

[CHAPTER SIX]

ANALYSIS OF REFORM OPTIONS
DEVELOPED BY OTHER STATES

States have significantly different levels of health insurance coverage due to differences in incomes, structure of employment (some states have more high-wage manufacturing and are more highly unionized), generosity of Medicaid and State Children's Health Insurance Program (SCHIP) eligibility levels, and even age. De-linking Medicaid from welfare in the 1980s opened up the possibility for some states to expand public health insurance coverage. Due to the relative prosperity of the 1990s, some of the impact of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the incentives afforded to states to expand children's coverage through SCHIP, a number of states were able to push their uninsured rates to nearly 10 percent or less. The economic slow-down since 2000 has had an impact on a number of states and led to cutbacks in SCHIP and Medicaid, and in some of the more innovative partnerships developed with private insurers and providers.

This paper summarizes some of the issues and options in health insurance coverage, and lists innovations adopted by several states in recent years to extend health insurance coverage to more people. Various aspects of health insurance coverage in Texas are studied, including demographics, Medicaid, SCHIP, small group incentives and private insurance regulation. Five states with different programs and varying levels of uninsurance, Maine, Florida, Arkansas, Colorado and Minnesota, are presented to examine the methods they have used to extend coverage. This paper concludes with some options that might work in Texas. Texas has the highest uninsur-

ance rate in the nation, so multiple initiatives will likely be needed to address the problem. This paper is an abbreviated version of the white paper "An Analysis of Reform Options Developed by Other States" by Warner et al. found in Appendix C.

ISSUES AND OPTIONS FOR EXTENDING COVERAGE

States have adopted a number of strategies in recent years in an attempt to extend or guarantee health insurance coverage to those who cannot otherwise obtain it. It is difficult to determine to what extent each of these strategies might reduce the number of uninsured, since more than one initiative is usually in place and working in tandem where these have been implemented. They are also subject to outside factors in the larger political and economic climate that affect industries, employment and insurance.

- *Develop premium assistance programs for an employer buy-in program for employees or dependents through SCHIP and Medicaid.* Six states currently have an SCHIP employer buy-in program (including one inactive), which lets SCHIP funds be used to help pay for employer-sponsored plans for eligible people when they have access to one and if enrollment would be more cost-effective than enrolling them in SCHIP (SCI, 2005a). Ten states, including Texas, have Medicaid Health Insurance Premium Payment (HIPP) programs. These programs are employer buy-in programs for Medicaid-eligible people with access to employer-sponsored insurance. They pay for premiums, coinsurance and deductibles, but only when proven cost-effective for the state (SCI, 2005a).

- *Allow families who do not qualify for SCHIP to buy SCHIP coverage at full price for their children.* Four states have a full-cost SCHIP buy-in program, including Florida, which lets higher-income families buy SCHIP coverage for their children at full premiums with no state subsidy (SCI, 2005b).
- *Establish reinsurance pools to partially subsidize small group insurance coverage or improve individual access to coverage.* Reinsurance pools are different from high risk pools in that they protect insurers from bearing the full cost of insuring individuals with high expenses. Reinsurance pools assume a portion of insurers' high-cost claims for individuals and/or groups, as well as help stabilize the market. At least 21 states have reinsurance pools, though many have very low enrollments or are inactive. Florida and Texas have active reinsurance pools, and Colorado and Minnesota have inactive ones (Chollet, 2004).
- *Pass legislation that permits the sale of limited-benefit policies that exclude a number of state-mandated benefits.* This lets insurers and thus employers offer lower-cost, less comprehensive insurance. The plans exclude some benefits and have high deductibles, limits on the number of doctor visits, and/or annual caps. Unfortunately, enrollees could develop serious medical conditions that exceed the coverage limits. At least 11 states have enacted or are considering legislation to allow insurance companies to sell limited-benefit policies to small groups, including Colorado, Florida, Minnesota and Texas (Friedenzohn, 2003). Texas law requires that all insurers that offer small-group coverage also offer limited-benefits policies. As of December 31, 2004, these plans had 14,000 enrollees in Texas, including 4,000 who were previously uninsured ("Insurers, enrollees," 2005).
- *Implement pared-down benefit packages for Medicaid or SCHIP expansion populations under HIFA (Health Insurance Flexibility and Accountability) waivers.* The HIFA demonstration

initiative is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources.

