oregon Health Policy and Research. In the *Road Map for Health Care Reform: Creating a High-Value, Affordable Health Care System*, the

Oregon Health Policy Commission outlines recommendations for state health care reform. Recommendations include:

- State-driven public-private collaboration on value-based purchasing, managing for quality, and increased transparency;
- Development of widespread and sharable electronic health records;
- Improvements to health care safety;
- Establishment of a medical home for every Oregonian; and
- Support for community-based innovations that align resources for more cost-effective, higher quality care (Oregon Health Policy Commission).

The Oregon Legislature, noting the importance of health care reform efforts in the state, convened two legislative committees: the Special Committee on Health Care Reform and the Interim Commission on Health Care Access and Affordability. Both work to study the health care reform efforts for the state. During the legislative session, several bills related to health care reform have garnered attention.

SB 362 – Expands list of individuals and entities that may participate in Oregon Prescription Drug Program. Requires Joint Legislative Audit Committee to evaluate and report on effectiveness of program.

Current Status: Signed into law by the Governor

SB 426 – Establishes the Oregon Educators Benefit Board to contract for health and dental benefit plans and other benefits for employees of certain school districts, education service districts, and community college districts.

Current Status: Signed into law by the Governor

SB 27 – At the request of the Archimedes Movement, this bill creates The Oregon Health Fund to pool state and federal expenditures for health care and to finance treatment of a defined set of essential health conditions. This bill also restructures the Health Services Commission and imposes new criteria for developing a prioritized list of health conditions.

Current Status: Referred to Health Care Reform and Ways and Means Committees
(As of 5/24/07)

HB 3368 – Creates the Health Insurance Exchange Corporation to purchase affordable health care and to work with insurers and other medical providers to develop health insurance packages that manage care, quality, and cost. This bill requires the Department of Human Services to seek federal approval to increase the income limits for Oregon Health Plan and Family Health Insurance Assistance Program coverage of children under age 19.

Current Status: Referred to Health Care, Revenue and Ways and Means Committees
(As of 5/24/07)

SB 329 – Establishes Oregon Health Fund program and requires board to adopt enrollment procedures, contract with health plans licensed to transact business in state to provide coverage, and issue Oregon Health Card to program participant. This bill also requires the board to establish procedures to assist cardholders who choose to execute advance directives and to establish a registry of advance directives.

Current Status: Referred to Health Care and Ways and Means Committees (As of 5/24/07)

HB 2201 – Creates Oregon Healthy Kids Program, which includes private health option to provide health care coverage to children. Increases taxes on cigarette and other tobacco products.

Current Status: Failed to Pass by Three-Fifths Majority

Challenges

Jeanene Smith, Administrator of the Office for Oregon Health Policy and Research outlined the challenges and possible solutions that Oregon is considering at this time. Oregon faces several challenges as it continues approaching health care reform. Governor Kulongoski's Healthy Kids Plan will continue to be a priority, although failure to pass the cigarette tax leaves the plan possibly without a funding mechanism. The Governor has indicated that he believes that covering uninsured children is the first step in reforming Oregon's health care system. In terms of the reform effort overall, many stakeholders had hoped for reform implementation in 2007 rather than planning for future reforms. Proponents of the planning have argued for the necessity of cost analysis when making funding decisions (Smith). Federal budget cuts in entitlement and discretionary spending have also proven to be challenging as Oregon continues to look for ways to maximize opportunities to leverage federal dollars to increase access to care.

The federal Deficit Reduction Act (DRA) of 2005 required Oregon to make adjustments to OHP, but, in some cases, provided flexibility to states in the design of their Medicaid programs. Oregon has made necessary adjustments in the OHP to meet compliance, which has affected the OHP and how services are delivered. A graphic representation of the changes is available in the Office for Oregon Health Policy and in the *Research Trends in Oregon's Health Care Market and the Oregon Health Plan* report.

Implementation Progress and Next Steps

Next steps in the process of planning for and implementing health care reform include more detailed planning and greater collaboration with businesses, provider associations, and policymakers (Smith). Groups like Regence Blue Cross Blue Shield of Oregon and the Oregon Medical Association have shown interest in changing how health care is delivered, and will continue to play an active role in those discussions (Kettler). Policymakers will also study the Office for Oregon Health Policy and Research report's recommendations as part of an ongoing planning process. Finally, the Senate Interim Commission on Health Care Access and Affordability will continue to meet after the close of the 2007 legislative session, and will submit a report during a short session in February 2008.

Works Cited

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List of Resources

Oregon Legislature
<http://www.leg.state.or.us/>

Former Governor Dr. John Kitzhaber and the Archimedes Movement
<http://johnkitzhaber.org/>

<http://wecandobetter.org>

Hope for a Healthy Oregon
<http://www.hopeforahealthyoregon.com/home.php>

Northwest Health Foundation
<http://www.nwhf.org/>

Office for Oregon Health Policy and Research
<http://www.oregon.gov/DAS/OHPPR/OHREC/index.shtml>

Office for Oregon Health Policy and Research: Trends in Oregon's Healthcare Market and the Oregon Health Plan
http://oregon.gov/DAS/OHPPR/RSCH/docs/LegRpt2007_Final.pdf

Oregon Business Council
<http://www.orbusinesscouncil.org/about.html>

Oregon Governor, Ted Kulongoski
<http://governor.oregon.gov/Gov/index.shtml>

Oregon Governor's Healthy Kids Plan
<http://governor.oregon.gov/Gov/sos2006/kids.shtml>

The Oregon Health Plan: Prioritized List of Health Services
<http://www.oregon.gov/DHS/healthplan/priorlist/main.shtml>

Oregon Health Policy Commission Report
<http://www.oregon.gov/DAS/OHPPR/HPC/docs/2007/roadmapreformdraft.pdf>

Oregon Health Reform Collaborative
<http://www.oregonhealthreform.org/>

Oregon Health Research and Evaluation Collaborative
<http://www.oregon.gov/DAS/OHPPR/OHREC/index.shtml>

Oregon's Health Care Safety Net
<http://egov.oregon.gov/DAS/OHPPR/SNAC/SNACWelcomePage.shtml>

Focus: Tennessee

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
6,038,803	13%	18%	9%	49%	5%	17%	13%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Introduction and Background

The State of Tennessee has had the distinction of being somewhat of an experiment in state health care coverage initiatives. First, it was a pioneer in providing health insurance coverage to a diverse population of low-income citizens. As one of the first states to implement major health care reform, the state's many problems in managing an eventually unwieldy program were in the national spotlight. Now, while still under public scrutiny, both at home and across the country, Tennessee is forging ahead with further major, comprehensive reform efforts.

TennCare, the state's health insurance program, was implemented in 1994 to offer benefits to the state's uninsured population. In the early nineties, like many states, Tennessee faced the major problems of a large population of uninsured persons and a fast-increasing Medicaid budget. With a wildly successful start, the program was underprepared for a number of barriers to its long-term success. Perhaps nearly as difficult to overcome as any administrative or fiscal barrier has been the highly politicized debate over TennCare for the last several years.

There are currently more than 800,000 uninsured Tennesseans, according to the US Census Bureau's American Community Survey in March of 2006. Fifty-three percent of the uninsured work for firms with 25 or fewer employees, according to a Tennessee Department of Commerce and Insurance Survey in December of 2005. The same survey found that 58 percent of uninsured families earn less than \$30,000 a year, and that 83 percent of the working uninsured hold permanent, full-time positions. The survey also found that eighty percent of the uninsured do not buy health insurance because they cannot afford it.

TennCare's Beginnings and Challenges

To launch the program, Tennessee received one of the nation's first 1115 Waivers from the Centers for Medicare and Medicaid and Services (CMS). The purpose of the CMS waivers is to provide states maximum flexibility for insuring citizens as long as the new program is cost-neutral to the federal government. One of TennCare's main innovations was the use of managed care organizations (MCOs)—a new development for Tennessee at that time. It was believed that efficiencies achieved under aggressively managed care would allow the state to cover more people.

The program was so successful in its first four years that it was used as one of the models for the development of the federal State Children's Health Insurance Program (SCHIP). One of its biggest successes was in covering "expansion" populations, or those who do not qualify for Medicaid under traditional criteria, including those whose incomes exceed Medicaid eligibility guidelines, but are considered medically uninsurable. This population is quite expensive to insure.

Despite early successes, TennCare found itself struggling against a number of problems as the years went on. First, significant inflation of health care costs contributed to the program's fiscal shortfall of hundreds of millions dollars in its fourth and fifth years. Second, like any new program of this magnitude, TennCare began with a bumpy start, but its speedy implementation uncovered more problems. Some critics claimed that actuarial errors made prior to implementation were to blame, or that smaller changes made over different gubernatorial administrations were not well-coordinated; others faulted the untested MCO system and alleged that people were enrolling in the program fraudulently (Hale). For many of these reasons, the program quickly became more expensive to the state than anticipated. Eventually, TennCare consumed one-third of the State's budget (Vock par. 25).

At the same time, larger administrative and legal problems began to plague the program. A rapid succession of directors of the program over three administrations contributed to a lack of continuity. Numerous difficulties with the MCOs resulted in the largest MCO pulling out of the system. Among these difficulties were financial problems developing within some MCOs as a result of "unlimited" benefits to some participants in TennCare. The State had begun the system with capitation rates per participant that MCOs found inadequate if clients had a high rate of accessing services. In response, MCOs began their own cost-saving measures, and citizens and advocacy groups began to voice very loud opposition to the denial of benefits, denial of enrollment, and disenrollment by MCOs, arguing that they deprived participants of due process. Participation of physicians and hospitals began to drop off as many lost trust in the system's ability to efficiently pay providers. Capitation rates were eventually replaced with risk pools in order to remove MCOs' motivation to secure cost savings by reducing benefits or enrollments (Hale).

Two issues related to benefits also greatly increased costs: prescription drugs and mental health service delivery issues. Tennessee has one of the nation's highest rates of prescription drug utilization. This fact, coupled with inflation, by which prescription drug costs were increasing by 20-30% each year, led Tennessee to limit TennCare participants to five drugs.

Secondly, mental health services began as integrated with other TennCare benefits, then were carved out. As MCOs struggled with capitation rates, access to mental health services suffered. Advocates in Tennessee continue to work to establish mental health parity.

A notable crisis point for TennCare was the approval of a series of consent decrees, whereby courts sided with plaintiffs who alleged that the TennCare program and, specifically, MCOs deprived them of notice and appeal rights when particular benefits were denied. One of the most far-reaching of these is *John B. vs. Goetz*, where the consent decree is used to enforce federal laws, “including principally the early and periodic screening, diagnosis and treatment (EPSDT) mandate that guarantees all Medicaid-covered children access to any medically necessary medical or mental health service” (Bonnyman 1). Consent decrees related to TennCare are what many say were the impetus for reform of the system.

Reform Efforts

TennCare has seen many smaller reform efforts, but the largest was a major retrenchment in the last two years. Nearly two hundred thousand Tennesseans were disenrolled from the program, and the Governor proposed an overhauled program, Cover Tennessee. The State was granted a demonstration amendment approval on March 24, 2005 to disenroll 323,000 individuals in optional and expansion groups (Centers for Medicare and Medicaid Services). That year, Governor Phil Bredesen had to cut 170,000 enrollees from the TennCare program because of perennial budget overruns, calling the program “too expensive, too rigid, too hard to control” (Vock par. 25). Concurrent with a major outcry from the public and advocacy groups, the State has been both redesigning its program and working to manage bad publicity.

Cover Tennessee

In 2006, Tennessee Governor Bredesen signed legislation that is designed to improve access and health care outcomes for Tennessee residents, with hopes to provide coverage to 600,000 of the state’s 800,000 uninsured. The Governor, a former health care executive, intends to emphasize personal responsibility for health with his Cover Tennessee initiative, including such measures as reduced premiums for quitting smoking or losing weight.

Cover Tennessee does not replace TennCare, but operates alongside it, meeting different needs. TennCare currently operates as two programs. TennCare Medicaid serves persons who are Medicaid eligible, and TennCare Standard serves persons who are not Medicaid eligible but who have been determined to meet the state’s criteria as being either uninsured or uninsurable (i.e., having severe chronic illness or pre-existing conditions). Historically, individuals in both programs have received the same services. However, TennCare Standard enrollees with family incomes at or above the federal poverty level (FPL) are required to pay premiums and copays (Bureau of Tenn Care). Cover Tennessee is a different set of programs that does not cover the Medicaid population.

According to a presentation about the program prepared by the Governor's Office, Cover Tennessee has five components, including three different insurance programs:

CoverKids is a comprehensive health insurance program for Tennessee children 18 and under whose family incomes fall below 250 percent of the federal poverty level (\$51,625 for a family of four.) Enrollees must be US citizens or legal residents who have gone without health insurance for at least three months. They cannot be eligible for other state programs like TennCare. Pregnant women and infants are also eligible for this program, which emphasizes wellness and prevention by funding immunizations and well-child exams. CoverKids went into effect in April 2007.

AccessTN is the state's high risk health insurance pool. It provides health insurance to Tennessee's chronically ill and medically uninsurable adults. There are no income or asset limits for people enrolled in this program, but enrollees must have been denied insurance for at least six months because of a preexisting condition. Enrollees must have resided in Tennessee for six months, and be US citizens or legal residents. The benefits offered in the AccessTN option are modeled after the state employees health insurance plan.

AccessTN offers three deductibles: \$1,000; \$2,500, which enrollees can use with a Health Savings Account; and, \$5,000. Premiums are capped at 1.5 to 2 times market rates, ranging from \$270 to \$1,160 per month. Premiums will vary based upon the type of coverage plan selected, age, tobacco use, and obesity status. AccessTN will be funded through a variety of funding sources. Premiums will cover 60 percent of the amount it costs to insure an individual. A state subsidy and an assessment on the insurance industry will cover the rest. AccessTN began in the first quarter of 2007.

CoverTN is affordable, portable health insurance coverage for employees of small businesses with 25 or fewer employees. In time, the Governor hopes that CoverTN can be expanded to firms with 50 or fewer employees. Under this program, employers must provide coverage to all employees and pay one-third of each employee's premium. Tennessee employers can choose to pay the employee's and spouse's share of the premium, but are not obligated to. Through CoverTN, an employee's monthly premium ranges from \$34 to \$99, depending upon their age, tobacco use, and whether or not they are obese. Enrollment in CoverTN began in November 2006.

For employers to be eligible for CoverTN, at least half of all employees must earn \$41,000 or less. Costs for employers are contained by limiting, rather than excluding services. Mental health services are covered under CoverTN. There are no deductibles under CoverTN, but there are co-pays, ranging from \$15 to \$20 for doctor and outpatient hospital visits, \$10 to \$25 for prescription drugs, and \$100 for emergency room visits. Insurance plans purchased under CoverTN are owned by the employee; they are portable if the individual changes jobs or if the individual becomes unemployed for a brief time.

CoverRX is not an insurance program. Rather, it provides access to prescription drugs for Tennesseans without pharmacy coverage. It offers access to more than 200 generic drugs, including mental health drugs. CoverRX also covers insulin and diabetic supplies.

To participate in Cover RX, participants must:

- Be age 19 to 64
- Reside in Tennessee for at least six months
- Be a US citizen or legal resident
- Have an income at or below 250 percent of the federal poverty level (\$51,625 for a family of four).

Individuals who participated in Tennessee's Mental Health Safety Net program were enrolled in December 2006, and open enrollment/participation began in January 2007.

Project DIABETES is an awareness campaign combined with programs designed to improve the health of Tennesseans. In GetFitTN, Governor Bredesen has recruited community leaders to improve community awareness and promote healthier lifestyle choices. Six million dollars in grants will be awarded to providers for education, prevention and treatment of Type Two diabetes and obesity. The Tennessee Legislature has also appropriated \$8 million in 2007 for the statewide expansion of a Coordinated School Health Program, which is designed to improve students' eating and exercise habits. In 2008 and 2009, this appropriation is expanded to \$15 million annually.

Most Current Reforms

Tennessee's health care reform effort has been almost exclusively led by the Governor's Office. Not only that, with the passage of legislation to create Cover Tennessee last year, the Legislature had relatively little to do related to health care in 2007. The Tennessee Legislature is still in session (as of 5/24/07), and the majority of legislation introduced around health care reform this year has centered on improving efficiency and reducing fraud and waste. An example follows:

- HB2273 / SB2226 TennCare – Removes requirement that state agrees to reimburse third party payor for medical services for reasonable costs incurred in conducting search of database for name of TennCare enrollee; increases period during which recipient of medical assistance for poor cannot transfer property to make recipient eligible for such assistance from three years to five years.

Current Status: Sent to Governor for Signature as of 5/23/07

Key Players

Over its embattled history, TennCare has had a number of key players. However, central to the current reform efforts have been Governor Phil Bredesen and the Tennessee Justice Center. Having campaigned on the notion that, as a former health care executive, he could "fix TennCare," expectations of the Governor were high when he took office. Though Governor Bredesen was perhaps better prepared to do battle with the MCOs than his predecessors were, some say it was the experience of sitting face to face with attorneys from the Tennessee Justice Center, who represented several plaintiffs in consent decree cases, that made him realize the severe limitations of the old system (Bouldin). The Governor personally

worked in negotiation with advocacy organizations to modify consent decrees to allow important changes in policy.

With his highly unpopular decision to disenroll thousands of Tennesseans from TennCare and create a new plan, Governor Bredesen faced continued scrutiny from other state and national advocacy organizations as well, such as the Tennessee Health Care Campaign and Families USA. Even government officials and insiders in the TennCare system credit these powerful advocacy organizations with bringing transparency and important research to bear on the issues, as well as putting a face on the uninsured in Tennessee. The Governor also relied on other key players for technical assistance in developing Cover Tennessee. First, he vetted specific benefit and cost information with major MCOs, like Blue Cross Blue Shield of Tennessee. Secondly, he tapped into the expertise of the State Insurance Division, who administers the state employees' health insurance plan.

Challenges for TennCare and Cover Tennessee

Having already faced so many challenges, Tennessee's state health care system is moving ahead to confront more. Regaining public trust will be, perhaps, the most difficult of these, but the Governor and TennCare officials have pledged a commitment to efficiency and fairness in administering health care coverage to eligible Tennesseans. It is hoped that the success of Cover Tennessee will help to rebuild the image of Tennessee's health care system as a national model once again.

Further challenges include rebalancing the system to be less dependent on the large amounts of federal matching funds TennCare once brought in under its expansion populations and continuing to manage its relationship with MCOs. Changing dynamics in the MCO marketplace highlight the need for an effective plan for communication and management of the state's MCOs.

Another important challenge lies ahead for Cover Tennessee: how to populate the program's rolls. Ron Harr, Senior Vice President of Government Programs and Public Affairs at Blue Cross Blue Shield of Tennessee, says, "The big question is, 'Will people buy in to Cover Tennessee in sufficient numbers to make it work?' We may need to retrain people who are used to getting coverage at no cost. We all really worked to design a program that provides low-cost benefits to help people get started."

Summary and Next Steps

At this point, still recovering from the problems of TennCare and early into the implementation of Cover Tennessee, the State is in a period of extremely cautious optimism. Among other things to figure out over the next year is an appropriate governance body and infrastructure for Cover Tennessee. Both the Bureau of TennCare and Cover Tennessee are currently housed within the state Department of Finance and Administration. As the

infrastructure for Cover Tennessee is developed, policymakers will need to ensure that transparency, communication, and effective stewardship of public funds are high priorities (Bouldin). AccessTN has a statute-created Board that will provide oversight.

The state is also in current negotiations with CMS about the extension of its 1115 Waiver. Finalization of that extension will allow other work to progress, including moving the state's long-term care system into one that reduces or eliminates institutional bias.

Like many states, Tennessee is looking at ways to move persons with disabilities and elder Tennesseans out of long-term care facilities and into home and community-based settings (HCBS). One way to shepherd this effort is a legislative proposal for the coming year to make the state's Commission on Aging and Disability into a state Department with some executive authority. Tennessee is currently using about 1,300 slots in its HCBS waiver program, and could be serving about 2,000 more under its current program. Bids for regional managed care providers will need to address how the MCO will use innovation to move elderly and disabled Tennesseans into home and community-based programs. TennCare is also looking at adding back in a program it cut a few years back: the medically needy spend-down program (Bouldin).

Tennessee's experience with TennCare and its development of the Cover Tennessee reform provide policymakers and advocates across the country with a wealth of opportunities to learn what works and what does not work. As a large experiment in public policy, TennCare held great promise as an equalizer, providing poor Tennesseans with health care coverage. For many, it was the first time in their lives they could seek needed medical care without fear of overwhelming costs. However, due to a number of complex problems, the promise of access to affordable health care was short-lived for many. The human costs of TennCare's near implosion have been severe. With the advent of Cover Tennessee, health care advocates and policymakers in "The Volunteer State" forge ahead, again as pioneers in health care reform, with the spirit of fairness, innovation, and determination.

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Bouldin, Ryan. Tennessee General Assembly, TennCare Oversight Committee. Personal interview. 24 May 2007.

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Harr, Ron. Blue Cross Blue Shield of Tennessee. Personal interview 25 May 2007.

Office of the Governor. State of Tennessee. “Cover Tennessee: Common Sense Health Coverage for Uninsured Tennesseans.” http://www.covertn.gov/pp_overview.pdf
Accessed 15 May 2007.

Resources

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Tennessee General Assembly and TennCare Oversight Committee
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Governor Phil Bredeson’s Priorities—Health Care:
http://www.tennesseeanytime.org/governor/TennCare.do;jsessionid=n_X8U4kX2wcishU6kr

TennCare Time Line
<http://state.tn.us/tenncare/news/TCoverview/TCtimeline1.htm>

Tennessee’s Bureau of TennCare
<http://state.tn.us/tenncare/index.htm>

Tennessee Justice Center
<http://www.tnjustice.org/>

Tennessee Health Care Campaign
<http://www.tenncare.org/index.html>

“Unwilling Volunteers: Tennesseans Forced Out of Health Care”
<http://www.familiesusa.org/tenncare-report.html>

Summary of State-Based Reforms

Alabama

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
4,599,030	14%	19%	6%	54%	3%	15%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The state of Alabama was already one of the poorest areas in the United States before Hurricane Katrina hit on August 25, 2005. Compared to Iowa and other states, Alabama already had significantly higher amounts of nonelderly Medicaid enrollees at 5 percent, compared with the national average of 1.6 percent. The devastation of Hurricane Katrina compounded the health care needs of the communities and significantly increased the number of Medicaid uninsured individuals. Alabama has made changes in the Senior Rx Program in the last year, concentrating on increasing the affordability of prescription medication.

In a speech delivered March 6, 2007 Alabama Governor, Bob Riley (R) proposed a bill allowing small businesses to deduct twice the amount they pay for health insurance premiums from their taxes, while allowing small business' employees to deduct twice the amount they contribute toward their health insurance. The Governor also proposed a plan designed to help Alabama residents with nonprescription medicine costs and suggested elimination of sales tax on all over-the-counter medicines.

The Alabama Senate has experienced little movement during the current session, which is set to adjourn the last week of May 2007, creating some speculation that a special session may be required to complete passage of the budget. A bill proposed by Representative Love (R) would have provided tax deductions for health insurance purchases, supported by funds diverted from the Alabama Education Trust Fund. Due to this funding, interest in education funding has slowed the progress of this bill.

Additionally, a bill aimed at creating a Joint Legislative Health Care Committee has been filed. Also, a bill has been introduced proposing that a health care provider may charge an uninsured individual no more than the amount Medicaid would pay for that same service. A bill allowing certain qualifying small businesses to deduct enhanced amounts for expenses

related to health insurance premiums has been introduced. Finally, a bill qualifying employees would be allowed to deduct certain amounts they contribute toward their health insurance premiums has been introduced in the House, but not assigned to a committee.

2007 Legislation and Study Efforts

HJR 176- Created the Health Information Technology Partnership to study all facets of health information technology in order to improve the quality and reduce the cost of health care through the integration of such technologies.

Current status: Enacted (Act 07-171)

Resources

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Alabama Legislature
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Alabama Governor Bob Riley
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Legislative Services Office
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Alaska

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
670,053	17%	22%	9%	52%	4%	16%	6%	5%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Alaska spent over \$5 billion on health care in 2005, with spending rising faster than any other state. About half of the state's private company workers obtain health coverage through their employer. Seventeen percent of Alaskans remain uninsured. The Alaska Health Care Roundtable, a consortium of Alaska corporations, health care organizations, and health care stakeholders cites unique lifestyle challenges, uneven access to care, and greater rural to urban disparity, as major health care issues facing Alaska. Business leaders have expressed concern that health care costs make the state's labor force more expensive, which places Alaska at a competitive business disadvantage. Alaska's increasing obesity and diabetes are causes of concern for Alaska policymakers.

Alaska also has fewer physicians than it needs to provide residents with the same level of care that is available for patients in other parts of the United States. Alaska has been experiencing a physician shortage for several years and an expanding elderly population further exacerbates the issue of access to care. The additional challenges of administering care in remote regions and the high risk of Alaska's logging and fishing industries make practicing medicine in Alaska more expensive.

By executive order, Governor Sarah Palin (R) created the Alaska Health Care Strategies Planning Council in the Office of the Governor on February 13, 2007. The Council will advise the Governor and the Legislature on ways to effectively provide access to quality health care and to help reduce the costs of health care for Alaskans. Governor Palin also proposed adjustments to the SeniorCare Program, which did not pass out of committee.

One of the most controversial policies up for debate during the session was an adjustment to the Senior Longevity Bonus Program. The Program at one point provided all Alaskans over age 65 with a \$250 monthly stipend. In the early 1990s the Legislature passed a law

phasing out the program. This program was repealed in its entirety by HB 198 during a midnight vote in the last few days of the session.

The Legislature adjourned May 16, 2007 from the first half of a two-year session. All legislation that has been introduced is considered active and viable even if it has not yet been passed out of a committee. Current legislation not passed out of a committee includes the establishment of a Prescription Drug Task Force, discounting prescription drugs through a purchasing pool, establishing an Alaska health care program to ensure insurance coverage for essential health services for all residents of the state, and establishing an integrated statewide health-related information and referral system. The state is also facing budget shortfalls in its State Children's Health Insurance Program, Denali KidCare. Legislation has been introduced to increase eligibility and encourage Alaska's Congressional delegation to support increased funding for the program.

2007 Legislation and Study Efforts

SB 27 – An Act relating to expanding eligibility for medical assistance for certain children, pregnant women, and persons in medical or intermediate care facilities.

Current Status: Sent to the Governor for Signature

HB 198 – This bill establishes the Alaska Senior Assistance Program to provide cash assistance payments to low-income Alaska seniors. This bill removes the current prescription benefits and increases the monthly cash payments to individuals who are 65 years of age or older. The new Alaska Senior Assistance Program in this bill repeals the SeniorCare and Longevity Bonus Payments programs.

Current Status: Passed Social Services Committee, Passed Finance Committee, Referred to Rules Committee, Session Adjourned

SB 4 – This bill extends the cash assistance benefit program for seniors under the senior care program and increasing the benefit amount; amending medical income eligibility provisions for persons less than 19 years of age and for pregnant women.

Current Status: Passed Social Services Committee, Referred to Finance Committee, Session Adjourned

SB 87 – This bill will expand the eligibility requirements for Denali KidCare to 200 percent of the federal poverty level and offer a co-pay option for children and pregnant women on a sliding scale who are in between 201 percent and 350 percent of the federal poverty level.

Current Status: Passed Social Services Committee, Referred to Finance Committee, Session Adjourned

HB 148 – This bill relates to the SeniorCare program as established by the Department of Health and Social Services to provide cash assistance benefits. To be eligible for cash assistance, an individual must meet certain provisions; be 65 years of age or older, be a resident of the state, have a household income that does not exceed 135 percent of the federal poverty level guidelines in Alaska, and may not be receiving a longevity bonus payment.

Current Status: Passed Social Services Committee, Referred to Finance Committee, Session Adjourned

Alaska Health Care Strategies Planning Council – Governor Palin signed the Administrative Order 232, which establishes the Alaska Health Care Strategies Planning Council to develop a statewide plan which will identify short-term and long-term strategies to effectively address issues of access to, cost and quality of health care for Alaskans. The Council will prepare a health care action plan for the Governor and the Legislature by January 1, 2008.

Advisory Committee on Public Reporting of Health Care Associated Infections – Proposed: An Act establishing the Advisory Committee on Public Reporting of Health Care Associated Infections; relating to reporting and dissemination of data concerning health care associated infections. This establishes the Advisory Committee on Public Reporting of Health Care Associated Infections to develop specific recommendations for the type of data to be collected, the mechanisms for data collection, and the optimal system for synthesizing and disseminating data in a manner useful to all Alaska health care consumers. This will enable patients to make more informed choices about their health care and will improve overall health care quality.

Resources

Legislative/Public Information Office

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Websites

Alaska State Legislature
<http://w3.legis.state.ak.us/home.htm>

Alaska Governor
<http://www.gov.state.ak.us/>

Alaska Health Care Roundtable
<http://www.commonwealthnorth.org/roundtable/roundtable.html>

Alaska Health Commissioner
<http://www.hss.state.ak.us/commissioner/jackson.htm>

Alaska Legislative Information Office
<http://w3.legis.state.ak.us/legaff/liolist.htm>

Arizona

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
6,166,318	18%	23%	16%	47%	5%	16%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Since the 1980s, Arizona's Medicaid system, called the Cost Containment System, has provided services for Arizona residents. This system was used as a model for other states and employs more restrictive coverage at a capitalized rate. Most care in Arizona is provided by private insurance companies.

The citizens of Arizona passed Proposition 203 in November of 2006, which increased the state cigarette tax from \$1.18 per pack to \$1.98 per pack to fund health and education programs for children five years and younger.

In 2006, the Arizona Legislature approved a measure that continued funding for KidsCare Parents, the state's insurance program for parents of children with SCHIP coverage. The adjustments required participants to pay a higher monthly premium for families with annual incomes between 100-200 percent of the federal poverty level.

Although discussions among leaders indicated an interest in health care reform in 2007, the Arizona Legislature and Governor did not align priorities for health reform and the state took little action. The Healthcare Group of Arizona, a state sponsored plan, received attention in 2007 by requesting \$8 million in state funds to continue providing coverage for 25,000 residents that are self-employed or work for businesses with fewer than five employees. This program is considered Arizona's high-risk care provider. Supporters cited the need for additional regulation and oversight of the program in order to pay future claims.

Comprehensive health care legislation was introduced in the 2007 session, which adjourned April 21st. Leaders dismissed the legislation as not providing meaningful solutions. Legislation to allow health insurance companies to exclude minimum coverage requirements had little impact on coverage for low-income Arizona residents.

2007 Legislation and Study Efforts

SB 1184 – Makes changes to numerous provisions related to Medicaid special treatment trusts (STTs), including the reimbursement of services provided by financially responsible relatives, outlining circumstances in which the Arizona Health Care Cost Containment System (AHCCCS) Administration waives its right as a trust beneficiary, and the procedures for handling violations of terms of trust.

Current Status: Signed into law by the Governor

HF 2757 – Allows health insurance companies to offer individual, basic health insurance policies that exclude some minimum coverage requirements.

Current Status: Passed Senate Rules Committee, Referred to Senate Health Committee, Session Adjourned

Resources

Legislative/Public Information Office

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Websites

Arizona Legislature
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Arizona Health Care Cost Containment System
<http://www.ahcccs.state.az.us/site/>

Arizona Legislative Council
<Http://www.azleg.gov/council/>

Arkansas

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
2,810,972	17%	24%	9%	47%	6%	15%	14%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Arkansas has more than 400,000 uninsured residents, and 72 percent of households have at least one full-time worker. Arkansas also has 26 percent of companies with fewer than 50 workers that offer a health benefit to their employees. In 2006, Arkansas secured a Federal waiver that launched an employer-based health insurance program that is set to provide health insurance for 80,000 low-income Arkansas residents. This program will require employers who participate to guarantee that all employees will receive coverage regardless of income. This program would cover six physician visits, seven days of inpatient hospital care, two outpatient hospital procedures or emergency department visits, and two monthly prescriptions. The program is set to be funded with proceeds from the 1998 Tobacco Settlement. A major driver of this reform was former Governor Mike Huckabee (R), who noted that almost half of the workers in Arkansas work for companies that have fewer than 100 employees.

In 2006, the state launched Arkansas Rx, a prescription drug discount program designed to pool prescription purchases for uninsured state residents. After assessing interest in the program, the Arkansas Department of Health and Human Services chose to cancel the program, due to lack of interest.

Arkansas Governor Mike Beebe (D) concentrated his 2007 Legislative Agenda on education and highways, but has indicated that health care will be at the top of his office's 2008 Agenda. Legislation related to health care called for technical changes to state-sponsored health plans and did not include significant reform. Several task forces were created to study possible changes to Arkansas' health care system in the next few years. The legislature discussed the reorganization of the children's mental health system in Arkansas, but has not formalized plans for this work. Senate Speaker Pro Tempore Jack Chritchler (D) and former Representative Jay Bradford (D) have been leaders in health reform efforts in Arkansas. The Arkansas Legislature formally adjourned May 1, 2007.

2007 Legislation and Study Efforts

Act # 842 – An Act to Create an Arkansas HIV-AIDS Minority Task Force and to Coordinate Statewide Efforts to Combat the Debilitating Effects of HIV-AIDS on Minority Arkansans. This Task Force will work to raise public awareness of the gravity of HIV-AIDS in minority communities in Arkansas. The Task Force was created in recognition that there needs to be more community-based organizations to intervene, prevent, and reduce the spread of HIV-AIDS. This Task Force will end December 31, 2015.

Current Status: Implemented April 3, 2007

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Arkansas Legislature
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Arkansas Department of Health and Human Services
<http://www.healtharkansas.com/>

Arkansas Governor
<http://www.governor.arkansas.gov/>

Arkansas State Government: Portal for Board, Task Force and Commission Websites
<http://www.arkansas.gov/>

Bureau of Legislative Research
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California

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
36,457,549	18%	24%	13%	48%	7%	16%	9%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The state of California has been in the process of health reform since 2003. According to the UCLA California Health Interview Survey, 6.5 million Californians were uninsured at some point during 2006, representing 20 percent of children and non-elderly adults. Of uninsured Californians, 75 percent were in working families, with the majority having no health coverage through their employers. Reform efforts in California have occurred since 1999 with the passage of legislation requiring the California Health and Human Services Agency to develop a report of options to provide universal health care coverage.

Legislators and the Governor have submitted proposals for reform that would assist the 6.5 million Californians without insurance. Legislation passed in 2003 as Senate Bill 2 called for health care reform. Assembly Bill 1528 added the creation of a commission on health care quality and cost containment. This “pay or play” law required California employers to pay a fee to the state to provide health insurance unless the employer provided coverage directly. Participation requirements varied with firm size; the smallest firms were exempt. The following year, Proposition 72 successfully repealed the implementation of Senate Bill 2 and rendered Assembly Bill 1528 inactive. Proposition 86, a measure that would have increased the state cigarette tax from 87 cents per pack to \$3.47 per pack to fund hospital emergency department operations, expanded health insurance for low-income children, and implemented smoking prevention and cessation programs, as well as other programs, was defeated in November of 2006.

After the reform effort was repealed, the Governor and Legislature were in agreement that changes needed to be considered for health care reform in California. Currently, three main proposals are being considered in the Legislature, which is still in session. Senate Pro Tempore Don Perata (D) and Assembly Speaker Fabian Núñez (D) have drafted similar legislation for health care reform that does not require all individuals to obtain health insurance but does require a mandatory contribution by businesses. Perata’s and Núñez’s plans

would expand coverage to about 3.4 million uninsured residents, representing about 70 percent of the state's uninsured population. Senator Sheila Kuehl (D) is once again sponsoring Senate Bill 840, a single-payer plan, which she has been working on for three years. Assembly Republican Leader Mike Villines has also shown support for overhauling health care in California.

Governor Schwarzenegger's (R) proposal, which has not been formally released, calls for an individual mandate, expansion of access to public programs, requirements for insurers to guarantee coverage, and an increase in Medicaid reimbursement. The plan is projected to cost about \$12 billion and would draw funds through mandatory contributions from doctors and hospitals, in addition to employers, the federal government and individuals. The plan calls for coverage to be expanded to all California residents. Passage of the Governor's plan would require a two-thirds majority, while passage of bills originating in the Legislature only requires a simple majority.

2007 Legislation and Study Efforts

AB 8 – Establishes a comprehensive structure of program changes, market reforms, and financing to expand public and private health coverage in California.

Current Status: Passed Health Committee, Referred to Assembly Appropriations Committee

SB 48 – Requires all taxpayers with a specified income to have a minimum health coverage policy, and requires employers to spend a certain percentage of payroll on employee health care or pay an equivalent amount into a newly-created Health Insurance Trust Fund. The bill would create the Connector, a state purchasing pool. Employees whose employers opt to pay into the trust fund could receive health coverage through the Connector. Additionally, the bill would also expand eligibility for Medi-Cal and Healthy Families coverage for low-income children and parents. The bill would also establish various insurance market reforms.

Current Status: Passed Health Committee, Passed Rules Committee, Referred to Senate Appropriations Committee

SB 840 – Establishes the California Universal Healthcare System (CUHS) under which all California residents would be eligible for specified health care benefits. The CUHS would, on a single payer basis, negotiate for or set fees for health care services provided through the system, and pay claims for those services. The bill would also establish various boards and offices, with duties as specified, related to the administration of the system.

Current Status: Passed Health Committee, Referred to Senate Appropriations Suspense File

Resources

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Websites

California State Legislature
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California Governor
<http://www.gov.ca.gov/>

California Health Care Foundation
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Comparison of California Health Coverage Expansion Proposals
<http://www.chcf.org/documents/ComparisonHealthReformProposals.pdf>

Governor's Stay Healthy California Plan Factsheet
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Colorado

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
4,753,377	16%	19%	14%	59%	7%	7%	8%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The state of Colorado has been introducing bills to reform health care for several years. Due to the large number of interest groups and levels-of-care reforms, leaders indicated that the measures were not addressing the overall problems in health care. The focus in Colorado on health care reform has centered on ways to expand coverage and reduce costs by joining a multi-state drug purchasing pool, increasing the use of Medicaid managed care, and increasing funding for Colorado’s SCHIP program. Colorado uses the Taxpayers Bill of Rights (TABOR) which requires ballot initiatives for many fiscal items once approved by the Legislature, so bills that require expenditures are often subject to ballot initiatives prior to implementation.

Governor Bill Ritter (D) has concentrated initial efforts on crafting a Colorado Health Plan and attending to the health care needs of small businesses. Health care reform in Colorado has been spearheaded by Governor Ritter, legislative leaders and organizations. Legislative leaders are Representative McGihon (D), Senator Shaffer (D), Senator Hagedorn (D), and Representative Stafford (R). A variety of organizations have submitted proposals to be considered, such as the Colorado Consumer Health Initiative, a statewide, unified membership organization comprised of organizational and individual health care consumer advocates.

In 2006, the Blue Ribbon Commission for Health Care Reform was created by legislative action to study broad-based approaches to health care reform in Colorado. The commission, which is comprised of consumers and business and industry experts, is currently considering proposals for health care reform. By May 18, the Blue Ribbon Commission will have pared down the number of proposals from 31 to 4. At that time, the commission may choose one lead proposal, a hybrid of the top four, or choose to write a new proposal. The proposal that is chosen will also be subject to legislative approval. The work of the commission has reduced the number of legislative proposals introduced this year related to health care

reform, as the state awaits the commission's report. Reform efforts from the 2007 session concentrated on streamlining mental health, prescription drugs, and insurance rates for small employers.

On January 31, 2007, Governor Ritter signed an Executive Order regarding the establishment of a preferred drug list for non-Medicare clients receiving drugs through the fee-for-service and primary care physician programs in the Colorado Medical Assistance Program.

2007 Legislation and Study Efforts

SB 1 – Establishes the Colorado Cares Rx program in the Department of Health Care Policy to provide generic and non-patented prescription drugs to eligible persons at discounted prices. The bill requires pharmacies to provide such drugs to eligible persons at the lesser of an amount negotiated by the department and the generic or nonpatented drug manufacturer, which is between the average manufacturer's price and the federal upper limit, plus a dispensing fee; or the amount of customary charge for the drug at the pharmacy.

Current Status: Signed into law by the Governor

SB 242 – Statutorily creates the Office of Health Disparities in the Department of Public Health and Environment. It specifies the powers and duties of the office, including administering the Health Disparities Grant program and eliminating racial, ethnic, and rural health disparities in Colorado by fostering system changes, collaboration, and education within multiple sectors impacting minority health and by using input from multicultural representatives. The bill creates in statute the Minority Health Advisory Commission and the Interagency Health Disparities Leadership Council.

Current Status: Signed into law by the Governor

HJR 1050 – Establishes an interim task force for the study of behavioral health funding and treatment, whose duty is to study mental health and substance abuse services in order to coordinate the efforts of state agencies, to streamline the services provided, and to maximize federal and other funding sources.

Current Status: Passed House and Senate, Sent to the Governor for Signature

HB 1355 – Removes claims experience and health status as case characteristics that may be considered by an insurance carrier in the determination of premium rates for small employers.

Current Status: Passed Business and Labor Committee, Passed Veterans Affairs Committee, Referred to Conference Committee, Session Adjourned

Colorado Blue Ribbon Commission – The Colorado Blue Ribbon Commission was created in 2006. The Commission is charged with making recommendations for comprehensive health care reform in Colorado. The Commission plans to look at ways to increase access to health care coverage and decrease costs for Colorado residents, with particular emphasis on the issues of the uninsured, underinsured and those at risk of financial hardship due to the costs of medical care. The Commission is required to make final recommendations to the Colorado General Assembly by November 30, 2007.

Resources

Legislative/Public Information Office

Office of Legislative Legal Services
State Capitol Building, Room 091
Denver, CO 80209
(303) 866-2045

Websites

Colorado State Legislature
<http://www.leg.state.co.us/>

Blue Ribbon Commission for Health Care Reform
<http://www.colorado.gov/208commission/>

Colorado Governor Bill Ritter
<http://www.colorado.gov/governor>

Legislative Services
www.state.co.gov_dir/leg_dir/olls

Other Contacts

Blue Ribbon Commission for Health Care Reform Project Coordinator, Anita Wesley
303 E. 17th Avenue, Ste. 400
Denver, CO 80203
(888) 776-2332

Colorado Consumer Health Initiative
<http://www.cohealthinitiative.org/>

Representative Anne McGihon
Chair, House Health and Human Services Committee
(303) 866-2921

Senator Bob Hagedorn
Chair, Senate Health and Human Services Committee
(303) 866-4879

Connecticut

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
3,504,809	11%	14%	8%	61%	4%	11%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Connecticut has been very successful in reducing the number of uninsured children, largely through its primary public health insurance program, The HUSKY plan. Yet in 2004 and 2005, nearly 400,000 residents had no insurance, and over half of these individuals had income less than 200 percent of the federal poverty level (\$19,600 annually for one person). Connecticut also was one of the first states to enact a mental health parity law in 2000.

Lawmakers, business representatives and advocates for universal health care coverage have met to discuss options for expanding coverage, but there has been little agreement between the groups. Universal health care advocates support a single-payer health system, while business leaders oppose the plan and suggest a state allocation to increase Medicaid reimbursements to hospitals and physicians to enroll more low-income individuals in public health programs. These business groups suggest that increased competition could help to lower health costs.

Governor Jodi Rell (R) released the Charter Oak health care proposal in December 2006. This plan is designed to provide low-cost health insurance to individuals and families who cannot afford insurance of their own. This is designed for low-income people who are employed but do not have access to employer-sponsored health insurance and do not qualify for programs such as HUSKY or Medicaid. Under the plan, Connecticut managed care companies would offer coverage for residents who have been uninsured for at least six months and would charge the same premiums no matter what the medical history or circumstances.

The Universal Health Care Foundation of Connecticut cites the need for the state to address the health care disparity due to factors such as transportation, language, and culture that account for ethnic or racial minorities making up almost half of the state's uninsured residents.

The Connecticut legislature, which is scheduled to adjourn on June 6, 2007, has been considering several possibilities to increase coverage for uninsured and underinsured residents. Proposed legislation includes a single-payer health system for which all state residents

age 65 and younger would qualify. Governor Rell does not support the proposal, noting that 94 percent of state residents are already covered by Medicaid, Medicare, and employer-subsidized insurance. Others cite significant costs as a roadblock for this proposal. Another proposal, the Connecticut Healthy Steps Program, addresses specified areas of the health care system and would be funded partially by a provider and vanity tax for persons that receive optional cosmetic surgery. The plan would also be financed by an increase in the cigarette tax. Provider groups have come out in opposition to the bill, noting that a provider tax “penalizes doctors for delivering care.” Other legislation includes creating a trust fund to pay for future universal health care and decreasing Medicaid benefits to the level of private insurance. Several universal health bills have been introduced, but have not passed out of committee as of May 17, 2007.