This approach is being further refined by the U.S. Department of Health and Human Services and HHS Secretary Mike Leavitt.

- *Allow group insurance purchasing arrangements or "pools" for small employers.* These pools seek to combine purchasing power and negotiate lower rates from insurance companies or health maintenance organizations (HMOs). The pools can be run by a state agency or established by individuals or employers, and may be for-profit or not-for-profit (Kofman, 2003). It is difficult to determine the exact numbers of these pools since there are different types and they do not have to register with any one authority. Texas used to have a state purchasing pool, and currently has several private pools. Small employers generally express interest in purchasing pools, but insurers are often not interested in working with them, as they fear adverse selection. (TDI, 2004).
- *Establish state-operated high-risk pools for people whose pre-existing conditions and medical costs make it impossible or too expensive for them to obtain coverage in the private market.* Funding for high-risk pools comes from government revenue or assessments on insurers. Thirty-two states operate high-risk pools, including Texas, Arkansas, Colorado, Florida and Minnesota (SCI, 2005c). The Texas program has increasingly become unaffordable for many, as the premiums have been increased to the maximum permissible.
- *Establish mandates for employers to provide health insurance.* Hawaii is the only state with an employer mandate currently in force. California passed the Health Insurance Act of 2003 in October 2003, but this example of a "pay or play" mandate was defeated by voters in a referendum in November 2004.

• *Establish state-only tax incentives that provide a tax deduction or credit to employers and individuals who purchase health insurance.*

Fifteen states including Maine and Colorado provide tax relief in one of these ways. Many of these states offer credits or deductions to the self-employed or individuals (and their spouses and dependents), while several offer them to small groups or other employers. Beneficiaries do not have to have low incomes to qualify for most tax incentive programs as long as they meet eligibility criteria (SCI, 2005d).

• *Regulate insurance rates for small groups.* Rates for small groups can vary widely depending on the characteristics of individual employees in the group since they are subject to individual underwriting (discussed in more detail in Chapter 10 “State Regulation of Health Insurance”).

Insurers can have quite a wide rate band for small employers. Rates are calculated on the anticipated risks of each individual, and thus insurance rates for small groups can vary significantly based on the factors of one or a few individuals in the group with higher risk (TDI, 2004). The most extreme example of regulation is community rating, where no adjustments for risk are allowed between different types of people, so everyone in a community pays the same rates, as implemented in New York State. Under modified community rating, insurers cannot vary premiums based on health status but can still use other factors like age and sex. In 2003, 47 states had regulations following one of these types of requirements, though the specifics of the regulations can vary widely. These included 35 states with different types of rate bands (including Texas), 10 states with modified community rating, and two states with pure community rating (GAO, 2003).

• *Implement guaranteed issue for individual policies.*

Guaranteed issue describes insurance coverage

that must be issued regardless of health status.

Only four states (Massachusetts, Maine, New Jersey and New York) have guaranteed issue for all individual insurance policies, though a number of other states have more limited forms. These include guaranteed issue for certain types of policies, by certain carriers, or for certain people such as HIPAA-eligible people (GUHPI, 2004). To be considered HIPAA-eligible, people must meet all the criteria set forth in the HIPAA legislation, such as not having other insurance, not being eligible for Medicaid or Medicare, and using up all COBRA benefits if offered (AIFS, 2005). COBRA is a requirement for most employers with group health plans to offer employees the opportunity to continue temporarily their group health care coverage under their employer’s plan if their coverage ceases due to termination, layoff or other change in employment status (referred to as “qualifying events”). Some feel that guaranteed issue without price controls or mandating coverage for everyone can be harmful, because it encourages people to seek insurance only when they think they will need it. This creates adverse selection and forces prices up, which causes more people to drop insurance, resulting in only the sick having insurance (CAHI, 2002; Garrett & Bradley, 2003).