2007 Legislation and Study Efforts

HB 6652 – Intends to reduce the number of Connecticut residents who lack health insurance benefits, reduce the cost of health benefits, promote the health of Connecticut residents, and improve the quality of health care services in this state. This bill establishes the Connecticut Healthy Steps Program, which addresses numerous health insurance requirements, tax provisions, HUSKY program changes, and public health initiatives. It establishes a Health Care Reform Commission, the Connecticut Connector, a Commission on Healthy Lifestyles, a health savings account incentive program, and a premium subsidy program. It also makes several appropriations.

Current Status: Passed out of Appropriations Committee, Placed on House Debate Calendar (As of May 17, 2007)

HB 6281 – Establishes a trust account with the State Treasurer to ensure funding for health insurance for all Connecticut residents and quality health care for such residents.

Current Status: Companion Bills in House and Senate Appropriations Committee (As of May 17, 2007)

SB 1127 – Creates the Charter Oak Health Plan for Connecticut residents who are ineligible for publicly-funded health care and who have been uninsured for at least six months.

The Charter Oak Health Plan has monthly premiums; a \$1,000 yearly deductible; tiered co-payments for prescription drugs depending upon whether the drug is on a formulary, a brand name, or whether it is mail-ordered; requires no fees for emergency visits to the emergency room; establishes a \$140 fee for non-emergency emergency room visits; and establishes a \$1 million lifetime cap for each enrollee. This bill provides premium assistance for residents enrolled in the Charter Oak Health Plan with incomes below 300 percent of the federal poverty level. The bill also establishes two task forces – one looking at the shortage of medical personnel providing services to residents enrolled in HUSKY, and the other looking at the use of electronic medical records.

Current Status: Placed on Senate Debate Calendar (As of May 17, 2007)

Governor Rell announced on April 18, 2007 a new task force that will study hospital finances and access to care initiatives. task force findings are scheduled to be released on December 31, 2007.

Resources

Legislative/Public Information Office

Legislative Commissioner's Office
William O'Shea, Human Services
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Hartford, CT 06106
(860) 240-8410

Websites

Connecticut State Legislature
<http://www.cga.ct.gov/>

Connecticut Governor
<http://www.ct.gov/governorrell/site/default.asp>

Connecticut Legislative Commissioner's Office
<http://www.cga.ct.gov/lco/>

Universal Health Care Foundation of Connecticut
<http://www.universalhealthct.org/>

Delaware

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
853,476	13%	16%	12%	59%	3%	10%	14%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Approximately 105,000 Delawareans, 12.7 percent of the population, are without health insurance. About 24 percent, or 25,300 people who are uninsured are actually eligible for public coverage through either Medicaid or the Delaware Healthy Children’s Program. The state struggles with the HIV infection rate, and with the sixth-highest AIDS prevalence rate of any state. Delaware expanded its Medicaid-covered family planning services in the 1990s to those women who lose Medicaid for any reason, not just after pregnancy as before. Additionally, Delaware put into place four waivers that expanded eligibility for Medicaid-funded family planning services by offering coverage to all women in the state, based solely on their income. Delaware is also one of the few states that have allocated funds for tobacco prevention programs at the minimum level recommended by the Centers for Disease Control.

The Delaware Health Care Commission has been in place since 1990 and works closely with the Legislative and Executive branches of Delaware state government to promote accessible, affordable, and quality health care for all state residents. Delaware outperforms regional and national averages in regards to the proportion of the population that is uninsured. However, challenges exist in maintaining insurance coverage levels, particularly for small businesses. The Delaware Health Care Commission also works in the issues of childhood and adult obesity rates, health disparities among diverse racial and ethnic populations, limited access to mental health services, and shortages of health professionals to care for the state’s growing and aging population. In its 2007 report, the commission recommended the preservation of Small Group Insurance Reforms and Small Group Insurance Pooling. In addition, the commission also recommended the expansion of SCHIP, Community Health Center Marketing, Geographic Facility Expansion, Primary & Preventive Care Expansion, and Universal Coverage: Single-Payer and Building Block Approaches. The Commission also coordinates efforts with several advisory committees and task forces that study mental health, chronic illness, physical activity, race and ethnic disparities, and other issues.

Delaware supports the Community Healthcare Access Program (CHAP), which helps fund low-cost health care services for uninsured people with incomes below 200 percent of the federal poverty level (\$40,000 for a family of four). This program provides services at a reduced rate by volunteer physicians and is administered by the Delaware Health Care Commission and also supported by AstraZeneca.

The Delaware Advisory Council on Cancer Incidence and Mortality first published its recommendations for fighting cancer in Delaware in a report, published in April 2002, called *Turning Commitment Into Action*. The Council is the first effort by any state to fund cancer treatment for uninsured residents. Governor Ruth Ann Minner (D) has supported increasing funding for the program.

The Governor recommended the state increase cigarette tax by 45 cents per pack to create the Delaware Healthy Life Fund which would be used to support critical health initiatives such as the uninsured and underinsured. This recommendation is being considered in the Legislature, which is currently in session and expected to adjourn June 30, 2007.

Delaware is currently devising a long-term strategy to address Delaware's uninsured. Key industries have pooled resources to launch a public awareness initiative to let the 105,000 uninsured Delawareans know what services are available to them. These resources are used by Healthy Delawareans Today and Tomorrow to provide outreach through the state's five community health centers. A major partner in this initiative is AstraZeneca Pharmaceuticals. The Legislature will also be tackling health care reforms in several bills. One bill requiring private insurers to offer lower-cost coverage to workers at small companies and those making \$50,000 or less is supported by the state Insurance Commissioner. Another bill raises the State Children's Health Insurance Program (SCHIP) eligibility to 300 percent of the federal poverty level. Another possibility is the creation of the Delaware Healthy Life Fund and a companion cigarette tax increase. Leaders are unsure if the Healthy Life Fund legislation would pass without the implementation of the cigarette tax, but the historical reluctance of Delaware to earmark funds has supporters hopeful that if the cigarette tax does not pass, other general fund monies will support the health care reform.

2007 Legislation and Study Efforts

SB 6 – Creates a statewide health insurance purchasing pool to allow individuals and small businesses to obtain the most favorable premiums possible from the private insurance market.

Current Status: Passed Senate, Referred to House Economic Development, Banking and Insurance Committee (As of May 22, 2007)

HB 25 – Includes all language for the Delaware General Fund Budget. Language relating the Delaware Healthy Life fund includes the implementation of the Delaware Health Information Network, an expansion of the SCHIP to include parents of eligible children, a two-year nursing program expansion, Medicaid enrollment increase and the implementation of programs to better serve racial and ethnic minorities.

Current Status: Appropriations Committee Markup (As of May 22, 2007)

HB 49 – Companion to HB 25, this bill increases the cigarette tax rate by 45 cents per pack and specifies that a portion of the tax’s proceeds will be earmarked for the Delaware Healthy Life Fund.

Current Status: House Revenue and Finance Committee (As of May 22, 2007)

Resources

Legislative/Public Information Office

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Websites

Delaware State Legislature
<http://www.legis.state.de.us/legislature.nsf/>

Community Healthcare Access Program
<http://dhcc.delaware.gov/information/chap.shtml>

Delaware Advisory Council on Cancer Incidence and Mortality 2007 Report
http://governor.delaware.gov/publications/Cancer_report.pdf

Delaware General Assembly, Division of Research
<http://regulations.delaware.gov/information/information.shtml>

Delaware Governor
<http://governor.delaware.gov/>

Delaware Health Care Commission
<http://dhcc.delaware.gov/>

Delaware State Insurance Commissioner
<http://www.healthyarkansas.com/>

Delawareans without Health Insurance Report
<http://www.delawareuninsured.org/DOCUMENTS/Hcc007.pdf>

Healthy Delawareans Today and Tomorrow
http://www.astrazeneca-us.com/content/attachments/Healthy_Delaware_eng.pdf

Other Contacts

Delaware Health Care Commission
Sarah McCloskey, Director of Planning and Policy
(302) 672-5187

Florida

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
18,089,888	20%	26%	17%	47%	5%	11%	16%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Florida maintains an active discussion over health policy issues that center in three areas: general ways to improve affordability of health care, Medicaid reform, and reforms to Florida’s State Children’s Health Insurance Program (SCHIP) program, KidCare.

The state has begun to implement reforms in several areas. Affordability improvements include considering private insurance reform and opportunities for individual and small group insurance pooling. The last major reform effort occurred in 2004 and included the initiation of a Governor’s Task Force and the creation of a joint Senate and House Health Policy Committee. The state has also not mandated, but discussed, health flex plans in order to increase the portability of services. Various political, citizen groups, and industry groups have participated in discussions and pilot implementation of reforms in the last few years.

Former Governor Bush (R) worked in the area of Medicaid reform and passed a plan in 2005 that changed the plan from a defined benefit to defined contribution plan.

The changes also included an acute care reform waiver, which the state has begun to implement after a 2005 special session granted implementation authority.

Florida’s KidCare preceded the federal creation of SCHIP and was used as a model for many other state’s programs. In 2006, members of the Florida Legislature hosted public forums about KidCare, as they plan to use it as a starting point for health care reform. Florida is also working on expanding their children’s dental care through Medicaid to better serve children enrolled in the program, after initial evaluations suggested needs for improvement. The forums focused on the uninsured and likely solutions to providing health care.

Florida’s legislature adjourned May 4, 2007, but will likely be called back for a special session to discuss property tax issues. There is a minimal possibility that health care issues may get some attention during this special session. Language contained in HB 7065, related to the Elderly Waiver, was designed to merge Medicaid and Medicare funding streams after a waiver was secured from the Centers for Medicare and Medicaid.

Major modification is planned after the bill changed the program in such a way that a new waiver application will be needed.

The Senate released a KidCare Evaluation Report in October of 2006 that became the cornerstone of debate in the 2007 Legislative session regarding the program. The debate on KidCare centered around ways to streamline the program, and discussions of expanding the program to other eligibility groups was placed on hold. A bipartisan group of legislators has urged Governor Charlie Christ (R) to intervene. The same Senator has submitted the same bill for the last five years calling for universal health care reform. At this time, the bill has not received attention.

2007 Legislation and Study Efforts

HB 7065 – Requires the implementation of federal waivers to administer integrated, fixed-payment delivery program for Medicaid recipients 60 years of age or older or those dually eligible for Medicare and Medicaid. It also requires counties to participate in Medicaid payments for certain nursing home or intermediate facility care for both health maintenance members and fee-for-service beneficiaries.

Current Status: Sent to the Governor for Signature

SB 930 – Revises funding sources for health benefit coverage provided to children under the KidCare program, specifies requirements for premium assistance eligibility, and revises health benefits coverage of the program. Companion bill: HB 7189.

Current Status: Passed Committee on Health Policy, Referred to Health and Human Services Committee, Session Adjourned

Resources

Legislative/Public Information Office

Office of Program Policy Analysis and Government Accountability

Rae Hendlin, Senior Policy Analyst

111 West Madison Street, Suite 312

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Websites

Florida State Legislature

<http://www.leg.state.fl.us/Welcome/index.cfm?CFID=19090598&CFTOKEN=13283224>

Office of Program Policy Analysis and Government Accountability

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Other Contacts

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Georgia

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
9,363,941	18%	23%	12%	53%	4%	14%	9%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Georgia is one of over a dozen states in 2007 expected to run out of money for their State Children’s Health Insurance Program (SCHIP), which in Georgia is known as PeachCare. Additional strain was placed on the program when Georgia added 43,000 children to the state’s population following Hurricane Katrina. Georgia had the most significant shortfall, \$131 million, and has placed a freeze on new participants in the program. Although the SCHIP program received much discussion this legislative session, no legislation passed to address the shortfall.

Georgia has focused many of its efforts in recent years on public health issues, and passed the Georgia Smokefree Air Act in 2005, which prohibits smoking in State facilities and public and private workplaces, with some exceptions. In March 2005, Governor Sonny Perdue (R) and the Department of Human Resources introduced the Live Healthy Georgia campaign in response to reports that nearly 60 percent of total deaths in Georgia were due to chronic diseases. The effort is designed to raise awareness about the prevention of chronic diseases through the promotion of healthy living. The Division of Public Health (DPH) and the Division of Aging Services (DAS) joined the partnership, and there are now two websites dedicated to the campaign.

Senator Judson Hill (R) has been at the center of reform initiatives aimed at reducing the number of uninsured in Georgia. In 2006, Senator Hill introduced legislation which created the Healthcare Transformation Senate Study Committee charged with reviewing Georgia’s health care system and recommending solutions to cover more of the state’s uninsured population. As a result, Senator Hill introduced legislation, Senate Bill 150, during the 2007 legislative session focused on personal responsibility and access to information. The legislation failed to receive action by the 2007 Georgia General Assembly. Among many components, it included a consumer website that provides information on cost and quality of health care in Georgia and the Georgia Health Insurance Exchange through which insur-

ers will market health insurance policies for consumers to compare and purchase. The Healthcare Transformation Senate Study Committee was re-established in Senate Resolution 637 to continue the work of the committee during 2007.

The Georgia General Assembly created two study committees during the 2007 session to address major issues of concern in the health care system. Senate Bill 60 establishes the Georgia Trauma Commission to receive and administer state, federal, and private funding; to develop and administer a compensation system for trauma centers and physicians; and to establish and maintain a trauma center network to coordinate the best use of existing trauma facilities in the state. This committee addresses significant concerns in Georgia about the quality and availability of trauma services throughout the state. Secondly, Senate Resolution 66 creates the Senate Study Committee on the Shortage of Doctors and Nurses in Georgia. The Committee is charged with examining the current shortage and making recommendations to combat future shortages. All Legislative Committee members are appointed by the Lieutenant Governor.

2007 Legislation and Study Efforts

Senate Bill 60 – Establishes the Georgia Trauma Commission to receive and administer state, federal, and private funding; to develop and administer a compensation system for trauma centers and physicians; and to establish and maintain a trauma center network to coordinate the best use of existing trauma facilities in the state.

Current Status: Signed by the Governor

Senate Resolution 66 – Creates the Senate Study Committee on the Shortage of Doctors and Nurses in Georgia. Findings and recommendations for proposed legislation are due on or before December 31, 2007.

Current Status: Passed Senate

Senate Resolution 637 – Establishes the Healthcare Transformation Senate Study Committee to identify gaps in the Georgia health care system and to study models from other states, including the provision of health care services through a consumer driven health care model.

Current Status: Passed Senate

Resources

Legislative/Public Information Office

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House Budget Office
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Websites

Georgia General Assembly
<http://www.legis.state.ga.us/>

Georgia Department of Human Resources
<http://dhr.georgia.gov/portal/site/DHR/>

Georgia Senate Research Office
http://www.legis.state.ga.us/legis/2007_08/senate/aboutsro.htm

Live Healthy Georgia
www.livehealthygeorgia.org and www.livewellagewell.info.

Hawaii

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,285,498	9%	12%	5%	60%	3%	10%	14%	4%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Hawaii was the first state in the nation to establish an employer mandate with the Prepaid Health Care Act in 1974. The law requires nearly all employers to provide health insurance to their employees who work 20 hours or more a week for four consecutive weeks. Employees must maintain the minimum of at least 20 hours a week to remain eligible.

In 1994, Hawaii received approval from the Centers for Medicare and Medicaid Services (CMS) to expand coverage to adults and children through a Section 1115 Demonstration Waiver. The Hawaii program, called QUEST (Quality care, ensuring Universal access, encouraging Efficient utilization, Stabilizing costs, and Transforming the way health care is provided to public clients), created a public purchasing pool that arranges for health care through managed care plans. The State converted approximately 108,000 recipients from three publicly-funded medical assistance programs into the initial demonstration, including 70,000 Aid to Families with Dependent Children (AFDC-related) individuals, 19,000 General Assistance program individuals, and 20,000 former state-funded SCHIP program individuals.

Since 1994, the QUEST program has expanded Medicaid to cover pregnant women up to 185 percent federal poverty level (FPL); all children age 19 with incomes up to 200 percent FPL, and all adults with incomes at or below 100 percent FPL.

Hawaii also has a program called QUEST-Net, a medical assistance program which was developed to provide coverage for individuals who no longer qualify for Hawaii QUEST or Medicaid Fee-For-Service. The program provides a full Medicaid benefit for children with family incomes that meet eligibility requirements. QUEST-Net also offers a limited benefit package for adults with incomes at or below 300 percent FPL who have lost Medicaid eligibility.

Hawaii's Section 1115 Demonstration Waiver was extended in January 2006, which continues the state's current coverage and expands coverage to children from 200 percent through 300 percent of FPL. Hawaii will also expand coverage through the QUEST Adult Coverage

Expansion (QUEST-ACE) for adults up to 100 percent of the FPL who are not otherwise eligible for coverage. Even with these reform efforts, approximately 9 percent of Hawaii's population remains uninsured. During the 2007 legislative session, measures were introduced to explore universal coverage and expand SCHIP coverage.

2007 Legislation and Study Efforts

House Bill 1008 – State Children Health Insurance Program (SCHIP) Expansion/Pilot Program. Establishes a three-year pilot program in which the state pays half the health insurance premiums for children under the age of 19 who are uninsured for any reason, including immigration status, and ineligible for public insurance. The bill also expands Hawaii's SCHIP program, QUEST, to cover children in families with incomes below 300 percent of FPL. Currently, families with incomes between 200 and 300 percent of FPL pay premiums for QUEST coverage on a sliding-scale.

Current Status: Sent to the Governor for Signature

House Bill 56 – Establishes the Hawaii Health Commission to develop a plan for health care for all individuals in the State.

Current Status: Passed Health Committee; Passed Commerce, Consumer Protection, and Affordable Housing Committee; Referred to Ways and Means Committee, No Action; Session Adjourned

Resources

Legislative/Public Information Office

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Hawaii State Capitol, Room 446
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Websites

Legislative Reference Bureau
www.hawaii.gov/lrb

Hawaii Prepaid Health Care Act, Department of Labor and Industrial Relations
<http://hawaii.gov/labor/dcd/aboutphc.shtml>

Hawaii QUEST
<http://www.med-quest.us/index.html>

Idaho

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,466,465	15%	19%	11%	55%	8%	12%	10%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

In 2006, Idaho became one of several states to redesign benefits to meet the needs of Medicaid beneficiaries. Changes allowed by the federal Deficit Reduction Act (DRA) of 2005 made it possible for states like Idaho to target benefits to a certain group of Medicaid beneficiaries. The Idaho Medicaid program offers three benefit packages aimed at meeting the health care needs of children, persons with disabilities, and beneficiaries who are eligible for both Medicaid and Medicare.

The Medicaid Basic Plan is for healthy low-income children and adults with eligible dependent children. The plan provides complete health, prevention, and wellness benefits for children and adults who do not have special health needs. The Medicaid Enhanced Plan is for individuals with disabilities or special health needs. The plan includes all benefits in the Basic Plan plus additional benefits including long-term or institutional care. The Medicare-Medicaid Coordinated Plan includes all the benefits of the state's traditional Medicaid program and serves Medicaid enrollees who are also eligible for the Medicare program.

This group is required to enroll in the Medicare outpatient coverage plan, or Part B, as well as the new prescription drug benefit, Medicare Part D. Some Medicaid participants pay a cost-sharing premium based on income.

The Idaho Legislature has a standing legislative Health Care Task Force charged with developing solutions to unprecedented increases in health insurance premiums. During the 2007 Legislative Session, there was a major focus on the availability of adequate substance abuse and mental health treatment. Successful measures included the creation of a plan to improve the mental health and substance abuse treatment delivery system, funding for the court system, community grant programs, and counselors.

2007 Legislation and Study Efforts

There were no major health care reform initiatives undertaken in 2007.

Resources

Legislative/Public Information Office

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Legislative Services Office
www.legislature.idaho.gov/budget/staff.htm

Idaho Legislature
www.legislature.idaho.gov

Idaho Department of Health and Welfare
www.healthandwelfare.idaho.gov

Other Contacts

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Illinois

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
12,831,970	13%	17%	11%	59%	4%	10%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

During the 2006 legislative session, the Illinois Legislature passed Governor Rod Blagojevich’s (D) All Kids program. With this program in place, Illinois became the first state to provide comprehensive health care coverage for all children. The All Kids program provides children up to the age of 18 with comprehensive health insurance which covers preventive care, dental and vision services, hospital costs, and prescription drugs, among other services. The program is available to all Illinois children without private health insurance and has no family income cap. Children do not need to be US citizens for their parents to buy in to the program, but they must not be eligible for state programs like Medicaid or Illinois CHIP. Premiums are based on a sliding income scale, starting at \$40 per month per child.

While all Illinois children now have access to health insurance, more than 1.4 million adults remain uninsured. In March of 2007, Governor Blagojevich announced a plan, called Illinois Covered, to expand access to health care coverage to all Illinois residents. The plan, based in part on recommendations from a legislative task force and research of other state reforms, would provide access to coverage for all state residents. This comprehensive reform would create an affordable health insurance plan for employers or individuals based on income, premium assistance for the state plan, or employer-sponsored insurance, and expanded coverage for low income families.

The Governor’s plan is under consideration by the Illinois legislature as Senate Bill 5. The legislation has been amended but the Governor’s plan is largely intact. While there is support in the state for the reform measures, there is controversy among the business community and legislators regarding the financing mechanism for the reforms. The Governor proposed a gross receipts tax that would be levied on business receipts from sales of products and services in Illinois. Governor’s staff remain optimistic for passage if consensus can be reached on financing.

2007 Legislation and Study Efforts

Senate Bill 5 – Creates the Illinois Health Care For All Act. Provides all Illinoisans access to comprehensive health insurance.

Current Status: Passed Public Health Committee (As of May 17, 2007)

Senate Bill 1 – Gross Receipts Tax. The tax would be levied on business receipts from sales of products and services in Illinois.

Current Status: Passed Education Committee (As of May 17, 2007)

Resources

Legislative/Public Information Office

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Websites

Illinois General Assembly
www.ilga.gov

Illinois All Kids
www.allkidscovered.com

Illinois Covered
www.illinoiscovered.com

Legislative Research Bureau
www.ilga.gov/commission/lrb_home.html

Office of Governor Blagojevich
<http://www.illinois.gov/gov/>

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Indiana

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
6,313,520	14%	18%	9%	58%	4%	12%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The state of Indiana ranks 23rd among states in the number of uninsured persons, with an estimate of 860,000 people or 14 percent of the population uninsured. In May 2007, Indiana Governor Mitch Daniels (R) signed into law a health care reform plan, known as the Healthy Indiana Plan (HIP). HIP, contained in House Bill 1678, was passed with bipartisan support during the 2007 Legislative Session. The plan will provide coverage to a target group of 367,000 residents.

The Healthy Indiana Plan will provide insurance for parents of children enrolled in Medicaid/State Children’s Health Insurance Program (SCHIP) from 22 percent - 200 percent federal poverty level (FPL), pregnant women up to 200 percent FPL, and childless adults under 200 percent FPL with federal approval. The plan will be financed in part through a 44-cent increase in the cigarette tax. Under the plan, participants would contribute up to \$1,100 or 5 percent of their annual gross income into a type of health savings account. After that money is spent on medical services, the new health plan will cover 100 percent of medical costs. Participants must be US citizens, Indiana residents for 18 months, uninsured for 6 months, and not be eligible for employer sponsored health insurance. The number of people who can enroll in the plan is dependent on available funding. The plan covers essential health services and is similar to commercial plans, including \$500 for preventive care, mental health and substance abuse treatment, dependent coverage, and buy-in options. The Healthy Indiana Plan Task Force is charged with monitoring and making recommendations regarding the plan to the state.

House Bill 1678 includes a number of additional health care reform measures such as expanded coverage for children through SCHIP up to 300 percent FPL, tax credits for small businesses offering wellness programs, tax credits for employers offering Section 125 Plans, and pooling of small businesses for the purchase of group health insurance.

2007 Legislation and Study Efforts

House Bill 1678 – Health matters. Provides for a tax credit related to small employer qualified wellness programs. Increases the cigarette tax by 44 cents per pack to fund various health related expenses. Allows an employer to take a tax credit for making a health benefit plan available to the employees for the first two taxable years that the employer makes the health benefit plan available. Increases the income limit for Medicaid eligibility for pregnant women. Makes funding changes to the hospital care for the indigent program, the municipal disproportionate share program, and the Medicaid indigent care trust fund. Provides for continuous eligibility of a child under Medicaid and SCHIP until the child becomes three years of age. Establishes the Indiana Check-Up Plan and the Indiana Check-Up Plan Trust Fund. Specifies requirements for the plan, including coverage, financial assistance, eligibility and enrollment, contracting, financial obligations, and funding requirements. Increases the SCHIP eligibility family income limit. Requires the State Department of Health to establish standards for and certify a small employer qualified wellness program. Requires health insurers and health maintenance organizations to cover children up to 24 years old upon request. Allows certain small employers to join together to purchase group health insurance and allows the Insurance Commissioner and the Office of the Secretary of Family and Social Services to develop a program to provide for such purchases. Requires the Indiana comprehensive health insurance association to administer plan benefits for high risk individuals insured under the plan. Requires application for necessary federal Medicaid approvals, including approval for presumptive eligibility for certain pregnant women and implementation of the plan. Establishes a plan task force. Requires the health finance commission to study and report concerning several issues. Makes appropriations. Makes conforming and technical changes.

Current Status: Signed into law by the Governor

Resources

Legislative/Public Information Office

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Websites

Indiana State Legislature
www.in.gov/legislative/

Indiana Family and Social Services Administration
www.in.gov/fssa/

Indiana State Department of Health
www.in.gov/isdh/

Other Contacts

Bill Sponsors

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Indianapolis, IN 46204
(800) 382-9467

Kansas

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
2,764,975	11%	14%	7%	59%	6%	10%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

On May 10, 2007, Governor Kathleen Sebelius (D) signed into law health care legislation, Senate Bill 11, which makes incremental steps toward comprehensive reform. The legislation requires the Kansas Health Policy Authority and the Kansas Medicaid Agency, to conduct wide-ranging studies on health care reform options. Information gathered from other states will be presented to the Governor and Legislature in November 2007.

Senate Bill 11 also includes premium assistance for the poor through state subsidies for private insurance premiums for families whose incomes are up to the federal poverty level. The premium assistance program will take effect in 18 months, and then it will be phased in over four years. It is estimated that as many as 30,000 of the state's uninsured could participate.

Governor Sebelius also put forward reform measures for children in her budget request, called the Healthy Kansas First Five. The program would increase the eligibility for children under age 5 from 200 percent of the federal poverty level (FPL) to 235 percent. First Five would have used state-only funds to allow families with incomes up to 300 percent of FPL to buy into the Health Wave program, the state's managed care program for publicly-funded insurance, with premiums on a sliding scale based on income. Families with incomes above 300 percent of FPL would be able to buy in to Health Wave at full cost. Healthy Kansas First Five failed during the 2007 Legislative Session.

During the legislative interim there will be considerable activity and information gathering among the legislative and state agency task forces. The Joint Health Policy Oversight Committee is specifically charged with monitoring and follow-up related to these efforts. Health and insurance reform issues are expected to be a priority for legislative committees in the 2008 Legislative Session.

2007 Legislation and Study Efforts

Senate Bill 11 – Kansas Medicaid reform act of 2007. The Kansas health policy authority will request the federal Centers for Medicare and Medicaid Services (CMS) to appoint a special representative to work with the health policy authority to expedite, coordinate and implement the changes to the Medicaid program in Kansas and to request additional funds. Current Status: Signed into law by the Governor

Resources

Legislative/Public Information Office

Kansas Legislative Research Department
300 SW 10th St – Room 545N
Topeka, KS 66612
(785) 296-3181

Websites

Kansas Legislature
www.kslegislature.org

Kansas Health Policy Authority
www.khpa.ks.gov

Kansas Legislative Research Department
<http://skyways.lib.ks.us/ksleg/KLRD/klrd.html>

Kentucky

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
4,206,074	13%	18%	8%	54%	4%	15%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Kentucky was one of the first states to gain approval from the Centers for Medicare and Medicaid Services (CMS) for Medicaid changes under the Deficit Reduction Act of 2005 (DRA). Kentucky’s Medicaid program now consists of four different benefit packages designed for the general Medicaid population, children, persons with disabilities, and individuals who need nursing care. Kentucky’s program, called KyHealth Choices, began on July 1, 2006. Global Choices covers the general Medicaid population, including foster children and medically-fragile children. Family Choices covers most children including those on SCHIP. Optimum Choices covers individuals with mental retardation and developmental disabilities in need of long-term care. Comprehensive Choices covers elderly individuals in need of a nursing facility level of care and also individuals with acquired brain injuries. KyHealth Choices includes prevention and disease management programs, wellness incentives, prescription drug limits, and self-direction as an alternative to traditional long-term care.

In 2006, the Kentucky General Assembly enacted a program created by Governor Ernie Fletcher (R) called Insurance Coverage Affordability and Relief to Small Employers (ICARE). Supervised by the Kentucky Office of Insurance, ICARE is a pilot program designed to help Kentucky employers pay premiums for workers. Small employers (2-25 workers) can receive a health care incentive payment to assist with the cost of employee health insurance if the business meets certain criteria. ICARE was appropriated \$20 million for two years; legislation will be required to fund the program beyond pilot stage.

2007 Legislation and Study Efforts

House Concurrent Resolution 79 – Directs the legislative research commission to conduct a study of the feasibility of establishing a system of universal health insurance coverage that provides access to affordable, high-quality health care for all residents of the Commonwealth.

Current Status: Passed Banking and Insurance Committee, Referred to Rules Committee, No Action, Session Adjourned

Resources

Legislative/Public Information Office

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Websites

Kentucky Legislature
www.lrc.state.ky.us

Kentucky Department for Medicaid Services
<http://chfs.ky.gov/dms/default.htm>

Kentucky Office of Insurance
<http://doi.ppr.ky.gov/kentucky/>

Legislative Research Commission
www.lrc.ky.gov/org_adm/lrc/aboutlrc.htm

Louisiana

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
4,287,768	17%	24%	8%	50%	5%	15%	13%	0%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The state of Louisiana ranks 48th in overall health status and has approximately 700,000 uninsured residents. In 2004, the Governor’s Health Care Reform Panel was created to take steps to address health care quality and access and reduce the rate of uninsured. In 2005, Hurricane Katrina devastated the health care resources and systems in Louisiana.

In response to the critical health care system crisis created by the hurricanes of 2005, the United States Department of Health and Human Services (HHS) Secretary Michael Leavitt charged Louisiana with creating an inclusive forum and process for comprehensive health care system development and requested the formation of a redesign collaborative to develop both short- and long-term health care recovery plans. In response, the Louisiana State Legislature created the Health Care Redesign Collaborative through House Concurrent Resolution 127.

The initial mission of the Health Care Redesign Collaborative was to develop and submit to the US Department of Health and Human Services a comprehensive system-wide Medicaid waiver and Medicare demonstration proposal for parishes of the Greater New Orleans area, which is Region 1 of the Louisiana Department of Health and Hospitals, to guide the rebuilding of its health care system.

The recommendations made by the Collaborative are modeled on a medical home system of care for the New Orleans region. Other recommendations included phased-in health insurance coverage, the Louisiana Health Care Quality Forum, and health information technology (electronic medical and health records that link all providers in a medical home network). The Louisiana Legislature is currently considering measures that contain recommendations of the Collaborative.

2007 Legislation and Study Efforts

House Bill 542 – Creates the Louisiana Children and Youth Health Insurance Program. Children with family incomes between 200 percent to 300 percent federal poverty level (FPL) who are not eligible for Medicaid or Louisiana Child Health Insurance Program (LaCHIP) would be eligible for health care coverage or premium assistance for private or employer sponsored health insurance. The program would require cost sharing based on family income.

Current Status: Passed House, Action Pending in the Senate

Senate Bill 238 – Health Care Redesign Fund. Recognizes the critical need for health care services in areas of the state affected by the hurricanes of 2005. The existing health care delivery system experienced severe stresses during its response to these disasters. Redesign of the system of health care delivery is desirable and necessary in both the hurricane-affected areas of Louisiana and on a statewide basis.

Current Status: Passed House, Action Pending in the Senate

Senate Concurrent Resolution 35 – Requests the Department of Health and Hospitals to engage in a cooperative effort with other public and private organizations and institutions in establishing the Louisiana Health Care Quality Forum, building on the guidance provided by the Louisiana Health Care Redesign Collaborative in its October 2006 plan.

Current Status: Passed House, Referred to Senate Health and Welfare Committee

Senate Bill 1 – Authorizes the Department of Health and Hospitals to develop and implement a health care delivery system for Medicaid recipients and low-income, uninsured citizens. The health care delivery system will be known as Louisiana Health First and will consist of a medical home system of care. The medical home system of care will incorporate the use of health information technology and quality measures to facilitate a safe, patient centered, quality driven, evidence-based, accessible, and sustainable health care system to Medicaid recipients and low-income uninsured citizens.

Current Status: Passed Health and Welfare Committee, Referred to Finance Committee

Resources

Legislative/Public Information Office

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Louisiana State Legislature

www.legis.state.la.us

Legislative Fiscal Office

<http://lfo.louisiana.gov/>

Louisiana Health Care Redesign Collaborative

www.dhh.state.la.us/offices/?ID=288

Maine

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,321,574	10%	13%	6%	62%	4%	20%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

In 2003, the Maine Legislature enacted comprehensive health care reform through the Dirigo Health Reform Act. The goal of Dirigo is to ensure universal access to health insurance coverage by 2009 and provide coverage to Maine’s then 130,000 uninsured residents. Dirigo is a broad health reform strategy that includes a new insurance product to improve health insurance coverage, cost-containment strategies, and statewide quality programs.

The Dirigo Health Reform Act establishes Dirigo Health as an independent agency responsible for arranging health coverage through a private insurance carrier to small business (50 or fewer employees), individuals, and the self-employed. The health plan, called Dirigo Choice, offers discounts based on income for individuals, families, small business employees and the self-employed with incomes below 300 percent federal poverty level (FPL). Employers pay 60 percent of employee costs, and discounts apply to the employee’s share. Dirigo Choice offers comprehensive benefits and covers preventive services at 100 percent, mental health treatment, and does not exclude based on pre-existing conditions. The Act also expanded MaineCare, the state Medicaid program, to cover more low income individuals and adults with MaineCare eligible children.

Since 2003, approximately 18,000 people have signed up for health insurance coverage through Dirigo Choice or as a result of the MaineCare expansion. Maine has experienced controversy over high health insurance premiums, smaller than anticipated enrollment, and program financing.

Maine is now considering reforms to Dirigo Health. Governor John Baldacci (D) created a Blue Ribbon Commission on Dirigo Health through an executive order on May 24, 2006. The Commission was charged with making recommendations on funding for Dirigo and methods to reduce and control costs. The Maine State Legislature is currently considering reforms to Dirigo that would expand program eligibility and allow Dirigo Health to self-administer the health care coverage to help control costs.

2007 Legislation and Study Efforts

Legislative Document 526 – An Act to Increase Eligibility for the Dirigo Health Program. Would reduce the number of hours an employee of an eligible business must work per week from 20 to 10 in order to be eligible to enroll in the Dirigo Health Program. The bill also requires the Board of Directors of Dirigo Health to adopt a rule that allows an eligible business to include employees who work on a temporary, substitute, or seasonal basis as eligible to enroll in the Dirigo Health Program so long as inclusion of such employees does not result in the reduction of hours or the reduction or elimination of coverage for eligible employees working more than 10 hours per week.

Current Status: Referred to Insurance and Financial Services Committee
(As of May 23, 2007)

Legislative Document 431 – An Act to Enable the Dirigo Health Program to be Self-Administered. Allows Dirigo Health to provide access to health benefits coverage through the self-administered plan after the board evaluates competitive bids for health benefits coverage for self-administered and fully-underwritten health benefits coverage.

Current Status: Referred to Insurance and Financial Services Committee
(As of May 23, 2007)

Resources

Legislative/Public Information Office

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Maine State Legislature
<http://janus.state.me.us/legis/>

Dirigo Health
www.dirigohealth.maine.gov

Office of Policy and Legal Analysis
www.maine.gov/legis/opla/

Maryland

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
5,615,727	13%	18%	9%	61%	4%	9%	11%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

In Maryland, about 760,000 people or 14 percent of the state’s population live without health insurance. During the 2007 legislative session, multiple bills were introduced to make health insurance more accessible to the uninsured. Some limited reforms were passed, but major reform proposals had little chance of success, as the state is facing a significant budget shortfall in the coming year.

The Maryland Children’s Health Program (MCHP) currently covers children up to 300 percent of the federal poverty level (FPL). House Bills 754 and 132 were introduced to expand this coverage. The expansion would have required a one-dollar increase in the state’s tobacco tax. While these measures did not pass, the Legislature did successfully pass some smaller reform measures such as continuation of coverage for child dependents until age 25, access to coverage for domestic partners, and the creation of a task force on health care access and reimbursement.

2007 Legislation and Study Efforts

House Bill 1057 – Requires insurers, nonprofit health service plans, and health maintenance organizations to allow a child dependent to remain on an insured’s plan until age 25.

Current Status: Passed House and Senate

House Bill 754 – Would have expanded eligibility for Medicaid and the Maryland Children’s Health Program (MCHP) and continued coverage for adult child dependents.

Current Status: Passed House, Senate Did Not Pass, Session Adjourned

House Bill 132 – State Children’s Health Insurance Program (SCHIP) Expansion. The Maryland Health Care Access Act of 2007, a comprehensive health care reform plan sponsored jointly by the governor and members of the legislature, expands Maryland’s SCHIP

program to children under the age of 19 in families with incomes below 400 percent of the federal poverty level (FPL). Families with incomes between 200 and 400 percent of FPL would pay premiums to participate in the program. Dependent on a Medicaid waiver.
Current Status: Passed Finance Committee, Referred to Health and Government Operations Committee, No Action, Session Adjourned

Senate Bill 107 – Establishes the Task Force on Health Care Access and Reimbursement; providing for the membership and duties of the Task Force; requires the Task Force to make specified recommendations and to make a report before June 30, 2008.
Current Status: Passed House and Senate

Resources

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Maryland General Assembly
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Maryland Department of Health and Mental Hygiene
www.dhmf.state.md.us/

Department of Legislative Services
<http://dls.state.md.us/index.html>

Michigan

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
10,095,643	11%	15%	6%	59%	4%	13%	12%	0%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Governor Jennifer Granholm (D) is seeking federal approval from the Centers for Medicare and Medicaid Services (CMS) for a \$1 billion plan that would allow Michigan to use Medicaid funds to help the uninsured buy private health coverage. It is estimated that the waiver could assist approximately 50 percent of Michigan’s 1.5 million uninsured. The Medicaid waiver request is pending and legislation introduced in the Senate has been proposed that includes similar components to those found in the Governor’s proposal.

The legislative proposal supporting the federal waiver request calls for the creation of an exchange mechanism, Michigan Helping Ensure Affordable and Reliable Treatment (MI-HEART), which would provide Michigan residents with a system for accessing health insurance. This legislation would not be enacted unless the pending federal waiver is secured as it contains needed matching funds. Legislation creating a single-payer system has also been introduced.

Comprehensive health reform legislation has also been introduced in the House (House Bill 4202), but this legislation had not been passed out of the House Appropriations Committee. In April 2007, Michigan business leaders and several health care groups announced the formation of the Michigan Health Insurance Access Advisory Council, which is intended to develop policies that would provide health care coverage to Michigan’s uninsured residents. The creation of the Council came about based upon a 2006 recommendation from the Michigan Department of Community Health.

The Michigan Legislature began a new session in January 2007, which is scheduled to conclude in December 2008. It is expected that the Legislature will work during its 2007 summer recess to address a number of complicated issues.

Additionally, in 2006, Michigan enacted Public Act No. 538, which requires any insurance policy that covers dependents while they are enrolled in school (either full or part-time) to

continue to cover those dependents for up to 12 months if they take a leave of absence from school due to injury or illness. If the student ages-out of the policy during the 12-month period, the insurance is terminated. The policy took effect January 1, 2007.

2007 Legislation and Study Efforts

Senate Bill 278 – Promotes the availability and affordability of health coverage; facilitates the purchase of health coverage; helps ensure affordable and reliable treatment exchange; and creates a board which provides the determination of eligible health coverage plans and eligibility for assistance of certain enrollees. The legislation calls for the creation of an exchange board within the Michigan Department of Community Health. The exchange board would be responsible for facilitating the availability, choice, and adoption of private eligible health coverage plans to individuals and groups as well as facilitating the purchase of health coverage products by individuals and groups through the exchange at an affordable price. The MI-HEART program would also be administered through the exchange board and in consultation with the Department of Community Health and Michigan Department of Human Services. The program works to provide subsidies to assist eligible individuals in purchasing health coverage based upon a sliding fee scale. The exchange board is also to consult with representatives of small employers, hospitals serving a high number of uninsured, and low-income health care advocacy organizations to develop a plan for outreach and education to target low-income, uninsured residents to increase enrollment in the MI-HEART program. The legislation also contains several provisions as to which individuals would qualify for the MI-HEART program.

Current Status: Passed Health Policy Committee, Referred to Committee of the Whole

Senate Bill 280 – Requires any provider of insurance to continue coverage for dependent children until the child attains the age of 26, even if the child is no longer considered to be a dependent. This legislation will not go into effect unless Senate Bills 278 and 283 also pass.

Current Status: Passed Health Policy Committee, Referred to Committee of the Whole

Senate Bill 283 – Requires any provider of insurance to continue coverage for dependent children until the child attains the age of 26, even if the child is no longer considered to be a dependent. Includes additional information about the role of health maintenance organizations. This legislation will not go into effect unless Senate Bills 278 and 280 also pass.

Current Status: Passed Health Policy Committee, Referred to Committee of the Whole

Resources

Legislative/Public Information Office

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Websites

Michigan Legislature
www.legislature.mi.gov

Michigan Department of Human Services
www.michigan.gov/dhs

Minnesota

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
5,167,101	8%	10%	6%	64%	7%	9%	11%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

According to U.S. Census data from 2003 to 2005, less than 9 percent of Minnesota's 5.1 million residents are uninsured, making it the state with lowest uninsured rate in the nation. In January 2007, Governor Tim Pawlenty (R) offered his health care reform plan, Healthy Connections, designed to drive down health insurance costs, improve quality, and increase access to affordable health care for the uninsured. This plan includes Medicaid reform, the expansion of health benefits to more than 70,000 uninsured children in the state, establishment of the Minnesota Health Insurance Exchange, assistance for small employers to provide more affordable health insurance, and lowering out-of-pocket costs for individuals purchasing health insurance through the private market.

The Minnesota General Assembly's adjournment date for the 2007 session is May 21. Several major funding bills were still being negotiated, including the health and human services omnibus bill (Senate File 2171), which was vetoed by Governor Pawlenty on May 8. Since the omnibus bill was vetoed, lawmakers have been working to reach compromise with the Governor's office. The bill was rejected by the Governor due primarily to the total appropriation amount, which was about \$170 million more than the Governor's proposed budget.

Lawmakers in Minnesota introduced several pieces of legislation to make health care more accessible and available to Minnesota residents, and components of the proposed legislation were included in the health and human services omnibus bill. These components include expanding coverage to 72,000 uninsured residents, including 30,000 to 40,000 children, by 2011; allowing military families to enroll in MinnesotaCare (Minnesota's Medicaid program) for one year without premiums; funding for an outreach campaign to encourage qualified residents to enroll in public health programs; creation of a health care access commission that would develop a statewide universal health care system; and creation of a health insurance exchange that would allow residents to purchase insurance tax free.

The omnibus bill also includes health care cost containment provisions and some elements of Senate File 1689 (Healthy Minnesota), which was rolled into the health and human services omnibus bill.

Additionally, the largest teachers' union, Education Minnesota, has offered a proposal that would allow for the creation of one large insurance pool which would include every teacher in the state. The proposal has passed the Minnesota House and Senate and will be reviewed by the Governor.

Finally, several options are being discussed among Minnesota lawmakers including an individual mandate proposed by Blue Cross, expansion of Medicaid, and coverage of all children. In September 2006, Blue Cross released its proposal for universal health care in Minnesota. This plan would establish an individual mandate, which would require insurers to offer all applicants health coverage and increase subsidies for the low-income. This proposal is estimated to cost \$900 million.

2007 Legislation and Study Efforts

Senate File 14 – Would bring before the voters a constitutional amendment establishing that Minnesotans have a constitutional right to health care. This bill would provide for an act relating to health; providing for a universal health care system that provides affordable access to high quality medical care for all Minnesotans; requiring a focus on preventive care and early intervention; providing comprehensive benefits; reducing costs through prevention, efficiency, and elimination of bureaucracy; directing the commissioner of health to prepare a plan to be implemented by 2010; proposing an amendment to the Minnesota Constitution, article XIII, by adding a section, affirming that every resident of Minnesota has the right to affordable, comprehensive health care; proposing coding for new law in Minnesota Statutes, chapter 144.

Current Status: Passed Health, Housing and Family Security Committee, Referred to Rules and Administration Committee

Senate File 15 (House File 1) – Would create the Children's Health Security Program, an insurance product designed to cover all children whose family income falls below 300 percent of the federal poverty level (FPL) by July 1, 2009. The bill also includes a Task Force on Children's Health Care Coverage which would provide recommendations for the Children's Health Security Program to cover all children.