Not all of these initiatives will work well in every state. Factors such as income levels, age distribution, number of immigrants, level of unionization, availability of public programs, and availability of employer-sponsored insurance influence the unique problems of each state’s uninsured population and which solutions might be more appropriate and effective.

INNOVATIONS IN OTHER STATES

Several states have developed their own unique or uncommon solutions to expand insurance. Some of these ideas are somewhat radical and may not work in other states for demographic or political reasons, but an overview of some of these initiatives could prove useful when considering creative options. New York State has passed a variety of proactive health insurance reforms, including guaranteed issue, community rating, and reinsurance plans. Eight states have obtained 1115 waivers to cover uninsured parents of SCHIP-eligible children. Utah received an 1115 waiver in 2002 to expend a limited Medicaid benefits package to low-income, previously ineligible adults. Maryland established a hospital cost containment program in 1974, setting rates for hospitals. This resulted in Maryland hospitals changing from the most costly to the most effective in the U.S. Details on these initiatives are available in the white paper in Appendix C.

PROFILES OF SELECTED STATES

It is useful to compare and contrast Texas to other states that differ in terms of income, percent uninsured, eligibility levels for public program, population and other factors. All of these states have used various means to reduce their uninsured rates. Florida, Arkansas, Colorado, Maine and Minnesota were chosen for different characteristics of their health insurance landscapes. These may not be similar to Texas, but a study of them can be helpful in terms of considering what might or might not work in Texas and why, or such questions as why poorer states like Arkansas and Maine have higher insured rates than Texas. Table I describes the demographic characteristics of the selected states. For comparison across the states, Medicaid eligibility criteria are presented in Table II, Medicaid financing strategies are in Table III, and characteristics of SCHIP eligibility for the selected states are in Table IV.

Table I: Demographics of Selected States

| State | 2003 Population | Median Household Income | 100 FPL | 100-199 FPL | ESI | II | Medicaid | Medicare | Uninsured |
|-----------|-----------------|-------------------------|---------|-------------|-----|----|----------|----------|-----------|
| Texas | 22.5 million | \$40,934 | 22% | 22% | 48% | 4% | 13% | 9% | 25% |
| Arkansas | 2.6 million | \$33,259 | 22% | 22% | 46% | 5% | 17% | 15% | 17% |
| Colorado | 4.6 million | \$50,224 | 13% | 17% | 58% | 6% | 11% | 9% | 17% |
| Florida | 16.6 million | \$38,572 | 17% | 20% | 48% | 6% | 12% | 16% | 18% |
| Maine | 1.3 million | \$37,619 | 15% | 20% | 51% | 5% | 18% | 15% | 11% |
| Minnesota | 5.0 million | \$54,480 | 9% | 15% | 65% | 6% | 10% | 10% | 8% |

Abbreviations: FPL- % of Federal Poverty Line; ESI- employer-sponsored insurance; II- individual insurance

Source: Kaiser Family Foundation, State Health Facts, available at <http://www.statehealthfacts.org>, accessed April 1, 2005. (Their source for the insurance data was the March 2003 and 2004 Current Population Surveys, conducted by the U.S. Census Bureau and based on self-reported data.)

Notes: Median Household Income is a yearly average from 2001-2003. Insurance categories may not add across exactly to 100 percent due to rounding, but they are intended to represent all insurance types. Medicaid/SCHIP category also includes military, veterans, and other types of public insurance, as well as people eligible for both Medicaid and Medicare. The Medicare category represents people with only Medicare, as well as people with Medicare plus private insurance.