Current Status: Passed Health, Housing and Family Security Committee; Passed State and Local Government Operations and Oversight Committee; Passed Rules and Administration Committee; Referred to Finance Committee

Senate File 102 (House File 479) – Establishes a state commission charged with developing a detailed plan to achieve universal health insurance coverage in Minnesota. Requires a focus on preventive care and early interventions.

Current Status: Passed Health, Housing and Family Security Committee; Passed State and Local Government Operations and Oversight Committee; Referred to Rules and Administration Committee

Senate File 2171 – Omnibus Health and Human Services Appropriations Bill. Among other provisions mentioned above, the reform legislation includes creation of a Minnesota health insurance exchange, electronic health record system, revolving account and loan program, requires an electronic health records system by 2012, establishes uniform electronic transactions and implementation guide standards, and creates a health care transformation task force with the responsibility of developing an action plan for transforming the health care system to improve affordability, quality, and access.

Current Status: Vetoed by the Governor

House File 1 – Universal Access/State Children’s Health Insurance Program (SCHIP) Expansion. The Children’s Health Security Act would expand Medicaid benefits to children in families with income below 300 percent of FPL, with no enrollee premiums or cost-sharing requirements. Two years after enrollment for this population opens, children in families making above 300 percent of FPL become eligible, with no income cap. Families with private or federal insurance policies may also join the program, but the state insurance must remain the secondary policy. Children are defined as under age 19, or unmarried, financially dependent full-time students up to age 25. The state will seek federal waivers and approvals as necessary to expand MinnesotaCare. Implementation would occur on July 1, 2008 or after federal approval.

Current Status: Passed Health and Human Services Committee; Passed Governmental Operations, Reform, Technology and Elections Committee; Passed Finance Committee; Referred to Health Care and Human Services Finance Division

House File 475 (Senate File 816) – Extends the age of dependency to age 25, regardless of enrollment in an educational institution.

Current Status: Passed Health and Human Services Committee, Referred to Commerce and Labor Committee

Resources

Legislative/Public Information Office

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Minnesota Senate Counsel, Research and Fiscal Analysis
(651) 296-4791
www.senate.leg.state.mn.us/departments/office_bio.php?office_id=1007#header

Minnesota House Research
(651) 296-2146
www.house.leg.state.mn.us/hrd/hrd.htm

Minnesota Healthy Connections Proposal
www.governor.state.mn.us/mediacenter/pressreleases/PROD007915.html

Minnesota Department of Human Services
www.dhs.state.mn.us

Mississippi

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
2,910,540	17%	22%	13%	46%	4%	20%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The Mississippi Legislature adjourned in April 2007. While the Legislature was not able to increase the cigarette tax this year, there has been discussion that this is a possible legislative agenda item for the 2008 session. For two years, Governor Haley Barbour (R) has blocked legislation that would increase Mississippi's 18-cent-per-pack cigarette tax. However, recent articles in the Northeast Mississippi Daily Journal have indicated the Governor may be willing to consider an increase next year if it is part of a larger package decreasing taxes for Mississippi residents.

The state has also undertaken Medicaid reform resulting in several controversial reform proposals. One proposal removed the Poverty Level Aged and Disabled (PLAD) group, which is made up of approximately 65,000 individuals with disabilities and the elderly, from the Medicaid program. The state received a federal injunction, which prevented Mississippi from removing the PLAD group from the Medicaid program. In 2005, Mississippi implemented a face-to-face interview re-determination requirement to enroll in Medicaid. It is estimated that approximately 55,000 children are no longer receiving Medicaid due to the requirement. In September of 2006, the state's Division of Medicaid announced that Mississippi saved \$150 million dollars as a result of the face-to-face interview requirement.

Additionally, Mississippi, along with Louisiana and Alabama, has been stretched to provide health care services given the destruction from Hurricanes Katrina and Rita. In January 2007, all three states received grants to restore health care services damaged by the hurricanes. Mississippi received \$60.5 million, which is to be directed to hospitals and nursing facilities facing shortfalls in health care professionals at every level.

This \$60.5 million grant is part of the \$2 billion appropriation included in the Deficit Reduction Act of 2005. The appropriation was administered by the Centers for Medicare and Medicaid Services (CMS). Of the total, Mississippi received just under \$600 million,

which was used to cover the nonfederal share of Medicaid and the State Children's Health Insurance Program (SCHIP) expenditures for eligible individuals impacted by the hurricanes, uncompensated care services for individuals with a method of payment or insurance, and the nonfederal share of Medicaid and SCHIP expenditures for existing beneficiaries.

Several studies have been conducted on the impact of the hurricanes. It is estimated that 53 percent of households in Mississippi with an annual income below \$10,000 lost all salaried jobs in the household following the hurricanes, compared to 15 percent of households with annual incomes above \$20,000. The same report also indicated that uninsurance coverage rates for children in Mississippi drastically increased following the hurricanes (from 8 percent to 20 percent).

The Mississippi Legislature did not pursue legislation in 2007 that would have supported comprehensive health care reform, which is most likely due to the impact Hurricanes Katrina and Rita had on the state.

2007 Legislation and Study Efforts

House Concurrent Resolution 52 – Urges the Mississippi Congressional Delegation to do all within their power to ensure that Congress reauthorizes the State Children's Health Insurance Program (SCHIP) in a timely manner.

Current Status: Signed into law by the Governor

House Concurrent Resolution 88 – Requests and encourages the Centers for Medicare and Medicaid Services (CMS) to cease and desist in their efforts to change the rules regarding Medicaid financing to the detriment of the hospitals and other health care businesses and professionals that provide essential health care services to the elderly, the disabled, and other needy populations in Mississippi.

Current Status: Signed into law by the Governor

Resources

Legislative/Public Information Office

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Websites

Mississippi Department of Health
www.healthys.com

Mississippi Division of Medicaid
www.dom.state.ms.us

Missouri

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
5,842,713	12%	16%	8%	56%	5%	13%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Missouri’s General Assembly officially adjourned on Friday, May 18, although there has been discussion of a special session. One of the top issues they addressed on the last day of the session was the Missouri Health Improvement Act of 2007 (Senate Bill 577), a Medicaid reform bill. Much of what is contained in the reform bill resulted from the work of the 2005 Medicaid Reform Commission.

The Senate and House reached compromise on the legislation, which changes the name of the Medicaid program to MO Healthnet, places greater emphasis on quality of care and patient responsibility, and would restore certain health benefits to certain groups that were cut two years ago. Governor Matt Blunt (R) will make the final decision as to whether Senate Bill 577 addresses all of the issues he was interested in pursuing around the issue of Medicaid reform and whether the Legislature provided adequate funding to support the reforms.

Missouri policymakers also passed the Missouri Health Insurance Portability and Accountability Act. Included in this large piece of legislation is the requirement that all qualified state employees and retirees have the option of receiving health care coverage through a high-deductible plan combined with a health savings account, new rules for insurance companies around the issues of preexisting conditions, new requirements for employers, rules about the Missouri Health Insurance Pool, among several other issues.

The Missouri Universal Health Insurance Act (House Bill 484) was introduced and referred to a special committee on health insurance, but did not advance out of the committee. The Act would have created a universal health care system for Missouri residents. A 2003 report on universal health care coverage was developed by the Missouri Foundation for Health, A Universal Health Care Plan for Missouri. This plan made estimates on the cost of such a system, how the system could be funded, and provided information about how private and public insurance, employers, and individuals would interact with the system.

House Bill 1071 was also referred to the special committee on health insurance, but did not advance out of the Committee. House Bill 1071 would have required group insurance policies to cover dependent children with chronic illnesses until the age of 25 or until the child marries. This legislation was also introduced in 2006 (House Bill 1612), but did not pass out of committee by the end of the regular session.

During the 2006 session, Missouri policymakers also explored legislation that would require applicants for state-funded medical assistance programs to disclose their employer or the employer of the person upon whom they are a dependent. Each year, the Department of Social Services would have reported the employers with over 50 employees that had at least 25 employees on public assistance. This legislation did not pass and was not reintroduced in 2007.

2007 Legislation and Study Efforts

Senate Bill 577 – Establishes the Missouri Health Improvement Act of 2007, modifying various provisions relating to the state medical assistance program and changing the name of the Medicaid program to MO HealthNet. The proposal focuses on reforming the Medicaid system, giving more access to health insurance, offering wellness prevention, improving quality of life, ensuring better health outcomes, and promoting disease preventions.

Current Status: Sent to the Governor for Signature

House Bill 818 – Establishes the Missouri Health Insurance Portability and Accountability Act and changes the laws regarding the Missouri Health Insurance Pool and health care insurance.

Current Status: Sent to the Governor for Signature

Resources

Legislative/Public Information Office

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Websites

Missouri Legislature
www.moga.mo.gov

2005 Medicaid Reform Commission Report
www.senate.mo.gov/medicaidreform

Missouri Department of Social Services
www.dss.mo.gov

Missouri Department of Insurance
<http://insurance.mo.gov>

Montana

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
944,632	17%	22%	14%	47%	8%	11%	14%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Montana has concluded its 2007 legislative session after reconvening briefly for a special session to address the budget bill. The Montana Legislature will not reconvene again until January 2009. Montana has begun to reduce the number of uninsured working residents through laws and programs that reduce the cost of insurance for small employers. The state has instituted tax credits for businesses to support the purchase of health insurance coverage for their employees.

The Insure Montana program, which was established by Montana Governor Brian Schweitzer (D) and the State Auditor John Morrison (also the Insurance Commissioner) in 2005, is funded by an increase in the state's cigarette tax. Currently, the program is serving over 1,400 businesses, which translates into health care coverage for nearly 8,000 Montana residents. The program has had to institute a waiting list as program funds have been depleted. It is still unclear whether or not additional funds were appropriated to support the program during this year's legislative session.

Small businesses with two to nine employees can take advantage of the program if they purchase health insurance for their employees. Businesses that pay for some or all of health insurance costs for their employees can take advantage of the tax credit, whether or not they have previously provided health insurance to their employees. Additional credits are available for providing health insurance to an employee's spouse and/or dependents.

The refundable tax credit is funded by a \$1 increase in tobacco tax and cannot be more than 50 percent of the premiums paid. Business owners or their employees who make more than \$75,000 per year are not eligible for the refundable tax credit and employers cannot pay premiums from a health savings account and receive the refundable tax credit. For each eligible employee, spouse and/or dependant, an employer may claim: \$100 per month per

employee of premium costs; \$100 per month per employee's spouse of premium costs; \$40 per month per employee's dependants of premium costs; and, if the average age of a business' employees is 45 or older the tax credit increases to \$125 per employee.

To take advantage of the refundable tax credits, businesses apply to the state auditor. Businesses then receive a letter confirming eligibility and providing them with their rank on the tax credit list. There are a limited number of slots available for businesses that want to take advantage of the refundable tax credit.

This year, the Legislature passed House Joint Resolution 48, which creates an interim study of health insurance reform and publicly-funded health care programs.

2007 Legislation and Study Efforts

Senate Bill 22 – Increases the State Children's Health Insurance Program (SCHIP) eligibility level for children in families with income up to 175 percent of federal poverty level from the current level of 150 percent provided there is funding available. The bill requires the state to leverage any federal dollars available to fund the program, possibly through a Medicaid waiver.

Current Status: Sent to the Governor for Signature

Senate Bill 419 – Allows young adults, up to age 26, to remain on parents' coverage.

Current Status: Signed into law by the Governor

Senate Bill 498 – Establishes a group to design a universal health care system for all Montanans and to develop legislation for putting the system in place.

Current Status: Passed Public Health, Welfare and Safety Committee; Referred to Appropriations Committee; No Action Taken in Standing Committee; Session Adjourned

House Joint Resolution 48 – Calls for a study of health insurance reform and publicly-funded health care programs to occur over the approximate 15-month interim period. Lawmakers in Montana are able to rank proposed studies, and House Joint Resolution 48 was the top-ranked study to pursue during the interim.

Current Status: Filed with Secretary of State

House Bill 687 – Expanded the age for well-child coverage visits, impacting insurance companies. The legislation expands the age from two to seven and would take effect on January 1, 2008.

Current Status: Signed into law by the Governor

Resources

Legislative/Public Information Office

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Websites

Insure Montana
www.insuremontana.org

Montana Department of Public Health and Human Services
www.dphhs.mt.gov

Montana State Auditor's Office
<http://sao.mt.gov/>

Nebraska

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,768,331	10%	14%	6%	59%	7%	10%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

In 2005, approximately 200,000 Nebraskans were eligible for Medicaid benefits, representing one in every nine residents. Between 1987 and 2005, Medicaid appropriations from the State General Fund grew astronomically, from \$201 million in 1987 to \$1.4 billion in 2005, representing 17.2 percent of General Fund appropriations. In 2006, the Nebraska Department of Health and Human Services (DHHS) projected that by 2025, if Medicaid continued to be funded at the current proportion of General Fund revenues, the state would need an estimated additional \$713 million in funding for the Medicaid program. In addition, Nebraska has a large percentage of its population living in rural and underserved areas. In 2005, over half of Nebraska’s counties (49 of 93) were federally designated, either in full or in part, as primary care Health Professional Shortage Areas. Seventy-one of its 93 counties were designated as a Medically Underserved Area or Population.

In response to excessive growth in Medicaid expenditures and concern about the program’s fiscal sustainability, the Nebraska Legislature mandated the development of a Medicaid Reform Plan in 2005 (LB 709). The Medicaid Reform Plan was prepared with input from the executive and legislative branches, as well as the public. LB 709 also established a Medicaid Reform Advisory Council, which reviewed the plan and provided recommendations during the development of the plan.

Since the publication of the Medicaid Reform Plan and recommendations, initial steps have been taken to implement reform in areas identified as concerns because of high utilization and costs, including long-term care and prescription drugs. The initial Medicaid Reform Plan established a Rural Long Term Care Committee, which identified barriers and suggested strategies to incorporate less reliance on institutional care and serve more consumers in their homes and communities. The recommendations are being incorporated into a Money Follows the Person grant received by Nebraska from the Centers for Medicare and Medicaid

Services. The Department of Health and Human Services plans to hire an independent manager for the grant and begin implementation by July 2007. The goal of the grant is to transition up to 900 individuals from institutional settings to home and community-based services in a five-year period. This represents 10 percent of the institutionalized Medicaid population.

Nebraska has also started a long-term care awareness effort, an opportunity afforded to states with the passage of the federal Deficit Reduction Act of 2005. With an emphasis on personal responsibility, Nebraska is providing incentives for individuals who take out long-term care insurance and later apply for Medicaid assistance. This effort will begin by the end of 2007.

The fastest growing expenditure category in the Medicaid program is prescription drugs. As part of the Medicaid Reform Plan, a work group was assigned to provide recommendations regarding Nebraska's prescription drug program. As a result, a Request for Proposals (RFP) was issued for an independent consulting agency to study the feasibility of implementing a Preferred Drug List and Pooled Purchasing. Mercer Human Resource Consulting was hired and will provide a report at the end of October 2007. Consumers groups in Nebraska, including the AARP, have advocated for a Preferred Drug List and Pooled Purchasing because of the benefit of public access to information.

LB 1248 passed the Legislature in 2006 as a follow-up to the Medicaid Reform Plan and provides for implementation of several reform recommendations. Among other things, LB 1248 provides for two studies that were initially recommended in the Medicaid Reform Plan. One study directs the department to study administering the State Children's Health Insurance Program (SCHIP) program as a separate program. The legislation requests that the study review the possibility of state flexibility in limiting coverage and charging higher co-payments, premiums, and deductibles. The current SCHIP program, called Kid's Connection, provides health care for children whose families earn up to 185 percent of the federal poverty level. The report is due December 1, 2007. The second study directs the department to study restructuring Medicaid from a defined benefit program, which includes entitlement to all medically necessary services available, regardless of cost, to a defined contribution model in which benefits vary according to individual needs. The final report is due by December 1, 2008.

Resources

Websites

Nebraska Legislature

<http://www.unicam.state.ne.us/web/public/home>

The Nebraska Health Information Project Data Book

<http://www.unmc.edu/nebraska/databooks/2005-data%20book/2005-default.htm>

Nebraska Legislature Legislative Audit and Research Office

<http://www.unicam.state.ne.us/web/public/legresearch>

Nebraska Medicaid Reform Website

<http://www.hhs.state.ne.us/med/reform/>

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Nevada

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
2,495,529	18%	22%	16%	58%	4%	7%	12%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Nevada ranks 48th in the US in the number of physicians, 49th in the number of nurses, and 48th in the number of dentists per 100,000 residents. Nevada’s population is growing at a very quick pace – the population will more than double in the next 25 years. The State also has one of the highest rates of uninsured residents at approximately 19 percent of total population, and contributing to this issue is the low participation in Medicaid. In addition, Nevada has a disproportionately high percentage of its population in poor mental health, ranking first among the western states in the prevalence of the population with mental illness. In 2006, Nevada received approval for an 1115 Health Insurance and Flexibility Act (HIFA) Waiver, which covers uninsured parents whose children are covered by Medicaid or Nevada Check Up, Nevada’s State Children’s Health Insurance Program (SCHIP), through employer-sponsored insurance, and pregnant women up to 185 percent of the federal poverty level (FPL). Eligible small employers are able to access this program, and the state contributes a portion of the monthly premium costs.

The Nevada Legislative Committee on Health Care met in ten interim meetings during 2006 and developed the State Health Plan for Nevada. The Committee included input and participation from citizens in various ways, including focus groups and a Stakeholders’ Health Summit. The Plan was published in February 2007 and focuses on seven major areas as a basis for its recommendations. They include: 1) Improve and expand opportunities for health care professional education to increase the number of licensed health care professionals in the state; 2) Expand Medicaid and SCHIP program eligibility, enrollment and service coverage (including expansion of income eligibility to 100 percent of the federal poverty level for parents and enhancement of services under the home and community based waivers); 3) Develop ways for small employers to access health insurance; 4) Support and expand the safety net provider network; 5) Increase access and funding for mental health and substance abuse services; 6) Expand and create prevention and wellness programs; and 7) Create

formalized planning bodies to coordinate and disseminate information on health care policy, quality, community needs, workforce issues, and health information technology.

Several major pieces of legislation are currently pending in the Nevada Legislature focused on key recommendations from the Legislative Committee on Health Care. Senate Bill 221 establishes an Office of Health Planning, Analysis, and Policy Support within the Department of Health and Human Services to conduct policy analysis and coordinate and disseminate information on health care quality and cost. The legislation provides for staffing of the Office and creation of an information system for warehousing of medical and health records data. Senate Bill 526 expands nursing programs within the Universities and Community Colleges in the state. This proposal is expected to help address the shortage of nurses employed in the state and assist nursing programs in opening more slots for nursing applicants.

Because of a significantly large population of individuals with mental illness who have overwhelmed the safety net system, the Legislature poured money into the mental health system last year by increasing the overall budget by about 30 percent and funding an additional mental health hospital. To expand and support the safety net provider network in Nevada, Senate Bill 522 proposes funding for expansion of federally qualified health centers and rural health clinics, as well as support for emergency services in rural counties.

2007 Legislation and Study Efforts

Senate Bill 221 – Establishes an Office of Health Planning, Analysis, and Policy Support within the Department of Health and Human Services and creates an information system for warehousing of medical and health records data.

Current Status: Referred to Senate Finance Committee

Senate Bill 522 – Proposes funding for the expansion of federally qualified health centers and rural health clinics and provides support for emergency services in rural counties.

Current Status: Referred to Senate Finance Committee

Senate Bill 526 – Expands nursing programs within the Universities and Community Colleges in the state by doubling their availability. The rationale is both a shortage of nurses and reports by nursing programs that they have to turn qualified applicants away because slots fill up quickly.

Current Status: Referred to Senate Finance Committee

Resources

Legislative/Public Information Office

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Websites

Nevada Legislature
<http://www.leg.state.nv.us/>

Nevada Legislative Committee on Health Care
<http://www.leg.state.nv.us/73rd/Interim/StatCom/HealthCare/>

Research Division of the Nevada Legislative Counsel Bureau
<http://www.leg.state.nv.us/lcb/research/>

New Hampshire

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,314,895	10%	13%	6%	67%	4%	6%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

New Hampshire is similar to Iowa in that it enjoys fairly low uninsured rates – 13 percent of non-elderly adults and 6 percent of children are uninsured. However, the state is characterized by high health insurance premiums and only three large private insurers in the state. Additionally, the New Hampshire Department of Insurance receives its funding from insurance companies through a levy upon insurance companies to cover administrative costs and direct billing to companies for examination costs. Employers in New Hampshire, specifically through the business and industry association, have expressed concerns about the rising costs of employer-sponsored health insurance. Long-term care is a significant concern in New Hampshire as it has, like many other states, an aging population with few financial resources for long-term care supports. Utilization of behavioral health services by adults at community mental health centers has also skyrocketed – an increase in state fiscal year 2007 of 29 percent from the previous year.

New Hampshire recently introduced HealthCost, a website hosted by the state that provides information on the price of medical care in New Hampshire. The New Hampshire Insurance Department and the Commissioner’s Advisory Committee on Health Insurance developed the website in 2005. The New Hampshire General Court has introduced a great number of bills this year that address health insurance costs and expansion. House Bill 517 establishes a commission to investigate cost drivers in providing health care, and is expected to pass in the House and Senate. House Bill 305 establishes a task force to develop legislation for expanding access to affordable health insurance for the 2008 and 2009 legislative session. Yet another bill, Senate Bill 135, provides for a study to lower the costs of health insurance for small businesses. Legislation to allow youth up to the age of 26 to stay on their parents’ insurance plans (House Bill 790) has received a lot of attention this year and is expected to pass the House and Senate. House Bill 790 also establishes a joint oversight committee on

insurance expansion initiatives. Legislation establishing a study of a single payer health care system (House Bill 88) passed the House this year, but was carried over to the 2008 Senate.

Public health initiatives have also been a large focus of legislative efforts this year in New Hampshire, including a smoking ban in bars and restaurants that is expected to pass the House and Senate. Legislation proposing a prescription drug discount program for those with no drug insurance (previously HB 628) has been tacked onto the previously-mentioned commission bill (HB 517) and would offer Medicaid discounts to non-Medicaid individuals who meet eligibility requirements.

2007 Legislation and Study Efforts

House Bill 790 – Expands the definition of dependent young adults to those who are less than 26 years old for purposes of insurance coverage and does not require enrollment as a student. A joint oversight committee on insurance expansion initiatives is established by the bill and charged with reviewing reports filed by the commissioner to monitor the effectiveness and cost of the insurance expansion program.