Table II: Medicaid Eligibility for Selected States

| State | Eligibility Constraints | Pregnant Women | Nonworking Parents | Working Parents | On SSI | Children 0-1 | Children 1-5 | Children 6-19 |
|-----------|---|----------------|--------------------|-----------------|--------|--------------|--------------|---------------|
| Texas | TX does not extend Medicaid via COBRA 1986 to aged, blind, disabled with incomes up to 100% FPL | 185% | 14% | 23% | 74% | 185% | 133% | 100% |
| Arkansas | AR does not have eligibility extension to aged, blind, disabled. Medically Needy program limited to 22% FPL | 200% | 16% | 20% | 74% | 200% | 200% | 200% |
| Colorado | CO does not cover aged, blind, disabled. Covers up to 79% FPL for State Supplementary Payments (SSP) | 185% | 32% | 39% | 74% | 133% | 133% | 100% |
| Florida | 90% FPL for aged, blind, disabled | 185% | 23% | 62% | 74% | 200% | 133% | 100% |
| Maine | Single adults eligible up to 100% FPL | 200% | 150% | 150% | 100% | 200% | 150% | 150% |
| Minnesota | 95% for aged, blind disabled, 85% for SSP | 275% | 275% | 275% | 70% | 280% | 275% | 275% |

Source: Kaiser Family Foundation, State Health Facts, available at <http://www.statehealthfacts.org>, accessed April 1, 2005. (Their source for the insurance data was the March 2003 and 2004 Current Population Surveys, conducted by the U.S. Census Bureau and is based on self-reported data.)

Table III: Medicaid Financing for Selected States

| State | Financing Mechanisms | Matching Rate (2006) | Average Spending per Enrollee |
|-----------|--|----------------------|-------------------------------|
| Texas | State portion of funding comes mostly from general revenue (small part from tobacco funds, hospitals, FQHCs, and fees from ICF/MRs) | 60.66% | \$3,284 in 2003 |
| Arkansas | Proceeds of a soft drink tax since 1992 go directly to AR Medicaid Trust Fund. New income, cigarette and other tobacco taxes fund expenditures | 73.77% | \$2,966 in 2000 |
| Colorado | State portion comes from general revenue, sliding scale premiums and copayments, 2% provider tax, 1% premium tax on HMOs and other networks | 50.00% | \$4,624 in 2000 |
| Florida | State portion from general revenues, provider assessments, cigarette taxes, tobacco, non-general, fraud funds, and county funds | 50.89% | \$3,131 in 2000 |
| Maine | Medicaid expenditures accounted for 20% of general funds | 63.00% | \$6,249 in 2000 |
| Minnesota | State portion from sliding scale premiums and copayments and the Health Care Access Fund (funded by a 2% provider tax, 1% premium tax on HMOs and other networks, and other funds including general revenue) | 50.00% | \$5,418 in 2000 |

Abbreviations: FQHC- federally qualified health center; HMO- health maintenance organization

Source: Kaiser Family Foundation, State Health Facts, available at <http://www.statehealthfacts.org>, accessed April 1, 2005. (Their source for the insurance data was the March 2003 and 2004 Current Population Surveys, conducted by the U.S. Census Bureau and based on self-reported data.)

Table IV: SCHIP Characteristics of Selected States

| States | Eligibility | Federal Share | State Share | Enrollment |
|-----------|---|---------------|-------------|----------------|
| Texas | Younger than 19, legal resident, not Medicaid eligible, no private or state employee coverage, family income <200% FPL | 72.15% (2004) | 27.85% | 328,350 (2005) |
| Arkansas | Younger than 19, legal resident, not Medicaid eligible, no private or state employee coverage, family income <200% FPL | 82% (2005) | 18% | 1,912 (2002) |
| Colorado | Younger than 19, citizen or legal resident, not Medicaid eligible, no private or state employee coverage, family income <185% FPL | 65% (2005) | 35% | 49,978 (2003) |
| Florida | Younger than 19, citizen or legal resident, not Medicaid eligible, no private or state employee coverage, family income <200% FPL | 71% (2005) | 29% | 319,477 (2003) |
| Maine | Younger than 19, citizen or legal resident, not Medicaid eligible, no private or state employee coverage, family income <200% FPL | 75% (2005) | 24% | 13,085 (2003) |
| Minnesota | Younger than 19, citizen or legal resident, not Medicaid eligible, no private or state employee coverage, family income <200% FPL | 65% (2005) | 35% | 2,731 (2003) |

Source: Kaiser Family Foundation, *State Health Facts*, available at <http://www.statehealthfacts.org>, accessed April 1, 2005. (Their source for the insurance data was the March 2003 and 2004 Current Population Surveys, conducted by the U.S. Census Bureau and based on self-reported data.)

TEXAS

Private Insurance Regulation

Texas has an 11.3 percent HMO penetration rate, meaning that 11.3 percent of the Texas population is enrolled in an HMO. Regarding small-group market reforms (applies to groups of 2-50), Texas does not apply community rating, limits pre-existing condition exclusions (to 12 months exclusion and 6 months look-back time), and mandates guaranteed issue and guaranteed renewability (community rating, guaranteed issue and renewability are discussed at length in Chapter 10 “State Regulation of Health Insurance”). Regarding individual insurance market reforms, Texas does not apply community rating, does not limit pre-existing condition exclusions, does not mandate guaranteed

issue, and does mandate guaranteed renewability. For people who have been denied coverage or could not afford the coverage they were offered, Texas has a high-risk pool funded by premiums and assessments on insurers. The number of people who can afford the high risk pool, however, is limited since the premiums are set at 200 percent of commercial rates for an individual’s gender, age, and county of residence. The state mandates that patients have access to an external review board for filing complaints against their health plans, and mandates mental health parity of benefits (for “biologically-based mental illness”). Texas has a state COBRA expansion program of six months for small firms that are not covered by the federal COBRA law (KFF, 2005a).

Incentives for Small Groups

A statewide purchasing pool briefly existed. The law allows privately sponsored pools to form. As of September 2004 there was currently only one active fully insured alliance in Texas, with about 2,700 participants. Insurers expressed little interest in participating and did not think that purchasing pools would lower rates as much as expected. In 2003 the legislature authorized a new kind of purchasing pool called a health group cooperative, which can be made up of both small and large employers, and for which insurers can be exempted from having to provide all the state-mandated benefits (TDI, 2005a). As of March 2005, there was one health group cooperative registered with the Texas Department of Insurance, based in Dallas (TDI, 2005b).

Another option for small businesses is reinsurance. The Texas Health Reinsurance System was established in the Texas Insurance Code (Chapter 26, subchapter F) for small employer insurance carriers to reinsure risks covered under small employer health plans by spreading losses among members. Due to declining carrier participation in the system, it is being phased out.

Medicaid and SCHIP Initiatives

In Texas, 41.5 percent of Medicaid beneficiaries are enrolled in managed care, as compared to 60.2 percent for the U.S. as a whole (KFF, 2005a). Texas does not have an 1115 waiver and has not used Section 1931 to expand Medicaid coverage. The state has five 1915(b) Freedom of Choice Waivers and seven 1915(c) Home and Community-Based Services Waivers (THHSC, 2004). A bill for an 1115 women's health waiver was passed in the 2005 Texas Legislature. Texas is one of 10 states with a Health Insurance Premium Payment (HIPP) program. HIPP is a Medicaid program that

pays for private health insurance premiums (like employer-sponsored insurance), coinsurance, and deductibles for Medicaid-eligible people and their families, when it is shown to be cost-effective. Texas offers 18 months extended eligibility for Transitional Medicaid Assistance (TMA), past the required 12 months (SCI, 2005e).

FLORIDA

Private Insurance Regulation

Florida has a 25.2 percent HMO penetration rate. Regarding small-group market reforms (applies to groups of 1-50), Florida applies community rating, limits pre-existing condition exclusions (to 12 months exclusion and 6 months look-back time), and mandates guaranteed issue (through a high-risk pool) and guaranteed renewability. Regarding individual insurance market reforms, Florida does not apply community rating, limits pre-existing condition exclusions, and mandates guaranteed issue (through a high-risk pool) and guaranteed renewability. Florida has a state-sponsored high-risk pool with 638 enrollees as of December 2002. Florida has a state COBRA expansion program to 18 months for small firms (KFF, 2005b).