Current Status: Passed House, Passed Senate with Amendment

Senate Bill 135 – Establishes a commission to study lowering the costs of health insurance for small business, including identifying approaches and products that can reduce the rate of cost growth.

Current Status: Passed Senate, Referred to House Commerce Committee

House Bill 517 – Establishes a commission to investigate cost drivers in providing health care. The commission shall review and study health care cost drivers including, but not limited to: cost shifting associated with federal and state reimbursements, cost shifting associated with providing care for the uninsured, costs associated with medical malpractice insurance rates, regional issues that may affect costs of providing health care, hospital new construction costs and overhead costs for the past five years, hospital new services and overhead costs for the past five years, other areas that may affect the cost of providing health care.

Current Status: Passed House, Referred to Senate Health and Human Services Committee

House Bill 305 – Establishes a task force to develop legislation to expand access to affordable health insurance for the 2008 -2009 legislative session.

Current Status: Passed House, Referred to Senate Commerce, Labor and Consumer Protection Committee

House Bill 88 – Establishes a committee to study single payer health care.

Current Status: Passed House, Laid on Table in Senate (carried over to 2008)

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New Hampshire General Court
<http://www.gencourt.state.nh.us/ie/>

New Hampshire General Court Office of Legislative Budget Assistant
http://www.gencourt.state.nh.us/lba/staff_all.html

New Hampshire Health Cost website
<http://www.nhhealthcost.org/>

New Jersey

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
8,724,560	14%	18%	10%	63%	3%	8%	12%	0%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The New Jersey Legislature is somewhat unique in that its sessions are year-long with a start date in January. They are currently in the 2006-2007 session, and legislation carries over from the first year into the second, so the current Legislature is able to consider all legislation proposed as of the start of the 2006 session. New Jersey is one of several states expected to run out of federal funding for the State Children's Health Insurance Program (SCHIP) sometime in May 2007. The SCHIP program is called New Jersey Family Care and provides coverage for uninsured children up to 200 percent of the federal poverty level at no cost and children up to 350 percent of the federal poverty level (FPL) with parents paying part of the premium and low co-pays. The program also provides coverage for low-income parents at 115 percent of the FPL or below.

New Jersey is known for having a high number of health insurance mandates, including coverage of some very costly services, such as infertility treatment. In 2003, to ensure that any newly-created health insurance mandates were appropriate, the New Jersey Legislature created the Mandated Health Benefit Advisory Commission to review the social and financial impact and medical efficacy of any proposed mandates. The Commission is charged with reviewing any bill introduced in either House that would require a carrier to provide a mandated health benefit and provide its comments and recommendations in writing to the prime sponsor, committee chairman, and presiding officer of the House in which the bill is pending.

New Jersey participates in many Medicaid waivers from the Centers for Medicare and Medicaid Services (CMS), including a self-directed, cash and counseling waiver for individuals receiving community-based services, a community care program for the elderly and disabled, and an Enhanced Community Options waiver. The Catastrophic Illness in Children Relief Fund and Commission were created in 1989 and provide awards to help families deal

with their children's extraordinary medical expenses. The funding is collected from an annual surcharge of \$1 per employee levied on all employers who are subject to the New Jersey Unemployment Compensation Law. Most families helped by the Fund are working parents with health insurance who have catastrophic out-of-pocket expenses (typically greater than 10 percent of their income).

Governor Jon Corzine (D) has a particular interest in ensuring financial responsibility and accountability in health care expenditures. In 2006, he signed an executive order creating the Commission on Rationalizing Health Care Resources. The hospital industry is the fifth largest industry in the State, employing nearly 150,000 New Jersey residents, and many hospitals have closed in the previous ten years. Because hospital services are an essential component of the health care system and provide crucial services to individuals who do not have a regular care provider, the Governor determined a need to review hospital capacity and demand for hospital services across the state. The Commission is charged with assessing the in-patient capacity and primary care outcomes to better understand how to improve access to care and promote better health outcomes. The Commission is expected to develop and publish a State Health Care Resource Allocation Plan and issue a written report of its findings and recommendations no later than June 1, 2007 to the Governor, the Senate President, the Senate Minority Leader, the Assembly Speaker, and the Assembly Minority Leader. Also, in 2006, the Smoke-Free Air Act was implemented. This act prohibits smoking in restaurants, workplaces, and other public places.

There are two pieces of legislation currently before the New Jersey Legislature that aim to improve the availability of and participation in health care plans among small employers and employees. Senate Number 503 (Assembly Number 2056), known as the Health Insurance Affordability and Accessibility Reform Act, attempts to restructure the health insurance marketplace to stabilize costs of, and enrollment in, individual and small employer health benefits plans. The legislation sets guidelines for premium rates and requires insurance carriers to offer individuals a choice of plans developed by the New Jersey Individual Health Coverage Program Board, and small employers the health benefits plans established by the New Jersey Small Employer Health Benefits Program Board. Assembly Number 3766 establishes the New Jersey Health Insurance Exchange as an independent public entity to make health coverage plans available to employees of small businesses. The Exchange would enroll eligible persons and small employers, operate a service center, and publicize the exchange's services, among other activities.

2007 Legislation and Study Efforts

Senate Number 503 – The Health Insurance Affordability and Accessibility Reform Act sets guidelines for premium rates and requires insurance carriers to offer individuals a choice of plans developed by the New Jersey Individual Health Coverage Program Board and small employers the health benefits plans established by the New Jersey Small Employer Health Benefits Program Board.

Current Status: Referred to Senate Commerce Committee

Assembly Number 2056 – The Health Insurance Affordability and Accessibility Reform Act sets guidelines for premium rates and requires insurance carriers to offer individuals a choice of plans developed by the New Jersey Individual Health Coverage Program Board and every small employer the health benefits plans established by the New Jersey Small Employer Health Benefits Program Board.

Current Status: Referred to Assembly Financial Institutions and Insurance Committee

Assembly Number 3766 – Establishes the New Jersey Health Insurance Exchange as an independent public entity to make health coverage plans available to employees of small businesses. The Exchange would enroll eligible persons and small employers, operate a service center, and publicize the exchange’s services, among other activities.

Current Status: Referred to Financial Institutions and Insurance Committee

Mandated Health Benefit Advisory Commission – Created in 2003 to review the social and financial impact and medical efficacy of any proposed mandates. The Commission is charged with reviewing any bill introduced in either House that would require a carrier to provide a mandated health benefit and provide its comments and recommendations in writing to the prime sponsor, committee chairman, and presiding officer of the chamber in which the bill is pending.

Commission on Rationalizing Health Care Resources – Created by executive order in 2006, the Commission is charged with assessing the in-patient capacity and primary care outcomes to better understand how to improve access to care and promote better health outcomes. The Commission is expected to develop and publish a State Health Care Resource Allocation Plan and issue a written report of its findings and recommendations no later than June 1, 2007, to the Governor, the Senate President, the Senate Minority Leader, the Assembly Speaker, and the Assembly Minority Leader.

Resources

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Websites

New Jersey Legislature:
<http://www.njleg.state.nj.us/Default.asp>
Governor’s Commission on Rationalizing Health Care Resources
<http://www.state.nj.us/health/rhc/index.shtml>

State of New Jersey Office of the Governor
<http://www.state.nj.us/governor/>

New Mexico

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,954,599	20%	25%	18%	44%	4%	17%	13%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

New Mexico is plagued by very high uninsured and poverty rates, as well as a large percentage of self-employed and small businesses. Because of its low per capita income, New Mexico has a high Federal Medical Assistance Percentage (FMAP) at 70 percent, and the state therefore attempts to take every opportunity to maximize its Medicaid programs. With Governor Bill Richardson’s (D) leadership, the State has implemented several programs and tools recently to try to expand the percentage of individuals in the state covered by some type of insurance plan. Insure New Mexico is an initiative led by Governor Bill Richardson to reduce the number of working New Mexicans without health insurance. Initiated in 2004 through an Executive Order, it includes a variety of strategies to help more individuals access health insurance.

Through a Health Insurance and Flexibility Act (HIFA) Waiver from the Centers for Medicare and Medicaid, which was approved in 2002, New Mexico offers State Coverage Insurance (SCI), affordable health care coverage to uninsured adults ages 19 to 64 with incomes up to 200 percent of the federal poverty level (FPL). The Small Employer Insurance Program (SEIP) began in Fiscal Year 2006 with a comprehensive benefit package available for employees of small businesses who have not had health insurance for the past twelve months. New Mexico has also provided insurance for high risk individuals since 1987 through the New Mexico Medical Insurance Pool (NMMIP). The Governor and New Mexico Human Services Department proposed a Medicaid expansion to cover all adults under 100 percent of FPL, and the Legislature provided \$7.9 million to implement the expansion (included in House Bill 2).

The Insure New Mexico effort includes the Health Coverage for New Mexicans Committee, which was charged with selecting three health care models for potential future implementation in New Mexico. Three models were selected by the committee in 2006, and an independent firm, Mathematica, was hired to analyze the costs to employers, the state, individuals, and health care companies for each model. The analysis is expected to be reported sometime before the end of 2007 and the Committee will make recommendations to the Governor and Legislature for the 2008 legislative session. The three models chosen are: the Health Security Act, a single plan administered by a commission appointed by the Governor; the New Mexico Health Choices Plan, market-based universal coverage through vouchers provided to individuals; and the New Mexico Health Coverage Plan, which builds on the current public/private health care system in the state.

2007 Legislation and Study Efforts

House Bill 2 – General Appropriations. Provides \$7.9 million for the expansion of a Medicaid program for individuals under 100 percent of federal poverty level.

Current Status: Chaptered

Health Coverage for New Mexicans Committee – Charged with selecting three health care models for potential future implementation in New Mexico. Three models were selected by the committee in 2006, and an independent firm, Mathematica, was hired to analyze the costs to employers, the state, individuals, and health care companies for each model. The analysis is expected to be reported sometime before the end of 2007 and the Committee will make recommendations to the Governor and Legislature for the 2008 legislative session.

Resources

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Websites

New Mexico Legislature

<http://legis.state.nm.us/lcs/>

Insure New Mexico Executive Order

http://www.governor.state.nm.us/orders/2004/EO_2004_058.pdf

Insure New Mexico Website

<http://insurenemexico.state.nm.us/index2.html>

New Mexico Office of the Governor Website

<http://www.governor.state.nm.us/index2.php>

New York

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
19,306,183	13%	17%	8%	53%	4%	18%	12%	0%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

On December 30, 1999, former New York Governor George Pataki (R) signed the New York Health Care Reform Act of 2000 (HCRA). Three new programs to help improve health care coverage for uninsured New Yorkers were implemented as a result of the legislation. The reform initiatives were funded through proceeds from a 55-cent per pack cigarette tax increase and a portion of New York’s share of the national tobacco settlement, as well as cost sharing with the federal government and counties, where applicable.

The Family Health Plus program (FHP) was part of the HCRA and offers health insurance at no cost to nonelderly adults with children who have incomes up to 150 percent of the federal poverty level (FPL), and nonelderly adults without children with incomes up to FPL. Healthy New York, another program begun in 2000, provides health care coverage for small businesses and working, uninsured New Yorkers at a reduced cost. All HMOs in New York State offer the streamlined, yet comprehensive Healthy NY health insurance benefit packages to eligible businesses and working, uninsured individuals. Lastly, the HCRA of 2000 created two stop-loss funds to help protect individuals from the high costs of individual health insurance plans. The funds provide reimbursements for insurers with high cost claims. Under this program, insurers are reimbursed for 90 percent of the cost their claims when costs range between \$20,000 and \$100,000 for each member per calendar year.

In 2006, New York implemented a Federal-State Health Reform Partnership (FSHRP) utilizing a Medicaid Section 1115 Waiver. The demonstration waiver targets restructuring of the acute and long-term care delivery systems by shifting to more community-based settings, investing in information technology to expand the use of e-prescribing and regional health information organizations, and expanding ambulatory and primary care services by shifting the system’s focus away from inpatient facilities to outpatient and primary care settings. The waiver is a five-year demonstration project and New York will conduct an evaluation of the impact of the project at the end of the period.

The current Governor Eliot Spitzer (D) has led an effort to address massive state spending on Medicaid and other health care initiatives. According to Governor Spitzer, New York spends more money on Medicaid per capita than any other state, and double the national average. The Governor's Patients First agenda focuses on implementing savings while also improving outcomes for patients. His approach is to shift money away from institutional settings and implement increased accountability and rational spending. The yearly Medicaid budget is \$45 billion a year, and more money is spent on hospitals and nursing homes in New York than in any other state in the US.

The 2008 fiscal year (FY) budget was recently approved by the Legislature and hailed by Governor Spitzer as a victory. The budget includes over \$1 billion in cost savings to Medicaid which significantly reduces the rate of growth in Medicaid spending as well as an expansion of Child Health Plus (New York's State Children's Health Insurance Program, SCHIP) to provide access to health coverage for all uninsured children in New York. The expansion of Child Health Plus includes coverage for children in families with incomes up to 400 percent of FPL. In addition, the 2008 FY budget streamlines the Medicaid enrollment process and makes a \$200 million investment in disease prevention and primary care. The Legislature enacted 73 percent of the reductions in Medicaid spending proposed by the Governor. Savings were achieved by reducing trend factors in reimbursement rates, decreasing workforce recruitment funds (and redirecting those funds to hospitals with high Medicaid populations), setting Graduate Medical Education costs based on current services, and eliminating historical trends that set such costs artificially high. Also, a Preferred Drug Program will be implemented January 1, 2008.

Resources

Websites

New York State Assembly
<http://assembly.state.ny.us/>

New York Governor Eliot Spitzer
<http://www.ny.gov/governor/>

New York State Senate
<http://www.senate.state.ny.us/senatehomepage.nsf/home?openform>

Family Health Plus website
<http://www.health.state.ny.us/nysdoh/fhplus/>

Healthy New York website
<http://www.ins.state.ny.us/website2/hny/english/hny.htm>

North Carolina

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
8,856,505	15%	20%	11%	53%	5%	13%	12%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Like many states, North Carolina’s uninsured population is on the rise, primarily due to a decline in employer-sponsored health insurance. A large percentage (approximately 23 percent) of its uninsured population represents small business employees. Blue Cross Blue Shield of North Carolina has a large presence in the state and is the only private insurer in North Carolina that will voluntarily cover any individual regardless of health status or preexisting conditions, although premiums are often too expensive for those who need it. North Carolina’s State Children’s Health Insurance Program (SCHIP) program provides coverage to low-income children with family incomes up to 200 percent of the federal poverty level (FPL).

In 2005, the North Carolina Department of Health and Human Services (DHHS) received a one-year planning grant from the Health Resources and Services Administration within the US Department of Health and Human Services. The grant activities were guided by a partnership between the North Carolina DHHS, the North Carolina Department of Insurance, the Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and the North Carolina Institute of Medicine (NC IOM). The NC IOM Task Force on Covering the Uninsured was formed to review issues unique to North Carolina and suggest policy recommendations. The final report was issued in April 2006 with several strategies, including expansion of the health care safety net, promotion of personal responsibility, an insurance product for small businesses, and a high risk insurance pool for individuals with pre-existing conditions.

The House Select Committee on Health Care was established in November of 2005 by the Speaker of the House of Representatives with the purpose of studying specific health care issues in the state and providing recommendations for legislation. The Committee issued its

final report in December of 2006 with some findings similar to the NC IOM Task Force. The Committee recommended, among other things, establishment of a high risk insurance pool, a ban on smoking in public places, expansion of community health care grants, and improving children's access to health care coverage.

The major legislation to occur as a result of the recommendations of the House Select Committee on Health Care is a bill to establish a high risk pool. House Bill 265 has passed in the House and appears to have a good chance of passing in the Senate. Several pieces of legislation provide for smoking bans. House Bill 1294 prohibits smoking in long-term care facilities and is likely to pass the Senate (and has already passed the House). Legislation banning smoking in public and work places (House Bill 259 and Senate Bill 635) died this year. Senate Bill 43, which prohibits smoking in state government buildings, did not make it out of committee. Also, House Bill 901 to amend the North Carolina Constitution to recognize the right for all to health care failed to pass out of committee.

Mental health reform that was initiated in 2002 has been slow being fully implemented and has been criticized for not reaching the goals set out by the project. Much like Iowa, mental health services are implemented locally through Local Management Entities (LMEs). With the reform, area mental health programs became LMEs and separated management and clinical functions. Direct services are provided through contracts with local private providers. The goals of the reform are to improve access to services, increase availability of service options (especially community-based services), and create system accountability. There have been some successful efforts as a result of the reform. A redesigned waiver for individuals with disabilities improved flexibility and allowed for self-directed care planning. North Carolina made changes to the system to better coordinate children's services following the System of Care best practice model, including funding for a System of Care liaison in every LME. Most importantly, the closure of bed spaces in many state psychiatric and developmental centers, provided savings that were transferred into community service budgets. The implementation of the reform is ongoing, and annual state plans address current status of the various components of the reform.

2007 Legislation and Study Efforts

House Bill 265- Establishes the North Carolina Health Insurance Risk Pool
Current Status: Passed House, Referred to Senate Committee on Commerce, Small Business and Entrepreneurship.

House Bill 1294 – Prohibits smoking inside long-term care facilities.
Current Status: Passed House, Referred to Senate Committee on Health Care

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North Carolina General Assembly
www.ncleg.net

House Select Committee on Health Care Final Report
[http://www.ncleg.net/documentsites/legislativepublications/Study%20Reports%20to%20the%202007%20NCGA/Health%20Care%20-%20House%20Select%20Committee%20\(Some%20Appendices%20Only%20in%20Print%20Version\).pdf](http://www.ncleg.net/documentsites/legislativepublications/Study%20Reports%20to%20the%202007%20NCGA/Health%20Care%20-%20House%20Select%20Committee%20(Some%20Appendices%20Only%20in%20Print%20Version).pdf)

North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
<http://www.dhhs.state.nc.us/mhddsas/whatsnew.htm>

North Carolina Institute of Medicine Task Force on Covering the Uninsured
<http://www.nciom.org/projects/uninsured/uninsuredreport.html>

North Dakota

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
635,867	11%	13%	9%	56%	10%	8%	14%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

North Dakota faces unique challenges and barriers because it is a very rural state. All but 5 counties of 53 are designated in full or in part as geographic, low income, or facility health professional shortage areas. Only three counties do not have some part of the county or all of the county designated as a medically underserved area. Two of those counties are designated as a medically underserved population. North Dakota has a high risk health insurance pool that has been in place since 1982, and also offers tax incentives for the purchase of long-term care insurance.

The North Dakota Legislature recognized that long-term care is a significant and growing issue in the state, and passed emergency legislation to study the state’s long-term care system. The study will review capacity, geographical boundaries, the need for home and community-based services, and development of a methodology for identifying areas of the state in need of additional skilled nursing facility beds, access, workforce, reimbursement, and payment incentives (Senate Bill 2109). Senate Bill 2109 also establishes a moratorium on the expansion of long-term care bed capacity.

Another major focus of the North Dakota Legislature this year was on access to emergency services, especially in rural areas. House Bill 1004 provided for a study of the emergency medical services system in the state, including a review of the funding, demographics, and impact on rural areas. Lastly, the North Dakota Legislature took a big step toward helping more children access health insurance by expanding the state’s State Children’s Health Insurance Program (SCHIP) income eligibility limit to 200 percent of the federal poverty level (FPL) from 140 percent (House Bill 1047). The North Dakota Legislature discussed universal health care coverage for children extensively, but no legislation was introduced or passed.

2007 Legislation and Study Efforts

Senate Bill 2109 – Establishes a moratorium on the licensing of basic care for medical assistance recipient beds and the moratorium on expansion of long-term care bed capacity; provides for a legislative council study of the long-term care system; and declares an emergency.

Current Status: Enrolled

House Bill 1004 – Provides for a 2007-2008 interim study of the emergency medical services system in the state, including the funding, demographics, and impact on rural areas.

Current Status: Enrolled

House Bill 1047 – Increases the income eligibility limit for the SCHIP program to 200 percent of the federal poverty level.

Current Status: Enrolled

Resources

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Department of Human Services
<http://www.nd.gov/humanservices/>

North Dakota Legislative Council
<http://www.legis.nd.gov/council/>

Ohio

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
11,478,006	11%	14%	8%	60%	4%	12%	12%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

While Ohio’s uninsured population is below the US average at 11 percent, the state is experiencing a growing elderly population. The US Census Bureau predicts that by the year 2025, Ohio’s elderly population will account for nearly 20 percent of its total population. Medicaid is the biggest single budget item in Ohio, and both chambers of the Ohio Legislature intend to conduct hearings on the issue of health care access. In the House, the newly-created House Health Care Access and Affordability Committee has already started hearing testimony.

Like most states, there has been an imbalance in Ohio’s spending for long-term care services with a greater funding emphasis on institutional care than community-based services. In 2004, the *Martin v. Taft et al* class action lawsuit was finally settled in Ohio. The Ohio Legal Rights Service (OLRS) filed the case in 1989 on behalf of 8,000 Ohio citizens with disabilities. The plaintiffs sought relief to the state’s bias toward institutional placement and a reduction to the state’s waiting list for community residential services. As a result of this lawsuit, the state expanded funding to the home and community-based waivers. On March 8, 2007, Governor Ted Strickland (D) issued a directive to increase the number of individuals able to receive services on the PASSPORT (Pre-Admission Screening System Providing Options and Resources Today) Medicaid waiver. Enough funding was identified to eliminate the waiting list through June 30, 2007.

The Ohio Legislature passes budgets that cover two fiscal years at a time. The Fiscal Year 2006 and Fiscal Year 2007 budgets have already been passed by the Legislature. In his Executive Budget for Fiscal Year 2008-2009, the Governor has proposed expanding the state’s current State Children’s Health Insurance Program (SCHIP), which currently covers children up to 200 percent of the federal poverty level (FPL) to 300 percent of FPL. The proposal would allow families with higher incomes to buy in to the SCHIP program.

The Governor's current proposed budget includes funding for expansion of the PASSPORT program. The House version of the budget (House Bill 119) does not expand the PASSPORT program, but it accounts for natural growth in the waiver by funding an additional 5,600 slots. The Governor is also seeking an increase in the eligibility level of parents on Medicaid from 90 percent to 100 percent of FPL and an increase for pregnant women from 150 percent to 200 percent of FPL. House Bill 119 removed from the budget a proposal to provide premium assistance for coverage of children between 300 and 500 percent of FPL. The Governor is advocating for a Medicaid buy-in program for workers with disabilities and plans to submit an amendment to the state plan to reflect this additional coverage population.