Incentives for Small Groups

The Governor's Task Force on Access to Affordable Health Insurance, created in 2003, recommended that Florida establish purchasing pools for small groups (2-25), and the Small Employers Access Program was implemented by the Florida legislature in 2004. Florida's Health Care and Insurance Reform Act of 1993 created 11 Community Health Purchasing Alliances (CHPAs) and implemented other significant insurance reforms on the small group market (FAHCA, 2003). Other reforms were adopted at the same time, including guaranteed availability to small employers and

modified community rating, requiring carriers to pool their small groups for rating purposes. These made the CHPAs not as important. They had a costly infrastructure and carriers began to drop out by 1997. They were repealed in 2003 and replaced with Health Care Alliances, which were also not embraced by insurers (HMA, 2004).

Medicaid and SCHIP Initiatives

In Florida, 64.3 percent of Medicaid beneficiaries are enrolled in managed care (KFF, 2005b). Florida has a family planning waiver that extends family planning services for up to two years for women who were pregnant and on Medicaid and who would have lost these services 60 days postpartum (KFF, 2005c). Florida has used Section 1931 to expand Medicaid coverage by increasing income disregards.

Not counting waivers that are pending or have expired, Florida currently has two 1915(b) Freedom of Choice Waivers (for children's inpatient psychiatric services and for non-emergency transportation). Florida has three current 1915(c) Home and Community-Based Services Waivers, for disability services, brain and spinal injuries and cystic fibrosis. The state has three 1115 waivers: the family planning waiver, a waiver for a pharmacy program for Medicare recipients, and a cash and counseling program (CMS, 2005a).

Other Health Insurance Reforms/Initiatives

Florida Governor Jeb Bush recently proposed, and the Centers for Medicare and Medicaid Services (CMS) approved, a fundamental restructuring of Florida's Medicaid program to control growing costs. He and his staff outlined a program where the state would pay the premiums for Medicaid beneficiaries to enroll in private health plans offered by insurance companies and HMOs, including

an employer's plan if a beneficiary has access to employer-sponsored insurance. Gov. Bush said the state can predict and control costs better by calculating a premium for each Medicaid patient and allowing for an appropriate rate of growth.

In May 2005, the legislature passed Senate Bill 838, which allows pilot projects in five Florida counties to test Governor Bush's managed-care-only Medicaid model, after a federal waiver is obtained. The Florida Agency for Health Care Administration can still request a waiver to implement the governor's full program, but the bill requires the legislature approve the implementation in the state of any waiver that CMS approves for the pilot project (Hirth, 2005).

ARKANSAS

Private Insurance Regulation

Arkansas has a 7.0 percent HMO penetration rate. Regarding small-group market reforms (applies to groups of 2-50), Arkansas does not apply community rating, limits pre-existing condition exclusions (to 12 months exclusion and 6 months look-back time), and mandates guaranteed issue and guaranteed renewability. Regarding individual insurance market reforms, Arkansas does not apply community rating, does not limit pre-existing condition exclusions, and mandates guaranteed issue and guaranteed renewability. Arkansas has a high risk pool funded by premiums and assessments on insurers. Arkansas has a state COBRA expansion program, up to 120 days, for small firms (KFF, 2005d).

Incentives for Small Groups

In 2001, the Arkansas General Assembly passed several health reforms targeting access for individuals. The reforms included scaled-down insurance policies (exemption from state-mandated coverage

benefits), small-employer purchasing groups, and a demonstration project allowing communities to self-insure to provide coverage (SCI, 2003).

Medicaid and SCHIP Initiatives

In Arkansas, 69.4 percent of Medicaid beneficiaries are enrolled in managed care, as compared to 60.2 for the U.S. as a whole. Arkansas has a family planning waiver that extends family planning services to women up to 200 percent FPL (KFF, 2005d). Arkansas has used Section 1931 to expand Medicaid coverage by increasing income disregards; the state may disregard a family's first \$120 in monthly earnings and one-third of the remaining monthly earnings before calculating if families' incomes are below the eligibility level to qualify for Medicaid (SCI, 2005d). Arkansas has various 1915 and 1115 waivers; details are available in Appendix C.

Other Health Insurance Reforms/Initiatives

Despite its history as a state with a high percentage of low-income individuals, low levels of employer-sponsored insurance, low Medicaid coverage for adults, and relatively poor health status, Arkansas has more recently been noted for its pursuit of coverage expansion. Arkansas' Medicaid expansion, ARkids B, which expanded eligibility to currently uninsured children through age 18 with family income at or below 200 percent FPL, has been considered a considerably progressive initiative. A component in the success of Arkansas' expansion efforts appears to be the Arkansas Center for Health Improvement, a joint project of the Arkansas Department of Health and the University of Arkansas for Medical Services created to provide support for state and local policy development and implementation (SCI, 2003).

COLORADO

Private Insurance Regulation

Colorado has a 27.2 percent HMO penetration rate. Regarding small-group market reforms (applies to groups of 1-50), Colorado does apply community rating, limits pre-existing condition exclusions (to 6 months exclusion and 6 months look-back time), and mandates guaranteed issue and guaranteed renewability. Regarding individual insurance market reforms, Colorado does not apply community rating, does not limit pre-existing condition exclusions, and mandates guaranteed issue and guaranteed renewability. Colorado has a high risk pool called CoverColorado funded by the unclaimed property trust fund, premiums, the CoverColorado cash fund, and assessments on insurers. The state mandates that patients have access to an external review board for filing complaints against their health plans, and mandates mental health parity of benefits. Colorado has a state COBRA expansion program to 18 months for small firms (KFF, 2005e).

Incentives for Small Groups

Colorado's small group reforms began in 1995. Currently, all small groups with 2 to 50 employees can purchase one of two plans (Basic and Standard) that have to be offered by all small group carriers, regardless of employee health status. Self-employed persons, referred to as a "Business Group of One" (BG1), also fall into the definition of small group. To qualify as a BG1, an individual must provide detailed documentation of sole proprietorship status (CHI, 2005). Guarantee issue is required of all small group plans offered in the state, not just the Basic and Standard plans.

SCHIP and Medicaid Initiatives

In 2003, 95.3 percent of Colorado's Medicaid beneficiaries were enrolled in managed care, as compared to 60.2 for the U.S. as a whole (KFF, 2005e). This rate has dropped significantly to date after the state had problems negotiating rates with the managed care organizations (MCOs). Several MCOs filed lawsuits against the state citing inappropriate rate-setting, leading to state officials' disenchantment with MCOs and a dramatic move towards fee-for-service. Information on other waivers in the state is available in Appendix C.

Other Health Insurance Reforms/Initiatives in the State

In 2003, the state began considering applying for a HIFA waiver to streamline Medicaid, CHP+, and the Colorado Indigent Care Program (CICP), with the goal of improving access and coverage for Colorado's low-income children and families. The concept of streamlining consists of merging benefit packages, delivery systems, risk arrangements for vendors and providers, and administrative management of these programs while maintaining budget neutrality and without reducing eligibility or benefits. The state obtained a HRSA grant as well as funding from several state foundations to conduct studies and analyses.

MAINE

Private Insurance Regulation

There is no separate high risk pool. There is a modified community rating system; insurance companies are permitted to vary premiums for coverage based on certain characteristics (e.g., age, location and type of employment), but they cannot vary premiums based on the health status or claims history of policy (MOG, 2004). There is a state rate review of individual and small group plans. Limited premium increases are allowed among

Maine's small group market. At least 78 cents of every premium dollar increase must be spent on medical claims (MOG, 2004). Insurers are required to report administrative costs and underwriting gain. Insurers are asked to voluntarily limit operating margins to 3.5 percent. Insurance companies will pay up to 4 percent of annual gross revenues.

Incentives for Small Groups

Small-group employers will be able to offer insurance at a reasonable price.