Ohio has also implemented the Best Rx program, which is a prescription drug discount card program for Ohioans with no drug insurance coverage who are either age 60 or older, or are under age 60 and have a disability with family incomes of less than 300 percent of FPL. Legislation enacting this program was passed in 2003 and Best Rx was operational in 2005.

2007 Legislation and Study Efforts

House Bill 119 – House Fiscal Year 2008-2009 Budget Bill including the health care proposals discussed above.

Current Status: Passed House

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Websites

Ohio General Assembly
<http://www.legislature.state.oh.us/>

Ohio's Best Rx Program
<http://www.ohiobestrx.org/>

Ohio Department of Job and Family Services
<http://jfs.ohio.gov/>

Ohio Office of Budget and Management FY 2008-2009 Executive Budget
<http://www.obm.ohio.gov/budget/operating/executive/0809/>

Oklahoma

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
3,579,212	19%	25%	14%	48%	4%	13%	14%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

In 2006, the state of Oklahoma completed a comprehensive reform of its Medicaid programs. For those Medicaid clients who qualify, an allowance is provided with which to purchase private insurance from preferred provider organizations. Among the changes is the establishment of personal health accounts. With a debit card, Medicaid beneficiaries participating in this new program can access their account to pay deductibles, co-payment, and out-of-pocket expenses. These reforms are currently being phased in through a series of pilot projects. The Medicaid reform bill also expanded a health insurance premium assistance program to small businesses that have up to 50 employees, and new technologies.

Oklahoma is working to implement these changes and did not tackle another comprehensive reform in their 2007 session, which is expected to adjourn in June. Oklahoma did work to make technical changes to the Employer-Employee Insurance Program and the state's State Children's Health Insurance Program (SCHIP). Governor Brad Henry (D), in early March, said the state should "make sure that Oklahoma's Medicaid coverage includes every child who can be covered under the federally-imposed guidelines." He added that it would be important to use the SCHIP program as a vehicle to leverage federal dollars in helping to insure Oklahoma's uninsured children. Henry also supported the Employer-Employee Health Insurance Program and the reimportation from Canada of prescription drugs that were made in the United States. Another issue that has garnered a significant amount of attention this year is that of transparency in health care. The legislature discussed several ways to assist Oklahoma residents on becoming smarter consumers of health care products and services.

2007 Legislation and Study Efforts

HB 1884 – Establishes a Task Force to study the issue of transparency in health care. This task force will study health care costs and the way that health care costs are

arrived at by health care providers. The Task Force shall submit an initial report on December 31, 2007.

Current Status: Sent to the Governor for Signature

HB 1818 – Establishes a Task Force to study health information technology. This Task Force will study strategies for reducing health care costs by decreasing the redundancy of health care services and strategies for the implementation of sharing health data among health care providers. Make recommendations for the development of a regional health information organization. The Task Force shall publish a report of findings and recommendations by December 31, 2007.

Current Status: Passed Public Health Committee, Referred to Conference Committee

HB 1225 – Expands the Employer-Employee Insurance Program eligibility to include businesses with up to 200 employees.

Current Status: Passed House Chamber, Referred to Conference Committee

SB 424 – Extends eligibility for All Kids Funding to children living in families up to 300 percent of the federal poverty level. Currently, children living in families up to 185 percent of t FPL are served by All Kids.

Current Status: Passed House Chamber, Referred to Conference Committee

Resources

Legislative/Public Information Office

Oklahoma Senate, Legal Division
Scott Emerson, Deputy Chief Counsel
State Capitol Building, Room 109
Oklahoma City, OK
(405) 521-3201

Websites

Oklahoma Legislature
<http://www.lsb.state.ok.us/>

Oklahoma Governor
<http://www.governor.state.ok.us/index.php>

Oklahoma Insurance Commissioner
<http://www.oid.state.ok.us/>

Other Contacts

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Oklahoma Senate Legal Division
(405) 521-3201

Pennsylvania

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
12,440,621	10%	13%	9%	58%	5%	11%	15%	0%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The Pennsylvania General Assembly began a new two-year continuous session in January 2007, which will run through November 2008. Governor Edward Rendell (D) has proposed one of the most comprehensive health care reform plans in the nation, which was preempted by the malpractice crisis in the state. Prescription for Pennsylvania phases in an insurance mandate for individuals whose annual income is greater than 300 percent of the federal poverty level (FPL). The proposal also includes a buy-in option for individuals with incomes below 300 percent of the federal poverty level, would create financial penalties for businesses that do not offer health insurance to employees, and would require students enrolled at four-year colleges or universities to have health insurance or access to a health clinic.

The Governor's proposal also includes a State Children's Health Insurance Program (SCHIP) and Medicaid expansion, with the goal of moving toward universal coverage. The Cover All Kids initiative and the Cover All Pennsylvanians initiative would help provide coverage to uninsured children and adults through the state's SCHIP and Medicaid programs, respectively. The Cover All Pennsylvanians initiative would expand coverage to approximately 800,000 uninsured adults and would allow uninsured adults and small employers to obtain basic coverage through private insurers. Premiums for the plan would be determined by a sliding fee scale based on income. The Cover All Kids initiative would further expand the state's SCHIP program, which already provides health care to children from families up to 300 percent of FPL, based upon a sliding fee scale and buy-in program.

Additional provisions include expanding the scope of mid-level medical practitioners, adding requirements for insurers, improving access to translators in hospitals, and investing in health information technology. The Governor's proposal also includes the provisions relating

to chronic disease management, quality initiatives, and prevention and wellness initiatives. Funding for the program would be provided through contributions from workers and employers, federal matching funds, state funds currently allocated to other health programs, an increased state cigarette tax, and a state tax on smokeless tobacco and cigars.

Members of the Pennsylvania General Assembly, which drafted House Bill 700 with many of the elements of the Governor's proposal, held hearings about the legislation in April and May 2007. Several legislators have specifically expressed concern with the requirement on businesses to provide health insurance as well as the 3 percent tax that would be assessed on businesses not providing health insurance to their employees. Small businesses would be exempt from the requirement of the first year, and discounts would be offered to small businesses with low income employees.

House Bill 700 contains provisions that would expand health insurance coverage to all state residents, assure price transparency for all health care providers, improve care management of patients with chronic conditions, and would require hospitals to have electronic health records by 2009 as a condition for continuing hospital licensing. This bill has not advanced beyond the Insurance Committee. Some have speculated that House Bill 700 is not likely to pass in its entirety, although certain pieces of the legislation may be introduced in separate bills.

Additional pieces of legislation have been introduced in the Senate, although none of them have advanced beyond the Banking and Insurance Committee. Senate Bill 127 amends the Tobacco Settlement Act and would expand adult basic coverage insurance and provide for health insurance tax credit for small employers. Senate Bill 128 would require the Insurance Department to develop various standardized basic health insurance plans that insurers may offer to individuals and small employers and provides for the filing of rates by insurers and for disclosure statement. Senate Bill 129 would authorize privately established and operated health insurance purchasing cooperatives (especially for small employers) and provides for the regulation of the cooperatives by the Insurance Department. Finally, Senate Bill 300 would provide for a statewide comprehensive health care system, establish the Pennsylvania Health Care Plan, and establish the Pennsylvania Health Care Agency, the Employer Health Services Levy, the Individual Wellness Tax and the Pennsylvania Health Care Board.

Resources

Legislative/Public Information Office

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Pennsylvania Legislative Reference Bureau
State Capitol Building, Room 641
Harrisburg, PA 17120
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www.palrb.us

Websites

Pennsylvania Legislature
www.legis.state.pa.us/index.cfm

Pennsylvania Department of Insurance
www.ins.state.pa.us/ins/site/default.asp

Pennsylvania Department of Public Welfare
www.dpw.state.pa.us

Pennsylvania Department of Health
www.dsf.health.state.pa.us/health/site/default.asp

Pennsylvania SCHIP Program (Cover All Kids initiative)
www.chipcoverspakids.com

Other Contacts

Jane D'Amico
Governor's Office of Health Care Reform
(717) 772-9022
www.ohcr.state.pa.us

Rhode Island

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,067,510	11%	14%	7%	56%	4%	17%	11%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Rhode Island has been implementing health care reforms in an incremental fashion for more than a decade. In 1994, Rhode Island obtained a federal waiver, which allowed the state to expand RItE Care, Rhode Island's Medicaid program. Rhode Island used the waiver to expand coverage to uninsured pregnant women and children. RItE Care also extended its program to include family planning services for 26 months postpartum for women who would have previously been uninsured again within two months after delivery.

More recently, Rhode Island also expanded its Medicaid program to provide coverage to children up to age 18 in families with incomes of up to 250 percent of the federal poverty level (FPL). Pregnant and postpartum women with incomes of up to 350 percent of FPL can also receive coverage for prenatal, maternity and family planning services through 26 months postpartum. Additionally, home-based child care providers participating in Rhode Island's subsidized child care program can access family health insurance through RItE Care.

The state is also one of many with new laws and programs designed to reduce the cost of health insurance for small employers, domiciled insurers, and direct-pay subscribers. The state legislature worked with insurers and in 2006, created the WellCare Advisory Committee that includes a variety of stakeholders. The Advisory Committee was asked to develop guidelines for wellness health benefit plans designed to lower costs for health care coverage for employers with 50 or fewer employees. As mandated by the legislature, qualified WellCare plans must include cost-saving incentives that advance affordability principles, including primary care, prevention and wellness; active management of the chronically ill population; use of the least cost, and most appropriate setting; and use of evidence-based, quality care.

As a result of the WellCare Advisory Committee, private health insurance companies have developed low-cost, basic health plans for individuals and small businesses. The legislation directed private insurance companies to keep premiums below 10 percent of the statewide, average annual salary. The plans were developed by insurers, using criteria established by the

state's Health Insurance Commissioner and the advisory committee composed of chambers of commerce representatives, insurance purchasers, insurance brokers, and direct purchasers. The plans emphasize disease management and have different cost-sharing responsibilities for consumers and for certain benefit mandates.

There has also been proposed legislation addressing the health care dilemmas of small business owners, part-time students, and the uninsured. In 2006, legislation passed that required insurance plans to cover dependent children until age 19, and, if students are financially dependent, coverage must be extended until the age of 25. If the dependent child is mentally or physically impaired, the plan must continue their coverage after the specified age of 19 or 25.

2007 Legislation and Study Efforts

Senate Bill 255 – Would provide that health care coverage terminating for a dependent at a specified age would give the insured the opportunity to continue the coverage as long as he or she is under the age of thirty and has no dependents of his or her own provided an additional premium may be charged.

Current Status: Referred to Health and Human Services Committee, Committee recommended the measure be held for further study

Senate Bill 327 – Provides that every health insurance plan, contract or policy that has been issued or renewed would provide coverage of an unmarried child under the age of 25 years and those financially dependent upon parent(s) regardless of whether the child is a student.

Current Status: Referred to Health and Human Services Committee, Committee recommended the measure be held for further study

Senate Bill 793 – Would provide that health care coverage would continue for dependents as long as he or she is under the age of thirty and has no dependents, provided an additional premium may be charged.

Current Status: Referred to Health and Human Services Committee, In Committee

Resources

Websites

Rhode Island General Assembly
www.rilin.state.ri.us

Rhode Island Department of Human Services
www.dhs.state.ri.us/index.htm

Rhode Island Department of Business Regulation, Office of the Health Insurance Commissioner
www.dbr.state.ri.us/divisions/healthinsurance/

Rhode Island WellCare Advisory Committee
www.dbr.state.ri.us/documents/divisions/healthinsurance/060921_WCAC_WellCare_Issue_Brief.pdf

South Carolina

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
4,321,249	16%	22%	9%	50%	4%	15%	13%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The South Carolina Legislature is not scheduled to adjourn until June 7, 2007. Currently, there is a bill moving through the legislative process that would create a small employee health group cooperative. The General Assembly has also introduced legislation that would amend South Carolina code and create the Small Business Health Insurance Premium Assistance Act (House Bill 3152).

This legislation would provide health insurance premium assistance to small businesses for employees who are at or under 200 percent of the federal poverty level (FPL), although this legislation has not yet passed the Ways and Means Committee. The legislation sets up rules for the program, aligns the program with the Medicaid program, notes that a certain percentage of the cigarette tax would be used to support the program, and directs the South Carolina Department of Health and Human Services to administer the program.

Additionally, House Bill 3562 has been introduced, but has not advanced past the Ways and Means Committee. House Bill 3562 would create the Health Communities Capacity Act, which would establish the Small Business Health Insurance Premium Assistance Program, but would also direct the South Carolina Department of Health and Human Services to apply for a waiver to support the program and would provide Medicaid coverage to children 18 years of age and younger whose family incomes do not exceed 200 percent of FPL.

In 2005, South Carolina submitted an 1115 Waiver request to the Centers for Medicare and Medicaid Services (CMS), which is pending approval. The waiver would make changes to South Carolina's Medicaid program and would encourage development of new, innovative health plan models, provide a choice of benefit plans to meet individual needs, provide incentives for plans and providers to improve member health, and increase efficiency through streamlining state administration. Detailed information about South Carolina's waiver request can be found on the CMS website (www.cms.hhs.gov).

2007 Legislation and Study Efforts

Senate Bill 68 (Senate Bill 210 and House Bill 3241) – Amends state code and provides that the Director of Insurance be elected by the qualified votes of South Carolina for a four-year term with that of the Governor.

Current Status: Passed Judiciary Committee

Senate Concurrent Resolution 436 (House Concurrent Resolution 3260) – Urges members of the South Carolina Delegation of the United States Congress and members of South Carolina state government to work together to reauthorize the State Children’s Health Insurance Program (SCHIP) in a timely manner.

Current Status: Passed Medical Affairs Committee, Passed Invitations and Memorial Resolutions Committee

Senate Concurrent Resolution 533 – Recognizes the urgency to take meaningful steps, beginning with covering all of America’s children, to solve one of America’s greatest problems, lack of sufficient health care. Designates April 23 – 29, 2007 as “Cover the Uninsured Week” in South Carolina.

Current Status: Passed Banking and Insurance Committee, Referred to Invitations and Memorial Resolutions Committee

Senate Bill 588 (House Bill 3751) – Amends state code and provides requirements, powers, duties, and restrictions of a small employer health group cooperative. Provides that the South Carolina Department of Insurance and Office of Research and Statistics of the Budget and Control Board submit a report to the Office of the Governor and General Assembly by January 1, 2010 on the effectiveness of the health group cooperative in expanding the availability of health insurance coverage for small employers.

Current Status: Passed Banking and Insurance Committee, Referred to Labor, Commerce and Industry Committee

Resources

Legislative/Public Information Office

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Websites

South Carolina Legislature
www.scstatehouse.net

South Carolina Department of Health and Human Services
www.dhhs.state.sc.us/dhhsnew/index.asp

South Carolina Department of Insurance
www.doi.sc.gov

South Dakota

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
781,919	11%	15%	9%	52%	9%	12%	13%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

South Dakota's Legislature has adjourned for the year. This year South Dakota established an interim study committee, called the Zaniya Project Task Force, to undertake a comprehensive review of health insurance. The Zaniya (Zaniya is the Lakota word for health) Project Task Force began meeting the end of April 2007 and includes representatives from the following organizations and entities: state legislators, health care providers, health care facilities, insurance carriers and producers, employers, state government, lay persons, trade associations, and tribal health professionals.

The Zaniya Project Task Force is scheduled to provide its final report to the Health Care Commission, the Governor, and the Legislature by September 30, 2007. The two primary legislators involved in this effort are Senator Tom Dempster (R), and Representative Joel Dykstra (R).

The Task Force is to develop a plan, with action steps and timelines, to provide health insurance to South Dakota residents who lack health insurance coverage. The Task Force has been asked to address options for creating efficiencies in the purchase of health insurance products. For any new proposal it recommends, the Task Force is to prepare cost estimates and designate funding sources. As part of its charge, the Task Force was also asked to explore and pursue opportunities available from the federal government, specifically related to Medicaid.

Twelve percent of South Dakota's nearly 400,000 residents are uninsured, which is below the national average of 16 percent. South Dakota is also one of a few states that have

received federal funds to establish a high-risk insurance pool for individuals with preexisting health conditions. These individuals would likely have trouble obtaining coverage elsewhere.

Governor Mike Rounds (R) has also proposed including seniors in a program that allows pharmacists to substitute generic drugs for brand name drugs for state employees. The program has saved the state \$500,000 thus far. Additionally, in November 2006, South Dakota increased the cigarette tax by \$1, which is estimated to increase the state's revenues by \$41 million. This initiative was voter-approved as part of the November ballot, and the state plans to use some of the additional revenue to develop and increase the number of programs that encourage individuals to quit smoking.

In 2007, South Dakota also codified Chapter 58-17-2.3, which states that no insurer or health carrier issuing a health benefit plan that provides dependent coverage for any qualifying child may terminate coverage due to attainment of a limiting age below age 19, or, if a full-time student in an accredited institution of higher learning, below age 24. If the dependent remains a full-time student upon attaining the age of 24 but not exceeding the age of 29, the insurer will provide for the continuation of coverage for that dependent at the insured's option. Nothing in this code requires the employer to contribute any portion of the premium for dependents that are full-time students and have attained the age of 24.

Lastly, in 2006, the state codified Chapter 265, which states that any insurance provider offering benefits to a dependent may not terminate those benefits by reason of age before the dependent's 19th birthday. If the dependent is enrolled in an educational institution, they are not to be terminated until they reach the age of 24.

2007 Legislation and Study Efforts

House Bill 1169 – Created an interim study committee to conduct a comprehensive review of the health insurance system. The committee will meet from April through September 2007 with the requirement of a final report being submitted.

Current Status: Signed into law by the Governor

Resources

Legislative/Public Information Office

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500 East Capitol Avenue
Pierre, SD 57501-5070
(605) 773-3251
<http://legis.state.sd.us/index.aspx>

Websites

South Dakota Department of Social Services
<http://dss.sd.gov/>

Other Contacts

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Texas

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
23,507,783	24%	30%	20%	49%	4%	12%	10%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Texas faces the significant dilemmas of a quickly-growing population which is increasingly low-income, high inflation of health care costs, and bad publicity surrounding its status of having the highest percentage (25 percent, or 5.6 million people) of uninsured people in the nation. Only 53 percent of non-elderly Texans are covered by employer-sponsored health insurance, and half of Texas families live below 200 percent of the federal poverty level (FPL). A very high number of families may be potentially eligible for Medicaid and State Children Health Insurance Program (SCHIP), depending on specific requirements, which are some of the most stringent in the US. At the same time, due to low reimbursement rates, only 38 percent of Texas physicians accept Medicaid patients. In 2003, the state made severe cuts to its Medicaid and SCHIP programs, and is still struggling to restore benefits at this time. Some benefits cut in 2003, such as eyeglasses, hearing aids, and mental health services, were restored in 2005, but others have not yet been restored.

Currently, the Governor Rick Perry (R) and the Legislature are responding to news that 17,000 children were dropped from SCHIP rosters from April to May 2007. This sharp decrease is attributed to SCHIP rules that require children to be re-enrolled every six months in order to qualify for the program. The Governor has publicly announced a change in his position on the issue, agreeing that a once-a-year enrollment process is adequate. This change in position may result in corrective yet legislation this year.

In addition, a battle at the Statehouse continues over what benefits the state should provide to aliens. The Texas Legislature is still in session, and important proposals remain on the table. The state's omnibus Medicaid reform bill (Senate Bill 10) is one of these, and has had numerous amendments. The bill includes such provisions as a coordinated billing system, expansion of the Health Insurance Premium Program, pilots for Health Savings Accounts,

an incentive program for Medicaid members to live healthy lifestyles, and sections related to allowing new 1115 Waivers. A mental health parity bill has also passed one chamber and awaits expected passage in the other.

2007 Legislation and Study Efforts

House Bill 1919 – Relating to health benefit plan coverage from several types of insurers for brain injuries and serious mental illnesses. Such care must provide coverage for care, rehabilitative therapy, and community reintegration after the incidence of certain brain injuries and mental illnesses. The bill calls for legislative review of these types of insurers. Current Status: Passed out of House, Passed out of Committee in Senate.

Senate Bill 10 – Relating to the operation and financing of the medical assistance program and other programs to provide health care benefits and services to persons in this state; providing penalties. The bill is intended to curb Medicare spending by encouraging weight loss and smoking cessation, discouraging non-emergency visits to the emergency room, and creating new partnerships to connect Texas with private health insurance. An amendment to the bill has created the potential for medical buy-in to Medicaid for those with disabilities with monthly premiums based on a sliding scale of family incomes.

Current Status: Passed in Senate, Under Approval in the House. Passed to third reading as amended.

The Texas Health and Human Services Commission (HHSC) is currently undertaking national research to identify promising practices in health care reform across all states. HHSC has completed preliminary research and analysis of ongoing Medicaid reform efforts in other states and how these efforts might be applied in Texas, including how the federal Deficit Reduction Act may affect said reforms. Research papers on a number of reform issues have been compiled and are being considered by the Commission and the Texas Legislature.

Resources

Legislative/Public Information Office

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Austin, TX 78711-2128
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Websites

Senate Research Center

<http://www.senate.state.tx.us/src/index.htm>.

House Research Organization

<http://www.hro.house.state.tx.us/>

Texas Health and Human Services Commission:

<http://www.hhsc.state.tx.us/>

Texas Council of Community Mental Health and Mental Retardation Centers

<http://www.txcouncil.com/default.aspx>

Texas Department of Insurance

<http://www.tdi.state.tx.us/>

Utah

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
2,550,963	15%	18%	12%	59%	7%	10%	8%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The state of Utah has a unique population and a unique system of health care. Unlike many states, children outnumber seniors. Secondly, Utah is a state with a large “safety net” through which many programs exist to assist low income persons with health care and other needs. Serving Medicaid and State Children’s Health Insurance Plan (SCHIP) clients primarily through a large primary care network, Utah also leverages a considerable amount of charity-funded care. Utah’s SCHIP program is one of a few states that caps enrollment in the program, an issue many, including the Governor, would like to see addressed next year.

Utah’s reform efforts are primarily driven by the Legislature. In 2006, a Medicaid Interim Committee was created and was extended for another year. The Committee’s first recommendation, the creation of a preferred drug list, was passed and signed into law this year. As a result, the state is in the process of implementing a two-category drug list, beginning an aggressive physician education program about the list, and joining with other states in a purchasing pool. The legislature also realigned the calendar of provider co-pays with the calendar of the state’s largest HMO. In the legislative interim, the Committee is expected to develop recommendations for 2008, including the expansion of SCHIP and implementation of an Insurance Connector program that assists small businesses in finding insurance providers who can meet their needs.