SCHIP and Medicaid Initiatives

In June 2003, Maine passed the Dirigo Health Reform Act "to make quality, affordable health care available to every Maine citizen within five years and to initiate new processes for containing costs and improving health care quality" (Rosenthal & Pernice, 2004). The program aims to ensure access to coverage to as many as 180,000 state residents by 2009, specifically targeting small-business employees, the self-employed and individuals (SCI, 2005c). The cornerstone of the act is the Dirigo Health Plan (DHP), a statewide voluntary health insurance program aimed at offering comprehensive health care through MaineCare (the state's Medicaid program) and private insurance carriers. The program largely depends on the success of several cost savings measures being implemented by the state. The success of the program is also dependent on the willingness of small businesses to participate in the plan. Details of the plan are available in the white paper in Appendix C.

MINNESOTA

Private Insurance Regulation

Minnesota has a 26.7 percent HMO penetration rate. Regarding small-group market reforms (applies

to groups of 2–50), Minnesota does not apply community rating, limits pre-existing condition exclusions (to 12 months exclusion and 6 months look-back time), and mandates guaranteed issue and guaranteed renewability. Regarding individual insurance market reforms, Minnesota does not apply community rating, limits pre-existing condition exclusions, and mandates guaranteed issue and guaranteed renewability. Minnesota has a high-risk pool funded by premiums, assessments on insurers, and state appropriations (KFF, 2005e). It currently has about 30,000 enrollees (MCHA, 2005). The state mandates that patients have access to an external review board for filing complaints against their health plans, and mandates mental health parity of benefits. Minnesota has a state COBRA expansion program to 18 months for small firms (KFF, 2005e).

Incentives for Small Groups

In 2001 the Minnesota legislature passed an initiative to form a reinsurance fund for businesses with 10 or fewer employees that would cover 90 percent of claims from \$30,000 to \$100,000 (Sacks et al., 2002). As of October 2004 it was considered inactive.

Medicaid and SCHIP Initiatives

In Minnesota, 63.9 percent of Medicaid beneficiaries are enrolled in managed care, as compared to 60.2 for the U.S. as a whole. Minnesota has a family planning waiver that extends family planning services to men and women up to 200 percent FPL (KFF, 2005e). Minnesota has used Section 1931 to expand Medicaid coverage by increasing income disregards; the state may disregard a family's first \$120 in monthly earnings and one-third of the remaining monthly earnings before calculating if families' incomes are below the eligibility level to qualify for Medicaid (SCI, 2005d). Minnesota has received one 1915(b) Freedom of Choice Waiver (for

chemical dependency treatment) and five 1915(c) Home and Community-Based Services Waivers. The state has received three 1115 waivers: the family planning waiver, a waiver for managed care (called Minnesota Prepaid Medical Assistance Project Plus), and a waiver for MinnesotaCare, a managed care program (CMS, 2005b).

Other Health Insurance Reforms/Initiatives

Minnesota is a national leader in efforts to cover low-income uninsured people, which is why it has one of the lowest uninsured rates in the U.S. Besides MinnesotaCare, the state has General Assistance Medical Care (GAMC), a free program for very low-income adults between the ages of 21 and 64 with no children under age 19 who are not eligible for any other state or federal programs and meet other criteria. The program is administered by counties.

MODELS FOR TEXAS

This chapter examined some of the issues in health insurance coverage in Texas, and options that have been adopted in other states that could be applied in Texas. Many models and strategies used to increase the number of people with health insurance in other states are unlikely to work in Texas due to the political climate, economy, types of industries and large population in Texas. Since Texas has the highest percentage of uninsured residents in the nation, it will take more than one strategy to solve the problem.

There are a variety of steps that Texas could take to better address the issue. Texas could restore the Medicaid Medically Needy spend-down program for non-pregnant people so anyone with a major medical condition facing large medical bills could get emergency coverage if needed. This

measure would lessen hardship and bankruptcy from medical bills. Another option for the state is to let sole proprietors buy into group plans. Texas could increase funding for the high risk pool to subsidize premiums, since they are unaffordable for many of the uninsured. SCHIP funds could be used to implement an employer buy-in and a full-cost buy-in for SCHIP insurance. Lastly, the state should work to obtain more federal dollars. One method would be to apply for a 1931 Waiver to cover parents of low-income families with children who are not otherwise covered by Medicaid. This could significantly reduce the number of uninsured.

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