2007 Legislation and Study Efforts

Senate Bill 42 – Allows use of a Preferred Prescription Drug List (PDL) in Medicaid, which “may include placing some drugs on a preferred drug list to the extent determined appropriate by the department” and repeals 2003 language restricting PDLs. Final version provides a blanket exemption for psychotropic or anti-psychotic drugs and allows prescribers to over-

ride restrictions in cases of medical necessity when documented in the patient's medical file and by a hand-written perscription.

Current Status: Signed into law by Governor.

House Bill 218 – This bill creates an ombudsman for the Children's Health Insurance Program. After existing, help the public and patients with eligibility, coverage, and complaints. The ombudsman also would make recommendations to the Department of Health on the SCHIP program.

Current Status: Signed into law by the Governor

Resources

Legislative/Public Information Office

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<http://www.le.state.ut.us/lfa/index.htm>

Websites

Governor Huntsman's Budget Recommendations

<http://governor.utah.gov/gopb/2008RecommendationsBook.pdf>.

Vermont

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
623,908	11%	15%	6%	52%	4%	19%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

In order to address soaring health care costs, Vermont passed the Health Care Affordability Act (House 861) in 2006. Vermont's health care reform was created from a realization by many policymakers that the fundamental goals of health care reform are all connected. An integral piece of this reform is a new health insurance program called Catamount Health. This program, a comprehensive model of health care, provides affordable coverage for the uninsured by focusing on two major components: better management of chronic care and making health care affordable and accessible. It goes into effect on October 1, 2007.

Since 70 percent of health care costs in Vermont can be attributed to care for chronic conditions, the Vermont reform focuses in on chronic care management. The act makes chronic care management more accessible by establishing a system which includes early and coordinated screening for conditions such as diabetes and asthma, better management of chronic care and an emphasis on patient self-management, and waiving co-pays for patients who seek appropriate care. Additionally, the act changes the provider reimbursement system to encourage high-quality chronic disease management. Through Catamount Health, everyone who is uninsured for 12 months or more will have access to, as well as help paying for, a comprehensive health insurance package, following the guiding principle that everyone is covered and everyone pays.

The plan will be offered by the private sector and subsidized with public funds through a sliding scale for anyone under 300 percent of the federal poverty level (FPL) and financed with sliding-scale co-pays, tobacco taxes, Medicaid dollars, and an employer assessment. State fiscal obligations are controlled through enrollment caps. Vermont hopes to cut costs by encouraging diabetics and heart patients to maintain treatment and by allowing HMOs to give discounts to policyholders who quit smoking or take steps to address chronic conditions. Vermont is also one of several states that expanded long-term care coverage by expanding HCBS waivers.

Vermont Governor Jim Douglas (R) and the Vermont General Assembly worked together to create the state's Health Care Reform of 2006. With over 35 specific initiatives, this reform is designed to contain cost, increase access, and improve the quality of health care for Vermonters. The Vermont approach shares many elements with Massachusetts' reforms: premium assistance for the working uninsured, enhanced Medicaid benefits, and an opportunity for all residents to buy insurance through the state, at premiums ranging from \$60 to \$135 a month. It also penalizes businesses that do not offer health insurance.

Act 191 assigns responsibility to the Secretary of Administration for coordination of Vermont's Health Care Reform among the executive branch agencies, departments, and offices in a manner that is timely, patient-centered, and seeks to improve the quality and affordability of health care in Vermont. As part of this responsibility, the Secretary is required to submit a five-year plan for implementing Vermont's health care system reform initiatives, together with any recommendations for administration or legislation, to the Governor and legislative committees on or before December 1, 2006. The Secretary also is required to report annually to the General Assembly on the progress of the reform initiatives, beginning on January 15, 2007.

2007 Legislation and Study Efforts

House Bill 0229 – An Act relating to corrections and clarifications to the Health Care Affordability Act of 2006 and related legislation. The bill is intended to clarify the Health Care Affordability Act, including clarifying definitions. It also sets eligibility for the Catamount Health insurance program that was enacted in 2006 at 300 percent of the federal poverty level, and that individuals who were previously eligible for Medicare do not have to go through the typical 12-month waiting period before becoming eligible for Catamount. Current Status: Passed Both houses

Joint Legislative Commission on Health Care Reform – In June 2006, the Joint Legislative Commission on Health Care Reform was created to monitor implementation of health care reform initiatives and recommend to the general assembly actions needed to attain health care reform goals.

There are six standing Task Forces related to the effort: Department of Labor Employer Assessment Task Force, Outreach and Enrollment Steering Committee, Common Claims Work Group, Health Systems Task Force, State Alliance Membership, and Cost Shift Task Force

Resources

Legislative/Public Information Office

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Websites

State of Vermont Legislative Joint Fiscal Office

<http://www.leg.state.vt.us/jfo/>

Summary of the 2006 Health Care Reform Act http://www.vthca.org/pdfs/Catamount_Health_Bill_simplified.pdf

Vermont's Agency of Administration, Health Care Reform Commission

<http://hcr.vermont.gov/>

Vermont's Blueprint for Health

<http://healthvermont.gov/blueprint.aspx>

Virginia

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
7,642,884	13%	17%	8%	61%	4%	8%	11%	3%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Alarming statistics about the health of Virginians have set Governor Tim Kaine (D) to work on a plan to improve health care in the state. According to the US Centers for Disease Control and the Kaiser Family Foundation, as many as 58 percent of all Virginians are overweight or obese, 23 percent do not exercise on a regular basis, and an estimated 25 percent of Virginians smoke or use other tobacco products. Since 1990, Virginia's obesity rate has climbed 154 percent, driving up the statistics on weight-related problems like diabetes, which affects hundreds of thousands of Virginians and is the state's sixth-leading cause of death.

In addition, one million Virginians lack health insurance. Seventy percent of those people are workers or their dependents. Most work for a small business. Furthermore, two babies die every day in Virginia, making Virginia's infant mortality rates one of the worst in the nation. With one out of every seven Virginians lacking health insurance, the need to expand access to affordable health care is compelling.

Two important initiatives include Healthy Virginians, a statewide program to support prevention and healthy lifestyles, and the Health IT Council, created by executive order on July 20, 2006 and currently working on the Electronic Health Records Initiative. The Electronic Health Records initiative is exploring methods for streamlining and digitizing the collection, storage, and sharing of health care information. The effort is intended to curb some of the soaring costs of health care; provide the public with better information on medical qualifications, drugs and services pricing; and help prevent errors in record keeping and treatment.

2007 Legislation and Study Efforts

Created by Governor Kaine in July 2006, the Health Reform Commission is charged with improving access to competent, affordable health care for all Virginians. The Commission holds public meetings and has a final report due in September 2007. Specifically, the commission works to identify and implement the national best practices at the state level with an emphasis on access, quality, and safety of care. The commission will also address long-term care and affordability. It will work closely with the General Assembly's Joint Commission on Health Care and the Joint Legislative Audit and Review Commission (JLARC), and work to foster cooperation between the Executive and Legislative branches on these important health care issues. Four work groups have been formed, including: Access to Care; Quality, Consumer Awareness (Transparency), and Prevention; Improving the Healthcare Workforce; and Long Term Care and Consumer Choices. Virginia was one of 25 states to expand long-term care options by expanding HCBS waivers. The Commonwealth also recently increased the pay rates of providers.

Resources

Legislative/Public Information Office

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Websites

Health Reform Commission website
<http://www.hhr.virginia.gov/Initiatives/HealthReform/index.cfm>

Healthy Virginians website
<http://www.healthyvirginians.virginia.gov/index.cfm>

Health IT Council website
<http://healthitcouncil.vi.virginia.gov/index.htm>

Virginia Division of Legislative Services
<http://dls.state.va.us/>

Washington

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
6,395,798	13%	17%	8%	56%	6%	12%	11%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

The government of Washington has become increasingly concerned that 13 percent of its population does not have health insurance. The uninsured in Washington tend to be those employed by small businesses and younger adults, who may or may not have children. Several factors affecting the political climate have led to major reform efforts being passed this year, including first the formation of a Blue Ribbon Commission on Health Care and Access and, secondly, like Iowa, control of both legislative chambers and the Governorship being held by the same party (Democrat). Washington developed a quite-ambitious scope of reforms for the next few years, and has successfully passed legislation that expands health care coverage. In addition, the Legislature has requested several studies it expects will lay the groundwork to inform future changes.

2007 Legislation and Study Efforts

Second Substitute Bill 5093 – On the basis that improving the health of children in Washington is an investment in a productive and successful next generation, this bill expands health care coverage for children and increases immunization efforts. The expansion includes expanding existing services offered and placing responsibility on parents to help provide their child with appropriate medical care.

Current Status: Signed into law by the Governor

Engrossed Second Substitute House Bill 1569 – Reforming the Washington health care system by establishing a health insurance partnership for the purchase of small employer health insurance coverage, evaluating the inclusion of additional health insurance markets in the health insurance partnership, and studying the impact of health insurance mandates.

Current Status: Signed into law by the Governor

Engrossed Second Substitute Senate Bill 5930: Reforming the health care system in Washington state. Recommendations include developing a five-year plan to change provider reimbursements to reflect health outcomes rather than simply services, improving doctor and patient communications, and designing and implementing cost-effective medical homes for the elderly, among others.

Current Status: Signed into law by the Governor (Partial Veto)

Blue Ribbon Commission on Health Care Costs and Access – In 2006, the Washington Legislature created a Blue Ribbon Commission on Health Care Costs and Access. The Commission, co-chaired by Governor Chris Gregoire (D) and Senator Pat Thibaudeau (D), held several hearings over the last year, vetting over 700 pages of various reform proposals, and releasing a final report with 14 basic recommendations. In addition, the Commission introduced its own bill this year focusing on quality and affordability in health care.

The Commission bill, along with several other pieces of health care related legislation, was successful in creating a comprehensive package of reforms around, quality improvement, studying on the impacts of adding insurance markets, expanding chronic care programs, piloting technology improvements, setting up restructuring of the state's health insurance partnership that serves small businesses, and expanding the income limits for children's health insurance eligibility to 300 percent of the federal poverty level (FPL).

Resources

Legislative/Public Information Office

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Websites

Governor's Blue Ribbon Commission on Health Care Costs and Access
<http://www1.leg.wa.gov/Joint/Committees/HCCA/>

Senate Committee Services' Final Report of Bills Passed in 2007
<http://www1.leg.wa.gov/documents/Senate/SCS/Reports/BillsPassed.pdf>

West Virginia

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
1,818,470	17%	23%	8%	49%	2%	14%	17%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

In West Virginia, Governor Joe Manchin (D) has spearheaded an effort to improve the health of West Virginians and reduce the costs of health care for the state. The state’s strategic health care plan has four cornerstones: making government more efficient as it relates to health care administration, making the health care system accountable for efficiency and quality of care, promoting healthy lifestyles prevention strategies, and increasing access to care. In 2006, House Bill 4021 created the Commission on Health Care Reform, which ends July 1, 2010. West Virginia is one of several states that restructured its Medicaid program in response to the federal Deficit Reduction Act.

The state’s redesigned Medicaid program, called Mountain Health Choices, has the concepts of personal responsibility and medical homes as its bedrock. Medicaid members must sign a member responsibility agreement, consenting to follow rules such as showing up for doctor’s appointments and getting their children immunized. With compliance, they qualify for extra benefits, such as mental health services and greater prescription drug coverage. If they refuse to sign either the member agreement or the health improvement plan suggested by their medical home, they receive only the basic benefits package. West Virginia recently began offering tax credits to small businesses that offer insurance to their employees.

The 2007 Legislature saw the passage of House Bill 2940, raising the age to which parents can keep their dependent children on their family health insurance plan, which some advocates say is the state’s most important health care reform adopted in the last five years. Currently in West Virginia, parents can keep their full-time college students on their health insurance until age 23. Dependent children who do not attend college can stay on their parent’s policy only until age 19, the most restrictive law in the country. With passage of House Bill 2940, West Virginia will join six other states in allowing parents to keep their children on their policy until at least age 25. It is estimated that the law will add an additional 10,000 to 20,000 young adults to the number covered by health insurance.

2007 Legislation and Study Efforts

House Bill 3223 – An Act creating a revolving loan fund to be administered by the West Virginia Health Care Authority Board to provide loans to assist hospitals in the rationalization and restructuring of their health care delivery systems; setting forth the criteria and conditions for approving hospital restructuring plans and loans from the revolving funds; and providing the Health Care Authority Board with reporting responsibilities and rule making authority to implement the provisions of the new article.

Current Status: Signed into law by the Governor

House Bill 2940- Relating to the public employees insurance program and group accident and sickness insurance; and increasing the age of certain dependents for health insurance coverage. Allows dependent children to remain on their parents' health insurance plans until the age of 25, including those covered by West Virginia's Public Employees Insurance Agency. With the passage, a child is able to remain on their parents' insurance policy until age 26 regardless of whether or not they are currently a student. The measure is expected to insure an additional 10,000 to 20,000 young adults.

Current Status: Signed into law by the Governor

Resources

Legislative/Public Information Office

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Websites

Governor Manchin's Strategic Vision and Action Plan for Health
<http://www.wv.gov/Offsite.aspx?u=http://www.state.wv.us/governor>

WV CHIP website
<http://www.wv.gov/OffSite.aspx?u=http://www.wvchip.org/>

WV Health Care Authority
<http://www.hcawv.org/>

Mountain Health Choices (WV's New Medicaid Website)
http://www.wvdhhr.org/bms/oAdministration/Medicaid_Redesign/MedRedesign_main.asp

Wisconsin

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
5,556,506	10%	13%	6%	59%	6%	12%	13%	1%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Wisconsin boasts a very high rate of insured citizens with 90 percent of adults and 96 percent of children in the state insured. Not only that, the state’s Medicaid spending has grown at only a modest rate in the last ten years. Beginning in 2006, Governor Jim Doyle (D) began pushing for expansion of Medicaid and BadgerCare, a program for those not covered by Medicare, to promote the concept that health insurance should be affordable for everyone in Wisconsin. With a tremendous commitment to insuring its population, the State is interested in cost containment measures.

The Governor’s 2007 budget contains several important recommendations that are still in play as the budget makes its way through the Legislature. Although the Governor believes these proposals will save money in the long run, some come with a significant short-term cost. First, there is a proposed demonstration project to expand medical coverage to childless adults when they have an income of up to 200 percent of federal poverty level (FPL), do not qualify for other assistance, and have not had health insurance for six months. The proposal to expand BadgerCare Plus, the state’s State Children’s Health Insurance Program (SCHIP) that currently covers families of eligible children, would include coverage of “fringe” eligibility populations, such as the self-employed and pregnant women up to 200 percent of FPL. BadgerCare Plus would replace the current BadgerCare program and part of the Medicaid program. A benchmark program would allow those at varying degrees above regular eligibility guidelines to buy in to the program. SeniorCare proposals would expand eligibility for buy-in programs by 40 percent of FPL and provide premium assistance for prescription drug plans.

2007 Legislation and Study Efforts

Senate Bill 40 – Made up of the Governor’s proposal for the 2007-2009 biennial budget, including several health care measures. In early 2007, President Bush denied Wisconsin’s request to continue SeniorCare, the successful prescription program that provides low-cost prescriptions for the elderly and disabled. The proposed budget will replace all spending allocated to SeniorCare to a new, yet similar prescription program, WisconsinCare.

Current Status: Referred to Committee of Finance

Assembly Bill 860 (Senate Bill 440) – Requires employers with 10,000 or more employees to offer family health insurance benefits under a group insurance plan in which the employer pays 80 percent of the cost, excluding co-payments and deductibles, for both full and part-time employees. If an employer fails to meet this standard, it must pay the Wisconsin Department of Health and Family Services an amount equal to the cost incurred by society for their failure to insure workers.

Current Status: Failed in Assembly and Senate

Resources

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Websites

Legislative Fiscal Bureau
<http://www.legis.state.wi.us/lfb/index.html>

Summary of Governor Doyle’s Budget Recommendations
<http://www.legis.state.wi.us/lfb/2007-09budget/Governor/dhfs.pdf>

Fiscal Summary of Medical Assistance, BadgerCare, SeniorCare, and Related Programs
<http://www.legis.state.wi.us/lfb/Informationalpapers/44.pdf>

Wyoming

State Snapshot

Total Population (2006)	Total Percentage of Uninsured (2005 – 2006)	Percentage of Uninsured Adults (2005 – 2006)	Percentage of Uninsured Children (2005 – 2006)	Percentage Covered by Employer-Based Coverage (2004 – 2005)	Percentage Covered by Individual/Family Purchased Coverage (2004 – 2005)	Percentage Covered by Medicaid (2004 – 2005)	Percentage Covered by Medicare (2004 – 2005)	Percentage Covered by Other Public Programs (2004 – 2005)
5,556,506	14%	18%	10%	54%	7%	11%	12%	2%

National Survey of Enrollees in Consumer-Directed Health Plans

<http://www.kff.org/kaiserpolls/pomr112906pkg.cfm>

Background and Reform Initiatives

Wyoming has three basic challenges in ensuring its population receives consistent health care: access to care, an aging population, and enrollment in its EqualityCare (Medicaid) and Kid Care CHIP program. Like many rural states, Wyoming struggles to attract and retain qualified physicians, dentists, and mental health professions. The medical professional shortage in Wyoming is all the more significant as the state has one of the most rapidly-aging populations in the US. These issues contribute to the fact that Wyoming’s Medicaid spending has grown much faster than the national average.

Wyoming has 80,000 uninsured adults and children. Those who are uninsured of the traditionally independent-minded citizens in Wyoming tend to be more likely to access care in regional community health centers than to sign up for Equality Care to pay for care locally.

2007 Legislation and Study Efforts

Senate File 89 – An act relating to long-term care and the Wyoming Medical Assistance and Services Act; modifying the Medicaid reimbursement formulas for nursing homes and other long-term care facilities; modifying limitations on new nursing home construction; expanding the Medicaid home and community-based waiver program; providing transition services; authorizing application to the federal government for Medicaid program long-term care waivers; authorizing and regulating an adult foster home care system; authorizing alternative long-term care pilot programs; granting rulemaking authority; requiring a report; providing appropriations; authorizing positions; and providing for an effective date.

Current Status: Enrolled

Wyoming Healthcare Commission – Since its inception during the 2003 legislative session, the Wyoming Healthcare Commission (WHCC) has been charged with examining a wide range of health care issues and drafting specific recommendations designed to improve access

to, and quality of, health care in Wyoming communities. Tasks assigned to the WHCC by the Legislature include suggesting solutions for reducing medical liability insurance costs, decreasing medical errors, addressing health-related workforce shortages, and compensating injured patients. The Commission has three standing work groups: Access and Affordability, Medicaid, and Rural Health Care Delivery Systems. One initiative of the Commission is Total Health Management, which includes a recent study on medical errors and current work on electronic medical records.

Resources

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Websites

Wyoming Legislative Services Office
<http://legisweb.state.wy.us/2007/budget.htm>

Wyoming Health Care Commission
<http://wyominghealthcarecommission.org/>

EqualityCare and the Office of Health Care Financing
<http://wdh.state.wy.us/healthcarefn/index.html>

Resources and Links

The American Association for Retired Persons (AARP)
<http://www.aarp.org>

The Center on Budget and Policy Priorities
<http://www.cbpp.org/>

The Centers for Medicare and Medicaid Services
<http://www.cms.hhs.gov/>

Families USA
<http://www.familiesusa.org/index.html>

The Federal Administration on Aging (AoA)
<http://www.aoa.gov/>

The Iowa Coalition on Mental Health and Aging
<http://www.public-health.uiowa.edu/icmha/>

The Iowa Department of Elder Affairs
<http://www.state.ia.us/elderaffairs>

The Iowa Department of Human Services
<http://www.dhs.state.ia.us>

The Iowa Foundation for Medical Care
<http://www.ifmc.org/>

The Iowa General Assembly
<https://www.legis.state.ia.us>

The Iowa Medicaid Enterprise
<http://www.ime.state.ia.us/>

The Kaiser Family Foundation
<http://www.kff.org>

The National Conference of State Legislatures
<http://www.ncsl.org/>

The National Governor's Association
<https://www.nga.org>

The Northwest Area Foundation
<http://www.nwaf.org/>

Robert Wood Johnson Foundation
<http://www.rwjf.org>.

2004 Annual hawk-i Report, Iowa Department of Human Services
http://www.legis.state.ia.us/lsadocs/Docs_Filed/2005/DFJYD022.PDF

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http://www.dhs.state.ia.us/reports_pubs/hawki_annual/hawki_annual.html

2005 Iowa Mental Health Parity Legislation, House File 420
<http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=BillInfo&Service=Billbook&ga=81&menu=text&hbill=HF420>

2006 Annual hawk-i Report, Iowa Department of Human Services
http://www.dhs.state.ia.us/docs/hawk-i_2006.pdf

2006 IowaCare Act Legislation, House File 841
<http://www.legis.state.ia.us/asp/Cool-ICE/DisplayBills.htm>

2007-2008 Health and Human Services Budget, House File 909
<http://coolice.legis.state.ia.us/Cool-ICE/default.asp?Category=billinfo&Service=Billbook&menu=false&ga=82&hbill=HF909>

Child Welfare, Outcomes, Contracting, and Managed Care, Child and Family Policy Center
<http://www.cfpciowa.org/pdf/ChildWelfareMedicaidManagedCare.pdf>

Children's Health Coverage: States Moving Forward, Implications for SCHIP Reauthorization, Georgetown University Health Policy Institute, Center on Children and Families, May 2007
<https://gushare.georgetown.edu/HealthPolicyInstitute/CCF/Web%20Site/SCHIP%20Site%20Documents%20%28Public%29/StatesMovingForward.pdf>

Iowa Coalition on Mental Health and Aging Workgroup Reports
<http://www.public-health.uiowa.edu/icmha/>

Iowa Covering Kids and Families Now Task Force Issue Briefs
<http://www.idph.state.ia.us/coveringkids/taskforce.asp>

Iowa Legislative Services Agency Issue Review: IowaCare Program
<http://www.legis.state.ia.us/lsadocs/IssReview/2007/IRKRJ001.PDF>

Iowa Medicaid Reform Information

<http://www.ncsl.org/programs/health/iamedicaid.htm>

<http://staffweb.legis.state.ia.us/lfb/medicaid/FAQ.pdf>

<http://staffweb.legis.state.ia.us/lfb/medicaid/medicaid.htm>

<http://www.dhs.state.ia.us/dhs2005/ime/docs/IHPAF043.pdf>

http://www3.legis.state.ia.us/noba/data/81_HF841_SF.pdf;jsessionid=743FF301F6929950AAB868E4E3CD512E

http://www.dhs.state.ia.us/dhs2005/ime/docs/MACIT_MEDICAID_POLICY_CHANGE_HISTORY.doc

<http://www.cbpp.org/9-22-06health.htm>

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